Counselling Psychology in Australia: Past, Present and Future – Part One

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Abstract

This is the first of two articles describing the specialisation of counselling psychology in Australia, situating it both internationally and historically. In addition this first article reviews some current challenges and considers the unique contributions of counselling psychology as a specialty. A second article will present information on the current employment of counselling psychologists in Australia, place current debates in the context of developments in counselling psychology over the last decade, and discuss the future of the specialty, including some promising new directions. These two articles represent the maturity of the counselling psychology specialty in Australia and recognise its growing voice and influence through specialist conference strands over the last decade, and the importance of self-representation for the specialty. They are put forward as contributions to counselling psychology's identity in this country, in the hope that they will contribute to clarifying the position of counselling psychology in Australia, produce discussion and debate, and promote the specialty in meeting the challenges of the future.

Keywords: Counselling psychology; Specialisation in counselling psychology; Medicare; future of counselling psychology

Counselling psychology is one of the most diverse of the specialisations in psychology. Its breadth and diversity has led to a rich and layered understanding of psychological problems and psychotherapeutic interventions with a wide range of client populations. However, this has also meant that it has been somewhat more difficult to define, describe, and delineate the boundaries of the specialisation, both here and overseas (Gelso & Fretz, 2001; Schoen, 1989; Strawbridge & Woolfe, 2003). This, in turn, has created some current challenges for counselling psychology in Australia.

In Australia, counselling psychology is one of 9 accredited specialisations within the Australian Psychological Society (APS). Like all psychology specialisations, the standard entry qualification is a Masters, PhD or professional doctorate from an accredited university program. There are currently 4 accredited postgraduate university programs in counselling psychology, including 3 in Victoria and 1 in WA (Curtin, La Trobe, Monash, and Swinburne universities). Completion of a program leads to registration as a psychologist with a state registration board and in WA leads to specialty title registration as a counselling psychologist. The APS College of Counselling Psychology has specific criteria for entry to the specialisation as well as course approval guidelines for university programs. There are 663 members of the College of Counselling Psychology and it is the second largest College in the APS (APS AGM presentation, 2008).

Counselling psychologists provide counselling and psychotherapy services to individuals, couples, families, children, and groups. They engage in psychological assessment and diagnosis, where appropriate, and are trained to work with a wide range of psychological difficulties and disorders. Counselling psychologists work with complex psychological problems and disorders such as depression, anxiety, self-esteem, eating disorders, post-traumatic stress and personality disorders. Identification and treatment of psychopathology is a significant aspect of the training and professional work. Counselling psychologists also work with challenging or prolonged difficulties encountered by high functioning clients, such as bereavement, intimacy issues, relationship breakdown, transition to parenthood, attachment issues, adjustment to step-parenting, involuntary redundancy, sexual assault or abuse, or release from prison.

The fact that counselling psychologists work across the developmental spectrum and across the normal to abnormal continuum in terms of psychological issues has been both its strength and a source of difficulty in terms of clearly delineating the specialty. In addition, counselling psychologists work in a number of settings in equivalent positions where other specialist psychologists work, such as forensic, educational, developmental, and clinical contexts. Indeed, two studies of counselling

psychology and clinical psychology graduates in the US have found only minor differences in terms of job related activities (Brems & Johnson, 1997) and only marginal differences between university program curricula, internships, and postdoctoral placements (Brems & Johnson, 1996).

Core Features of Counselling Psychology

What then are the foundations, core practices, and core principles of counselling psychology? The specialty of counselling psychology has moved a long way from its original foundations in vocational counselling and counselling for war veterans in the US during the 1950's (Munley, Duncan, McDonnell, & Sauer, 2004) and continues to develop. The contemporary practice of counselling psychology has three major areas of focus: mental health difficulties and disorders, developmental issues, and prevention (Gelso & Fretz, 2001; Munley et al, 2004). Although counselling psychologists work with diverse client populations from the very disturbed to the more normal end of the continuum and with diverse interventions, there are a number of core features of contemporary counselling psychology. They are summarised under the following headings:

Expertise in Counselling and Psychotherapy

Expertise in the provision of counselling and psychotherapy is the cornerstone of the specialty. In academic programs world-wide there is a heavy emphasis on the acquisition of therapeutic skills and competence in the psychological therapies. This includes training in empirically-validated therapies and the principles of evidence-based practice. However, the specialty has also remained open to compelling empirical evidence that the therapeutic alliance predicts a much larger part of the variance than specific models or techniques of therapy and that comparative outcome studies have repeatedly shown few differences between models of therapy (Wampold, 2005). Counselling psychology draws on the evidence of all these important streams of research in psychotherapy to guide psychotherapeutic intervention. Because of this, counselling psychology in Australia has tended to be more inclusive of a wider diversity of established models of therapy than other specialties, including cognitive-behavioural, psychodynamic, humanistic-existential, and process-experiential (Brown & Corne, 2004; Grant & Mullings, 2005)).

Expertise in Developmental Frameworks

One of the cornerstones of counselling psychology has always been the capacity to work from a developmental perspective across the lifespan and across the full range of psychological functioning (Murdock, Alcorn, Heesacker, & Stoltenberg 1998). This developmental perspective is underpinned by an in-depth understanding of child, adolescent, and adult development and how normal developmental processes can become derailed. However, even more salient is the strong philosophical position in counselling psychology that emphasizes client health, assets and strengths. This means that whatever the level of disturbance or psychopathology in clients, counselling psychologists will place an emphasis on acknowledging client strengths and adaptation to adverse circumstances as well as on addressing psychopathology (Gelso & Fretz, 2001; Munley et al 2004). This also means that there is a focus on the precipitating factors in psychological distress and disturbance, including the family of origin experiences, social and educational experiences, and wider culture.

Expertise in other Modalities: Couple, Family and Group Therapy

Perhaps this perspective on developmental frameworks leads to the strong emphasis in counselling psychology on expertise in other modalities as well as individual therapy. Although accredited training programs across Australia vary, they all include at least one additional modality such as couple, family, or group therapy as a significant part of the training. These modalities may range across the three major areas of focus (Gelso and Fretz, 2001). For example, couple therapy may be provided for *remedial* purposes for a very disturbed relationship or where one partner has mental health issues. On the other hand, group therapy might be provided for *developmental* purposes, focusing on personal growth and development, or on *prevention* such as parenting groups for at-risk populations.

Expertise with Mental Health Disorders

Assessment and diagnosis of psychopathology and capacity to work with mental health disorders is a core feature of counselling psychology in the US (APA, 1999) and in Australia (Australian Psychological Society, 2008a; Psychologists Board of WA, 2008). Although in the past, counselling psychologists were perceived as working predominantly at the 'normal' end of the continuum, this has clearly changed over the last two decades (Munley et al 2004). A number of studies in the US, UK, and Australia have repeatedly confirmed that counselling psychologists work as mental health providers (Munley et al, 2004; Schoen, 1989; Orrum, 2005).

For example, a study done in Western Australia indicated that the majority of counselling psychologists worked frequently with clients with mood disorders (84%), anxiety disorders (91%), sexual abuse (including both PTSD symptoms and perpetrators) (62%), with a substantial proportion working frequently with substance-related disorders (48%) and personality disorders (50%) (Orrum 2005). However, they reported working infrequently with psychotic disorders (82%), eating disorders (89%) and cognitive disorders such as dementia and delirium (93%) (Orrum, 2005).

It would appear that most counselling psychologists do not *frequently* work with the very severe in-patient

population, although clearly some counselling psychologists do, particularly those who have found employment in psychiatric settings, for example in forensic mental health services. However, it is also clear that the perception that counselling psychologists work predominantly with the 'normal' population is erroneous. Counselling psychologists work with a range of diagnosable mental health disorders in various settings, including private practice, clinics, veterans' counselling services, the Australian Federal Police, university counselling services, and hospitals.

Expertise with Challenging Difficulties in the Usual Course of Living

The area that has been most stereotypically associated with counselling psychology is that of expertise in working with clients nearer to the normal range, with a more sustained focus on psychological health, personal growth, and prevention (Lightsey, 1996). Although this paper challenges the myth that counselling psychologists work *only* with this population, it is clear that they are trained to *also* work with a variety of psychological issues. These issues may not lead to a diagnosable mental health disorder. Nonetheless, many clients present with challenging and/or chronic difficulties in living their lives, where early intervention may prevent the development of serious psychopathology. These issues typically include areas such as grief and loss, relationship breakdown, difficulties in parenting, substance use, childhood sexual abuse, family dysfunction, intimacy issues, and employment issues.

The caseload mix depends very much on where the counselling psychologist is employed. For example, in WA there are a number of counselling psychologists employed at private hospitals, where they manage programs in mood disorders, PTSD, and eating disorders and thereby work almost exclusively with the more severe end of the mental health continuum. On the other hand, counselling psychologists employed in schools, relationship counselling agencies, and Employee Assistance Programs (EAP), would tend to work far more with clients at the more normal end of human functioning. However, it has become clear that client populations are becoming more disturbed, even in these agencies. Our experience with student placements in community agencies is also that they are increasingly being expected to deal with clients with personality disorders, severe depression, and other mental health disorders. Furthermore, the distinction between metropolitan and rural locations is a critical aspect of context that will impinge on the scope and diversity of client work. Thus, even those counselling psychologists who have oriented their careers to working with the higher functioning population need to be equipped and prepared to also diagnose and work with psychopathology. Current training in counselling psychology addresses this requirement.

The Development of Counselling Psychology

Counselling psychology in the US

In the late 1940s, counselling psychology emerged as a specialist discipline in the USA. Whitely (1984) pointed to the influences of several socio-historical developments around that time. First, there was a growing recognition in the USA that psychologists could assist not only with severe mental health problems, but also with difficulties that arise in the usual course of living, such as bereavement, work problems and relationship issues. At the time, the growing use of psychometric measures led to increased interest in the individual differences amongst people and appreciation for diversity across society. There were concerns about the stigma associated with mental illness, along with increased recognition about the significance of personal experiences and the need to place greater emphasis on preventative methods. Behavioural and person-centred therapies were being developed as adjunct and alternative treatment models. Following World War II there was also an unprecedented demand for psychologists to provide psychological services outside of psychiatric hospitals, to help returning servicemen adjust back into civilian life (Munley, Duncan, McDonnell & Sauer, 2004). These combined forces led to calls for a new kind of psychologist to meet the complex needs of people living in the community, with appreciation for factors that went well beyond a symptomatic understanding of psychiatric illness (American Psychological Association, 1952).

The official title *counselling psychology* emerged in the early 1950s, with the specified role of facilitating optimum psychological development across all levels of adjustment including severe psychological disturbance (American Psychological Association, 1952). Counselling psychologists of the time distinguished themselves from other specialists by their recognition of the psychological strengths and assets of the people they saw and their aim to prevent further psychological dysfunction (Super, 1955). Even then, the distinction from clinical psychology was slight, and reflective of the broader needs of people across society, rather than being restricted to those presenting in the psychiatric setting (Scott, 1980). In 1968 the American Psychological Association published a booklet that outlined three principal roles for counselling psychology practice: (1) rehabilitative and remedial roles, (2) preventative roles, and (3) educational and developmental roles (Jordaan, Myers, Layton & Morgan 1968). This tripartite definition of roles emphasised the treatment and prevention of mental health disorders, but added the growing importance of psycho-education and developmental approaches to counselling psychologists in that era.

By the 1970s, counselling psychologists were increasingly identified by the community as psychological health providers (Munley, 2004). The appearance of insurance coverage for mental health services in the

US, led to increased focus on standards of training and licensure that reflected the role of counselling psychologists as providers of psychological therapy. Towards the end of the 1970s counselling psychologists were being described as "mental health's primary care workers" (Kagan, 1977, p.4). This gradual shift towards psychotherapy was prompted by the growing number of people in the community turning to counselling psychologists to meet their mental health needs.

Counselling Psychology in Australia

It was some 20 years after counselling psychology appeared in the USA, that it finally arrived in Australia. The Rose committee report signalled the first attempt in Australia to define the training, roles and functions of counselling psychologists (Rose, 1971). The first chairman of the APS Division of Counselling Psychologists noted that this official report made no reference to the three roles for counselling psychology practice cited in the 1968 APA booklet (Williams, 1978). The Rose committee report did however emphasise the need to reach all sectors of the population, which required specialist-level training in psychological assessment, diagnosis and therapy. The distinctive approach of counselling psychology was presented as being to assist all people in society to fully develop and overcome psychological barriers, not only in the clinical setting, but also in the community. Counselling psychology had the task of bringing together complex factors beyond traditional psychological methods, including training about interpersonal, vocational, educational, social, and neurological issues.

Williams (1978) noted the distinctive focus of counselling psychology in Australia on empowering people to assume control of their lives. Clinical psychologists rejected the medical model in Australia at that time, but had struggled to adopt alternatives such as those utilised by counselling psychologists. Postgraduate training in counselling had only recently been established at that point in time (Williams, 1977) and only a few of the courses available were specific to *counselling psychology* (Williams, 1978). As the case remains, there was a great deal of confusion associated with the word *counselling* and around differentiating it from the title of *counselling psychologist*. During this era, Wills (1980) explored some of the distinctive functions of counselling psychologists in comparison to various other sorts of counsellors in the community. While he identified some distinct functions for counselling psychologists (e.g., psychological testing), his broad conclusions were that maintaining the high standards of expertise amongst counselling psychologists was far more important than claiming exclusivity. This view is consistent with the current US standards for specialist status in counselling psychology, which are defined by the distinctive features of the specialisation rather than exclusive or unique qualities (American Psychological Association, 1999).

In light of the growing numbers undertaking postgraduate training in counselling who went on to regard themselves as *counselling psychologists* during the 1980s, Penney (1981) surveyed the APS divisional membership to see whether a group comparable to the APA division had formed. He noted that the division in Australia was small and practice-oriented, ranking the activities of counselling and psychotherapy as tasks that occupied large proportions of their time. He identified the high quality of counselling work done and the capacity to both theorise and practice as being distinctive features of counselling psychology. However, around a quarter of the sample preferred not to identify with the title *counselling psychologist*. Penney concluded that there was "...not as yet a professionally visible group whose members can readily be distinguished as counselling psychologists. There are some individual psychologists whose training, experience and interests are primarily in counselling" (p. 28). It should be noted that at that point in time there were no postgraduate training standards for either counselling or psychology in Australia (Khan, 1983; Penney, 1981).

By the mid-1980s in the USA, counselling psychology increasingly focused on psychotherapy, rather than vocational or educational functions (Fitzgerald & Osipow, 1986) as had been the case in Australia since the late 1970s (Williams, 1977). With clinical psychologists beginning to take an interest in preventative roles and community functions, some were calling for a merger between clinical and counselling psychology (Watkins, 1985). Schoen (1989) confirmed that the same pattern had emerged in Australia, with counselling psychologists identifying psychotherapy with 'disturbed' persons as comprising the bulk of their work activity, above counselling with essentially 'normal' clients. This may reflect features of Australian culture, where people tend to access support for significant problems rather than personal development (Sharpley, Bond & Agnew, 2004). Corroborating Penney's survey, Schoen found that 43% of her sample identified themselves as counselling psychologists. She contended that identity confusion amongst counselling psychologists in Australia was unrelated to activities or aspirations of a practitioner, but rather, the professional title they preferred.

As a result of the convergence between clinical and counselling psychology in the late 1980s, questions grew about whether any valid differences remained. Johnson and Brems compared clinical and counselling psychology in the US across a number of areas, including training content (1991), publication productivity (Brems, Johnson, & Gallucci, 1996), job-related activity (Brems & Johnson, 1996) and theoretical orientation (Brems & Johnson, 1997). Very few practical differences were found, re-kindling calls for a merger between clinical and counselling psychology. Some important philosophical distinctions remained however, guiding the approach

of counselling psychologists. These were articulated in the 'Model Training Program for Counseling Psychology', developed by APA Division 17 (Murdoch et al., 1998, p. 662), namely: (a) a focus on working within a developmental framework across a wide range of psychological functioning; (b) a focus on assets and strengths, regardless of level of functioning; (c) the inclusion of relatively brief counselling approaches; (d) an emphasis on person-environment interactions, rather than an exclusive focus on either person or environment; (e) an emphasis on prevention, including psycho-educational interventions; (f) emphasis on the educational and vocational lives of individuals; (g) attention to issues of and respect for individual and cultural diversity; and (g) evaluation and improvement through critical thinking and a commitment to the scientific approach.

Counselling Psychology in Britain

It was as late as 1994 that the British Psychological Society (BPS) formed a Division of Counselling Psychology. Initially envisaged simply as a return of counselling practices to the domain of psychology, the BPS defined counselling psychology as "the application of psychological knowledge to the practice of counselling" (Woolfe, 1996, p.4). Less than a decade later however, Strawbridge and Woolfe re-framed counselling psychology in line with trends in the US and Australia as "a return to psychology initiated by psychologists trained in counselling and psychotherapy" (2003, p.4). Counselling psychology in Britain presently shares some of the core philosophical features found in the USA, namely: (1) a focus on the importance of helping relationships to positive client outcomes, (2) a questioning of the exclusivity of the 'disease model' in mental health, and (3) an emphasis on building strengths and well-being rather than focusing exclusively on sickness. British counselling psychology also emphasises the view that people actively contribute to their psychological change, explicitly giving the working alliance a central place. As can be seen, there is a consistent identity for counselling psychologists in the USA, Britain and Australia

In the first two decades of counselling psychology in Australia, the theoretical approach of practitioners was predominantly 'eclectic' (Williams, 1977; Khan, 1983). By the late 1990s however, most counselling psychologists in Australia were reporting an integrative rather than eclectic stance. In a survey conducted by Poznanski & McLennan (1998) the most popular primary theoretical approach was cognitive-behavioural, with nearly the entire sample drawing on some concepts and techniques from psychodynamic and experiential orientations. This is clearly an integrationist stance.

From a historical perspective it can be seen that counselling psychology is a specialty area that has been developing in Australia for around 30 years, focused on serving all members of the wider society. With its emergence in Australia, practitioners were already beginning to focus on therapeutic functions as a response to this development in the USA. This trend has continued largely due to the ongoing influence of north-American counselling psychology and the tendency of Australian people to consult a psychologist for complex and enduring problems, rather than for personal growth. This has shaped Australian counselling psychology into a specialist field that balances skills in psychological assessment, diagnosis and treatment, with an orientation towards building psychological strengths and harnessing positive change in relationships between people in intimate, group, organisational and community contexts (Barrett-Lennard, 2005).

Special Challenges: Access to Counselling Psychologists' Services

For many years, psychologists in Australia have been calling for government to provide funding for the community to access psychologists (McCallum, 1977). In July 2001 the 'Better Outcomes in Mental Health Care' initiative was launched, allowing people to access subsidised psychological services when referred by their GP. This has been hailed by many as an overwhelming success, with APS figures showing that such initiatives are reaching their target populations in the community (Giese, Lindner, Forsyth & Lovelock, 2008). However, while this has been an important initial step forward for Australia, the policy to date has excluded counselling psychologists from specialist roles. In turn, this has blocked the public from accessing the higher-level specialist rebates from counselling psychologists, and has meant that counselling psychologists can only provide the lower generic psychological rebate.

The source of this discrimination is in the terminology of the policy, which defines "psychological therapy" as being a treatment of a mental disorder by a clinical psychologist (Department of Health and Ageing, 2008; Kingdon, 2008). By comparison, all other psychologists who apply psychological techniques are regarded under this policy to be delivering "focussed psychological strategies" – a term that was invented when these initiatives were first drafted. This distinction is not acknowledged in any other jurisdiction. Instances of these supposed differential forms of intervention have not been provided, leading to the conclusion that they are either theoretical or political in nature, rather than any real signifier of differential practice. The effect has been that the specialist Masters-level training, experience and competence of counselling psychologists in the public health system has been overlooked.

There is not room in this article to list the raft of problems with the current policy. However, one significant problem has been the requirement of counselling psychologists to apply for registration with the APS College of Clinical Psychologists in order to

be recognised as specialists. As part of the registration process, applicants are required to show that they have undertaken 1000 hours of supervision by a clinical psychologist (APS, 2008b). This is a slow and expensive process for counselling psychologists, who have routinely already completed significant amounts of supervised professional experience in settings with mental health clients. In effect, this ultimately makes counselling psychologists less accessible, and in turn, reduces the number of specialists available to the public.

It is important to note that while some counselling psychologists have succeeded in having their specialist skills recognised, the official APS College competency criteria already recognise counselling psychologists as specialists in the assessment and treatment of complex mental disorders (Australian Psychological Society, 2008a). The requirement to demonstrate eligibility for membership with the APS College of Clinical Psychologists diminishes the value of diversity in psychology and undermines client choice. The current policy also sends the implicit and misleading message to GPs and the public that counselling psychologists are not competent to deliver "psychological therapy". In some cases the message has been more direct:

> Psychological therapy can only be provided by clinical psychologists who ... are able to undertake assessment and treatment of clients presenting with more complex mental disorders and those co-existing with drug and alcohol problems (Australian Psychological Society, 2007 p. 13).

Such misperceptions and misrepresentations of counselling psychology are regrettable both in the community and within the profession itself. One error made by those naive to counselling psychology is to interpret *counselling* as merely 'giving advice' and therefore to misrepresent *counselling psychologists* as those of the profession who 'give advice'. Considering the history of the development of counselling psychology, this view clearly does not apply to those bearing the title *counselling psychologist*.

Those outside the profession rely on what spokespeople for the profession tell them. Many have little knowledge of specialism within the profession. Amongst private health insurers for instance, this issue has begun to create some difficulties for counselling psychologists and their clientele, with the largest private health insurer in Western Australia granting provider numbers exclusively to clinical psychologists. To our knowledge, HBF are the only Australian private health insurer to restrict the choice of their membership in this manner. In the short-term future, excluding access to the available pool of trained specialists in psychology clearly presents a significant and ongoing challenge. Counselling psychology services should be made more readily available to the range of people who need them and who would benefit from the wider provision of specialist psychological services.

Unique Contributions of Counselling Psychologists

Counselling psychology, like all the psychology specialties, is underpinned by the scientist-practitioner model. Thus, counselling psychologists are experts in drawing upon scientific evidence when making decisions about what form of psychotherapy intervention will be appropriate for a particular client with a specific disorder or difficulty. However, counselling psychology is additionally characterised by three distinctive threads working their way through both professional and research activities. We have called these respectively *centrality of the relationship, a process orientation*, and *the voice of the client.*

Centrality of the Relationship

Partnership and collaboration is essential for human productivity in the arts and sciences, not to mention its role in biology in the reproductive cycle and the maintenance of life. Psychology's individualistic inflection has meant that it is constantly in need of re-orientation to these facts of social life. Its roots in biology and economics (Foucault, 1973) and its disengagement from social theory (Parker, 2002) may begin to explain this over-emphasis on individualism, though there are counterbalancing epistemologies circulating in the discipline (see for example, Harré,1983; Parker, 2002; Potter & Wetherell, 1987; Prilleltensky, 1997).

In that context, counselling psychology's corrective contribution to the understanding of relationship needs to be set against two areas of misunderstanding of psychotherapeutic intervention growing out of an unreflective individualism – the notions of *treatment-of-passive-patient*, on the one hand, and on the other, the *invisible-participation-of-the-therapist.*

Treatment of passive patient.

This is a misapprehension of how therapeutic gains are achieved. Many psychologist researchers and clinicians have attempted to construe therapeutic gains as brought about by the ministrations of therapists against a backdrop of assumed therapeutic relationship, empathic relationship, working alliance or supportive relationship. In this way of thinking elements of therapy – assumed to be the active ingredients of psychotherapy – are given prominence while the milieu in which the therapeutic intervention is delivered is accorded a *background* status and often mistakenly identified as a placebo feature of psychotherapy (Wampold, 2001).

The evidence continues to mount that this is a skewed view of the work of therapy. As Fonagy and Paris (2008) so cogently argue, the therapeutic alliance is a central feature in successful psychotherapy outcome.

> Client and therapist factors intersect in the concept of a therapeutic alliance. This term describes the collaborative relationship between patient and therapist. One of the most consistent findings in the

research literature is that the quality of the alliance is one of the better predictors of outcome (Luborsky & Crits-Cristoph, 1990; Orlinsky, Ronnestad, Willutski, 2004). Whether therapy will ultimately succeed is often apparent in the first few sessions, depending on the extent to which patient feel understood, and by the extent to which patients feel they are working (Horvath & Simmonds, 1991) well with their therapists. When therapy starts well, it is likely to continue well (Fonagy & Paris, 2008, p.107).

Wampold, a high profile counselling psychologist in the US, presents compelling scientific evidence about the centrality of the therapeutic alliance to outcome, the lack of evidence about specific factors, and the lack of evidence of superior outcomes in comparison studies of different models of therapy (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997; Wampold, 2001; Wampold, Minami, Tierney, & Baskin, 2005; Wampold, Lichtenberg & Waehler, 2005; Ahn & Wampold, 2001). Wampold (2001) provides a substantial review of hundreds of psychotherapy outcome studies which meticulously documents the factors that influence psychotherapy outcome. The scientific evidence he presents has led him to seriously question the usefulness of the current research preoccupation which focuses so heavily on specific models of therapy. This has led the Counselling Psychology Division 17 of the APA to take a much broader view of empirically supported treatments than other Divisions, including an emphasis on client choice, clinical judgement, and meta-analystic reviews which indicate the key common factors in outcome (Wampold, Lichtenberg & Waehler, 2005).

The work of counselling psychologists and the scientific critique they and others have provided have had a major impact on the taskforce which revised the APA Policy Statement on Evidence-Based Practice in Psychology (American Psychological Association, 2005). The revision is an excellent statement that now includes sections on the importance of clinical expertise, patient characteristics, values and context, patient choice, as well as scientific evidence. This quote from the document captures the move to a much more detailed, nuanced, and complex definition of evidence-based practice:

> Clinical expertise is used to integrate the best research evidence with clinical data (e.g., information about the patient obtained over the course of treatment) in the context of the patient's characteristics and preferences to deliver services that have a high probability of achieving the goals of treatment. ... A central goal of EBP is to maximize patient choice among effective alternative interventions (American Psychological Association, 2005. p.1)

In summarising the value of the working alliance Horvath (2001), a Canadian counselling psychologist, points out that a weak working alliance jeopardises psychotherapeutic outcomes; that a strong working alliance is not a by-product of therapeutic gains; and that over time the notions of the working alliance entertained by client and counsellor converge.

The invisible participation of the therapist.

The second act of reorientation renders the therapist's participation visible in bringing the psychotherapeutic relationship itself into view. Counselling psychology recognises the therapeutic relationship itself as an exemplar of adequate relationship in the patient's world of abusive or often inadequate relationship (Grant & Crawley, 2002). A substantial Australian contributor to the person-centred approach (and a member of the College of Counselling Psychology), Barrett-Lennard puts relationship at the core of psychotherapeutic healing.

> The term 'individual psychotherapy' can be misleading. Language categories often have unseen effects in practical affairs, and dropping the term 'individual' would be a healthy, small step towards a concerted approach to the healing development of relationship (2005, p.119).

A relationship focus is found in one of the therapeutic approaches, Interpersonal Therapy (IPT), investigated in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Wampold, 2001; Elkin, 1994). This key piece of research has been subjected to repeated analysis. IPT was initially formulated as a time-limited therapy for depressed adults. In focusing on depressive symptomatology and current interpersonal relationships it articulates the connections between the client's current functioning, social relationships, and expectations of these relationships, and their contributions to the client's malaise (Fonagy & Paris, 2008). This large efficacy study showed IPT & CBT as achieving equal therapeutic outcomes and concluded that both were efficacious in the treatment of depression (Wampold, 2001). Furthermore, ratings of the working alliance were made by patients and therapists over the course of the study. The following provides a summary.

> The results also showed a significant relationship between total therapeutic alliance ratings and treatment outcome across modalities, with more of the variance in outcome attributed to alliance than to treatment method. There were virtually no significant treatment group differences in the relationship between therapeutic alliance and outcome in interpersonal psychotherapy [IPT], cognitive behaviour therapy [CBT], and active and placebo pharmacotherapy with clinical management (Krupnick, Simmens, Moyer, Elkin, Watkins, Pilkonis, 1996, p.536).

Recent contributors to cognitive therapy approaches have added components to CBT to make it more useful in addressing characterological problems (Young, 1999, 2003; Ryle & Kerr, 2002; Ryle & McCutcheon, 2006). The CBT assumptions that clients will comply with treatment protocols, that clients will report their cognitions and emotions faithfully, and that the procedures of empirical analysis, logical discourse, and gradual steps will be effective strategies have been called into question by a group of integrationist thinkers particularly in response to the difficulty of addressing personality disorder problems (Ryle & Kerr, 2002; Young, 2003). One of the responses has been to place "much greater emphasis on exploring the childhood and adolescent origins of psychological problems, on emotive techniques, *on the therapist-patient relationship*, and on maladaptive coping styles" (p.5) [our italics], and on collaborative re-formulation with patients (Ryle & Kerr, 2002).

Much more has been said about the importance of relationship and the working alliance to successful psychotherapeutic work. It is a key and acknowledged feature of a counselling psychology approach.

Process Orientation

Processes in psychotherapy refer to unfolding change events in the therapeutic engagement including the client's and therapist's ongoing work in formulating and re-formulating issues, problems and predicaments and their resolution (Ryle & McCutcheon, 2006). A process orientation adds to a *treatment-for-disorder* framework in recognising that clients often determine the goals of psychotherapeutic work in collaboration with their therapist whether or not they have met with a 'diagnosis'. Furthermore, process-oriented approaches to psychotherapy recognise the contribution of the therapist to the process of psychotherapy. Process approaches develop the relationship focus in the domains of both practice and research. The importance of reflexive psychotherapeutic practice is also emphasised as the practitioner is an acknowledged participant in the therapeutic endeavour (Grant & Schofield, 2007). Reflexive practice is specified as an important variable in the US (APA, 2005) and New Zealand (New Zealand Psychologists Registration Board, 2006) for all psychologists in training.

While recognising the value of diagnostic categories, a process orientation suggests using them as fixing points in time – as snapshots of client functioning at a particular point in time – rather than as final and defining ontological statements (see Webster, 2008). A process orientation is employed in the knowledge that attention to the process elements of psychotherapy will result in good outcomes, and may well lead ultimately to the discovery of the common process elements of all effective psychotherapies.

Currently the difficulty for the well-established approaches to psychotherapy is the lack of evidence for the mechanisms of change they propose. Although several mechanisms of change have been posited, their specification has eluded research corroboration (see for example Tang & DeRubeis, Hollon, Amsterdam, & Shelton, 2008; Tang & DeRubeis, 1999; for recent attempts to specify cognitive restructuring as the agent for change for sudden gains noted in CBT). It may turn out that the difficulty in specifying a mechanism for psychotherapeutic change is a result of looking for it in the wrong place – within the individual. The suggestion that refigurative and representational work in the therapeutic engagement is the locus for change may well prove to be a fertile ground for research work on therapeutic change (Denham, 2008b).

Emotion focused therapy (EFT) provides a conceptual framework for a process-oriented approach (Elliott, Watson, Goldman, & Greenberg, 2004). Greenberg & Goldman (2007) articulate an EFT perspective below:

> We believe that that which is most problematic, poignant, and meaningful emerges progressively, in the safe context of the therapeutic environment, and that the focus is co-constructed by client and therapist (p.380).

For them, therapy consists of helping the client to articulate and organise this experience into a coherent narrative and change occurs through:

> ...the processes of emotional awareness and expression, regulation of emotion, making sense of emotion by reflecting on it, and finally transformation of maladaptive emotion... Self-acceptance and the ability to integrate various disowned aspects of the self as well as the need for restructuring maladaptive emotional responses are the central means of overcoming psychological dysfunction (p.383).

Whether or not the account of change offered by EFT is corroborated, it is certainly important as a guiding statement for the effective conduct of therapy. A process orientation does keep therapists focusing on the experience of their patients and is likely to lead to a strong working alliance.

The Voice of the Client

While counselling psychologists have recognised the value of proper assessment and diagnosis of human distress, a central therapeutic task for counselling psychologists are the relational events between therapist and client which lead to successful dialogues, the co-construction of new narratives, or the re-working of relational patterns (Grant & Crawley, 2002; Crawley & Grant, 2008). Counselling psychologists argue that successful interventions are as much about *providing resources for* clients as they are about *treating them.*

If it is to be successful, psychotherapeutic work must engage with clients' understandings and accounts of their distress. A productive dialogue is a necessity for psychotherapeutic progress. Counselling psychologists acknowledge that there are a range of accounts of psychological distress varying in the degree to which they are inflected with biomedical and/or psychotherapeutic notions.

Many of the professional psychotherapeutic approaches posit an *intrapsychic deficits* model contributing to client distress (Prilleltensky, 1997). Perspectives in counselling psychology have continued to also acknowledge the voices of clients in *their* formulations of distress, of how distress is constellated, and of how they might work their way through their distress. The task of effective psychotherapy is conceived as building on client understandings and formulations of their predicaments, problems, and indeed, solutions to these dilemmas. This includes a recognition of extra-psychic factors.

The recognition of different voices is particularly important in transcultural work, and counselling psychologists have made a significant contribution in this area where there is some considerable disparity between the formulations proposed by health practitioners and those proposed by ethnic and minority groups. There is much to learn about working in transcultural mental health contexts. For example there is among some African people, the idea that there best way to recover from traumatic events (the extreme event being genocide) is to actively forget them (Fabian, 2003). Of course, such a notion is in considerable tension with our current psychological understanding of post traumatic stress disorder and therapeutic models which indicate the efficacy of exposure therapy (Australian Centre for Posttraumatic Mental Health, 2007). Recently the emphasis on working with refugees' resettlement in the aftermath of torture/trauma has shifted to understanding recovery and what clients do to help themselves in this process and how that endeavour can be supported (Herman, 1995; Denham, 2008a)

Using these transcultural therapeutic encounters as a starting point, successful psychotherapy treatment outcomes can be conceptualised as a productive dialogue between explanatory models of disorder, distress, and suffering as proposed in medical anthropological writing (Kleinman, 1978). This is a very useful heuristic for work in transcultural mental health. Two fundamental models articulating human distress, a Disease Explanatory Model and an Illness Explanatory Model have been proposed. The Disease Explanatory Model is informed by biomedicine, while the Illness Model is informed by folk medicine and local popular culture. At the conclusion of therapeutic contact, how the client now thinks about his/her issues, predicaments, disorders, and problems is quite important, and leaves open the possibility that clients may well hold beliefs or ideas inconsistent with psychotherapeutic or biomedical orthodoxy in successfully negotiating psychological distress. At a cultural level, healing is conceived as a mingling of explanatory models, not as the demonstration of the superiority of a privileged psychotherapeutic and/or biomedical account.

Some have advocated a patient-focused research effort to improve treatment outcomes by carefully monitoring patient progress and providing formal feedback to clinicians. Findings suggest this as a promising approach to ensuring that psychotherapy is tailored to the needs of individual clients (Lambert & Archer, 2006).

In recognising clients' contributions to their own recovery from distress in the various ways outlined, counselling psychologists underscore the value of collaboration and partnership in therapeutic activity, and refuse an understanding of professional activity which posits a psychological practitioner as the final arbiter of human distress, and how it is to be overcome. In giving status to the voice of the client, a dialectic is maintained between a practice informed by a professional psychotherapeutic discourse on the one hand, and the cultural and local understandings of distress and suffering that come from the client and their cultural contexts, on the other, and a confluence of the two.

Conclusions

Counselling psychology has a long and interesting trajectory from its origins in the US during the 1950s. The core features of counselling psychology include expertise in: counselling and psychotherapy; developmental frameworks; other modalities such as couple, family and group therapy; mental health disorders; and expertise with challenging difficulties in the usual course of living. Although counselling psychology in Australia (unlike the US or UK) is often misrepresented as exclusively dealing with populations at the more 'normal' end of the continuum, it is hoped that this paper has dispelled this peculiarly Australian myth. Indeed, as we have argued, one of its defining features is the breadth and diversity of populations and issues that counselling psychologists address.

Counselling psychology, like all the specialities, is heavily invested in the scientist-practitioner model and has been active in engaging with psychotherapy outcome and process research and the surrounding debates regarding evidence-based practice, empirically supported practice and practice-based evidence. The Counselling Psychology College has sponsored international speakers notably Professor Bruce Wampold in 2004 and Professor Dawn Freshwater in 2005 at APS conferences that have enriched these debates. However, in addition to this perspective, we have argued that counselling psychology has three unique threads which include: *centrality of the*

relationship; a process orientation; and *the voice of the client*. This has led counselling psychology to place a particular (but not exclusive) emphasis on variables such as the therapeutic alliance, client variables including culture, gender, and race, and the processes of psychotherapeutic engagement and working alliance maintenance.

Recently there have been some major challenges in the political landscape of the profession of psychology to counselling psychology. These challenges have undermined a number of the specialities in Australia. For counselling psychologists, who work extensively in the health and mental health arenas, the lack of specialist recognition of their health and mental health expertise in relation to specialist rebates has been particularly invidious. There are new developments in the profession, including national registration and proposed changes to education and training models for psychologists. It remains to be seen whether these developments strengthen or further challenge the speciality of counselling psychology.

In conclusion, this paper has attempted to clarify the identity of counselling psychology so that existing and future challenges in the provision of high quality mental health services can be met. Counselling psychologists have provided a high level of psychological assessment and therapy in government, non-government and private settings for the last three decades. Counselling psychology has been a rich and diverse specialisation that is currently thriving in the both the US and the UK, where practitioners are seen as core mental health and psychotherapy service providers. It is hoped that delineating the specialty and naming some of its core features and strengths will contribute to the continued healthy growth and development of the specialty within Australia.

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