Psychotherapy and counselling in Australia: Profiling our philosophical heritage for therapeutic effectiveness

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Introduction

Psychotherapy and counselling are relatively recent players in the higher education and professional regulatory context in Australia, with specific challenges and conditions to negotiate. The profession is well-organised and self-regulated, and the industry is growing. However, the mental health space is predominantly serviced by the professions of psychology, psychiatry and nursing (Department of Health and Ageing, 2013) operating within a medical model of health. Unless it is content to be reduced to a subset of these, a clearly articulated disciplinary base is imperative for the still emergent profession of psychotherapy and counselling.

This article presents an argument for deeper consideration to be given to the philosophical roots of the disciplines of psychotherapy and counselling. The common factors research is changing the landscape of theory and practice (Duncan, Miller, Wampold & Hubble, 2010); and the predominance of the relationship as a factor in therapeutic effectiveness calls for greater rigour in the understanding of how the therapeutic relationship works. If the common factors show that the therapeutic relationship is critical to effective therapy, the philosophical lineages of the disciplines of psychotherapy and counselling stake out the grounds of what it consists of and how it works. The timing of the common factors research with the emergence of the psychotherapy and counselling profession in Australia provides fertile ground for the professional differentiation that is the hallmark of a clear identity.

The argument is structured through discursive analysis of key factors in the current context of psychotherapy and counselling in Australia: the disciplinary bases of psychotherapy and counselling; important differences between psychotherapy and counselling; the range of models of health and what best matches the practices of psychotherapy and counselling; relational practice and client informed outcomes.

The profession in Australia

Professions generally grow through a range of factors including client demand, practitioner professionalism and organisation and, most significantly, a strong disciplinary base. The first two of these factors are evident for the profession in Australia, but the third could benefit from greater clarification and articulation.

Client demand for services is strong. Depression, anxiety and substance abuse, domestic violence and sexual assault are common presentations and there is a growing demand for mental health services. The National Mental Health Report (Department of Health and Ageing, 2013) re-iterates the now axiomatic 1 in 5 statistic, that 18 – 20% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders). The annual national survey of service providers in 2013 found that frontline agencies are strained and unable to meet growing demand (Australian Council of Social Services, 2013). In particular 47% of mental health services and 46% of domestic violence and sexual assault services reported being unable to meet demand (Australian Council of Social Services, 2013). In response to demand the industry is growing. The national Job Outlook site presents counselling – though it does not have a category for psychotherapy – as a medium sized occupation (21,700 in 2013) that has experienced significant growth in the past two years, and predicts it to be steadying to moderate over the next five years (Australian Government, n.d.).

Practitioner professionalism is also assured through well-organised self-regulation. Peak bodies such as the Psychotherapy and Counselling Federation of Australia (PACFA) set and monitor training standards and minimum practice standards (clinical hours, supervision and professional development), and provide registration pathways. There are, in addition, the important national professional bodies such as the Australian Register of Counsellors and Psychotherapists (ARCAP); the tertiary education based National Heads of Counsellor Education (NHCE), and the Society of Counselling and Psychotherapy Educators (SCAPE).

The terms psychotherapy and counselling, however, are not protected through a government regulatory framework. Although PACFA monitors training and registration of psychotherapists and counsellors it does not own the term and therefore there is a significant diversity of training and disciplinary backgrounds for allied health practitioners who practice in the field and are not registered with PACFA or the Australian Counselling Association (ACA). By contrast Social Worker and Psychologist are protected terms requiring specific training through their accredited courses and registration through their respective peak bodies. This situation derives in part from the lack of a clearly articulated disciplinary base for psychotherapy and counselling.

Along with the profession's challenge of self-regulation and protection of the terms psychotherapy and counselling, a number of factors have brought significant pressure to bear on its emergence as a distinct profession in the mental health and wellbeing space. These include the earlier effective lobbying of government by the profession of psychology for the science-practitioner model; and the pressure of pharmaceutical companies for modes of research that support their interests. On the latter point it has been found, for example, that more than half of the panel members responsible for contribution to the diagnostic criteria of the DSM-IV had one or more financial associations with pharmaceutical companies. Financial connections were "especially strong in those diagnostic areas where drugs are the

first line of treatment for mental disorders" (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006, p. 154). These factors have contributed to the trend in which positivist empirical research stands in for all forms of research, and determines what qualifies as evidence for the evidence base of practice, despite the compelling case from the common factors meta-research that evidence-based techniques turn out to be peripheral to therapeutic effectiveness.

Notwithstanding the increased regulation and development of the profession in this century, the question of its disciplinary base underlies its relative lack of recognition and standing in the broader allied and mental health space.

The disciplinary bases of psychotherapy and counselling

Most professions derive the application of their central ideas and organising principles from a core disciplinary base, or paradigm of thought, such as engineering, medicine and law do. Inevitably there will be variations, additions and cross-disciplinary elements as the profession develops. There is however, no single discipline nor research method that informs the work of psychotherapists and counsellors. This does not represent a deficit in their constitutions, though. Rather, it is the effect of the development of the various strands of practice outside institutes of higher education.

Developing from individual schools and private training institutes, the wide range of practices that gather under the terms psychotherapy and counselling have emerged sometimes in reaction to earlier iterations – humanistic approaches for example emerging in reaction against the reductiveness of some behaviourist schools in the 1950s, and the postmodern approaches emerging in reaction against the apparent theoretical naïvete of some forms of humanism – and, although they overlap in many elements, the divergences are both important and challenging to manage in terms of professional organisation. Therapeutic approaches continue to develop across a spectrum of disciplines from the philosophically informed to the science practitioner approaches; with influences from social theory (Aron & Starr,2012), sociology (Goffman, 1961; Bueskens, 2014) and neuroscience (Cozolino, 2010; Siegel, 2010), among others.

In order to clearly articulate what is core in the disciplines of psychotherapy and counselling, therefore, it is useful to reconsider the different paradigms that generate knowledge production. The philosophical influences in psychotherapy and counselling that form the basis of depth relational work are based in ontological forms of knowledge production, while the science-practitioner approach, taken largely from psychology, is based in positivist empirical forms of knowledge production.

Philosophy has been engaged principally with questions of being and consciousness, and the body mind relationship. The practice of philosophy developed from the Socratic period to the current, into the five branches of: ontology (the study of being), epistemology (the study of knowing), logic (the study of reasoning), ethics (the study of morality) and, by the early twentieth century, phenomenology (the study of things and events as they appear to consciousness).

As the branch of philosophy concerned with the study of being, ontology is arguably the most apt form of knowledge production for understanding the experience of being, of embodied subjectivity and human existence. If it has not concerned itself with objective reality, its dimensions and measurable elements, it is not through lapse or accident. It has precisely concerned itself with those elements of subjective experience that do not lend themselves to the devices of external measurement. In its development through to phenomenology, important ontological thinkers from Kierkegaard (1813-55) to Husserl (1859-1938), Heidegger (1889-1976) to Buber (1878-1965), Levinas (1906-1995), Sartre (1905-1980), Merleau-Ponty (1907-1961), and Beauvoir (1908-1986), have informed the practice of working with the moment-to-moment unpredictable movements of consciousness.

Both Kierkegaard and Nietzsche critiqued the overreach of empirical methods into broader fields of thought, arguing that a reduction of things to their materiality only, is based on a naïve assumption that the measurement and observations of the object from the standpoint of the subject can comprehensively report on the essence of the thing (Kierkegaard, 1843; Nietzsche, 1889). For Kierkegaard, philosophy starts with human experience. Ontology assumes a capacity to tolerate degrees of not knowing in order to deepen an enquiry. Later in the development of phenomenology Husserl aimed for a description of consciousness, and understand the meaning and process of knowing (Husserl, 1913). His student, Heidegger, shifted the enquiry toward the meaning of being, setting out to directly address the question of what it means to *be*:

In medieval ontology this [question of Being] was widely discussed … without reaching clarity as to principles. And when Hegel at last defines 'Being' as the 'indeterminate immediate' and makes this definition basic for all the further categorical explications of his 'logic', he keeps looking in the same direction as ancient ontology, except that he no longer pays heed to Aristotle's problem of the unity of Being as over against the multiplicity of 'categories' applicable to things. So if it is said that 'Being' is the most universal concept, this cannot mean that it is the one which is clearest or that it needs no further discussion. It is rather the darkest of all (Heidegger, 1927, p 2).

The question remains perennial because the general question of the meaning of being requires clarity about one's own being as an inquirer (Crowell, 2010). The phenomenological philosophy that emerged through the work of Husserl and Heidegger, provided the disciplinary basis and method for understanding the intersubjective process and the development of relational therapy.

Whereas an ontological frame of reference privileges the potentialities and uncertainties of an intersubjective approach, and generates 'pure', 'foundational', 'basic' research, epistemology is concerned with theories of knowledge, enquiring into how we know what we know, and what are the grounds for knowledge. While it is effective on its own terms, it remains one of several types of knowing that includes not only empiricism, but essentialism, historicism, idealism, rationalism. Empiricism, influenced by logical positivism, has come to be the dominant paradigm in health professions and national discourse. A positivist empiricist frame privileges certainty. It is a more objectively-intended approach to its objects, informed by measurement, repeatability and validity of knowledge production. It generates 'applied' research. What is often overlooked in that context is that it is neither complete in itself nor closer than other paradigms to accessing any truth about existential and phenomenal reality. The paradigmatic differences that exist within psychotherapy and counselling are important to note, as it explains some of the divergence in therapeutic practice and some of the politics of the profession.

The politics and differences that have emerged in the great disciplines of the humanities and the sciences are replicated in the disciplinary domains of the psychotherapy and counselling profession, each with the hubris that their disciplinary methods provide the surest access to truth. Yet the family tree of psychotherapy has over the century since Freud developed multiple branches that include these main influences alongside input from sociology, social theory, anthropology, literary and critical theory, gender and sexuality politics, and post-colonialism. These subjects grow out of the paradigms elucidated earlier. The spectrum of disciplinary bases of psychotherapy and counselling can be a strength and weakness. The profession emerged with a multitude of disciplinary influences before it ever had disciplinary clarity. This is a reversal of the usual order in which a discipline develops, clarifies and gives rise to applications in professional fields.

This analysis is not an invitation to an either/or decision around which paradigm is better for the profession of psychotherapy and counselling. Neither does it invite the anodyne conclusion that there is room for all. Rather, it is intended to support a more intentional location of core concepts and practices within the profession – some elements are ontologically derived, others empirically derived. It is also intended to highlight the important influence of the ontological paradigm – with its rigorous attention to the phenomenological and inter-subjective landscape of being – on the relational work that the common factors research has found is core to therapeutic effectiveness. Recently we can see the rise of the relational orientation within many modalities (psychodynamic psychotherapy, psychoanalytic psychotherapy, relational gestalt psychotherapy, hakomi, for example). While it is not the whole of the therapeutic enterprise, it is a significant part of it and its philosophical basis requires due credit and articulation.

Psychotherapy and counselling: same but different

Psychotherapy and counselling have significant areas of overlap, to such an extent they exist side by side in the peak professional body, PACFA. Their clinical applications vary, though, depending on the range of training of the clinician. PACFA describes how practitioners of both psychotherapy and counselling use an interpersonal relationship to enable people to develop self-understanding and make changes in their lives and work within a clearly contracted, principled relationship enabling clients to explore and resolve issues of an interpersonal, intrapsychic, or personal nature (PACFA, n.d.). Differences are cautiously described in terms of scope of practice. Whereas counselling focuses on specific problems, changes in life adjustments and fostering clients' wellbeing, psychotherapy is more concerned with the restructuring of the personality or self and the development of insight (PACFA, n.d.).

The differentiation here may be contentious in a profession working on integrating and speaking with one voice, but it is perhaps increasingly important to allow the differences to be part of a larger professional conversation. This is not a question of division, but of increasing transparency and deeper consideration of the intellectual heritage and lineages of the strands that are woven together under the collective and generalist term of psychotherapy and counselling. The profession's aims for inclusivity might otherwise let it down when it comes to identifying and articulating the disciplinary lineage that supports the relational orientation of the field.

The philosophical influences based in enquiry about the experience of *being* are the basis of much psychotherapeutic training. They are present also in counselling training, however their origins lie in the schools of psychotherapy such as existential, gestalt and later variations of relational practice. The phenomenological approach is a good fit for professionals working in the uncertain space of human experience. Rather than attempting to set aside subjectivity in a pursuit of objective truths about human experience, phenomenology recognises its inherent subjectivity and has developed systems for working carefully with that reality (Buber, 1934/2004; Merleau-Ponty, 1945/2012; Orange, 2010). This philosophical influence has generated a capacity for therapists to maintain competence and steadiness in the face of the genuine uncertainties of working inter-subjectively with other human beings. The influence is most evidently present where a therapist works intentionally and skillfully with the therapeutic relationship, attuned to the present reality – to the 'in-between' – of the exchange flowing between them and their client (Yontef, 1993; Jacobs, 2003; Parlett, 2005).

Psychotherapist researchers continue to develop and refine understandings of the workings of relational therapy. Within gestalt for example, the relational field is a core concept for relational work. It refers to the field that is evoked when engaged subjectivities interact intentionally. Parlett (2005) enunciated principles for working intentionally with the relational field; Jacobs (2003), Latner (1992) and others have contributed to these developments (and for examples of research into field theory in the Australian context see O'Neil, 2008, and Day, 2015).

Models of practice and health

Disciplinary bases inform the models of health that are applied in allied health professions. With such diversity of influences in psychotherapy and counseling, clinical work principally divides along the lines of either the science-practitioner, or the reflective practitioner model. Moreover, clinical practice occurs within a broader and regulated context in which models of health compete for attention and funding. The principal models of health in the current Australian context (as elsewhere) are the medical and social models.

The definition of research based on these different approaches is as much political and contextually based as it is about specific methodologies. We know from Foucault that technologies of knowledge are derived from the broader socio-political context in which they arise and are deployed (Foucault, 1969). They are not neutral or unaffected by the vortices of cultural and economic relations of their context. Within the allied health field, too, the instrumentality and politics of knowledge production are relevant, if frequently ignored. For example, Norcross and colleagues note that 'defining evidence, deciding what qualifies as evidence, and applying what is privileged as evidence are all complicated matters with deep philosophical and huge practical consequences' (Norcross, Beutler & Levant, 2006, cited in Sparks & Duncan, 2010, p. 357). Attention to the disciplinary bases of the different practice models, and the contexts of their emergence, allows for consideration of their benefits and limitations.

The science-practitioner model emerged from the specific context of North America during the Second World War, and in response to a specific set of problems in that context. It was proposed by American psychologist David Shakow in a report to the American Association for Applied Psychology in 1941 to inform clinical psychology programs under pressure at that time to meet the needs of the large numbers

of war veterans with what was then referred to as shell shock (Benjamin, 2007; Cautin, 2006). The model is informed by the disciplines of behaviourist and related sciences using positivist empirical research methods that aim for objectivity and repeatability and exclude consideration of the role of the practitioner from the techniques they deploy.

The model was critiqued for ignoring the different skills sets required for researchers and for practitioners; and for not producing better clinical practitioners (Albee, 2000). As a result a practitioner-oriented model was adopted in the 1970s, and both models coexisted in academic settings in the USA (Frank, 1984). Australia has tended to follow overseas developments on these matters. Shakow's contribution to the training of clinical psychologists may have been effective for the initial systematisation of training in that profession. It is puzzling, however, that psychotherapists and counsellors would want to adopt a primarily science-practitioner model without the training in psychology, on the one hand; but with, on the other hand, the rich philosophical training in phenomenological practice – whether or not that was made explicit in the training – and specifically in the development and maintenance of a strong therapeutic relationship.

The reflective practitioner model took shape, also initially in the US, around the work of Schön (1983) who coined the term in his analysis of a range of professions, including psychotherapy, to present how professionals work in practice. Schön notes a professional emphasis on interaction and improvisation learned in practice, rather than a technique-driven orientation. The reflective practitioner model is informed by the disciplines of the humanities and social sciences. Rather than eradicating the subjective elements of practice and knowing, it incorporates them as a direct contribution to the ongoing development of knowledge.

The medical model of health (Scott & Marshall, 2005) refers to the framework of ideas about causation and treatment of illness, from a natural science perspective, that focus on physical causes and physical treatment. In a literal interpretation of this model the orientation of the health service provider to their patient is of an expert treating the pathological presentation of the patient. The model has been extended by some practitioners to include other approaches, to become the bio-psycho-social model. This adaptation is however more nominal than actual as the integration of these approaches is difficult in practice (Scott & Marshall, 2005). Moreover the disciplinary bases of the range of approaches captured in bio-psycho-social, or even bio-psycho-social-spiritual, require more than superficial attention in order to be mastered.

The other key model of practice is the World Health Organisation's (WHO) social model of health, emphasising the social, economic and ecological, rather than simply intrapsychic and biological, determinants of health. As the leading international organisation dedicated to global health and wellbeing the WHO auspiced the First International Conference on Health Promotion in 1986, producing the Ottawa Charter for action to achieve global health. The Charter defined the prerequisites for health as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity, and asserted that 'improvement in health requires a secure foundation in these basic prerequisites' (WHO, 1986).

This approach was reiterated at the WHO World Conference on the Social Determinants of Health in Rio in 2011:

Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels (WHO, 2011).

The metaphor commonly used to emphasise the social and economic benefits of health promotion is of servicing 'upstream' (Maller, Townsend, Pryor, Brown & St Leger, 2006; VicHealth, 2007). This refers to the priority of addressing the causes and conditions of illhealth, upstream, before people fall into the 'stream' of illheath. This prevents having to focus all resources into crisis management 'downstream'. This model has strong explanatory force regarding health and wellbeing, through situating it within a broader context of lives as they are lived and experienced, and the interconnectedness of our subject positions.

A similar contextualising influence within community psychology gave rise to the critical practitioner model. This places the work of psychology within its broader social context and incorporates into its intellectual framework influences from important systems of thought including feminism, postmodernism, critical theory, the practice of hermeneutics and subjective reflection (Fox & Prilleltensky, 1997). It has not been widely accepted within the Australian context of psychology, where the science-practitioner model predominates (see for example the training standards set for accredited psychology courses in Australia at APAC, 2010).

The social model of health aligns well with the more philosophically and socially informed practices in the profession of psychotherapy and counselling, and its extension of services beyond acute care to the pejoratively termed but no less significant 'worried well'. The clinical practise emphasis of psychotherapists and counsellors on the intersubjective therapeutic relationship favours the reflective practitioner model and the social model of health. Clients of psychotherapy and counselling present for a wide range of reasons across the spectrum from acute mental illness to existential enquiry. Presentations may include: depression anxiety, childhood or current sexual abuse, domestic violence; substance abuse; anomie, or general discontent; specific life problems, largely to do with relationships with self and world; major life transitions; grief and so on. As socio-economic and political factors are considered constitutive of a person's health and wellbeing, context is taken into account for treatment or optimal responsiveness.

Many of these presentations would be considered concerns of the 'worried well'. This is a term that speaks from the context of resource pressure where funds are funneled toward the acute end of the spectrum of health, rather than being 'wasted' on those whose concerns are not considered sufficiently serious. Although the preventive benefits of therapeutic support are acknowledged by government and other funders from time to time, it seems the upstream argument has not been fully understood.

The objectively evident indicators of crisis can be more tangible, and often more measurable, than the subtle subjective processes of ennui. The medical model of health and science-practitioner model have a strong influence on government funding practices. While there are benefits in this influence, it has been inflated at the cost of other important influences because the regulatory climate in Australia favours measurable and quantifiable factors. Governments are more swayed to fund practices that are subject to predictability and repeatability, with quantifiable outcomes. This is misleadingly referred to as evidence-based practice, as though practices that do not readily submit to measurability are not evidence-based and implicitly lack effectiveness. As a result they influence an over reliance on the outcomes of positivist empirical forms of research, at the cost of knowledge production from other methods. This has tended to edge the mental health space – including the practice of psychotherapists and counsellors – toward assessment for diagnostic purposes, and the application of manualised treatments based on diagnosis. While there are clearly contexts in which this approach is beneficial, it errs on the side of excluding the role of the practitioner from the technique/s they deploy.

Although many therapeutic modalities can meet requirements for quantifiable outcomes, those that tend toward manualisation – to a focus on technique – are more readily measurable and conform to the frame of evidence-based practice narrowly defined in terms of positivist empirical studies. This may in part explain the over-representation of cognitive-behavioural therapy in mainstream discussions on therapeutic effectiveness. McLeod (2013) argues that not only quantitative but qualitative and other forms of research can influence policy; and that researchers in psychotherapy and counselling are responsible for making known the specific strengths of other forms of research evidence precisely to this end (p 129).

Apart from the rich lineage of ontological philosophy that presents a framework for intricate work with subjective experience, the positivist empirical approach to evaluating therapeutic effectiveness has also been significantly challenged by the common factors research.

The common factors and relational practice

The common factors meta research involved analysis of forty years of outcomes data across a diverse range of practice modalities to identity what factors are common to effective therapy. The key research finding was that that the client's own life space and the quality of the therapeutic relationship together constitute the most significant factors of therapeutic effectiveness (Hubble, Duncan, & Miller, 1999; Duncan et al, 2010). The four factors consistent with therapeutic effectiveness in order of significance are: the client's life space (40%); the therapeutic relationship (30%); the element of hope held by client and therapist in the usefulness of therapy (15%); and the technique/s employed in the therapeutic encounter (15%) (Asay & Lambert,1999).

According to Wampold (2010) this research signifies that particular therapeutic treatments ought no longer to be mandated. This is because all are effective on the basis of the therapeutic alliance between client and therapist, and because there is no evidence that a given technique or approach is more effective than another (when researcher allegiance to the model being researched is accounted for): 'the notion of requiring clinicians to use empirically supported treatment or evidence-based treatments simply is not supported by the research evidence' (Wampold, 2010, p. 72.). By this logic it no longer makes sense to use documentation of a specific evidence-based treatment as a measure of accountability. Rather, the therapist themself becomes accountable for the outcomes and the primary measure of effectiveness is the therapeutic relationship, based on implicit and explicit client feedback.

Much of the work of psychotherapists and counsellors, described by PACFA (n.d.), centres on the therapeutic relationship as the pivot point for therapeutic effectiveness.

Elements of the work include:

– the use of a set of advanced interpersonal skills to facilitate clients' change processes;

– respect for clients, their uniqueness and their right to self-determination

– consideration of the client's cultural and socio-political context and how these factors affect the presentation;

– recognition of social and cultural influences (age, development, (dis)ability, religion, cultural identity, Indigenous identity, sexual orientation, socioeconomic status, nationality and gender);

and, importantly:

– recognition that practitioner self-awareness and self-development are central to effective and ethical practice, and to the capacity to utilise the self of the practitioner effectively in the therapeutic relationship (PACFA, n.d.).

This describes a set of skills and orientation tailored to the development and maintenance of a strong therapeutic relationship for the purposes of facilitating the changes desired by clients of psychotherapy and counselling. Backed up by accredited training and post-training supervision and professional development, registered psychotherapists and counsellors deploy the wide range of evidence-based techniques but, critically, do this within an orientation that has the therapeutic relationship at its centre (Schofield & Roedel, 2012).

The quietly radical common factors research provides opportunities for psychotherapy and counselling professionals to clarify the profile of the profession in the health space, especially in reference to the continued rise of relational therapeutic orientations. The renewed emphasis on the therapeutic alliance is a prompt for relational psychotherapists and counsellors to articulate more proactively how the therapeutic relationship works and to foreground the philosophical and phenomenological bases for their particular practices of relational intersubjective therapy.

Client informed practice

Although the common factors research has been published for some time – and ideas central to it date back to early and mid last century (such as Rozensweig, 1936, and Frank & Frank, 1961) – it has not yet yielded the transformations of the field, nor taken it significantly beyond technique-focused practice. An increased emphasis from the profession on the common factors, along with the move toward client informed, outcome oriented practice, would focus attention on the philosophical elements of the training of psychotherapists and counsellors. The logic of the research findings displaces the emphasis on evidence-based practice in favour of practices and measures relating to the therapeutic relationship.

Shaw and Murray make an ethical case for including routinely gathered formal client feedback in therapy, seeing it as collaborative, empowering and valuing of client input into the direction of the therapeutic process: 'Collecting feedback from clients directly privileges their voice, attends to the client-counselor relationship, and establishes a framework for constructing individualised, client-directed counseling' (Shaw & Murray, 2014, p. 44).

The use of client feedback instruments has the potential to manifest therapists' commitment to clients' therapeutic goals, and to monitor the effectiveness of the alliance and the outcomes in achieving these goals (Miller, Duncan, Brown, Sorrell, & Chalk, 2006).Moreoverthe use of outcomes scales can provide evidence of therapist effectiveness to third-party payers, although that is not the main aim of outcome informed practice.

Clinicians may have concerns that feedback instruments may create obstacles to the maintenance of a strong therapeutic relationship, or represent an inelegant intrusion into the intimate space of therapy. Research has shown, however, that the process can provide openings into productive conversations about the relationship in real time, and yield unexpected benefits, such as a deepening of the therapeutic process (Sundet, 2012, p. 126). In addition it allows clinicians to take responsibility for, and control of, their own real-time feedback and development.

A wide range of validated feedback instruments exists. Some are of greater length (OQ45), others brief such as the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). Anker, Duncan, and Sparks (2009) found a 90% improvement of therapeutic outcomes when counsellors used the ORS and SRS for formal feedback from their clients. Interestingly, prior to the trial those counsellors indicated their belief that they had already gained feedback from their clients without needing formal feedback.

At this stage of the development of the profession of psychotherapy and counselling in Australia a concerted effort on the part of registered practitioners to gather ongoing feedback from clients about the therapeutic session and relationship, stands to benefit clients and clinicians, and the developing profile of psychotherapy and counselling as the profession at the heart of relational practice.

Concluding thoughts

This article has aimed to show the importance for the profession of psychotherapy and counselling of a clearly articulated disciplinary base. The predominance of the therapeutic relationship as a factor in therapeutic effectiveness calls for greater rigour in the understanding of how that relationship works. The argument here has been to sketch how the philosophical and relational roots of the disciplines of psychotherapy and counselling provide that rigour through an ontological orientation and a phenomenological method; and how through the specific requirements of training and practitioner personal development this provides the solid theoretical and practical grounding in the maintenance of a therapeutic relationship.

The centrality of the therapeutic relationship to effective therapeutic outcomes subordinates the definitional politics and differences between psychotherapy and counselling to the skills and capacity of a given therapist – psychotherapist or counsellor – to establish, maintain and work intentionally within the therapeutic relationship. This research has the potential of changing how therapy is practised in Australia; or, at least, of changing the terms in which the psychotherapy and counselling profession articulates its disciplinary base and its points of difference within allied health; and re-structuring how the profession is regulated.

At this juncture in the establishment of the profession of psychotherapy and counselling it is timely for the profession to acknowledge that the allied health practices of psychology and psychiatry arise out of different models of health; and that it project its own specific offering into the allied health space. With the reversal in emphasis from manualised techniques to the common factors of therapeutic effectiveness, spurred on by the work of Duncan, Miller, Wampold, and Hubble (2010), the profession of psychotherapy and counselling can present a distinct profile with its embeddedness in the humanities and social sciences, and its relational orientation based in phenomenological philosophy.

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