

Response to PLG report July 2009 from National Council of Psychotherapists (1971)

Before detailing specific comments on the report by the HPC Professional Liaison Group on the proposed statutory regulation of psychotherapists and counsellors, it is helpful to make some general points about the report and the draft standards of proficiency which are attached to it. All of these general points have been made repeatedly in meetings with the HPC as well as in written correspondence over the last three years both by ourselves and others:

- 1) The Government White Paper on Trust, Assurance and Safety had given the Health Professions Council the task of assessing the 'regulatory needs' of the field and 'ensuring that its system is capable of accommodating them'. These two briefs have simply not been met by the HPC consultation or by the work of the PLG. There has been both an absence of sustained rational debate on the central issues and an exclusion of critical voices, a fact which has been brought to the attention of HPC and of MPs repeatedly.
- 2) Many practitioners of talking therapies do not see their work as constituting in any way a health profession, and their traditions have been critical of the received notions of health, illness and wellbeing that the HPC consultation and the PLG report take as given. Despite the fact that this point has been made innumerable times, it is not reflected in either the content of the report or the standards of proficiency.
- 3) The view of therapy presupposed in many parts of the report and in the standards of proficiency is at odds with many traditions of therapy over the last century. Therapy is not conceived as an intervention to be applied to a patient, but rather as an activity which the patient him or herself engages in, facilitated by the therapist. It is thus not a question of the transmission of knowledge or skills from one party to another, just as it is not in any way comparable with a medical style intervention such as the administration of a drug or any other form of predetermined procedure.
- 4) The report and the standards of proficiency presuppose a concept of self that is radically rejected by many schools of psychotherapy. This is the modern idea that the self is reducible to a set of skills and competencies which must be forever improved. On this model, the human being is seen as a business which has to better itself, making it an ever more viable competitor in the marketplace. Although there may be some therapists who subscribe to this view, it is totally opposed to many therapeutic traditions which base the very work of therapy on a critique of socially accepted notions of selfhood.
For these therapies, the self is not there to be 'improved' or 'bettered', but rather to allow its history to be explored, and its fractures, frustrations and disappointments to be recognised. The growth and change that may follow do not constitute an 'improvement' or 'bettering', as this would suggest a normative view of what people should be. The standards of proficiency thus presuppose the very idea of self that thousands of therapists work every day to undermine in their practice. There is thus both a contradiction and an absurdity in trying to force

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therapists to frame their work within standards of proficiency that uphold the very values that the therapeutic process aims to put in question.

Comments on HPC Draft Document on the Statutory Regulation of Psychotherapists and Counsellors.

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The constitution of the PLG is described here as including “individuals representing professional bodies, education and training providers, a qualification awarding body and organisations representing the interests of service users”. It is not pointed out that the choice of the 17 members rigorously excluded all those who had critical views of HPC regulation who had been nominated by their organisations or who had nominated themselves for the PLG. It was thus a highly biased collection of individuals, which also excluded the service user group the Association of Psychoanalysis Users. Instead HPC chose the advocacy group Witness, which is funded partly by the Department of Health and which has worked closely with HPC. It is also incorrect to state that the PLG included “organisations” representing service users, as there was only one, if Witness can be so described.

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The report states that ‘the responses to the [HPC’s] Call for Ideas informed the discussion and recommendations of the PLG’. In fact there has been a remarkable failure to respond to any of the critical responses to the Call for Ideas aside from noting which groups had made which points in a previous HPC document. After this cosmetic registering of some criticisms, HPC has failed to respond in any detailed or serious way to the points made in response to the Call for Ideas. It was pointed out several times to the HPC that the PLG meetings had failed to include adequate discussion of the majority of the points that had been made.

Paragraph 19 and 20 refer to the stakeholder events held in Manchester in March 2009. There is no mention of the criticisms made of the HPC project there or of the HPC’s refusal to hold a further meeting in response to the request from stakeholders and members of the public who attended and saw an absence of any engagement with the points that were made. The Manchester event was simply there as an airbrushing exercise to create the false impression that HPC had ‘listened’.

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Paragraph 26 It is stated that ‘the role of the PLG was to discuss and make recommendations about how psychotherapists and counsellors might be regulated in light of the conclusions in the White Paper’. Yet the White Paper had required the HPC to **assess the ‘regulatory needs’** of the field and whether it was suited to ‘accommodate’ this field. Neither of these crucial questions was in fact taken up in any sustained or serious way by the PLG meetings, the minutes of which are publicly available.

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Voluntary registers to be considered for transfer to HPC require that members demonstrate a commitment to CPD. Although many therapists would accept this idea, there are also important traditions in psychoanalysis and psychotherapy which do not accept the idea of CPD. Becoming an analyst or therapist, according to these traditions, involves profound psychological change which is not the result of knowledge or anything that can be taught in a course or learning environment. Such change can be more accurately compared to losing a limb than to memorising a handbook of information. For these traditions, that is what allows the person to then be open to working with the unconscious of other people. Given this view, it makes little sense to argue that the practitioners need to update their knowledge and skills on an annual basis. This would be like making the person prove on an annual basis that their limb hadn't miraculously re-grown. These traditions also hold that the result of any serious analysis or therapy is a questioning of the vanity of human knowledge. This is completely at odds with the modern mentality of CPD in which an 'expert' is brought in to dispense the latest knowledge to those who wish to better or improve themselves. Psychoanalysis and many forms of psychotherapy do not have a cumulative model of knowledge, but rather sees the loss of knowledge as decisive. Freud, for example, said that the analyst must forget everything they know each time they see a patient. Taking this seriously, CPD would involve ensuring that the practitioner is able to not know anything. The paradoxes of this form of assessment are also well known, with clinicians feeling that they have to prove themselves to some external authority: This, indeed, is exactly the kind of dynamic that many forms of therapy aim to collapse.

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Point 9 Here, and at several other places in the document, there is a reference to clinicians only being able to practice 'in those fields in which they have appropriate education, training and experience'. On the surface this may seem a very reasonable obligation, but it introduces important political factors which have an impact on how the fields are defined for which such education, training and experience are relevant. There is a very real danger here that models of diagnosis and categorisation of human distress – such as that provided by DSM – will be used here as benchmarks, despite the fact that many traditions in psychoanalysis and psychotherapy have their own classificatory systems which disagree with those of DSM, or indeed, which object to the very notion of the classification of human beings into groups through the process of dividing them via external symptoms. The danger is that notions prevalent in modern healthcare, such as 'best practice', 'evidence based research' and 'mental illness' will be used uncritically in order to tell therapists who they can and cannot work with.

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The document states that if a registrant's competence is called into question, the 'standards of proficiency set by HPC are taken into account in deciding whether any action is necessary'. Since the standards of proficiency proposed are so dramatically incompatible with many long established traditions in psychotherapy, it puts registrants at great risk of having their practices adversely affected by the application of frameworks which are unsuited to assess or evaluate them.

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There are several paragraphs here which state the requirements of certain standards of proficiency in English language to enable a therapist or counsellor to be able to practice. This is a rather absurd requirement as there is no intrinsic reason why a therapist should have to speak a certain level of English: this may be for the obvious reason that the patients they receive would wish to speak in their own mother tongue, shared with the therapist, which is not English but also, and more fundamentally, because language is itself a psychological variable which will form part of the transference. If someone has been brought up by a parent who couldn't speak the language of the country they happen to be in, they may well seek out later in life a therapist who clearly has difficulty speaking a language. As long as the therapist does not claim to have standards of proficiency which they do not in fact possess, it is surely the choice of the patient who they wish to speak to. Insisting on a certain proficiency in English language removes that freedom of choice from members of the public.

NCP Response to the HPC Draft Standards of Proficiency for Psychotherapists and Counsellors.

Before providing comments on the individual standards of proficiency, it is important to make some general points which concern issues which recur repeatedly throughout this document.

1) The HPC standards have been drafted with hardly any thought as to the specificity of the talking therapies: there are references to the use of equipment, to infection control, and to the wearing of protective clothing. *The fact that requirements that are obviously tailored to medical work within hospitals or NHS trusts feature so predominantly in the HPC standards, begs the question of how much attention has been paid to the particularity of the talking therapies, despite the fact that the HPC has been exploring this field apparently for at least the last three years.* Nearly all of the requirements would be highly controversial when applied to the talking therapies, although less so in relation to medical work carried out within the NHS.

2) The standards of proficiency presuppose a view of therapy which is contested by most major traditions in psychotherapy today. Therapy is seen as a procedure to be applied to a passive patient, and the standards suggest time and time again the image of a patient as an object being described, assessed, evaluated and acted on by a team of experts. This view completely ignores the central feature of psychotherapy: the fact that it involves a relationship between two parties, and that the main work of the therapy is conducted not by the therapist but by the patient. The patient is not a passive object who receives treatments and procedures from a therapist, but is rather the active agent in the process of therapy. The standards repeatedly conceive the therapeutic process as the localised application of knowledge or skills to a patient rather than seeing the dynamical relations between patient and therapist as the central component of the work.

3) The standards repeatedly presuppose a view of the self which is not accepted by most of the main traditions in psychotherapy. The self is seen as a project to be realised, as if human beings were like faulty pieces of equipment that needed to be repaired and then continually upgraded. Psychotherapists have not been the only critics of this view of human life: philosophers and social theorists have observed and commented on this contemporary view of the self over the last three decades. On this view, the self must be continually improved and bettered, following

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both the old religious discourse about self improvement and the discourse applied to inanimate objects that are deemed to require continual upgrades (a well known principle of the modern economy). While there may be some therapists who adopt this view, the main traditions in psychotherapy do not see the self as something that needs perpetual improvement and bettering, but rather believe that therapy involves a recognition of the points of fracture, loss and disappointment that the new rhetoric of the self 'to be improved' tries to obscure. Growth and change are not about 'improving' or 'bettering oneself', but emerge as possibilities based on recognition of often painful realities. *Using the vocabulary of self improvement in the standards effectively makes therapists subject to the very principles that they are doing their best to challenge in their patients.*

4) The standards repeatedly refer to procedures of audit, management and predetermined outcome. These terms may be applicable in most medical and business contexts, yet have little purchase for the main traditions of psychotherapy. These traditions see therapy as involving the fostering of a freedom in the patient from precisely these irrational forms of external 'audit' and 'management'. The HPC standards would thus force the therapist to do exactly what they are trying to get their patients to question and move away from. Clinically, this will produce therapists who constantly feel they are being watched, the private space of the therapy becoming the stage for an internalised judge or examiner. The consequences of this on therapeutic practice cannot be underestimated, and there is an irony here that many traditional descriptions of psychotherapy define it as the effort to free oneself from the internalised observer-judge that may be the cause of the patient's unhappiness.

Commentary on the Draft Standards

Please note that throughout this document, for the sake of convenience, we use the term 'patient' rather than 'client' or other terms used in different traditions of psychotherapy or counselling. It is not intended to imply a passive or medicalised position, but rather that of an active agent in the therapeutic process.

Point 1A.1

It is stated here that psychotherapists and counsellors must 'understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing'. This requirement would not be accepted by a large number of practitioners. There is no reason why a therapist should respect the values of a 'service user', just as many therapists would not see it as their role to maintain the health and wellbeing of the patient, seeing this as in fact the responsibility of the patient. Many therapists do not see themselves as doctors or health professionals: they provide a space for a conversation about human life, rather than any kind of healthcare delivery. Similarly, many therapists would see it as a central part of the work to voice, on occasion, their own personal disagreement with the value systems of the patient. Should the Jewish therapist respect the values of the Nazi patient? The clash of value systems may in fact be a crucial instrument of change and development within a therapeutic practice. The references here to autonomy are also unclear, and may be problematic for those traditions which aim not to foster notions of autonomy in the patient, but on the contrary, to collapse them. It is also unclear what the reference to, *the patient's role in the diagnostic and therapeutic process*, is meant to mean here.

1.6

Psychotherapists and counsellors are required here to 'understand their duty of care with regard to the legislation on safeguarding children, young people and vulnerable adults'. There is a

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question here of differentiating the duty of care of the healthcare professional and the responsibility of a therapist. Many therapists would believe that they certainly have a duty in relation to their clinical work, but this duty must be differentiated from the standard notion of duty of care, especially when it concerns questions such as confidentiality.

1A.6

The requirement that psychotherapists and counsellors must be able ‘to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem’ would not be accepted by many therapists. They would disagree with this medicalised conception of their work, which is based on the idea of localised intervention: a problem is defined and a procedure deployed to act on it. For the many schools of therapy which see their work as an open-ended conversation about the problems of human life, this requirement is entirely inappropriate. It suits more those therapies which seek concrete outcomes and solutions to problems. Many therapists, on the contrary, do not believe that they are in the problem-solving business. The danger here is that healthcare models of problems and solutions are used as a benchmark to both exclude and sanction alternative therapeutic approaches.

The requirement that psychotherapists and counsellors must ‘be able to initiate resolution of problems’, may be applicable to a small number of therapies but is largely antithetical to the practice and ethos of most forms of psychotherapy which are not focused on the resolution of problems and do not make any such claims to the public.

1A.7

The requirement that psychotherapists and counsellors must ‘recognise the need for effective self management of work load and resources and be able to practice accordingly’ may be applicable for staff working in organisations or NHS contexts but has nothing to do with the practice of psychotherapy.

1A.8

The requirement that psychotherapists and counsellors ‘understand the need for high standards of personal conduct’ may be applicable to some therapists, but there are many traditions of therapy which highlight precisely the human nature of the therapist, and hence human weaknesses and failings. ***This is of course not to condone misconduct or breaches of professional boundary***, but it is important as a part of the therapeutic process that the moral values of a society do not contaminate the individual value systems that can be fostered through the work of psychotherapy and counselling. The point has been made several times that psychotherapy has always offered a system of values freed from the moral judgments of recognised social authorities. Hence it makes no sense to apply these latter standards to those who undertake therapy and become therapists precisely in order to find something different.

The requirement that psychotherapists and counsellors ‘understand the importance of maintaining their own health’ is also inapplicable to the majority of schools of therapy. Therapists can drink, smoke and lead sedentary lifestyles just like anyone else. ***They do not have a duty to conform to any particular imperative of physical wellbeing obtaining in any particular historical period.*** Of course, if problems with their physical health make it impossible for them to practice, this is an altogether different question, one which all current codes of ethics and practice recognise and proscribe against.

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The requirement that psychotherapists and counsellors ‘understand both the need to keep skills and knowledge up to date and the importance of career long learning’ may be applicable to some therapies but is at odds with many established traditions of psychotherapy which involve an engagement with the limits of knowledge. The idea of career long learning is part of the contemporary ideology of betterment or improvement of the self, as if the self is a project which must be realised, to allow one maximum satisfaction and efficacy in one’s work. Many traditions of psychotherapy reject this view of the self, arguing that the work of therapy involves a recognition of human fracture and frustration, a recognition of the vanity of human knowledge and a profound scepticism as to the idea of a cumulative knowledge. The kind of knowledge operative in psychotherapy is unconscious knowledge rather than academic knowledge which can be simply and readily transmitted. Training in psychotherapy involves profound psychological change and it is this change that will allow the person to work with other people as a therapist. It is not about acquiring skills and knowledge, but rather about losing them, to open oneself up to another human being. The fact that this perspective is central to a large number of established traditions of psychotherapy must be recognised in any consideration of proposed standards of proficiency.

The requirement that psychotherapists and counsellors must be able to recognise ‘their own distress and disturbance and be able to develop self care strategies’ also supposes a view of the self antithetical to many traditions of psychotherapy. For these traditions, therapy is not about self care strategies, and the whole notion of self care has been the subject of sustained conceptual criticism. It supposes the contemporary ideology of management of the self rather than traditional views of a recognition and engagement with conflict, contradiction and fracture. The therapist here is once again put in the place of a kind of business manager whose job it is to pursue the work of risk management of the patient at the same time as a management and audit of the self. There may be some therapists who would subscribe to this view, but this is not a part of the relational person-centred version of psychotherapy that has been established in the UK for many years.

1B.1

The requirement that psychotherapists and counsellors ‘understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team’ may well be applicable to some therapists working within the NHS but will not apply to the majority who work in private practice and who are clear about the importance of independence and, in some cases, not being part of a team. The internecine fighting between therapy groups over the last eighty years has meant that many therapists see it as a virtue not to work within a group and it is precisely this independence, even solitariness, which will attract certain patients to them rather than to other practitioners who work more closely within groups. This does not mean, of course, that the practitioner is not responsible and accountable for their work, but it means respecting the value of independence both for the therapist and for their patient.

The requirement that psychotherapists and counsellors ‘understand the need to engage service users and carers in planning and evaluating the diagnostics, treatment and interventions to meet their needs and goals’ may be applicable to a small number of therapies offering targeted interventions, but is not applicable to the majority of therapies which offer an open-ended exploration of human life and history. ***Planning and evaluating diagnostics, treatments and interventions is a medical paradigm that puts the patient in the position of an object, to whom a treatment is applied.*** Most therapies offer no set outcome and can make no honest promise about what will happen. Furthermore, many forms of psychotherapy aim specifically not to meet the needs and goals of the patient, with the idea that needs and goals are conscious phenomena, formulated as conscious demands, and if a distinction between conscious and unconscious thinking is recognised, the therapist has an ethical obligation to listen to the patient beyond their conscious wishes and demands. *This is a fundamental feature of all psychoanalytic therapies,*

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where the idea of meeting the patient's needs and goals makes absolutely no sense. The central ethical position of a psychoanalyst, according to the most widely practiced form of psychoanalysis, is the refusal of the analyst to meet the patient's demand.

1B.2

The requirement that psychotherapists and counsellors 'be able to contribute effectively to work undertaken as part of multidisciplinary team' may be applicable to certain therapists working in the NHS but has no application to most private practice therapy or counselling.

1B.3

The requirement that psychotherapists and counsellors must 'be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relative and carers' may be applicable to certain health professionals but has little to do with the work of therapists and counsellors. There are many reasons for this. Confidentiality, for instance, means that clinicians do not broadcast their opinion, and, for most therapists, therapy is not about advice or instruction. As for communication skills, this may be important for some forms of therapy but is certainly inappropriate for others: a Freudian psychoanalyst, for example, might remain totally silent and refuse to say anything for months or even years. The specificity and particularity of different traditions of talking therapy must be respected here and the public given the choice to pursue the form of therapy they consider appropriate, regardless of whether the therapist has communication skills or not. That is why the next requirement, in which therapists and counsellors be able to communicate in English to Level 7 of the international English language testing system is absurd. There is no intrinsic reason why a therapist should have to speak any particular level of English: this may be for the obvious reason that the patients they receive would wish to speak in their own mother tongue, shared with the therapist, but also, and more fundamentally, because language is itself a psychological variable which will form part of the transference. If someone has been brought up by a parent who couldn't speak the language of the country they happened to be in, they may well seek out later in life, a therapist who clearly has difficulty speaking a language. *As long as the therapist does not claim to have standards of proficiency which they do not in fact possess, it is surely the choice of the patient who they wish to speak to.* Insisting on a certain proficiency in English language removes that freedom of choice from members of the public.

The many other requirements in this section involve basic misunderstandings about language, presupposing the dated and much criticised view that language is simply a medium of communication. For most traditions of psychotherapy, as well as for the human sciences in general, language is less a medium of communication than in itself a body which has effects: the act of saying something in itself may produce change and the performative aspects of language have been well studied.

The requirement in this section that psychotherapists and counsellors 'recognise that relationships with service users should be based on mutual respect and trust' would not be accepted by all schools of therapy and it is precisely, in some cases, a lack of respect and trust that will generate the development and the dynamic of the therapeutic work. There is no intrinsic reason why a patient should trust a therapist, and indeed, it has often been argued that in an ideal world the patient's attitude should be one of sustained scepticism. It is well known that unconditional trust is the best possible framework for the abuse of power and the violation of professional boundaries. There is also no intrinsic reason why a therapist should automatically respect the patient, even if they may learn to respect them as the therapy progresses. To make it a rule that one human being should respect another is an arbitrary imperative: should the Jewish therapist automatically respect

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the Nazi patient for example? Note that this does not mean that a therapist should in any way mistreat a patient, an entirely different matter which is codified against in all current codes of ethics and practice of psychotherapists.

The requirement that psychotherapists and counsellors be ‘able to communicate appropriately and effectively with other professionals about the client and proposed therapeutic work’ may be applicable to some therapists in NHS contexts but, even then, it raises serious questions of confidentiality. We find here yet again the view that runs thorough all the HPC’s standards of proficiency that the patient is an object about whom therapists and other ‘professionals’ may have a discourse. The characteristic of most established psychotherapy traditions is to treat the patient as a subject and not an object. The fact that this kind of requirement keeps on emerging in the HPC standards shows the centrality of the medical model which underlies it: a group of people discuss a human being as an object of medical style interventions to be applied to them. In contrast, for most traditions of psychotherapy, the patient is an active subject with an active engagement in the work they undertake. The main work in the therapy, after all, is performed not by the therapist but by the patient.

1B.4

The requirement that psychotherapists and counsellors ‘understand the need for effective communication throughout the care of the service user’ begs the question of whether the therapist subscribes to the notion of communication and what theory of efficacy is assumed. The Freudian’s complete silence, for example, may be felt as an effective communication by one patient but as a total lack of communication by another. The therapist him or herself may likewise not feel that they are in the business of communication: they may well see their work as allowing the creation of a space in which the patient can hear themselves in a new way. It is thus not a question of communicating information or knowledge to the patient. Many therapists would also see the idea of communicating information to the patient as constituting a form of suggestion and hence consolidating the place of the therapist as a kind of master in the therapy, a situation which most therapists would want to avoid.

2

The requirement that psychotherapists and counsellors ‘be able to build, maintain and end therapeutic relationships with clients’ might seem natural enough, but it once again supposes a model of therapy as something that is applied to the patient, rather than seeing therapy as the work done by the patient. It is really the work of the patient to build, maintain and end the therapeutic relationship, although the therapist will no doubt work to facilitate this to the best of their ability. This asymmetry is another feature that is consistently ignored and unrepresented in HPC’s standards of proficiency, which see therapy as a set of techniques to be applied to a patient rather than an active work performed by a patient. How, after all, can a therapist be able to end relationships with clients? A moment’s reflection on this requirement shows its absurdity: if therapy is a relationship between two people with all the complexities and emotions of any passionate human relationship, it would be as if a requirement were imposed on human beings in their love relationships that they be able to end them competently. There are no rules for ending a human relationship, and to pretend that there are is pure charlatanism. Rather, what is particular to psychotherapy is precisely the fact that the difficulties, the horror, the pain and the complexity of endings actually form a part of the therapeutic work, rather than being a skill to be applied to it.

2A.1

The requirement that psychotherapists and counsellors ‘be able to gather appropriate information’

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may be applicable to some health professionals working in the NHS but has little to do with most practices of psychotherapy and counselling, which are not about the gathering of information.

2A.2

The requirement that psychotherapists and counsellors 'be able to select and use appropriate assessment techniques' may be applicable to some therapists who work within a particular diagnostic paradigm, but there are many traditions of psychotherapy which use alternative models, in particular those which see therapy as simply a human conversation. Such therapies specifically aim to avoid the objectification of a patient through 'assessing' them. This point would apply to the following requirement, that psychotherapists and counsellors 'be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment'. It is remarkable that this latter phrase has been included in HPC's generic standards for psychotherapists and counsellors: even the most cursory review of the field would remind the HPC that psychotherapists and counsellors do not use equipment.

The next requirement obliges psychotherapists and counsellors to 'be able to devise a strategy and conduct and record the assessment process that is consistent with the theoretical approach, setting and client group'. This may apply to some therapies but certainly does not fit the many traditions of psychotherapy that do not subscribe to the idea of an objectifying assessment and also do not accept the principle of recording and the reduction of the patient to a written record. There are also many therapists who do not accept the idea that there is such a thing as a 'client group': rather they work with each unique individual who approaches them. When one starts to make client groups out of individuals, one necessarily imposes what some may see as arbitrary classificatory structures, something which is specifically contested by certain traditions in psychotherapy which see their work as attending to specificity and uniqueness rather than inclusion in groups and classificatory schema.

The next requirement that psychotherapists and counsellors 'be able to observe and record client's responses and assess the implication for therapeutic work' is problematic not only in terms of the issue of recording but also as it neglects the fact that responses can be constructed retroactively and so may only 'be observed' years later within the context of the therapeutic process. Once again the HPC standards of proficiency suppose the idea of the patient as the passive unchanging recipient of therapeutic knowledge: in other words, someone who is talked about and thought about, rather than someone whose own activity constitutes the main part of the therapeutic work.

2A.3

The requirement that psychotherapists and counsellors 'be able to undertake or arrange investigations as appropriate' is clearly inapplicable to the field of the talking therapies although it may have purchase within the work of an NHS health professional.

2A.4

The requirement that psychotherapists and counsellors 'be able to analyse and critically evaluate the information collected' is clearly inapplicable to the work of the talking therapies, showing once again the view of the patient as an organism rather than a human participant in a person-centred therapeutic process. Hardly any forms of psychotherapy would see their work as involving the collection of information, although this is of course exactly what characterises some aspects of the medical model of healthcare delivery. In therapy, the therapist does not collect information about the patient and then use it to apply a procedure to a patient. Rather, there is an ongoing dialectical relation grounded in speech, which is of course radically different from information.

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The next section is entitled 'Formulation and delivery of plans and strategies for meeting health and social care needs'. The very title of this section is indicative of HPC's failure to understand the basis of most forms of talking therapy, which do not involve the delivery of plans and strategies, just as they do not involve meeting health and social care needs of patients. These paradigms belong to a medical model of health care in which a team are treating a patient with targeted intervention such as the administration of a surgical procedure, a treatment via pharmaceuticals or other forms of medical and quasi-medical process. Most psychotherapists would fail to recognise their work in the requirement that they are there to meet the health and social care needs of their patients. And in fact, most would probably see the particularity of their work as offering precisely something which did not fit within the health and social care paradigm. Trying to fit their work into this paradigm not only does an injustice to this work and to the work of many patients in therapy, but would also have detrimental effects on trainings which, as the PLG report makes clear, will have to formulate teaching to fit these standards of proficiency.

2B.1

The requirement that psychotherapists and counsellors 'be able to use research, reasoning and problem solving skills to determine appropriate action' may be appropriate for a minority of cognitive-based therapies but is at odds with most traditions of psychotherapy which do not see their work in terms of problem solving skills and do not aim to formulate specific actions to respond to specific problems.

The next requirement that psychotherapists and counsellors 'be able to engage in evidence based practice, evaluate practice systematically, and participate in audit procedures' is once again entirely inappropriate for many forms of psychotherapy, which eschew the rhetoric of evidence based practice and believe that its ubiquity today is based on profoundly flawed premises. There is now a large literature critiquing the notion of evidence based practice and many traditions in psychotherapy see it as of the utmost importance to distance their work from the rhetoric of evidence based research, which of course carries the danger that - once inappropriate research 'shows' that one method of treatment is 'best practice' for a particular symptom - that other forms of therapy be excluded, thus depriving patients of the choice of working with the therapeutic process they choose. Many schools of psychotherapy, likewise, would not accept the notion of audit procedures, a practice linked to management and to the world of business or managed health care rather than to the individual and creative conversation about human life that constitutes the stuff of many forms of psychotherapy.

The requirement that psychotherapists and counsellors be able to 'demonstrate a logical and systematic approach to problem solving' once again supposes that therapists are in the business of problem solving. As we have noted several times above, there may be some forms of therapy that do but in general this is not the case.

2B.2

The requirement that psychotherapists and counsellors 'be able to change their practice as needed to take account of new developments' in the area of 'knowledge and skills' is applicable to a medical based model but not to the majority of forms of psychotherapy where the large part of the work is done by the patient, facilitated by the psychotherapist. In medicine, a doctor may learn that a drug being prescribed is harmful and may then cease to prescribe it. This would be an example of a new development informing a practice, but knowledge in psychotherapy is different from knowledge in medicine. The 'new developments' that matter in the therapy will be those that come from the patient rather than from the therapist.

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The following requirement that psychotherapists and counsellors ‘be able to demonstrate a level of skill in the use of information technology appropriate to their practice’ is absurd and may apply to some health professionals working in the NHS but has nothing whatsoever to do with psychotherapy and counselling.

The requirement that psychotherapists and counsellors ‘be able to recognise when further therapy work is inappropriate or unlikely to be helpful’ is problematic as the articulation of such a view to a patient may have catastrophic effects.

Although the issues here are clearly complex, it seems likely that the formulation of this requirement is based on a medical model in which a team is responsible for the health of a patient. It also opens up the obvious question of third party complaints, as there must be tens of thousands of spouses and family members of people in therapy across the country who are convinced that the therapy that their loved one is undertaking is inappropriate and unhelpful. This is an everyday situation which therapists and counsellors are familiar with, and the particular formulation of the ‘standard of proficiency’ here runs the risk of implying that there are objective, externally verifiable standards of whether a therapeutic work is inappropriate or unhelpful.

The requirement that psychotherapists and counsellors ‘be able to make informed judgments on complex issues in the absence of complete information’ is one of the most absurd in all of the standards of proficiency. It is obviously just taken from a medical model where information may be necessary about health issues prior to the prescription of a drug or surgery. In psychotherapy, how can information ever be complete? What sort of fantasy would either the patient or therapist have if they believed in the idea of complete information?

2B.3

The requirement that psychotherapists and counsellors ‘be able to formulate specific and appropriate management plans including the setting of timescales’ may be suited to some staff working within NHS contexts but has little to do with the open-ended work of psychotherapy which often does not have a time limit and which eschews the very idea of a ‘management plan’. ***Since it is never possible to predict in advance what will happen in the therapy, it is clearly absurd to believe one could formulate ‘specific and appropriate management plans’.*** While this may have a sense in the context of a targeted health care intervention, it has little to do with the talking therapies, many of which specifically reject the concept of the ‘management’ of human beings. These therapies differentiate themselves from practices associated with social engineering.

2B.4

The requirement that psychotherapists and counsellors ‘be able to conduct appropriate diagnostic or monitoring procedures, treatments, therapy or other actions carefully and skilfully’ may be appropriate for a laboratory technician but not for most forms of psychotherapy. Psychotherapy does not involve the application of a procedure or treatment to a patient but is the work created by a patient, facilitated by a therapist. Very few forms of therapy involve the application of any procedure, and it is often argued that those that do this, in effect disqualify themselves as psychotherapists for that very reason. As noted above, many forms of therapy, likewise, would not accept the notion of diagnostic or ‘monitoring procedures’. As for the reference to skills, there may be some therapists who pride themselves on performing their work skilfully, yet there are many others who give a central place to blunder, error, failing and any of the other difficulties which constitute human life. For many therapists, it is an engagement with these failings that a large part of the work of therapy is about. This would involve a questioning of ideals of both autonomy and mastery and fantasies of one’s own self image as a skilful ‘expert’.

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The requirement that psychotherapists and counsellors ‘understand the need to maintain the safety of both service users and those involved in their care’ has a very limited application for psychotherapy. The primary responsibility of the therapist is not to ensure the health of their patient but simply, for many clinicians, to allow a conversation to take place. They would obviously need to ensure that there is an appropriate fire exit from their office and that there are no dangerous obstacles which might put the client in danger of slipping or falling in the consulting room, but beyond this, most traditions of psychotherapy see the maintaining of health as a personal responsibility of the patient rather than being a duty that the therapist must take on for them.

The requirement that psychotherapists and counsellors ‘be able to establish an effective, collaborative working relationship with a client’ is inapplicable to most forms of psychotherapy since, for many psychotherapy traditions, psychotherapy is not something that one person applies to another, but is rather a property of the relationship between two people. Given this, it is hardly a requirement for the psychotherapist to establish an effective collaborative relationship, since a large part of this work will come from the patient. The parallel is obviously in terms of everyday relationships between people. Whether a relationship works or not does not depend on one person but on both.

The requirement that psychotherapists and counsellors ‘be able to enable and work with expression of client emotion’ is problematic in that there are different theories about what constitutes emotion and whether, indeed, there is any difference between emotion and the expression of emotion. There is a vast literature on this question. Some traditions of psychotherapy do not place great value on the expression of emotion, arguing instead that what matters are the unconscious thought processes underpinning emotions, which in themselves may be misleading. Other therapies do place a great emphasis on the release of emotion, but there is no consensus view on either the nature or place of emotion in the field of psychotherapy.

The requirement that psychotherapists and counsellors ‘be able to communicate empathic understanding to clients’ would be rejected by many traditions of psychotherapy which hold that empathy with a patient is a sign that something has gone wrong in the therapeutic process. For these traditions, there must be a certain distance established between the therapist and the patient, and, most importantly, the therapist must recognise that they can never know exactly what is going on in the patient’s mind and certainly can never claim to understand their experiences. For these traditions in psychotherapy, listening may be sympathetic and attentive but is not empathic, which would imply that the internal states of the patient are accessible and shared by the therapist. This may be experienced by the patient as a gross intrusion and a denial of the singularity of their own experience. Other traditions and therapies do of course emphasise the importance of empathy. There is no consensus on this issue in the field.

The requirement that psychotherapists and counsellors ‘be able to initiate and manage first and subsequent counselling/psychotherapy sessions by developing rapport and trust’ is inapplicable to many traditions of psychotherapy. For example, the Freudian who sits there in silence may not be aiming to actively develop rapport and trust with a patient, even though rapport and trust may result from the resolute maintaining of this silence. Many traditions of psychotherapy would also argue that if the therapist actively tries to make the patient trust him or her, there is something wrong with the therapeutic process. Trust should not be an automatic property of the relationship, but will rather depend on transference issues. If a patient systematically mistrusts their therapist, the reasons for this may be explored. This would be very different from the therapist trying to make themselves trusted, which can only be a symptom of the instability of their own position.

The requirement that psychotherapists and counsellors ‘be able to respect and take into account

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the client's capacity for self determination' is problematic given the fact that many traditions of psychotherapy see the very concept of self determination as in question. For many traditions, autonomy and self determination are fictions, often with a political agenda. For these traditions, what matters would be to explore the structures that determine the lived experience of the patient and, at the end of the therapy, it may become clear to the patient that there are profound limits to any supposed autonomy or self determination.

The requirement that psychotherapists and counsellors 'be able to work with both the explicit and implicit aspects of the therapeutic relationship' is mystifying: it is unclear what exactly this might mean.

2B.5

The requirement that psychotherapists and counsellors 'be able to keep accurate, legible records and recognise the need to handle these records and all other information with applicable legislation, protocol and guidelines' may be applicable to those working in the NHS and for most health professionals, but is at odds with many traditions in psychotherapy. Freud and most other subsequent psychoanalytic thinkers advised against record keeping, arguing that it blocks the spontaneity of unconscious communication between patient and analyst. It is also widely recognised that record keeping may simply serve as a way to block the therapist's anxiety, and that they would be better served by discussing the relevant issues in their own personal therapy or supervision.

The requirement that psychotherapists and counsellors 'understand the need to use only accepted terminology in making records' is absurd, as it implies that there is such a thing as accepted terminology in the field of the talking therapies: would the terminology include 'shadow', 'jouissance' 'plane of identification', 'matheme' etc?

The danger here, as elsewhere, is that therapists will gradually begin to not only document but also think about their own practice through the eyes of someone they think is watching them, be this benevolent or malign. The moment that therapy becomes experienced in these terms, as if taking place on a stage for a third party to monitor, it ceases to be true psychotherapy and perpetuates the very dynamic that the therapy itself may be trying to free the patient from.

2C.1

The requirement that psychotherapists and counsellors 'be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly' is at odds with many traditions of psychotherapy which do not plan intervention or activity, seeing therapy rather as an ongoing, creative and unpredictably unfolding conversation. It is not a question of formulating and applying specific procedures which can be monitored and checked.

The requirement that psychotherapists and counsellors 'be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care' may be applicable to some health professionals but is at odds with most traditions of psychotherapy, which do not seek to gather information or to perform procedures of evaluation.

The requirement that psychotherapists and counsellors 'be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user' may be applicable for some health professionals but has absolutely no application to most forms of psychotherapy. Most forms of psychotherapy do not involve the establishment of intervention plans that are then applied to the patient as the recipient of a procedure, and in most psychotherapies there is no notion of 'recognised outcome measures'. It is often argued that the

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difference between psychotherapy and mental hygiene is precisely this: that in mental hygiene the therapist knows what is best in advance for the patient and tries to implement this. In psychotherapy, on the contrary, the psychotherapist listens to what the patient has to say.

The requirement that psychotherapists and counsellors ‘recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes’ is totally inapplicable to the field of psychotherapy. This is not just due to the problems with the idea of ‘monitoring and evaluating’ that we have discussed above, but gives the therapist the role of a bureaucrat, with the task of managing the patient rather than that of a partner in a dialogue accompanying the patient on their journey. The notion of ‘quality assurance’ is anathema to those traditions of psychotherapy that are not based on a business model of service provision, and the notion of an ‘improvement programme’ also belongs to a modern ideology of the self which most of the major traditions in psychotherapy eschew.

The requirement that psychotherapists and counsellors ‘be able to make reasoned decisions to initiate, continue, modify or cease treatment for the use of techniques or procedures, and record the decision and reasoning appropriately’ is at odds with most forms of psychotherapy which do not use techniques or procedures, and once again, this requirement begs the question of why every clinical decision would need to be recorded and explained. This would create a mindset in which everything the therapist did would only make sense given an observing eye that would be judging their action. This form of internalised authority may be useful in techniques such as policing but runs counter to the major traditions in psychotherapy which are about freeing oneself from the tyranny of internalised forms of irrational authority.

The requirement that psychotherapists and counsellors ‘be able to help clients to reflect on their process [progress?] of therapy’ is certainly applicable to many forms of psychotherapy today, but it is equally incompatible with many other forms of contemporary practice. Some forms of psychotherapy involve a continued focusing on the relation between the patient and the therapist, whereas other forms aim to open up a space beyond the consulting room and to subordinate the therapeutic process to these other variables. There is thus no consensus view on the importance or necessity of making patients reflect on the therapeutic process. This point applies to the following requirements that the therapist ‘review and evaluate’ their work with the patient. For many forms of therapy, it is technically a mistake to bring things back to the relation between the two parties, following one version of the object relations tradition.

The requirement that psychotherapists and counsellors ‘be able to evaluate the therapeutic work in collaboration with the client’ supposes once again that there is some kind of external position from which the work of therapy can be assessed and evaluated, rather than seeing it as an organic, unfolding and open-ended process. Since this process is constituted by the relation between the patient and the therapist, neither is able to abstract themselves from it to give an ‘objective view’ or evaluation.

2C.2

The requirement that psychotherapists and counsellors ‘be able to audit, reflect on and review practice’ would be acceptable if it was limited to the verb ‘reflect on’. Psychotherapists do not audit their practice although no doubt those who work in business or in some forms of healthcare delivery might wish to do so.

The requirement that psychotherapists and counsellors ‘understand the principles of quality control and quality assurance’ may be applicable to business contexts and some forms of healthcare but is largely inapplicable to most traditions in psychotherapy which do not use the

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conceptual vocabulary of quality control or quality assurance. The key to these traditions is precisely the fact that they offer a space outside the market place, one in which human beings are not seen as ‘resources’. Most traditions of psychotherapy do not view human life as a series of business-style transactions and they do not use business vocabulary to describe human beings.

The requirement that psychotherapists and counsellors ‘be aware of the role of audit and review in quality management including quality control, quality assurance and the use of appropriate outcome measures’ is absurd and inapplicable for the reasons outlined above. As has been repeated, these concepts are at odds with the ethics of most forms of psychotherapy, which likewise, do not have a notion of ‘outcome measures’.

The requirement that psychotherapists and counsellors ‘be able to maintain an effective audit trail and work towards continued improvement’ is totally inappropriate for most forms of psychotherapy, although it may be appropriate for business contexts. Likewise, many of the major traditions in psychotherapy do not believe in the modern ideology of ‘continual improvement’ but rather aim to give a place to the central experiences of disappointment and frustration that lie at the heart of human life. It is precisely the wellbeing industry which promotes the idea of ‘continual improvement’, often in order to sell products to the public. Most forms of psychotherapy, on the contrary, are characterised by their refusal to enter into this form of transaction, and do not make promises to the public about results or endeavour to sell products.

The requirement that psychotherapists and counsellors ‘be able to critically reflect on the use of self in the therapeutic process and engage in supervision in order to improve practice’ may be applicable to some forms of therapy today, but would be at odds with many traditions of therapy which do not see the self as a tool to be used in the therapeutic process, or even as any fixed entity. There are also several traditions of psychotherapy which are critical of the very notion of the ‘self’ and, for those who do accept it, it is not always seen as a variable that can itself be the object of reflection: this would once again suppose that the therapist could abstract themselves from ‘themselves’, precisely the kind of dissociation that the HPC framework is designed to foster. As regards supervision, although all traditions of psychotherapy give a central place to the practice of supervision, there is no general agreement that the role of supervision improves practice.

3A.1

The requirement that psychotherapists and counsellors ‘understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction’ may be applicable to those working in the medical field but has little to do with most forms of psychotherapy. There are some forms of therapy which do involve a focus on the body, yet these may presuppose different models of structure and function from those presupposed by mainstream medicine. Likewise, many traditions in psychotherapy do not accept the concept of health, disease, disorder and dysfunction as applied to psychological matters.

The requirement that psychotherapists and counsellors ‘be aware of the principles and application of scientific enquiry, including the evaluation of treatment efficacy and the research process’ is not unreasonable in the field of the talking therapies, but there is the serious danger here that it would involve a limited conception of scientific enquiry, efficacy and research. HPC and Skills for Health, for example, have very limited and monolithic notions of these variables, foreclosing completely the rich tradition in history and philosophy of science that has been developed in this country over the last hundred years. There is a grave risk that fashionable notions of scientific enquiry, efficacy and research are used as benchmarks to evaluate therapeutic practice, rather than themselves being the object of critical enquiry in the tradition of work in the history and philosophy of science.

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The requirement that psychotherapists and counsellors ‘understand the typical presentations of severe mental disorder’ is at odds with many traditions of psychotherapy which are critical of the very notion of mental disorder. There is the risk here that psychiatric notions of mental disorder are used as a benchmark in the evaluation of therapeutic practices when these practices may either reject classificatory systems or use alternate classificatory systems to those of psychiatrists. For example, there is massive disagreement as to the clinical signs of non-triggered psychosis and different traditions will have radically different views as to what these signs might consist of. These concerns apply to the following requirement that psychotherapists and counsellors ‘understand methods of diagnosis of severe mental disorder.... and be able to conduct appropriate diagnostic procedures’.

The requirement that counsellors ‘understand theories and research on mental health and wellbeing and obstacles to wellbeing and be able to use these to facilitate the client’s development’ might be applicable to some forms of counselling but not to those which are critical of the notion of wellbeing, which is effectively the market place today for selling products to the public. The appearance of the term here under the rubric of ‘counsellors’ only shows a certain disrespect to the important work that counsellors do, as if the counsellors were just concerned with wellbeing and the therapists were doing something different.

3A.2

The requirement that psychotherapists and counsellors ‘select or modify approaches to meet the needs of an individual, group or community’, may be applicable to a small range of therapies but is at odds with those major traditions of psychotherapy which do not see the work of therapy as involving meeting anyone’s needs. Many forms of therapy involve a questioning of what the patient feels they want and the needs that the patient presents are, in these traditions, taken as symptoms which need deciphering rather than ‘meeting’. In psychoanalysis, for example, the central ethical position of the analyst involves the sustained refusal to meet the needs of the patient.

3A.3

The requirement that psychotherapists and counsellors ‘be aware of applicable health and safety legislation and any relevant safety policies and procedures in force in the workplace, such as incident reporting, and be able to act in accordance with these’ is obviously applicable to those working in NHS contexts but hardly for therapies conducted in private practice beyond the most obvious measures taken to ensure that the consulting room does not contain hazardous objects or, have a slippery floor, or any craters into which the patient might fall.

The requirement that psychotherapists and counsellors ‘be able to select appropriate hazard control and risk management, reduction or elimination techniques’ is likewise inapplicable to most private practice psychotherapy contexts, just as is the requirement that they ‘be able to select appropriate protective equipment and use it correctly’.

The next requirement regarding ‘hazard control and particularly infection control’ is obviously inapplicable to the talking therapies. It is extraordinary that these latter requirements have been included in such an important document, after the HPC has been supposed to have been thinking about the field of talking therapies for at least three years now.