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## **CPCAB Response to Psychological Therapies Consultation**

This response was arrived at by consultation and consensus among the counselling professional employees within the organisation. CPCAB is a specialist awarding body that designs, develops and delivers counselling qualifications through registered centres mostly in the FE sector up to Level 6. We register approximately 10,000 candidates per annum. We are regulated by QCA. Some centres running our qualifications also have BACP accreditation for their training courses.

All counselling professionals employed at CPCAB are also practising counsellors, psychotherapists and counselling psychologists who are accredited with BACP, UKCP or BPS. They are also experienced supervisors and trainers. The therapeutic models represented in the team include humanistic, person-centred, psychodynamic, transpersonal and integrative.

Our qualifications are unique in that they are designed using generic assessment criteria that can be delivered within different counselling approaches, models and modalities and maintain an emphasis on relationship and interpersonal qualities as well as skills.

The consultation paper was circulated to all members for comment then a joint meeting was held to collate our response.

### **General comments**

CPCAB believes that this is a very important consultation and we would like to commend Skills for Health for grasping this particularly difficult nettle. We would like to be centrally involved and contribute to any further project work to take this forward because of its central importance to establishing shared standards which the public can have confidence in.

### **Scope of standards**

It is not clear at this stage whether these standards will compliment or replace the counselling NOS. This is a crucial point as our response would be different for these

two eventualities. We understand, however, that this will depend on the outcome of this consultation. In the meantime we have responded from the standpoint that these standards will “cover” counselling and await further clarification.

### **Expressing Therapy as competencies**

When experienced therapists work with clients – whatever the model of therapy being used – the work is best understood in terms of a highly complex multi-layered parallel processing system. Successful interventions are often “intuitive” in the moment to moment of relating to another human being. This does not make the intervention random but rather the product of learning, experience, empathic responsiveness, nonverbal forms of communication and other interrelated complex processes. The ability to use measurable skills is part of this process but is not in itself the sum total of the process. A useful analogy from the electronic world might be the difference between “machine code” and “software applications” – one is basic the other highly sophisticated. The standards as they appear in this consultation are far more like machine code than complex software applications – they address the therapeutic activity at the wrong level and the result misses the core sense of how therapy (whatever model) helps people to change. It also results in a strange imbalance where the nuts and bolts of what must be “done” for the work to go ahead has greater weight when expressed in standards than the work itself. E.g. what is described on p12 no. 2.1 is probably the most important part of the section (“*Create and maintain a relationship and environment that allows the patient/client to collaborate in the therapy*”) yet this crucial process is undefined and overshadowed by all the “must do” activities which follow. The “must do” activities are not wrong (although we would take issue with the language) but the balance is wrong.

This does **not** mean that we believe that therapy is a mystery which cannot be broken down into competencies and standards but it does mean that the terms used to capture the competencies needs to be at a “higher level”, “softer” and more “engaged” in flavour; by “engaged” we mean expression the relational nature of the activity. This will then filter down to the knowledge and understanding which underpins the standards. (e.g. P6 1.8.1 is an example of good engaged language but 1.8.1 and 1.8.2 are mechanistic and unengaged).

### **Medical/mechanistic model versus the relational model**

Your paper states (p.7 no. 3) that you do not want this to be a “mechanistic” model - which is traditionally focussed on symptom relief and yet the approach and language are essentially mechanistic. Words like treatment and problem are controversial. Most counselling approaches would see client difficulties as problems within the “self”<sup>1</sup> which are manifest/expressed in symptoms. In this context medical symptoms are signposts to difficulties - not the problem per se. In therapeutic terms removal of the presenting symptoms is achieved through resolution of the underlying ‘problem within the self’. The work is not necessarily on the simple removal of a symptom. There is room for different emphasis and different approaches particularly given the diversity of human beings and their needs. However, the example before us conveys very little sense of the difference and diversity of individual clients and their different forms of distress

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<sup>1</sup> Self in context of relationships with other selves (past, present and fantasised)

experienced as human beings – making them sound more like machines that have “gone wrong”.

In addition, much of the work of counselling is preventative in its function. As a result of working on self, further symptoms are prevented.

### **Importance of relationship**

To continue this theme; the consultation document places very little emphasis on the quality of the therapeutic relationship which research conclusively shows to be the **single most effective factor** in therapeutic change whatever the model/approach being used. This is a key issue which should be reflected in the standards. The personal qualities of therapists and their ability to work “in relationship” are as important as the “skills” they learn.<sup>2</sup> This is true of all therapists whatever their model although some approaches clearly put greater emphasis on these qualities as part of the way they work. This is also a key issue for employers and providers who want **relational** competency not just skills. Assessing these “soft” skills and finding a language to include them in the standards is not easy but it cannot be ignored.

### **Need for generic standards across approaches**

We fundamentally challenge the assumption that it is not possible to write generic standards for all therapies as (a) it will never be possible to cover all the models/approaches and (b) new ones will continue to emerge and multiply– which is a good thing and a direct result of evidence based practice. Furthermore many/most counsellors work integratively.

The key here is to focus on the counsellor’s competence within their own theoretical framework (and associated skills/ techniques/ways of being) both in working with the client’s presenting issues for the clients benefit and being able to explain, reflect and improve their own professional performance. All approaches must embrace the need for observable outcomes – although the language for expressing and measuring these outcomes will be different.

It is possible to find language that does not exclude/alienate particular groups. For example:

- Establish a therapeutic relationship with your client
- Establish an agreement to work together which meets the client’s needs
- Use a coherent theory of counselling and personal psychological history to understand your client’s issue(s)
- Use counselling skills and interventions associated with your theoretical model to enhance your client work
- Use a coherent theory of counselling and the counselling relationship to understand and work with common mental health problems

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<sup>2</sup> Humanistic Psychotherapies: Handbook of Research and Practice.by [David J. Cain](#) (Editor), [Julius Seeman](#) (Editor), American Psychological Association (31 Aug 2001)

- Use a coherent theory of counselling and the counselling relationship to understand and work with common life problems
- Use a coherent theory of the therapeutic relationship to enhance your client work
- Use supervision and self reflection to work more effectively for the benefit of client
- Evaluate the effectiveness of your client work using established principles/methods consistent with your counselling approach
- Skilful use of self and self awareness (etc. etc)

We wonder also whether use of terms “approach” and “model” could be defined more carefully as it can lead to ambiguity eg in 2.5 and 2.6 where it is not clear whether “approach” means theoretical approach or “response” to client. (see comments in that section).

Specific responses to the questions in the consultation follow:

### **Question 1**

Yes counsellors and therapists do all these things but ... see below

### **Question 2**

We do not feel that any attention has been give to establishing the **professional and ethical framework** within which the therapy takes place. The consultation document mentions (p11 point 6) that these aspects are covered by other NOS. This needs clarification. The key issue is **working safely**.

#### **Work safely**

- Work within an ethical and legal framework for counselling
- Assess the client’s needs/risk in relation to what you can offer and support referral if indicated

We feel it is important to stress not just “work” and the “working alliance” but the **therapeutic relationship** even at this macro level.

#### **Establish the relationship**

- Negotiate a user-centred contract
- Establish a therapeutic relationship

#### **The Therapeutic Work**

- Work within a theoretical framework
- Use understanding and skills to work therapeutically
- Work with difference and diversity (*there needs to be something about the need for empathic understanding of and respect for individuality*)

- Work with Self-awareness (*the therapist needs to be aware of themselves and their own impact on the client even in the most cognitive/rational approaches. This central to most humanistic approaches*)

### **End/Referral**

- End the therapeutic relationship safely
- Use professional judgement to make referrals where appropriate

### **Evaluation/Support**

- Use supervision to support and enhance your work
- Evaluate the effectiveness of your client work using established principles/methods consistent with your counselling approach

## **Question 3**

At this level of heading it is difficult to see anything that is not relevant. However please see responses below to example standards on p.12 which expand this section.

### **1. Preparation – starting the therapy**

NB. see earlier comments about need for a professional framework for counselling.

We agree on the need to have tools for assessing client need and difficulty in relation to models for understanding and working with presenting issues.

1.1 Different approaches will view client problems in different ways and have different strategies for working with clients on particular issues. These are equally valid. What is important is that the counsellor is clear about how they work, how that relates to the problem, how it might help and be able to negotiate with the client whether there is a match between what they can offer and what the client is looking for/needs.

Perhaps language which is more applicable across different approaches could be: “Use knowledge and skilfulness grounded in theoretical understanding to respond to the client’s difficulties”

For this reason the whole issue of “referral” (how, why, what) needs to be included as part of assessment (at the beginning, not just at the end) which is not just about the level of client distress/ability to engage/mental health assessment/safety etc but the match between the therapy being offered and the client’s need.

1.2 Client are not usually able to make choices about what therapy would best suit them – and the reality is that there is often no choice anyway. It does help however if the therapist is clear about whether they can help and what the “therapy” will involve. Research shows the relationship is more important than the approach used. (see also 1.1)

1.3 How important this step is at the beginning stage will depend on your model but it could be useful. There could be a discussion on when therapy is judged to have started!

1.4 Assessment of the client against a theoretical/evidential model is important. Perhaps the word “using” rather than “against” allows for a wider inclusion of approaches and models.

1.5 Language like “plan a programme or strategy of treatment with the patient” is rooted in a cognitive/behavioural model - although therapists will agree that they work with a therapeutic process in which they have an informed understanding. (See general comments about mechanistic versus relational approach)

1.6 Agree with “idea” but unhappy about the language see 1.2

1.7 and 1.8 could be merged into “Reaching agreement/contract and establish the boundaries for working together”

1.9 Already covered by 1.1 and 1.2 if well done. “Agree goals”: the notion of ‘goals’ is very behavioural but it is important to have a clear idea of what is being undertaken in the therapy whatever language is used. eg the person centred approach has an underlying ‘goal’ of enabling the client to be more in touch with their organismic self but this is not expressed as an explicit goal at the outset of therapy and the word “goals” jars because of the nature of this process.

Goal implies a “fixed place” to be reached which the therapist somehow determines – this is at odds with many approaches which leave the direction with the client and puts value on “not knowing”. In the psychodynamic approach (where the work is focussed on making the unconscious conscious) it is important that goals are unknown at the outset on the basis that often we do not know what we really want because defense mechanisms keep this in the unconscious.

Hope and realistic expectations: important research shows that having “magical” expectations is an important part of creating impetus for change (see James Mann : Time Limited Therapy). In that model dealing with reality of what can be done is a step which is addressed later on in the therapy. “Engendering hope and realistic expectations” are therefore not necessarily an important part of starting therapy. Furthermore, it would be totally antithetical in some approaches where the client would be encouraged to face their despair rather than focus on the positive.

1.10 Perhaps it is important to include “risk assessment” with regard to client safety/harm to others (which is different from the risks of therapy). There should be clear standards about how to make risk assessment (albeit in different ways within different approaches) and a standard for making referral at this stage if indicated.

## **2. The therapeutic work**

This section appears to give a quite mechanistic description of working with a human being and does not convey what is required to work sensitively and effectively with vulnerable people in a way that encourages them to grow, change and develop (regardless of the approach being used). The barrier of language is often why it has been so difficult to find common ground between different approaches.

**However, what lies behind this language is common to all:**

The need to work with evidence-based practice<sup>3</sup>

The need to review and evaluate the progress of the therapy

The need to work in ways that are consistent with a sound theoretical approach in

- the use of skills
- understanding of common mental health problems
- an understanding of the therapeutic relationship
- an understanding of the therapeutic process and how this facilitates change
- working with the clients personal history
- working with the client's patterns of relating (explicit and implicit)
- working with and understanding of the "self"

The need to create safety so the client can work with vulnerable aspects of self

The need to stay focussed on the client's agenda

The need to help the client explore blocks to change

The need to examine and work through counsellor's own blocks and prejudices

The need to work through difficulties in the relationship

The need to maintain professional boundaries throughout the therapy (see comment in section 4 below)

The need to work towards change

In addition:

2.1 See comments above which suggest the importance of describing this sensitive work. See general comments under Underlying Assumptions.

2.2 Suggest this is covered first in 1.4 and then in 2.10.

2.3 Would prefer not to have language like "formulate" and also this belongs better in the starting section.

2.4 This is fine though "difficulties" might be more open than "problems", assuming this means difficulties in the relationship not the client's difficulties.

2.5/2.6 There was some worry that this criteria could imply that therapists change their approach if one method doesn't work – which given the difficulty of sound theoretical

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<sup>3</sup> "Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients" John C. Norcross, OUP Inc, USA (30 Sep 2002). See Appendix 1

training can be a problem. However, if it is intending to convey the fact that the therapist mindfully (or from a sound theoretical basis) adapts their response to the client – this is fine but the language may need tweaking.

2.7 -2.15 Agree with all these processes but see comments and suggestions at beginning of this section.

But also:

2.14 An important point which we agreed with. Just to note that supervision can have a much wider remit. Counselling supervision would normally include support for the therapist, raising personal awareness, sharing learning, professional development as well as addressing difficulties, stuckness etc. See comments in Section 4.

Finally: working with self-reflection and self-awareness are important in all approaches but to differing degrees and needs to be **specifically** mentioned.

### **3. Ending the Therapy**

This section is OK. Our only comment would be that “relapse” is a problem-oriented word which can sound mechanistic. Some orientations would also value this as a “revisiting” of core work.

### **4. Evaluation**

This section is fine. However, the aspect that seems to be missing is both reflection on skilful use of self and self awareness.

Also continuing the theme of generic standards it might be useful to add something in the evaluation criteria (4.1 and 4.2) which recognises that the tools for evaluating effectiveness could be wide and varied but need to be consistent with the therapist’s approach.

Suggestions here could be:

- Use self awareness and self reflection to enhance your client work
- Use supervision to support/enhance your client work
- Use supervision to address and work through difficulties in your client work
- Evaluate the effectiveness of your client work using established principles/methods consistent with your counselling approach

4.4 We don’t understand why this appears here. It’s not really part of evaluation and a counsellor would not normally “supervise another therapist” unless they had undertaken supervision training. This requires a different set of standards altogether.

4.5 This seems very late in the day to mention maintaining boundaries. This falls more logically into “the therapeutic work” section 2.

#### **Question 4**

Our suggestions are already covered in the general comments section and questions 2 and 3 where we have made suggestions.

#### **Question 5**

Not really clear what this question is asking but I don't think so.

#### **Question 6**

See comments already made on professional and legal framework.

Many humanistic approaches need to include greater understanding of common mental health problems and mental health frameworks and how other related services/job roles within multidisciplinary teams do/do not relate to each other. Training in these approaches can sometimes encourage a lack of attention to the context in which counselling takes place, particularly in the public sector. Having standards which encourage these issues to be addressed would be useful for signposting in all counselling qualifications. eg demonstrate an understanding of mental health frameworks

#### **Question 7**

There has been an increase in the demand for therapy and for higher quality provision and the attempt to meet this demand has resulted in practitioners from very different backgrounds (mental health and counselling) moving into the same practitioner space. This has highlighted the inevitable tension between science (as exemplified by the medical model) and practitioner "art" (as expressed in many counselling models). However, this development is welcome and important because it throws into sharp relief the much bigger debate about what makes people ill and how to help them get well<sup>4</sup> and offers the opportunity to bring together the best from both approaches.

This scoping project to develop competencies for psychological therapy is in itself an expression of this shift in the psychological therapy landscape and the challenges that this presents.

It will be a major service to the field if this project can enable us to work on our differences in order to develop a shared understanding of what all psychological therapists have in common rather than what divides them.

#### **Question 8**

We would like to contribute in any way we can. We attach the generic assessment criteria which we have developed for our Diploma in Therapeutic Counselling as an

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<sup>4</sup> See Why Do People Get Ill (Hamish Hamilton) by D. Leader and D. Corfield

example of generic standards which are being used by centres teaching different counselling models (including CBT). We recognise that these could be improved particularly if they are to be widened to include all psychological therapies. It would make a great deal of sense if our qualifications could be mapped directly to the relevant psychological therapy NOS (both in terms of qualification design and more importantly for ensuring that our qualifications meet the needs of the sector).

We have ready access to tutors/trainers (approximately 400 active at present) who are also practitioners and could arrange a working group to comment on new standards as well as pilot the utility of mapping counselling qualifications to any new draft standards for psychological therapy.

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23rd February 2007

## Appendix 1

Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients"

John C. Norcross

Oxford University Press Inc, USA (30 Sep 2002)

### Synopsis

Many efforts to improve therapy have focused on codifying evidence-based treatments, but in doing so have left the psychotherapeutic relationship behind. *Psychotherapy Relationships That Work* is the first book to assemble the numerous advances in understanding the critical relationship between the clinician and the patient into one accessible volume. The volume brings together a distinguished group of psychologists to take stock of which elements of the therapy relationship work, which look promising, and how relationships can be customised to the individual patient. **It represents the culmination of three years of systematic analysis on the part of the APA Division 29 Task Force on Empirically Supported Therapy Relationships to identify, operationalize, and disseminate information on empirically supported therapy relationships. These eminent researchers and clinicians examined the empirical research done to date that illuminates the therapeutic relationship as well as the evidence-based practices that may be used to cultivate and customise that relationship.** Each chapter defines the relationship or patient quality - such as empathy, congruence, or attachment style - provides clinical examples, reviews the empirical research and highlights therapeutic practices ensuing from the research results. The volume concludes with recommendations and a discussion of the implications for future training, research and policy. *Psychotherapy Relationships That Work* will be an indispensable reference for all mental health practitioners, including psychiatrists, psychologists, clinical social workers, counselors and mental health consultants.

Humanistic Psychotherapies: Handbook of Research and Practice

by [David J. Cain](#) (Editor), [Julius Seeman](#) (Editor)

American Psychological Association (31 Aug 2001)

### Synopsis

A compendium of research and practice techniques in the field of humanistic psychotherapies. In addition to the editors' comprehensive overview of the history, defining characteristics and evolution of humanistic psychotherapies, the contributors illustrate significant research results in the last decades and document the effectiveness of major humanistic therapeutic approaches, including client-centred, Gestalt, existential and experiential. The research presented shows these approaches to be equivalent and, in many cases, superior to others in treating a wide range of psychopathology. Contributors also offer guidelines for practice and introduce innovative methods for working with an increasingly difficult, diverse and complex range of individuals, couples, families and groups. There are chapters focusing on empirical evidence from humanistic psychotherapeutic practice that demonstrate the importance of the psychotherapeutic relationship and therapist empathy in effecting successful client outcome. Also stressed is the effectiveness of humanistic psychotherapies in establishing methods for working with client emotion and enabling patients with severe disabilities such as schizophrenia to progress in their development and functioning.