

Chapter 1

The nature and the role of counselling in primary care

Tim Bond

Introduction

The development of counselling services in primary health care is at a critical and fairly unpredictable phase. By 2000, it was estimated that over half the practices in Britain had counsellors as members of the primary care team (Mellor-Clark *et al.*, 2001). The introduction of primary care group purchasing has created a period of uncertainty and change, with some practices losing counselling services either temporarily or in the longer term. Equally, in some areas, there has been a growth in provision with counselling being made available to more practices. The management of counselling services also appears to be changing with a trend towards delivering counselling within psychological therapy teams through mental health trusts. Coincidental with all these changes are strong indications that government is determined to introduce statutory regulations for the psychological therapies. This has inevitably sharpened the competition for territory and status between the different professional bodies brought together under this broad title in ways reminiscent of the regulation of medicine in the nineteenth century. At the time of writing (2001) it is difficult to see how this combination of circumstances will unfold, other than to say that the provision of counselling may look very different in five years' time. One of the immediate effects is to sharpen attention on the relationship between counselling, counselling psychology and psychotherapy. The providers of counselling in primary care are rapidly becoming more attentive to professional requirements determined by one or more of the relevant national bodies, namely the British Association for Counselling and Psychotherapy (BACP), the British Psychological Society (BPS) and the United Kingdom Council for Psychotherapy (UKCP).

In this chapter, I will be seeking to cast some light on what frequently seems to those outside, and often to those inside, the field to be rather abstruse and arcane differences between counselling, counselling psychology and psychotherapy. One further trend is noteworthy. Counselling in primary care and in health settings in general is becoming a specialism within its own right. Arguably, large professional bodies covering a full range of counselling in a wide variety of settings have struggled to keep pace with the rapidity of developments in this sector. BACP has developed a Faculty of Healthcare Counsellors and Psychotherapists to address this need. A parallel organization has grown out of the Counselling in Primary Care Trust—the Association of

Counsellors and Psychotherapists in Primary Care. Both bodies have been active in monitoring and responding to the rapidly changing circumstances of their members.

My experience of talking to GPs, primary care staff and the providers of services that are the subject of this book suggests that 'counselling' will remain the popular generic title for the provision of systematic consultations in primary care for addressing emotional, psychological and social issues that influence a person's health and well-being. Although I am not aware of any research on the subject, it appears that counselling is perceived by patients and some staff as less stigmatizing or pathologizing than referral to psychology, psychotherapy and, especially, psychiatry. This is in part due to the stigma and fear of mental illness. Perhaps more significantly, counselling is a term that is more wide ranging and includes assistance with difficulties arising in everyday life which do not necessarily imply any deficiency in the person affected. The potential for a wide range of applications of a generally popular term can become a source of confusion. Although there are numerous different meanings given to counselling in medical settings, I think most of the confusion around 'counselling' arises from three different usages, which are mutually incompatible. Because the same term is used for each of these different activities, it is very easy for two people to assume they are talking about the same thing when this is not the case. I have heard health workers talking about 'the desirability of a patient receiving counselling' and for the conversation to go on for some minutes before it becomes apparent that one person is advocating a series of sessions of psychosocial support to help with a general mood of anxiety and depression, in contrast to the other person who is thinking in terms of some practical advice about the patient's child-care problems. These misunderstandings often become apparent if the conversation continues for some time. However, in the hurried exchanges between people working in a busy practice, differences in meaning can go unnoticed. This can be confusing for staff. What is expected when someone is asked to counsel someone? It is even more confusing for patients. I have had some say to me that 'Dr ... has been giving me counselling, but it was rather different from what you are doing'. The patient's perplexity could be the result of the doctor and myself having trained in different methods of counselling. However, more often the confusion seems to arise from the different meanings of counselling currently in use in medical settings.

Current usage of 'counselling'

There are wider and narrower usages of the term 'counselling'. Some of the narrower ones are mutually exclusive.

Generic use

There are some considered reasons why some people prefer to avoid using 'counselling' in more precisely defined ways and advocate a more inclusive or wider meaning. One of the reasons for retaining a generic approach to counselling is a concern that the exclusive use of 'counselling' by a select few working in specialized roles, who are trained, certificated and members of professional bodies, has the effect of restricting the wide availability of counselling in the community (Murgatroyd 1985). From this

perspective, counselling and helping are synonymous and complementary ways of offering assistance in everyday life that ought not to be colonized as the basis for forming a new profession. This seemingly antiprofessionalization argument may be a form of professional protectionism by other mental health professions against the intrusion of a new service. However, this argument cannot be simply dismissed as thinly disguised self-interest. The development of the distinction between formal counselling and counselling skills (see later) is arguably an attempt to disseminate and foster aspects of counselling within general society whilst enabling the accumulation of knowledge and expertise by a profession of counsellors.

Philip Burnard's views (Burnard 1999) are of particular interest because his preference for the wider usage of 'counselling' is based on his experience of working in health care settings and a concern to ensure the dissemination of aspects of counselling more widely across services. As a nurse tutor, he was concerned to discover that nurses are reluctant to use facilitative skills with patients. This is not merely a matter of skills, but of an attitude and a belief that the nurse knows best, or at least better than the patient. This is contrary to the growing practice of involving patients in decisions about their own care. Therefore, Burnard is interested in extending nurses' skills to include more facilitative interventions which involve the patients in making decisions for themselves about their treatment. He draws on John Heron's six categories of therapeutic intervention as the underpinning model. Heron (1990) divided the possible interventions into authoritative and facilitative. Authoritative interventions include: prescriptive (offering advice), informative (offering information) and confronting (challenging). Facilitative interventions include: cathartic (enabling expression of pent-up emotions), catalytic (drawing out) and supportive (confirming or encouraging). Burnard concluded that it is desirable for nurses to use the full range of interventions, and, therefore, defines counselling as the effective use of verbal interventions involving 'both client-centred *and* more prescriptive counselling' [his emphasis]. He is, therefore, taking a strongly generic view of counselling.

In contrast to this wider definition of counselling, there are two narrower definitions in popular use which are mutually exclusive.

Counselling as advice

The first of these regards counselling as the same as giving advice. This view has had a long tradition which reaches back to at least the seventeenth century. In 1625 Francis Bacon, the essayist, wrote 'The greatest Trust, betweene Man and Man is the Trust of Giving Counsell'. It is a reasonable inference that he is thinking of advice because as he develops his argument he identifies the 'Inconveniencies of Counsell'. These include 'the Danger of being unfaithfully counselled, and more for the good of them that counsel than of him that is counselled'. He also states that only people with expertise are suitable to provide 'counsell'. In modern dictionaries, both 'counsel' and 'counselling' retain the general meaning of 'advise' (Pearsall 1998). This usage is still commonplace in legal and medical circles. When I was working on a report about HIV counselling, a doctor was so committed to the use of 'counselling' to mean 'advising' that he wrote to me to express exasperation at all the fuss being made about counselling which he regarded as merely a 'popular term for giving advice to people' (Bond 1992).

However, modern dictionaries also acknowledge the existence of a more specialized use of ‘counselling’ as a method used by trained professionals to help someone resolve personal, social or psychological problems (Pearsall 1998). This more specialized usage has a shorter history of at least 70 years, which I will consider next.

Counselling in psychological and social care

The use of the word ‘counselling’ in its narrowest meaning first became popular in the 1920s in the USA. The term emerged in reaction against the exclusivity of psychoanalysis and psychotherapy. When Carl Rogers started working as a psychologist in America, he was not permitted to practise psychotherapy, which was restricted to medical practitioners. Therefore, he called his work ‘counseling’ (US spelling) (Thorne 1990). It seems probable that Rogers took the term from vocational counselling that had been developed as part of a radical community action programme by Frank Parsons (1854–1908) when he established a counselling centre in the North End of Boston, a deprived city area. Rogers also had a radical agenda. The person-centred nature of his method meant that counselling itself was part of a movement to democratize talking therapies by emphasizing the importance of the client’s contribution. This has remained an important influence, even though as counselling has developed many new models for practice have developed. In all of these, there is an emphasis on counselling as the principled use of relationship, with the aim of enabling the client to achieve his or her own improved well-being. Two major ethical principles are closely associated with this way of counselling: respect for the client’s capacity for self-determination and the importance of confidentiality. This is the use of the term ‘counselling’ espoused by the BACP. The definition used within the *Code of Ethics and Practice for Counsellors* (British Association for Counselling 1997) makes specific reference to the client’s capacity for self-determination.

The overall aim of counselling is to provide an opportunity for the client to work towards living in a way that he or she experiences as more satisfying and resourceful ... The counsellor’s role is to facilitate the client’s work in ways which respect the client’s values, personal resources, and capacity for choice within his or her cultural context.

Sometimes self-determination is referred to as ‘autonomy’ or ‘independence’. Although the suitability of some of these terms is increasingly questioned from feminist and multicultural perspectives, these disagreements tend to be about the best way of representing respect for the client’s sense of self and self in relation to society. The ethical importance of respecting the client as a person, accepting differences between people in how they conceive of and respond to issues presented in counselling, and building on clients’ existing resourcefulness are shared values that most counsellors would regard as informing their professional ethic.

Nearly a decade ago, the Counselling in General Practice Working Party of the Royal College of General Practitioners adopted the use of the term ‘counselling’ in this narrower usage of a professionally distinctive service. They used ‘counselling’ to refer to an activity undertaken by a trained counsellor working in accordance with the role as defined by the British Association for Counselling with its distinctive ethic and philosophy (Sheldon 1992).

Counselling and advice

In comparison to most other professions, counsellors are diffident about making claims to give advice. For nearly a decade successive codes for counsellors have included a statement that 'Counsellors do not normally give advice' (British Association for Counselling 1997, B.13.6).

It is doubtful whether this statement is any longer accurate. It may once have been a convenient way of challenging preconceptions about counsellors as being primarily advisors and asserting a more facilitative style of working. However, there is some empirical evidence that the prohibition on giving advice sometimes resulted in thinly disguised advice-giving (Silverman 1996). Some approaches to counselling have also found the prohibition to be problematic, especially those working in a cognitive behavioural tradition. After all what is the ethical value of withholding advice without good reason if that advice could contribute to the well-being of the client? It is probably more accurate to say that counsellors are judicious in their use of advice. To offer authoritative advice too readily could be counterproductive. It could induce dependence and passivity in a relationship that depends on the client's active involvement to be effective. The aim of counselling is to enable the client to discover and build on his/her own wisdom rather than have wisdom imparted to them from the counsellor. Perhaps because of the growing body of knowledge available to counsellors, they are more willing to offer information that is considered helpful and even to express opinions as to the best way of acting on that information. However, the way that this is done is likely to be intended to elicit the client's reactions and to work towards a solution to which the client is personally committed. The increasing use of short-term and time-limited work has contributed to a change in practice over advice-giving. Sometimes, in primary care, the counsellor's role is assisting clients in deciding how to respond to information and opinions provided by clinicians.

Counselling and psychotherapy

There is no universally accepted distinction between the terms 'counselling' and 'psychotherapy'. They have developed out of different historical traditions, which has led some practitioners to suggest a clear distinction between them in purpose and level of expertise required. One view seeks to differentiate them on the basis that counselling is primarily concerned with current environmental and social issues, in contrast to psychotherapy which is more concerned with personal psychology and neurosis. Some support for the differentiation of counselling and psychotherapy would be found amongst those working in psychodynamic and cognitive behavioural approaches. However, practitioners working within the humanistic approaches tend to regard the distinction as relatively insignificant as counsellors and psychotherapists tend to work in the same way. Comprehensive considerations of the issue in Britain concluded that there was little evidence of counselling and psychotherapy being distinguishable in terms of training, function or methods of working (Feltham 1995; James & Palmer 1996). Differentiation may be more concerned with claims to social status and territory. Memorably, Windy Dryden (1996) suggested that the only

Table 1.1 Characteristics of counselling and psychotherapy

Counselling	Psychotherapy
Educational	Reconstructive
Situational	Issues arising from personality
Problem-solving	Analytic
Conscious awareness	Preconscious and unconscious
Emphasis on working with people who do not have severe or persistent emotional problems	Emphasis on 'neurotics' or working with persistent and/or severe emotional problems
Focus on present	Focus on past
Shorter length of contract	Longer length of contract

significant difference is the hourly rate of pay, with psychotherapists charging substantially more. The situation is fluid at the moment. It is probably the case that the UKCP will seek to maintain a hierarchical distinction of roles in which counselling is concerned with current problem-solving whereas psychotherapy addresses personally 'deeper' issues rooted in the personality. In contrast the British Association for Counselling has changed its name to the British Association for Counselling and Psychotherapy (BACP) with effect from September 2000. This association has members supportive of the kinds of distinctions epitomized in Table 1.1 as well as members who view the terms 'counselling' and 'psychotherapy' as no more than different labels for the same activity.

Counselling and counselling skills

One of the most important distinctions to emerge in recent years is that between counselling and counselling skills. It is also a distinction with considerable implications for medical practice. Unfortunately, it is also one which has been subject to considerable misunderstandings.

The most obvious misunderstanding is based on the idea that 'counselling skills' is a label for a set of activities unique to counselling. Although the term 'counselling skills' is sometimes used on this basis, it is quickly discredited because any attempt to list specific 'counselling skills', for example active listening, paraphrasing, using open questions, reflective responses, etc., quickly looks indistinguishable from lists labelled social skills, communication skills, interpersonal skills, etc.

In order to understand what is meant by 'counselling skills', it is useful to examine the two words separately. Here the use of the word 'counselling' is an indication of the historical source of the concept. It serves to indicate that whilst these skills are not unique to counselling, it is the way they have been articulated in counselling that has been useful to other roles which employ counselling skills. For example, advice-giving has a much longer history than counselling skills, but the tendency has been to concentrate on the content of the advice rather than the way it is delivered. However, the methods which advisers use to communicate with clients can be adapted to improve the way advice is given and hence maximize the client's involvement in the decision-making. 'Counselling' in this context is acknowledging the source of the concept and

Table 1.2 Detection of counselling skills in the pattern of communication

Style	Pattern of flow	Time ratio (I : R)
Imparting expertise	Interactor → Recipient	80 : 20
Conversation	Interactor ↔ Recipient	50 : 50
Counselling skills	Interactor ← Recipient	20 : 80

I, interactor; R, recipient.

method of communication. Similarly, nurses, tutors, personnel managers, social workers and many others have all recognized that there are advantages in adopting the methods of communication used in counselling to aspects of their own role. One way in which an outside observer might detect that counselling skills are being used is in the pattern of communication (Table 1.2).

Imparting expertise involves the expert in communicating his/her knowledge and expertise to the recipient which takes up most of the consultation time available. This contrasts with conversation where both participants tend to contribute for equal lengths of time and in a pattern which flows backwards and forwards. The use of counselling skills will usually change the pattern of communication in favour of the recipient, who speaks for most of the available time. Part of the expertise in using counselling skills is learning how to communicate briefly in ways which do not interrupt the flow of the speaker, but at the same time help the speaker to address more effectively the issues which concern them. When counselling skills are being used, an outside observer might notice that the recipient is encouraged to take greater control of the agenda of the dialogue than in other styles of communication. In other words, the values implicit in the use of counselling skills are similar to those of counselling, placing an emphasis on the client's capacity for self-determination in how help is sought as well as for any decisions or actions that may result (Bond 1989).

Other things which might be apparent to an outside observer include the way the recipient is encouraged or enabled to participate in deciding the agenda for the total transaction. In other words, the values implicit in the interactions are similar to those of counselling, with an emphasis on the client's capacity for self-determination.

The term 'skills' in 'counselling skills' is sometimes taken very literally to mean 'discrete behaviours' but this is not the way 'skills' is understood in the social sciences. Skills which are used to enhance relationships can be distinguished from 'physical skills', as in sport or work, and 'mental' and 'intellectual skills', not merely on the basis of observable behaviours. They are inextricably linked to the goal of the person using them. For instance, Michael Argyle (1981) defines 'socially skilled behaviour' as 'behaviour effective in realising the goals of the interactor'. In the context of counselling skills, these goals are to implement the values of counselling by assisting the self-expression and autonomy of the recipient.

One of the ways in which an independent observer might be able to distinguish between counselling skills and counselling is by whether the contracting is explicit between the two people. This is highlighted in one of the alternative definitions for

counselling which is still in popular use:

People become engaged in counselling when a person, occupying regularly or temporarily the role of counsellor, offers or agrees explicitly to offer time, attention or respect to another person or persons temporarily in the role of client. (British Association for Counselling 1984)

This definition was originally devised to distinguish between spontaneous or *ad hoc* counselling and formal counselling. The overt nature of the latter involving 'offers' and explicit agreements was seen as 'the dividing line between the counselling task and the *ad hoc* counselling, and is the major safe-guard of the rights of the consumer' (British Association for Counselling 1985). In primary care the distinction between counselling and using counselling skills provides a way of valuing situations in which clinicians offer *ad hoc* counselling as an integral part of their work without necessarily presenting it as though it is the same as a formal session with a counsellor. Recent changes in the curriculum for the training of doctors and nurses have tended to incorporate training in counselling and communication skills (Smith & Norton 1999). Where this occurs it increases the potential for mutual understanding between clinicians and counsellors in primary care as well as greater consistency and coherence between the range of services offered in the practice as experienced by the patient. There are three frequent misconceptions that I encounter in discussions about counselling skills. These are:

- 1 *Using counselling skills is always a lower order activity than counselling.* This need not be the case. Arguably the user of counselling skills may be working under more demanding circumstances than the counsellor who usually has the benefit of more extended periods of time, which have already been agreed in advance. In comparison, the user of counselling skills may be working more opportunistically with much less certainty about the duration of the encounter. Users of counselling skills can be more or less skilled, just like counsellors. However, using counselling skills is not a role in itself but something important used to enhance the performance of another role. This means that the capacity to use counselling skills effectively will depend not only on being skilled in their use but also on someone's competence in their primary role, for example the nurse, tutor, etc. For all these reasons, using counselling skills can be more skilled than counselling. It certainly cannot be assumed that using counselling skills is a lower order activity.
- 2 *People in occupational roles, other than counsellor, cannot counsel.* This would mean that doctors, nurses, youth workers, etc., cannot counsel but can only use counselling skills. This is not the case. With appropriate training, counselling supervision, and clear contracting with the client in ways consistent with counselling, it seems to me anyone can change roles to that of 'counsellor'. There are important issues about keeping the boundaries between different roles clear and managing overlapping roles or dual relationships, but these are separate issues (Herlihy & Corey 1992). In 1998 the Medical Defence Union noted an increase in the number of practice nurses who offered counselling. It was willing to offer assistance to them but expected them to be properly trained and supervised (Medical Defence Union 1998). It seems reasonable to me that not every doctor wants to become a counsellor. It is a

specialized activity which appeals to relatively small numbers of health workers and, realistically, probably only a few of these have the time to devote to it. On the other hand, my experience is that most doctors who have been trained in the use of counselling skills have found them useful in consultations with patients. They provide a way of responding immediately to the large number of emotional difficulties presented by patients in primary care that do not in themselves justify referral on to counselling or other types of assistance.

- 3 *Anyone with the occupational title 'counsellor' is always counselling.* This is not the case. As the concept of counselling has narrowed down into a specifically contracted role, there is a need for counsellors to distinguish between when they are counselling and when they are performing other roles, including training, supervision, managing, etc. In each of these other roles a counsellor is likely to be using counselling skills.

I opened this section by suggesting that the distinction between counselling and counselling skills is one of the most important to have emerged. It is a distinction that has enabled counsellors to continue to develop a range of knowledge and expertise without necessarily making exclusive claims to everyday helping skills, a claim that would be manifestly absurd. Instead the opportunity for systematic reflection provided by a professional context has led to a degree of refinement in understanding and practice that can be offered back to people with caring roles in the community and other professions. One of the contributions that many counsellors can offer to multidisciplinary health teams is training in more effective listening and counselling skills.

Background of counsellors working in primary health care

The background of counsellors working in primary health care settings is quite varied. Many have been trained by Relate, formerly known as the National Marriage Guidance Council. This training consists of over 150 hours of formal training and between 170 and 220 hours of closely supervised counselling practice. The use of Relate-trained counsellors in primary health care has a long and successful history (Marsh & Barr 1975; Corney 1986). Alternatively, others have been accredited by the British Association for Counselling (BAC), which requires 450 hours of training and 450 hours of supervised practice and having received personal counselling. Accredited status by BAC or a number of other professional organisations with comparable requirements is the main way of achieving registration with the United Kingdom Register of Counsellors. Many counsellors working in primary health care are also members of either the Faculty of Healthcare Counsellors and Psychotherapists, a section of BAC, or the recently formed Association of Counsellors and Psychotherapists in Primary Care, a development initiated by the Counselling in Primary Care Trust. Many are members of both. In addition some counsellors may acquire their professional standing through the Counselling Psychology Section of the British Psychological Society or the United Kingdom Council for Psychotherapy. All these organizations and their schemes are widely accepted as reputable although the proliferation of bodies with an interest in this area of work is a potential source of confusion.

Table 1.3 What is essential and desirable in a counsellor in primary care

Criteria	Essential	Desirable
Education and professional qualifications	450 hours training	BACP accreditation or equivalent
Knowledge	One theoretical approach to counselling Psychosomatic disease and psychology of chronic or terminal illness BACP code of ethics—particularly about confidentiality	Variety of counselling theories and methods Psychotropic drugs and their side effects Psychopathology by visiting admission unit of psychiatric hospital
Experience	250 hours <i>supervised</i> counselling over 2 years	At least 300 hours gained over at least 3 years
Personality	Dependable Considered approachable by a wide range of patients?	Aware of boundaries around punctuality Friendly
Physical attributes	Good enough health and sufficient sight and hearing not to make special demands on clients	Able to work under pressure and to monitor and manage own stress level
Special circumstances	A constructive member of a multidisciplinary team	Understanding of culture of medical settings and willingness to develop appropriate counselling skills among team members

The Counselling in Primary Health Care Trust (1992) was one of the first organizations to consider what is the essential background for a counsellor working in this setting and to make suggestions for what is desirable. I have updated their recommendations in Table 1.3.

Ethics and standards of practice for counsellors

Counsellors have developed reasonably comprehensive ethics and standards of practice. Inevitably, because counselling is such a new role, the standards are still evolving. However, it is useful to be aware of a number of key issues.

Confidentiality

For medical staff and counsellors alike, confidentiality is both an ethical and legal requirement. However, the implementation of confidentiality is different. Medical services are provided on the basis that the treatment needs to continue even if the person providing it changes due to rotas, or for other reasons. Information about

patients is, therefore, not usually confidential to a single person, but is shared across a team on a confidential basis in order to ensure continuity of treatment. In contrast, the counselling relationship depends on the client's trust in a particular individual and there is no assumption that the counsellor is interchangeable with others. This is reflected in the caution required of counsellors in how they manage personally sensitive information disclosed in confidence. Whereas it is probably common practice for members of the primary care team to rely on implicit consent for disclosures to other members of the team, counsellors are more likely to require explicit consent unless there substantial reasons in favour of disclosure. This has implications for record-keeping. The code of practice which accompanied the Human Fertilisation and Embryology Act (HFEA) 1990 provides a useful example of how counsellors and team members can manage confidentiality about personal information relating to patients, whilst ensuring that essential information can be communicated. The code states:

6.24 A record should be kept of all counselling offered and whether or not the offer is accepted.

6.25 All information obtained in the course of counselling should be kept confidential subject to 3.24.

3.24 If a member of the team has a cause for concern as a result of information given to him or her in confidence, he or she should obtain the consent of the person concerned before discussing it with the rest of the team. If a member of the team receives information which is of such gravity that confidentiality *cannot* be maintained, he or she should use his or her own discretion, based on good professional practice, in what circumstances it should be discussed with the rest of the team.

This code of practice assumes a slightly more rigorous separation of records and practice over confidentiality than the procedures advocated by Dr June McLeod (1992) in her contribution to the Counselling in General Practice Working Party. The HFEA code would simply require that an entry of whether a patient was offered counselling and whether the offer was accepted or rejected was entered on the medical records. In contrast, McLeod recommends that counsellors complete a card with a brief record of dates, progress and outcome of counselling to be kept with the medical records. The counsellor's working notes would be kept separately and would be confidential to the counsellor. Whatever method is adopted, it is important that the patient is informed about the limits of confidentiality.

After misunderstandings about what constitutes counselling, tensions arising from differences about the practice of confidentiality are the second major source of difficulty which can frustrate the most effective use of counsellors in primary care.

Counselling supervision

In most professions, supervision is mandatory for trainees and for those in a probationary period after training. In contrast, counsellors are required to have regular and continuing counselling supervision. The code for ethics requires that 'counsellors must have appropriate, regular and on-going supervision' (British Association for Counselling 1997, A.6).

Counselling supervision is not in any way a managerial relationship. Managerial issues should be dealt with between the counsellor and the medical practice. The counselling supervisor is someone who is experienced as a counsellor and independent of the situation in which the counselling is provided. The supervisor's role is directed towards helping the counsellor to develop his/her own standards of practice and to foster an 'internalized supervisor'. The tasks of supervision can be categorized thus:

- 1 Formative: learning new methods and insights.
- 2 Restorative: getting personal support and relief from the consequences of being exposed to others' emotional pain as well as that of the counsellor's.
- 3 Normative: ensuring adequate standards of ethics and practice are maintained.

These three tasks were first described by Francesca Inskipp and Brigid Proctor (1989). As a result of my study of good practice in HIV counselling, I have added a fourth:

- 4 Perspective: stepping back to take an overview of the total pattern of work with clients and to review the interface between counselling and other methods of helping or treating clients, including interprofessional relationships.

These tasks have to be held in balance with each other so that one does not predominate over the others. For example, if the restorative were to dominate over the others, counselling supervision would become indistinguishable from personal counselling. The counsellor's 'internalized supervisor' needs to be an all rounder.

Discussions in supervision are anonymous. The identity of individual clients is protected in the interests of preserving confidentiality.

A minimum frequency of supervision recommended by the British Association for Counselling is one and a half hours per month, but some counsellors have more frequent supervision because of the difficulty of their cases, volume of work or because they find it increases their efficacy.

Prohibition of sex with clients

Unfortunately, a small number of counsellors abuse their position of trust by entering into sexual relationships with clients. This phenomenon is shared with all the caring professions. So far as I am aware, no such accusations have been made against counsellors in primary care. However, the belief that counsellors have sex with clients is sufficiently commonplace to be worthy of consideration.

There is no doubt that any sexual activity between a counsellor and a current client is regarded as unethical by the BACP. Sex with former clients is also considered unethical in many circumstances, particularly if the subject matter of the counselling concerns relationship or sexual difficulties.

Counsellors who are members of BACP view sexual intimacy with clients in ways which parallel health care workers' relationships with patients. Counselling inevitably involves psychological intimacy rather than physical exposure and, therefore, requires comparable levels of trust. Clients also sometimes imbue counsellors with power, or experience a sense of dependency. For all these reasons, counsellors need to be

scrupulous about maintaining personal boundaries between themselves and clients. When a complaint of sexual misconduct has been upheld, counsellors have been expelled not only from BACP, but also from other professional bodies. This does not stop someone continuing to practise as a counsellor, for it is currently an unregulated occupation, and anyone can set up as a counsellor. However, it illustrates the importance of ensuring that a counsellor adheres to an appropriate code of ethics and practice for the protection of clients and the primary health care team in which the counsellor is working.

Counselling in practice

What does counselling look like in actual practice? Many counsellors are restricted in the number of sessions that can be offered to individual patients in the first instance. Six to 10 sessions of 50 minutes appears to be usual (Rowland 1992). Clients with exceptional needs who are showing significant progress may be offered more sessions depending on the resources available.

The counselling relationship is probably most widely thought of in terms of stages. In the initial stage, the emphasis is on trust-building and enabling the client to describe the situation which is causing the difficulty. With some clients this may remain the major activity, because the client regains a sense of control and order in the process of exploring the issue which causes them concern. In parallel with this initial phase, the counsellor may be conducting a systematic assessment. For some clients merely identifying and voicing the nature of the problem is sufficient for them to progress without any further assistance. With most clients, however, it is necessary to move on to a second stage which is primarily directed at creating a change which will give the client additional resources to assist with the problem. This may involve gaining new insight, learning new skills, redefining personal goals or reassessing important relationships. A third stage involves considering alternative ways of applying the new resources and then putting them into action.

All counsellors probably use rather similar approaches in the initial stage. The aim is to provide an enabling relationship characterized by warmth, genuineness and empathy. These are qualities which are widely considered essential to the effectiveness of counselling (Truax & Carkhuff 1967) and certainly to the stage of trust-building. The counsellor may also attempt to negotiate a contract with the client about the practical arrangements, confidentiality and the therapeutic goal of the client. These negotiations help to increase the client's sense of control and also to identify the focus of the counselling. In this way the client is encouraged to focus on what he/she is really concerned about. Many other strategies and techniques may be used to this end. The counsellor's task is to notice what a client experiences as significant, and to build up a picture of what is said, what is implied and what is left unsaid. Gradually a picture of the client's perception emerges and this forms the foundation upon which the counsellor builds.

The next stage in the counselling relationship will vary according to the theoretical model of the counsellor. There are probably over 200 different published models of counselling. I will describe three of the most widely used. Psychodynamic counselling

has developed from the work of Sigmund Freud but is often considerably modified. The counsellor's concern is the client's internal relationships with people who have been significant in that person's development. These internalized relationships and associated feelings may have their origins in early childhood and may no longer rely on the promptings of an external person to evoke them. The aim of successful counselling in this model is to enable a person to balance the potentially conflicting demands of basic psychological needs, the demands of conscience and the external realities of the situation (Jacobs 1999).

Person-centred counselling was developed by Carl Rogers and is superficially quite different from a psychodynamic approach. In contrast with psychodynamic counselling, which emphasizes the counsellor's ability to understand the effect of past influences on the client's present experience, a person-centred counsellor seeks to use the current relationship between client and counsellor as the source of new personal development and emphasizes the role of the client as the expert in selecting what is important and healing to him or her. The quality of the relationship is extremely important and is sometimes described as '*trying to put the loving into helping*' (Mearns & Thorne 1999).

In contrast, again, cognitive behavioural counselling is primarily directed towards changing the way someone 'self-talks' in order to achieve beneficial changes (Trower *et al.* 1988).

Some counsellors are purists and work exclusively with one model. Others are committed to drawing on a range of models in order to find the method best suited to a particular client. It is generally considered better to be systematically rather than randomly eclectic as this reduces the risk of presenting the client with mixed messages and potentially confusing the client's problem further (Culley 1990).

Who will benefit from counselling?

A wide range of people appear to benefit from counselling. Anyone who is capable of expressing themselves verbally and who has usually been quite resourceful in the way they have coped with life until they become troubled by a particular issue will almost certainly benefit. Sometimes counselling can be useful to people who have a long history of not coping, but this is much less certain.

There are certain issues which are generally considered as being suitable for counselling:

- ◆ Bereavement
- ◆ Recovery from trauma due to accident, major disaster, major medical treatment, diagnosis of serious illness or physical/sexual abuse (post-traumatic stress syndrome)
- ◆ Terminal illness
- ◆ Coping with anxiety associated with major transitions in life, for example adolescence to young adulthood, changes in occupation, moving out of work due to redundancy or retirement, or changes in relationships
- ◆ Stress management

- ◆ Problems associated with the use of alcohol or drugs
- ◆ Interpersonal and relationship problems
- ◆ Sexual problems
- ◆ Family planning
- ◆ Infertility
- ◆ HIV/AIDS
- ◆ Psychological and less severe psychiatric problems
- ◆ Decision-making about the best course of treatment when the patient has alternatives to choose between.

Surveys suggest that the most common issues referred to counsellors are relationship problems, depression, anxiety and bereavement (Clark *et al.* 1997).

Many of these issues are discussed in more detail elsewhere in this book. It is not unusual for several issues to be closely related. For example, the diagnosis of a major illness will not only be the start of a process of personal adjustment but may also involve the patient in planning what to tell a partner, and perhaps reassessing personal relationships. There may also be a need to learn how to manage personal anxiety better. When someone presents with multiple issues, the counsellor's role is to help them prioritize the issues to be addressed. Typically the choice is made on the basis of what is most urgent, or causing greatest discomfort, or most likely to create the possibility of other successes if it improved. Depressed patients are an exception to this general rule for prioritizing the issues. Often it is better to start with the most manageable issue and work progressively towards the most demanding so that a sense of confidence and of regaining control can emerge. This approach counters the sense of helplessness and dispiritment associated with depression.

An important factor to take into consideration in deciding who could benefit from counselling is the aptitude of the counsellor. His or her training and experience may be decisive in who will be the most helped by counselling. However, counselling is possible only when the client becomes actively committed to the process. Therefore, the most important factor is the client's attitude to the offer of counselling. A positive attitude considerably increases the likelihood that the client will take advantage of the opportunities offered in counselling.

Who is unsuitable for counselling?

Not everyone is suitable for counselling. However, there appears to be no agreed classification of the situations unlikely to be helped by counselling. Probably the aptitude of individual counsellors is a more important factor than any general list. None the less, experience suggests that some situations may be less suitable for counselling. These include:

- 1 The person who does not want counselling. Counselling requires the active involvement of clients and, therefore, is essentially a voluntary activity.
- 2 The person who consistently externalizes problems on to other people or attributes his/her problems to his/her state of physical health. For example, a client who

attributes her emotional fluctuations exclusively to premenstrual tension and is unwilling to take any role in managing her situation other than to demand tablets from a doctor is unlikely to be suitable for counselling. In contrast, someone who wants to do what she can to improve her situation or is willing to explore whether there could be other factors contributing to her changes in mood is much more suitable for counselling. The counselling is most likely to complement any medical treatment.

- 3 Someone who has no insight into his/her condition due to a personality disorder or severe psychiatric disorder is unlikely to benefit from short-term counselling.
- 4 People with undiagnosed clinical conditions which would account for their problems. For example, counselling cannot help a tired, weepy patient who has untreated thyroid deficiency or pernicious anaemia because the appropriate tests have not been conducted. This situation is quite different from the patient who has done the rounds of all the possible medical specialities without any physiological explanation for the problems being discovered. In these circumstances, counselling may help a client to explore whether the problems could have psychological or social origins.

Some clients may be suitable for counselling but can be made unsuitable by being given unrealistic expectations of the counselling. It is important that the referrer conveys a realistic hope that counselling will be beneficial. Counselling can sometimes help people to solve problems. However, in many situations there is no immediate solution. Counselling cannot bring a loved relative back to life or remove the inevitable tensions of looking after an adolescent dependent, but it can help people manage their bereavement or difficult relationships better.

Effectiveness of counselling versus acceptable outcomes

It is important to consider the effectiveness of counselling and what are the outcomes. There are problems in answering these questions. Some of the problems relate to the nature of counselling itself. It is difficult to quantify the input of the counsellor in comparison to a medical or surgical procedure. Psychosocial factors are by nature often elusive and difficult to quantify. Many workers in primary care recognize the difficulty in assessing the contribution which verbal communications and the emotional climate of the relationship make to the well-being of the patient. There are also potential difficulties in identifying what changes can be ascribed to particular aspects of the counselling.

For example, I remember seeing someone after an attempted suicide who was experiencing social isolation, difficulties with her mother, and problems arising from an inability to say 'no' to people in need of her help. The counselling, at her direction, focused on these last two problems, but when I asked her what had been most useful, her response surprised me:

It is the experience of being listened to. You remember when I started I talked about my loneliness and feeling I am the only one with these problems. I have taken you as a model and have started listening to other people and I have discovered many other people have similar problems.

The other topics addressed in counselling had been useful but for her this was the most useful.

It is also possible that beneficial changes are due not to the counselling but to events occurring in other aspects of the client's life.

The final methodological hurdle to be overcome is in deciding what constitutes a beneficial outcome in order for counselling to be considered effective. Is it sufficient that the client reports feeling better? Or is some more observable physiological or behavioural change required? In Chapter 5 of this book, these issues are examined from a researcher's perspective and are outlined in ways in which qualitative and quantitative methodologies have been applied to assess the effectiveness of counselling. Studies about the effectiveness of counselling are increasingly important for the medium- and long-term development of counselling, especially in a context where there is a strong expectation that practice can be justified by scientific evidence of effectiveness.

Primary health care teams require more readily available indicators of the results achieved by investing resources in counselling. In some cases these gains may be demonstrated better by secondary indicators. In the opinion of Dr Graham Curtis Jenkins, the Director of the Counselling in Primary Care Trust, acceptable outcomes might include:

- ◆ Reduction in GP consultations
- ◆ Patients in receipt of counselling making more appropriate use of consultations with health care staff
- ◆ Reduction in prescribed medicines
- ◆ Reduced referrals to psychiatric outpatient and psychiatric patient clinic admissions
- ◆ Reduced costs in managing some patients.

Eventually the monitoring of these secondary gains may accumulate to be used as benchmarks for the effectiveness of a particular counselling provision. Changes in the secondary gains may reflect changes in the quality of counselling being provided, if the kind of issues referred and the method of referral are constant.

Monitoring counselling

Regular and systematic monitoring of the counselling is important. There are different levels of complexity and sophistication in monitoring. At one time it was considered desirable to keep monitoring relatively simple. One of the reasons for doing this was to maximize the time available for delivering counselling. Generally there is only very limited time available for counsellors outside face to face contact with clients in primary care (Clark *et al.* 1997). The British Association for Counselling (1992) originally suggested restricting routine monitoring and auditing to: how many patients are seen, how often, from which partner, appointment failures and reasons for referral. This can be done at six-monthly intervals, and the results can appear in the annual report.

Even such basic auditing will expose important issues, such as whether referrals are evenly spaced across the practice or are mainly from a few sources. Changes in the

pattern of appointment failures may be indicative of the underlying problem. It is reasonable to start with the rebuttable assumption that failure to attend first appointments may indicate problems with referral or reception. On the other hand, increases in failure to attend second or subsequent appointments may indicate dissatisfaction with the counselling facilities or with the counsellor, or the patient's deteriorating mental or physical health.

During my study of good practice in HIV counselling (Bond 1992), counsellors and their managers were invited to identify the criteria for monitoring the quality of counselling being provided. I have adapted their suggestions to primary care as possible ways of augmenting the simple audit already mentioned.

1 *Service delivery*

- (a) *Pre-counselling information*: is a leaflet or other means of explaining to patients what counselling entails readily available?
- (b) *Approachability*: are the counselling services attractive to intending clients? Are they provided by people who are acceptable to the clients in terms of gender, and ethnic, cultural and social background? Can clients choose a counsellor who is likely to satisfy their requirements?
- (c) *Accessibility*: has the location of the counselling sessions been considered in terms of its nearness to likely users of the service and its accessibility by public and private transport? Is access to the premises possible for people with difficulties with mobility or in wheelchairs? Are there arrangements for counsellors to visit clients in hospital, at home or at other venues if these are more appropriate?
- (d) *Availability*: does the availability of the service correspond to clients' needs, for instance during weekdays, evenings or at weekends?
- (e) *Continuity*: are the services provided with sufficient continuity to gain the confidence of potential client groups? Is counselling staff turnover taking place at an acceptable rate?
- (f) *Confidentiality*: are the established practice and procedures about confidentiality understood and implemented by staff? Are any limitations on confidentiality communicated to clients?
- (g) *Statement of standards and ethics*: is there a readily available statement or code of practice which sets out the standards and ethics of the counselling? Is the code available to clients?

2 *Client participation in monitoring*

- (a) *Client feedback*: is client feedback sought regularly about the service provided to them?
- (b) *Complaints procedure*: is there a procedure to deal with complaints from clients? How does the agency respond to the complainant? How does the agency learn from complaints and revise its practice?

3 *Staffing*

- (a) *Selection*: what are the selection criteria for counsellors? What are the selection procedures?

- (b) *Training*: what provision has been made to ensure counsellors receive appropriate basic training for their role? What provision has been made for the continuing training of counsellors?
 - (c) *Supervision and support*: what are the arrangements for supervising counsellors by management, and for independent supervisors for counselling supervision/consultative support?
- 4 *Co-operation with others*
- (a) *Liaison with other staff and agencies*: how effectively do counsellors and their managers liaise with other service providers within the same agency and between agencies?
 - (b) *Reputation of the counselling service*: what is the reputation of the counselling service amongst other agencies? How are these views collected and responded to?
- 5 *Counsellors can contribute to the monitoring by the following methods*
- (a) *Client's manner*: changes in the client's manner towards becoming more competent and assertive in counselling sessions are generally thought to be positive indicators.
 - (b) *Changes attributed to counselling by clients*: constructive changes that are attributed to the counselling by the client are considered to be positive indications of the usefulness of the counselling. However, the counsellor also needs to consider the possibility that the changes were exclusively due to other factors or a combination of counselling and other factors.
 - (c) *Clients keeping prearranged appointments*: attendance at prearranged second and subsequent counselling sessions may be an indication that the client is getting something of value from the sessions.
 - (d) *Returning for further sessions*: clients who return for further sessions after an interval without counselling may be demonstrating with their feet a belief that counselling has helped them previously.
 - (e) *New clients recommended to seek counselling by former clients*: the recommendation of counselling by former clients is generally considered to be a very positive indicator.
 - (f) *Informal feedback from clients*: some counsellors ask for informal feedback at the end of sessions about what has/has not been useful to the client. This can be extremely informative.
- 6 *Other members of the primary care team or the practice manager may wish to participate in the use of any of the following*
- (a) *Monitoring attendance for appointments*: significant changes in the frequency of non-attendance for appointments usually indicates changes in the client group's perception of the counselling service. Generally, a reduction in missed appointments is considered to be a positive indication unless there is evidence of excessive dependence on counsellors.
 - (b) *Distributing questionnaires to current and former clients*: questionnaires can be a useful means of obtaining information from clients who are able to read and write and who are confident enough to express their views in writing.

An alternative approach is to use structured/semistructured interviews by a skilled interviewer, although problems over confidentiality often make this approach impossible.

- (c) *Using an independent consultant*: the independence of the consultant adds to the credibility of the monitoring.
- (d) *Monitoring complaints and unsolicited positive feedback*: reviewing complaints and unsolicited feedback can be very informative.

This list is the accumulation of methods adopted by a variety of agencies. It is not envisaged that any single practice would attempt to undertake all the activities suggested in any single review. The list is intended to stimulate consideration of alternative methods and issues to be taken into account during monitoring. One way of using the list would be to select one topic from the list for specific attention during routine monitoring and to change the topic periodically so that over an extended period there has been a wide-ranging consideration of the quality of the counselling available.

An increasingly popular and well-respected approach routine to the monitoring of counselling services has been developed by the CORE systems group in the Psychological Therapies Research Centre at the University of Leeds. This has the advantage of a professionally developed and progressively refined system that would ordinarily be outside the areas of expertise of even reasonably well-informed counsellors. It is also proving to be a valuable method of accumulating anonymized data on a significantly large scale to make meaningful contributions to assessing the effectiveness of counselling generally and in specific settings (Mellor-Clark & Barkham 2000).

Formal monitoring is no substitute for regular meetings between the counsellor and other members of the primary health care team. If a new counsellor has been appointed, these meetings are necessary in order to establish how the counsellor works and to provide opportunities for team members to express their hopes and misgivings and to plan the detailed integration of the service into the work of the practice (McLeod 1992). Extra meetings are a burden on professionals who have many other demands on their time. However, it has been shown that regular meetings are beneficial both to the primary health care staff and to counsellors (Marsh & Barr 1975). They are the best means of ensuring that referrals are appropriate and that expectations are realistic. Of benefit to the counsellor is the breaking down of isolation. These meetings do not need to be all of the same kind. June McLeod (1992) suggests different ways of meeting members of the primary health care team:

- 1 Discussing particular patients with particular doctors or other staff.
- 2 Reporting back in general terms, particularly the discussion of practical problems.
- 3 Opportunities for more detailed discussions of referrals and outcomes, and opinions about the counsellor's role.
- 4 Using the counsellor to offer support and training in basic counselling skills for other team members.

A variety in the kinds of meetings between the counsellor and other staff reduces the burden on any individual member of staff and helps to disseminate knowledge about the service throughout the practice.

Conclusions

Counselling is a relatively new activity in primary health care, notwithstanding its rapid adoption by large numbers of practices. The need to establish sound professional standards is paramount. A great deal of progress has been made by the British Association for Counselling and Psychotherapy, the Counselling in Primary Care Trust and the Royal College of General Practitioners. Work about clarifying the nature of counselling, the implications of its particular values and methodology will be continued within national bodies such as these. However, the justification for the provision of counselling must be the outcomes for individual patients and their level of satisfaction with the service in the first instance, and the secondary benefits this additional service brings to the work of other members of the primary health care team. The rapid growth of counselling provision in primary care has been generated by the high level of demand by patients for help with relationship and emotional problems. Many general practitioners have found counselling a useful resource for responding to these needs. However, the future scale of counselling provision seems uncertain unless those committed to the provision of counselling services can establish evidence-based justifications for these services and can sustain an argument for services that extend beyond the usual scope of mental health. These challenges are considerable and the outcome is uncertain. The evidence of demand-counselling services and the way counselling has adapted in the past to the demands of providing a professional service within the primary care team give grounds for optimism about its future, but more is needed to secure that future.

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