

Editorial

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Working with 'complex' clients is a relevant subject for most, if not all, healthcare practitioners. Indeed, some would argue that *all* presentations in healthcare contexts are complex. After two issues of *HCPJ* reporting and debating the current changes in the NHS with regards to psychological therapies, it is good to return to clinical matters. Many of the features in this issue serve as a reminder that the work we do with clients as counsellors and psychotherapists continues despite the changes and upheavals going on around us.

Ian Kerr and Tim Leighton's article on working with 'difficult' clients using cognitive analytic therapy (CAT) brings into focus the deep-level thinking we are required to carry out as part of our practice. They ask us to consider: What is the difficulty in working with 'difficult' clients? Does this 'difficulty' belong to the clients, or to us? What comes across strongly, regardless of the mode of therapy, is the key importance of the client/therapist relationship. 'What such individuals most require,' they write, 'is not a set of diagnoses, but a reliable, and if possible durable, relationship with a trusted clinician or team of therapists.'

Running in tandem with the clinical focus is another theme. In reporting on work with clients with a range of complex issues – substance misuse, obesity, and domestic violence among them – the wider changes taking place and the demands on practitioners to adapt to these changes are naturally reflected. Margaret Smith's description of her innovative approach to working with perpetrators of domestic violence reflects the need for building an evidence base, for instance, as does Michelle Oldale's investigation into the unique nature of the signed relationship and a lack of consideration of the needs of Deaf clients in regard to therapeutic provision.

Counsellors and psychotherapists in healthcare settings everywhere in the UK are certainly busy equipping themselves for the new service shapes to come. Jane Boyd and colleagues' study of using CORE in supervision accordingly seems important and timely at a point when practitioners are being asked to prove outcomes, and indeed proving outcomes is an integral part of the Improving Access to Psychological Therapies (IAPT) programme. The findings demonstrate that counsellors are willing to embrace this way of working, and put some concerns to rest about how best we can work within a culture of accountability.

Glyn Hudson-Allez's examination of assessment likewise not only reflects adaptations that are ongoing, but informs and leads us in making changes ourselves. Counselling assessments are something which, she points out, have not traditionally been included in counselling training courses. Intriguingly she posits assessment as a dynamic process that is and should be an ongoing part of counselling, rather than a one-off, information-gathering exercise, which gives food for thought about how we might adapt creatively to a formal requirement for assessments.

Elsewhere the debate about wider changes continues. Francesca Haydon will strike a chord with many in her reflections on the future of counselling in the NHS in relation to the IAPT programme. The counsellors in her service are being asked to cut their session times and see more clients as part of their new way of working, among other things. Are we going to be required to change out of all recognition, she wonders: 'Can a 30-minute, integrative, high-intensity session delivered by a trained counsellor be considered a counselling session, or is it something else?'

Working with clients, of course, is what we do best, and this issue is an acknowledgement of the challenging and complex work that goes on in the therapy room, mostly unseen by the national planners.

Penny Gray
Editor