What's the good of therapy?

- Switch focus from theoretical models or therapy in general to specific settings;
  - Primary care / GP surgery
  - Business & occupational
    - Occupational health, HRM; eg. The Post Office
  - Military
  - Conditions (eg. Panic disorder)
- One possible response to ethical and practical criticisms of therapy

So far have looked at efficacy and effectiveness

- Considering specific settings broadens this to look at the benefits from more than the client viewpoint.
- It is also appropriate in the UK where responses to distress and disturbance are more likely to be publicly or organisationally funded and focused on certain client groups / disorders / settings than the traditional individual practitioner / private client model that is implicit in much literature.
- Material on specific settings also responds to critics of therapy (which often take a much broader view than whether it 'works' or not) by looking at real-life applications.

Business model in the NHS

- Purchaser / provider distinction
- Services commissioned and funded to meet new needs, apply new capabilities, respond to new agendas
  - Eg. New focus on social anxiety
- Means clinical psychologists have to be competent, active, academics and researchers

Organisational settings 1: Military / defence

- Military – *'can do'* philosophy thriving on *risk, the dignity of risk and the excitement of risk*. Individuals pushed and may grow, autonomy given up for the benefit of the group in return for group support and protection - the psychodynamics of the military family
- The soldiers dilemma: accept risk *or* feel a failure - grief and loss, guilt and shame
- Evacuation syndrome; if kept in the social role of soldier (not patient) and not evacuated beyond rear area, comradeship, self respect, sense of belonging are retained.
- Proximity / immediacy / simplicity / expectancy
    - Palmer 2002 in Feltham *What's the good of counselling and psychotherapy?*

Employee assistance programmes (EAPs)

- Post Office EAP study (Cooper & Sadri 1991)
  - Significant benefits anxiety, absences, depression, down; self esteem up – but not to typical level.
  - Implies that investment in recruitment comes first
- Benefits to organisations? US studies have mixed results but some strong cost-benefit outcomes
- Little UK evidence, results suggest both parties may benefit.
- Altruistic and organisational motives

Counselling in primary health care

- Substantial growth – but is it evidence-based?
- Some evidence of reduced medication, GP appointments
- NICE – if no RCT evidence of benefit, no funding. Fine in what Cochrane (1999) calls *cure* conditions (heart disease, cancers) , fraught with problems in *care* conditions.
- Important to establish evidence with counselling to differentiate from the margins of acceptable practice
- Clinical audit procedures such as CORE may help