Draft HPC Standards of Proficiency – a personal critique from a humanistic perspective

By John Gloster-Smith, MAHPP.

Introduction

This brief commentary is a response to the Health Professions Council (HPC) Draft Standards of Proficiency which have been issued for consultation.

To get a clear flavour of what is likely to be the new regime for all psychotherapists and counsellors, the reader might profit by pausing at the very start of the Draft, and looking at the "key". Here the authors state that the "HPC generic standards" are shown in black and that those specifically for psychotherapists and counsellors in blue and red. This distinction between the generic and profession-specific is crucial. A quick glance may tempt the reader to think that the latter have been "slotted in" arbitrarily with the former. This is however no mere accident but a very clear and, for these professions, disastrous strategy by people who seem to be operating from administrative convenience and demonstrating that they do not understand the therapies they are claiming to be able to regulate. Thus no wonder there is a crisis of confidence within the professions with the HPC.

For this commentary therefore, it is useful to separate the psychotherapy and counselling standards from the generic standards.

The generic HPC standards

These generic standards seem to be more suited to a health care environment, for which I think they were prepared. The HPC is now bringing into this framework a very large group, perhaps the largest, who probably in the main do not work in this mode. This is perhaps one reason why so many are having problems with it. These are very different professional worlds.

These health-care related issues have already been discussed elsewhere in Alliance publications, but it might be useful just to list a few of the draft standards by way of reminder.

Registrant psychotherapists and counsellors, we are told, "must" demonstrate these standards. "Must" as a term will provoke uncomfortable reactions for humanistic practitioners, whose focus in their professional work is to support clients (not "patients") in liberating themselves from received social introjects. There is therefore immediately an incongruence between a seemingly parental if not paternalistic supervisory body, and the integrity of the therapist. It is therefore not surprising that the advent of the HPC is provoking such a crisis of conscience for practitioners, a contradiction between ownership of their professional world and externally imposed authority.

If we move on to look at some of the generic standards, here are some that the therapist "must" demonstrate. They "must", to quote

- be able to work, where appropriate, in partnership with other professionals, support staff, service users and their relatives and carers
- understand the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals

- be able to contribute effectively to work undertaken as part of a multi-disciplinary team
- be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment
- be able to undertake or arrange investigations as appropriate
- be able to use research, reasoning and problem solving skills to determine appropriate actions
- be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely and skilfully
- be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care
- be able to audit, reflect on and review practice
- be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures
- be able to maintain an effective audit trail and work towards continual improvement
- participate in quality assurance programmes, where appropriate
- understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction
- be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process

The therapist reader might be pardoned for their incredulity at this point, but these are the HPC's actual words. It should be very obvious to such a reader that many of these were written for a health care group of professions. Yet this is a generic list of criteria. Psychotherapists and counsellors are not in the main health care professionals. Thus for a psychotherapy or counselling practitioner, being compulsorily moved into the HPC orbit might seem like a highly artificial creation, one probably for administrative and public policy convenience. It is all the more likely that such practitioners will feel that this is not "their" body. This will probably heighten a defensive mentality when dealing with the body in question, rather than feel involved with a group committed to excellence in the profession for the benefit of all, both practitioners and ultimately and most importantly, the client.

The psychotherapy and counselling draft standards

Reading the psychotherapy and counselling aspects separately however gives a different picture. From a humanistic perspective, there are clearly areas where they would have difficulties. However, one suspects this could partly be overcome by changes in wording that take more account of the differences. However, the more one reads through what has been produced, the more a humanistic practitioner may get an accumulative sense that what is being planned for her or his profession is something alien to their world.

These have been made clear in the comments in black against selected criteria, with the comments marked "J", for "John". The theoretical framework for illustrative purposes is Gestalt but this use of Gestalt terminology is not meant to be exclusive of other approaches within the humanistic field. The original wording in the draft standards is given in blue or red, with the draft's heading and item references also given to help find them in the text.

Professional autonomy and accountability

1 a 1. Be able to practise within the legal and ethical boundaries of their profession

Be able to recognise and manage the dynamics of power and authority

J.: Setting aside the obvious preceding generic criteria in this section about boundaries and accountability, particularly to the "legal" framework, ie. the HPC, a response from a humanistic perspective would be that to "recognise" and especially "to manage dynamics of power and authority" is a terminology that removes the client from being involved in developing awareness of their process and how they create relationships. It is also powerfully suggestive of the field conditions for the therapist of now working within a context of externally imposed authority, which would be a contradiction of their orientation towards supporting the autonomy of the client.

Professional relationships

1 b 1: **be able to work, where appropriate, in partnership with other professionals, support staff, service users and their relatives and carers**

- be able to demonstrate sensitivity to organisational dynamics

J: It is highly likely that most therapists do not work within organisations and that this section as a whole is likely to be fairly meaningless to them. So to "demonstrate" such "sensitivity" would seem irrelevant, except as in being sensitive to the field conditions in which their client might live.

1 b 4 *Be able to build, maintain and end therapeutic relationships with clients*

J.: Humanistically, we would describe the relationship as one that is co-created, not "built" by the therapist. Humanistically, we support clients in moving away from a world where things seem like they are "done to" them, and towards taking responsibility for what they create.

Identification and assessment of health and social care needs

- be able to devise a strategy and conduct and record the assessment process that is consistent with the theoretical approach, setting and client group
- be able to observe and record clients' responses and assess the implication for therapeutic work

J. Note that the generic heading is that of health care, not psychotherapy or counselling. With regard to the items in blue, the use of the word "assessment" might be one that is alien to many humanistic practitioners, although probably widely used by others in practice. It has connotations of remoteness from the client, a complete contrast from the warmth, aliveness and closeness of the relationship that so often occurs. It is also worth pointing out that many would not be recording "client's responses" in an actual session, since note-taking is often alien to the aliveness, contact and present-moment orientation of the work. "Client group" is a term a humanistic therapist might avoid, since it belongs with categorising people rather than affirming their uniqueness.

Formulation and delivery of plans and strategies for meeting health and social care needs

J: Once the managerial bits are taken out, almost all this section is probably acceptable to humanistic practitioners. There is however one major objection.

This major issue is the use of the term "**evidence-based practice**" in the generic framework in this section. While this might belong in the generic section just discussed, it is also referred to here because of its obvious therapeutic implication.

This term in my view is a Cognitive-Behavioural approach and actually one that belongs in one modality or group of modalities and is emphatically NOT applicable across the range of psychotherapy and counselling professions as a whole. Here particularly the framework loses its impartiality, at a potential cost to certain widely-used modalities. Humanistic practitioners do not conceptualise their work in this manner. For example, a Gestaltist would rather be facilitating awareness in the client, by for example helping them become more aware of their own phenomenology, and the practitioner would regard that as within their own field of awareness, which is likely to be different to that of the therapist. The "evidence" would then become the client's own evidence, one to be explored together with the therapist. To speak of "evidence" as the generic standards do, would then simply be an invitation to a humanistic practitioner to share a perception and therefore only a partial and subjective perspective on what is occurring in the work. Such pseudo-scientific jargon is meaningless in this context.

Use of "evidence" jargon will heighten the sense in the practitioner of being hijacked by a specific modality, which is already occurring elsewhere for example in the way the NHS has been switching to CBT, and which is not actually proven to have the pre-eminence that its proponents claim.

2 b 4 *Be able to establish an effective, collaborative working relationship with the client*

- be able to initiate and manage first and subsequent counselling / psychotherapy sessions by developing rapport and Trust

J.: The words "to establish", "initiate and manage" and "developing rapport and trust" are problematical for humanistic practitioners, as they suggest something "being done" by the therapist. As stated above they would see the process as co-created and would seek to support the client in taking responsibility and creating rapport. They may for example have very poor rapport "skills" and have an issue with trusting people. The very work might be about learning to trust the therapist and then to extend that to their relationships. Humanistically, we might say that we become able to trust and do not have our trust "developed" by someone else. It is an internal not an external process. The words used here however seem to come right out of an NHS manager's competency framework.

Critical evaluation of the impact of, or response to, the registrant's actions

J: This section seems acceptable, once one steps aside from the jargon.

Knowledge, understanding and skills

3 a 1. Know and understand the key concepts of the bodies of knowledge which are relevant to their profession-specific practice

understand and be able to evaluate theories and research on the following, consistent with the theoretical approach....
psychopathology...

J.: Despite the reference to psychopathology in the text, there are well-established ways of looking at this topic that humanistic practitioners can work with that is not necessarily or only from the DSM4. The latter is more associated with the psychiatric world. In Gestalt this might be explored for example through a client's "style of relating in the world" or his or her "interruptions to contact".

However, the use of the term “psychopathology” can be problematic to certain humanistic practitioners, as it has mental health associations.

Now, to take some of the sub-sections listed in the draft Standards:

“mental and emotional health”, “mental disorder”, “common / general mental health problems” .

J: Humanistic practitioners do not tend to regard what a client is experiencing as within a “health/illness” polarity. This sharply distinguishes them from a mental health/psychiatric perspective. “Order/disorder” is not a humanistic way of conceptualising a person’s process. To my example from Gestalt, this modality would see her or his “process” as a “creative adjustment” and would be wary of categorising people.

The standards in this section then move to a very controversial area, where psychotherapists and counsellors are treated differently.

J: In the sub-sections for psychotherapists separate from counsellors, and visa versa, highly controversial distinctions seem to be made that suggest that psychotherapists deal with more severe levels of disorder than counsellors. This ignores the work that has been done over the last few decades that have led to the view that the two professions cannot be so clearly distinguished. The HPC would appear to be on very shaky ground here.

Psychotherapists for example “must” exclusively be able to

- conduct appropriate diagnostic procedures
- understand and implement treatment methods to address symptoms and causes of severe mental disorder

J: Humanistic practitioners would have particular issues here, since the terms “diagnostic procedures”, “treatment” and “symptoms” would to many of them, I suspect, smack of a “mental health” and DSM4 model of responding to human pain, more appropriate to an NHS environment and psychiatry. Diagnosis would remove the client from involvement in working on themselves and make them more of a patient for whom a set of treatments would be devised, as in the health care model.

Conclusion

To me, the fundamental weaknesses of these draft proficiencies are the apparent attempt to put them into a health care context, a tendency towards a behavioural bias in terms of the over-arching theoretical model used, and a health-care managerial mind-set in terms of practical application. It is not surprising therefore that so very many practitioners, who in the main do not see themselves as health practitioners, feel that this project is “not for them”. Moreover these draft standards emphasise how misconceived is the whole project of the Health Professions Council regulation of psychotherapy and counselling.

John Gloster-Smith, MAHPP
Calne, Wiltshire
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