Counselling Psychology in Medical Settings: The Promising Role of Counselling Health Psychology

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Abstract

In recent decades a biopsychosocial understanding of health predominated, and health problems stopped being just a physician's job. Consequently, the role of experienced psychologists in health care is gradually becoming more important. Counselling Psychology as a major field of psychological science with an enormous knowledge and experience in dealing with a diversity of problems has only to offer to the medical health care. Our purpose is to present the multiple roles of counselling psychologists (e.g., as evaluators, advisors, therapists) in health and health care. Issues regarding the training of 'health counselling psychologists' are also being discussed. Finally, I argue about the opportunities and difficulties that counselling health psychologists may meet in daily practice.

Keywords: counselling health psychology; medical health care; health care provision.

During the second half of the 20th century the field of human health and health care was faced with significant changes and new challenges. Gentry (1984) highlighted several aspects of this new environment in health and health care, such as the failure of the biomedical model to fully explain health and illness, the shift to chronic diseases as the main health problem, the realization of the role of psychological and life-style factors in the manifestation and maintenance of health problems, the development of sophisticated psychological theories about health. These factors facilitated the formation of relatively new initiatives within the field of psychological science, while new specialties and professional categories emerged. During the '70s and '80s certain major national and international associations were established with the aim to promote 'behavioural medicine' or 'health psychology', whereas new relevant scientific journals were published (for a more detailed review, Belar & Deardorff, 1995; Kaptein & Weinman, 2004). As a result, in the following decades a new understanding of health and illness appeared, psychological research

on health and health related factors increased, and health problems, especially chronic diseases, stopped being just a physician's job. Patients were increasingly referred to psychologists for treatment and symptom management, while psychologists were involved in the efforts for health maintenance and health promotion in almost every population (e.g., Ayers et al., 2007; Bennett, 2000; Sarafino, 1999). Thus, the role of health, clinical and counselling psychologists in health care gradually became more important.

The purpose of the present article is to briefly present the multiple roles of counselling psychologists in health and health care, discuss relevant training demands, argue about ethical issues, as well as about the opportunities and difficulties of working in medical settings. Of course the whole issue is vast. Therefore, the present document intends to be only a brief discussion of issues related to counselling health psychology.

Counselling Psychology and health care

In 1982, Millon defined health psychology as "the application of knowledge and methods from all substantial fields of psychology to the promotion and maintenance of mental and physical health of the individual and the prevention, assessment and treatment of all forms of mental and physical disorder in which psychological influences either contribute to or can be used to relieve an individual's distress and dysfunction" (p. 9). Counselling psychology as a major field of psychological science with an enormous knowledge and experience in treating a diversity of problems has only to offer to medical health care. As a developmentally based specialty that emphasizes building on person's strengths, treating persons with respect and care, taking into consideration and incorporating environmental factors and resources, using psycho-education in treatment, employing the biopsychosocial model for understanding health and managing health problems, and being familiar with interdisciplinary collaboration, counselling psychology can significantly contribute in health-related applications (Altmaier & Johnson, 1992; Roth-Roemer, Robinson Kurpius, & Carmin, 1998).

Counselling psychology was directly related to health care for the first time in 1979, when Krumboltz, Becker-Haven and Burnett published an article on counselling psychology in the Annual Review of Psychology, and discussed treatments for certain health problems, including pain and insomnia. Following that, a relevant chapter in the first edition of the Handbook of Counselling Psychology was published by Thoresen and Eangleston (1984), while the same authors published next year a similar article in The Counselling Psychologist (Thoresen & Eangleston, 1985). In 1998, a first edition exclusively dedicated to the role of Counselling Psychology in health care was published (Roth-Roemer et al., 1998). This edition focused on a variety of topics, like professional issues, areas of practice, and interventions in special populations. Since then, several efforts to promote

counselling psychology in health care have been developed. For instance, within the Society of Counselling Psychology of the American Psychological Association (Division 17) a section of Counselling Health Psychology has been established. This section is dedicated to the science and practice of counselling psychology in health-related contexts through research, intervention, training of young students or professionals, and development of health policy initiatives (for more information, http://www.div17.org/sections_chp.html). Also, the Division of Counselling Psychology of the British Psychological Society acknowledges the breadth of places that a counselling psychologist may work, including medical settings (for more information, http://www.bps.org.uk/dcop/). Indeed, the role of counselling psychologists in such settings is fast growing.

The role of counselling psychologists in medical settings

As experts in human behaviour, counselling psychologists can assume a diversity of roles within health care services. They may evaluate and assess the psychological functioning of the patients; act as advisors for the treatment team; provide training; organize and implement research projects; provide counselling or other types of psychosocial interventions to the patients and their families.

a) Carmin and Roth-Roemer (1998) underlined that psychologists are frequently asked to perform a psychological assessment of medical patients. They are asked to evaluate whether patients suffer from problems that might interfere with or complicate medical assessment and treatment (such as cognitive deficits, anxiety or mood disorders), or to differentiate between a medical and a physical condition. In fact, Rief (2004) reported that about 20% of the visits to a physician involve symptoms that cannot be explained by a typical medical disorder, while Ansseau et al. (2004) in a sample of 2316 adult patients found that 42.5% of them are met with some type of psychological difficulty, mainly emotional, anxiety and somatoform symptoms. Furthermore, there is a significant problem of under-diagnosing psychological difficulties in typical health care services, like hospitals or medical centers. Kunen, Smith, Niederhauser, Morris and Marx (2005) reported that under-diagnosis reaches almost 75% of all relevant cases. Moreover, mental health problems constitute a major financial burden to the health system and the national economy (Layard, 2005).

   Medical staff is rarely ready to identify and, of course, address psychological difficulties (Layard, 2005). Therefore, the role of the psychologist in assessing and addressing psychosocial problems, as well as in alleviating the frustration that medical personnel often feels when dealing with such problems, is crucial and in favour of both patients and staff.

The assessment of psychosocial functioning usually relies on the classical clinical interview and use of diagnostic instruments, some of which are especially designed for use within medical settings (for a review, Bennett, 2000; Belar & Deardorff, 1995). In the assessment process not only the patients might be involved, but also family and relatives, or even the medical personnel. However, assessment and diagnosis in a medical setting is subject to limitations, such as the lack of a private place for the interview to take place, lack of time, need for quick answers, medication side-effects etc. Consequently, psychologists are often called to improvise in order to effectively adapt and perform under these conditions (for a review and related suggestions, Van Egeren, 2004).

b) Counselling psychologists are especially trained in consultation. This is critical whenever they have to act as advisors or consultants to the treatment team of a patient. This part of the counselling psychologists' role is important as they can provide information regarding the psychological well-being of the patients (BPS Division of Counselling Psychology, 2007; Kagan et al., 1988), but also offer specific recommendations that will assist medical staff. Moreover, counselling psychologists can provide medical staff with pieces of advice or instructions on how to manage everyday difficulties (e.g., work-load, difficulties in decision making, dealing with death and dying patients) (BPS Division of Counselling Psychology, 2007; Earll & Bath, 2004). In their efforts, counselling health psychologists have to consider information regarding all major parts of the medical milieu: patients and their needs, medical personnel, the environment, and any special conditions (Carmin & Roth-Roemer, 1998). It is a rather difficult task and, therefore, psychologists should be familiar with a diversity of factors both psychological and medical.

c) Additionally to their role as advisors or consultants, counselling psychologists are frequently called upon to train physicians or nurses in counselling related issues, such as effective communication, patient-medical staff relationships, stress management, psychological factors associated with health and illness and so on (Kagan et al., 1988). They can also teach specific techniques for dealing with problems like pain or insomnia, or specific ways for managing personal and professional difficulties, like burnout or troubled communication (Walker, 2004). Training can also be addressed to the patients as a component of an intervention program.

d) A most crucial aspect of the counselling psychologist's role within a health setting is to provide counselling or other types of intervention to those in need. According to Bennett (2000), and Belar and Deardorff (1995), a psychologist can offer substantial help at every level of the patient's

functioning: physical level (e.g., pain and other symptoms management, reduction in psychophysiological arousal), emotional level (e.g., stress management, dealing with symptoms of depression and anxiety), cognitive (e.g., provide information, help in changing dysfunctional thoughts), and behavioural (e.g., modification of maladaptive behaviours, increase adherence to medical therapy). Furthermore, counselling psychologists can offer help to the families of the patients (e.g., by means of providing information, support, training etc.), as well as to the medical personnel for dealing with special conditions, or to the broader socio-cultural milieu (e.g., by mobilizing a social support system, organizing and implementing prevention efforts etc).

In fact, the range of possible intervention targets for the patients is quite wide: from preparing patients for difficult operation procedures, to training them to effectively cope with the post-surgery problems or with medical treatment side-effects; from helping them to change unhealthy behaviours (including weight control and smoking cessation) to providing counselling for dealing with emotional and adjustment difficulties; and from breaking bad news to helping the dying (Karademas, 2005).

In order to achieve their intervention goals, counselling health psychologists may choose from an array of intervention strategies and techniques: individual and group counselling, brief therapies, providing information and training, crisis intervention, stress management, motivational interview, guided imagery, behaviour analysis and modification, cognitive restructuring and many more. The majority of these techniques and strategies are based on the cognitive-behavioural model, which has been found really effective in treating many health conditions, including: cardiovascular disorders (e.g., Bellg, 2004; Gidron, Davidson, & Bata, 1999); neoplasms (e.g., Khazam, 1996; Spira & Reed, 2002); diabetes mellitus (e.g., Norris, Engelgau, & Narayan, 2001); HIV/ AIDS (e.g., Bor, du Plessis, & Russell, 2004; Bor & du Plessis, 1997; Chesney & Antoni, 2002); sexual health (e.g., Aarø et al., 2006); surgical procedures (e.g., Lang et al., 2000; Petry, 2000); renal disease (e.g., Griva & Newman, 2007); urological disorders (e.g., Nicolau, Toro, & Perez Prado, 1991); dermatology (e.g., Kent & Keohane, 2001; Papadopoulos, Walker, Aitken, & Bor, 2000); obstetrics (e.g., Klock, 2004); transplantation (e.g., Blumenthal et al., 2006) etc. Medical patients are rather interested in short-term and focused interventions that can facilitate their recovery, than long-term insight-oriented therapies (Carmin & Roth-Roemer, 1998). These requirements are typically met by behavioural (e.g., conditioning, operant conditioning, modeling), cognitive (e.g., self-management, cognitive therapy), and cognitive-behavioural approaches (for more details, Bennett, 2000; Bennett, Conner, & Godin, 2004; Lorig, 1996;

Rutter & Quine, 2002). An interesting tool, which provides guidelines for the development of intervention programmes, for the application of theory, as well as for the transformation of theory into practice and the selection of appropriate methods and strategies, is the Intervention Mapping (see, Kok & Schaalma, 2004). Intervention Mapping may be really useful for practitioners, especially at the beginning of their career.

In any case, psychologists must be cautious when selecting a strategy, as they have to take into consideration issues like the effectiveness of each strategy, possible interference with the physical functioning and possible side-effects of the medical treatment, the cost/ effectiveness ratio, time limits and so on. Counselling health psychologists should also follow all necessary steps to secure an evidence-based practice, which is the best way to promote patients' well-being (Spring, 2007; Walker & London, 2007).

Additionally, in recent years, the intervention role of counselling psychologists is expanding to new fields, including genetic testing and related counselling services (Wang, Gonzalez, & Merajver, 2004), telehealth counselling services (Miller, 2006), and spiritual issues and health (Thoresen, 1999). As our understanding of the role of psychosocial and behavioural factors in health deepens, more and more efficient intervention programs are developed in favour of the patients and the health care system. The implementation of these programs, however, requires for highly trained and capable experts, an issue that I will refer to later on.

e) Finally, counselling health psychologists may plan and implement research activities. Psychological factors related to health and illness, adaptation to illness, well-being and quality of life and many more, are the issues that counselling health psychologists can study in order to gain a better understanding of health and illness and achieve a better practice. A significant field of research might also be the empirical testing and evaluation of the several intervention strategies. In these efforts, psychologists should collaborate with the medical personnel and include in their studies medical and biological variables as well (Suls & Rothman, 2004).

Gatchel and Oordt (2003) underlined the fact that the approaches for providing psychological services fall on a continuum, depending on the characteristics of each health service. According to the authors, within this continuous lie four major models. These models were described in relation to primary health care, but I think we can easily adopt them in relation to any health care setting. In the "collocated clinics" model, the psychologist is usually with a traditional psychological clinic and not integrated into the health care clinic. Actually, medical and psychological (or psychiatric) clinics remain two different entities. In the second model, the psychologist may act as a provider within the medical clinic. Accordingly, he/she

may provide counselling or therapy for both mental health and medical conditions. The psychologist collaborates with the medical personnel, although he/she is still an 'independent provider' of health care. This model resembles the first one, but in this case the psychological work is offered as part of the same clinic. In the third model, the psychologist acts as a "behavioural health consultant". She/he is a member of a multidisciplinary team and responsible for the behavioural and psychological aspects of treatment. The psychologist evaluates the patient and makes recommendations to the case manager (the physician). She/he may see the patient for a limited number of sessions (one or two) to monitor the implementation of the recommendations or provide specific advice. In parallel, the psychologist can provide targeted services to specific groups of patients (e.g., stress management to heart attack patients). In case of more intense problems the psychologist may refer the patient to other specialized psychological services. The final model refers to the psychologist as the "staff adviser", who consults only the medical staff. She/he has no independent contact with the patients, but rather uses her or his expertise to assist the medical staff with defining and treating the problem.

Each of the models presented by Gatchel and Oordt (2003) has advantages and disadvantages and may be appropriate for one setting, but not for another. It lies with the setting and the scientific staff to decide upon which model better fits their needs. Of course, the models presented are not mutually exclusive (Gatchel & Oordt, 2003). A combination of these might be the most efficient and proper solution. Likewise, Pruitt, Klapow, Epping-Jordon and Dresselhaus (1998) proposed a stepped-care approach: the psychologist initially provides advice to the medical staff in order to deal with a patient. Should no improvement occurs, the psychologist may be engaged in a personal contact with the patient in order to make a more thorough assessment and provide the appropriate treatment. If also no improvement is achieved, then the psychologist may decide to provide a more extensive therapy or refer the patient to another service.

I believe that counselling psychologists working within a medical setting should (a) originally evaluate current conditions in the setting, (b) assess the needs of the typical patients of that setting, as well as (c) of the medical personnel, (d) collaborate with the other members of the scientific staff, and then (e) determine and finally adopt the most appropriate model that will permit them to perform the necessary diagnostic, intervention, consulting, training and research work.

At this point, I should emphasize the fact that especially in United Kingdom a fast growing number of counsellors work in primary care and general practice. As Foster (2000) reports, from almost no primary care counselling provision in 1980, there were counsellors in 51% of the surgeries in England and Wales at the time "the new National Health System" was launched. This expansion of counselling services was rapid but, according to many, haphazard and fragmentary (Eatock, 2000; Melloc-Clark, 2000). Still, the numbers of counsellors and counselling psychologists in

general practice are growing and the National Health System is probably the major employer of counsellors in UK (Eatock, 2000). However, their work is primarily focused on mental health issues. Although mental health is of great importance for all medical patients and their survival and quality of life, working as a mental health professional is different than serving as a 'counselling health psychologist'. For instance, a mental health professional focuses on psychosocial issues and their association with health. On the other hand, a 'counselling health psychologist' focuses not only to mental health issues, but also on many more topics related to physical health (e.g., adherence, physical symptoms management, life-style etc), even when no mental health difficulty is present. It is my opinion that counselling psychologists working within primary care in UK could also assume the role of a 'counselling health psychologist' with success and expand their responsibilities within the health care system. After all, there is evidence suggesting that their services are effective and the help they offer substantial (Baker, Allen, Gibson, Newth, & Baker, 1998; Bower, Rowland, & Hardy, 2003), while their contribution to the development of primary care is more than significant (e.g., Lenihan & Iliffe, 2000).

Ethical issues

Beside competence, which is an always challenging aspect of practice, there is an array of ethical issues related to the practice in a medical setting. Indeed, counselling psychologists are sensitive to issues associated with the psychologist's responsibilities and the patient's rights (Robinson Kurpius & Vaughn Fielder, 1998). However, protecting rights within a health care service could be challenging at times, especially regarding confidentiality and the proper use of psychological information (Hudson-Allez, 2000). Sometimes it is difficult to uphold confidentiality in a medical setting, due to three major factors: the psychologist usually has to share information with the other members of the multidisciplinary team (e.g., physicians and nurses) or keep notes in the patient's medical record (if there are no separate psychological records); the psychologist might not be able to see the patient privately, but in multibed rooms; the psychologist often needs to inform the patient's family, since collaboration with family members is frequently critical for the treatment (Bennett, 2000; Belar & Deardorff, 1995; Hudson-Allez, 2000).

In order to deal with these challenges, the counselling health psychologist must enrol brains and talent. She/he must also be sure that patients understand the procedures of sharing information with medical personnel or keeping informed the hospital record. He/she has to obtain consent to provide confidential information, unless the patient is unable to make informed decisions (Bennett, 2000; Papas, Belar, & Rozensky, 2004). Of course, patients should always be given the option of declining psychological services, after a discussion on its purposes, aims, and restrictions.

Opportunities and difficulties of working in medical settings

Despite the opportunities that health care provides, and the significant contribution that counselling psychology can make, only a relatively small number of counselling psychologists seem to work in such services, while not many programs provide systematic training for such a possibility. In fact, until early '90s only a small percentage of counselling psychologists were working in the health domain (Good, 1992), despite the growing employment opportunities (see for example, http://www.health-psychology.org.uk./menuItems/what_is_health_psychology.php). Altmaier in 1984 reported that almost 60% of the counselling psychology training programs in the USA had no health psychology course work, whereas more than half reported practicum placements in health psychology. Furthermore, students reported a moderate interest in the area. More recently, however, the interest in health psychology practice appears to be increased, but not much. Neimeyer, Bowman and Stewart (2001) reported data from 1989 to 1998 indicating that about 17% of graduates of counselling psychology programs in the US have been employed in hospitals, whereas more than 80% were still placed in counselling and mental health centres, in private practice, and in academia. In the same line, Stedman, Hatch, Keilin, & Schoenfeld (2005) in their description of internship training of clinical and counselling psychologists concluded that training still focus heavily on the traditional clinical-provider role, while there is little evidence of innovation towards new areas of research and practice (like health settings). In the United Kingdom, only 4% of the applied psychologists work with clients suffering from physical health problems, according to recent surveys (BPS, 2007). On the other hand, about 40% of the chartered counselling psychologists in England are employed at the National Health System (BPS, 2005). Obviously, they work with mental health-related problems. It is possible that the disadvantages of working in a physical health care setting (i.e., coming to terms with the medical hierarchy, maintaining confidentiality, as well as the difficulties in communicating with the medical personnel (Good, 1992) are keeping young counselling psychologists from practicing their profession in such settings, despite the existing advantages (e.g., the diversity of the roles a counselling psychologist could assume). Moreover, the traditional focus of counselling psychology and relevant training programs on the more typical mental difficulties and psychosocial troubles, which usually does not include chronic diseases and physical health, might be another significant reason for this trend.

Indeed, working within a medical setting might be really demanding and complex. I will use the primary care services as an example. Primary care is defined as the very first care provided to the patients when they enter the health care system (Bray, 1996). As Gatchel and Oordt (2003) pointed out, psychologists working in such settings usually have to give up some level of their autonomy. At the same time, they have to see the entire population served by the clinic. As a result, they need to develop specific skills for focused and quick assessments, provide brief practical

advice, do their job in very short times, make decisions with limited amount of data, develop skills for enhancing motivation to change, use brief interventions, communicate efficiently with the medical staff (i.e., avoid jargon, be brief and focused), tolerate a rather low position in the hierarchy (physicians are usually the 'chief'), be flexible in their hours and available to patients and medical staff whenever there is need. Psychologists in primary care might also have to be quite 'creative' in their practice in order to be more effective (e.g., use telephone or web conferences, use the phone of even the fax to provide advice, advise the other members of the team in 'unusual' opportunities, e.g., during lunch). Furthermore, counselling psychologists sometimes have to work hard to spotlight their identity and their skills, since there is still considerable confusion and lack of information regarding their role in care provision (e.g., Lewis & Bor, 1998). All these can be quite burdensome to the psychologists and significantly tax their abilities to adapt. Consequently, they often avoid primary care settings.

On the other hand, medical settings may provide opportunities for the counselling psychologists to display their unique knowledge and skills, as in the case of cross-cultural health care. The ways a person perceives symptoms, reacts to illness, thinks about health and behaves are routed in her/his culture and culture-related belief system (Pedersen, 1997). A growing literature describes the strong associations between differences in culture, and health, well-being, health related beliefs and behaviours (e.g., Arrendondo et al., 1996; Marks, Murray, Evans, & Willig, 2000; Salant & Lauderdale, 2003), while there is evidence that cultural differences are associated with perceptions about the cause or the appropriate treatment of a disease (e.g., Karasz, 2005). Culture is so important for health and illness that many diseases seem to be 'caused' by local cultural habits (e.g., Boirin, 1997; Schensul, Mekki-Berrada, Nastasi, Saggurti, & Varma, 2006). Nevertheless, a major problem in the medical setting is the difficulty of the medical personnel to take into consideration the role of culture or cross-cultural variables (Atkinson, 2002; Prislin, Suarez, Simpson, & Dyer, 1998). Therefore, it lies with the psychologists to help medical personnel realize the significance of culture and cultural differences, and also promote 'cultural sensitive' or 'cultural focused' intervention programs (Pedersen, 1997), in order to facilitate patients' adaptation and enhance well-being and health.

Even with these opportunities, there is still a possibility that some counselling psychologists worry about counselling psychology losing its identity (Tyler, 1980). For example, Bernard (1992) and Good (1992) are afraid that counselling psychologists working in medical settings will alienate from their colleagues. On the contrary, Altmaier, Johnson and Paulsen (1998) support that no alienation will occur and counselling psychologists will keep their identity. In the same line, Mrdjenovich and Moore (2004) believe that counselling health psychology will maintain ties with the substantial area of counselling psychology and will not turn to be a 'subspecialty' of health psychology. These authors define professional identity as the sense of

connection to the values and emphases of counselling psychology. If counselling psychologists retain this sense of connection, then they will preserve their identity and will be able to make a unique contribution to the field of medical care. I concur with their opinion and, as Hudson-Allez (2000) suggests, I also believe that a counselling psychologist, irrelevant of his/her working environment, should always be an experienced practitioner with a solid counselling or psychotherapeutic training. Such training combined with a constant integration of new counselling/psychotherapeutic knowledge and techniques, and a continuous focus on the patient as a 'person' differentiates counselling psychologists from other psychology specialists and help them keep their identity. And by keeping their identity, they can effectively collaborate with medical staff and other specializations in psychology (such as health psychologists) in favour of the patients and in order to deal with the multiplicity and the complexity of their needs. After all, as Walsh, Frankland, and Cross (2004) underline, "*counselling psychologists also endeavour to modify the medical model system of relating from within the medical world, without compromising our* [counselling psychologists'] *or their standards and ethos"* (p. 326).

Training counselling psychologists for the medical settings

Training in counselling psychology is insufficient for practice in a medical setting. Moreover, with the exception of rehabilitation counselling, post-graduate and doctoral programs in counselling psychology are very slow or even reluctant to add health-related courses and practice (Alcorn, 1998; Stedman et al., 2005). In this section I will discuss certain aspects of training in counselling health psychology in brief. For a more extensive description of the educational and training demands linked to counselling health psychology I refer to Alcorn (1998), Michie, Abraham and Johnston (2004), Papas et al. (2004), as well as to the BPS Board of Examiners in Health Psychology (2001).

Although, counselling psychologists are traditionally trained in those areas that are commonly used within the field of health care, including psycho-education, human relationships, and behaviour modification, they should also be trained in a "health psychology" philosophy, as well as in specific skills. According to the American Psychological Association Council of Representatives (1997), for instance, psychologists working in medical health settings should be familiar with and have a broad understanding of several issues and quite a lot areas of knowledge, such as: biological, cognitive, affective and social bases of health, disease and behaviour; anatomy and human physiology; health behaviours and related factors; illness and disability effects on cognition, emotion and behaviour; the role of a diversity of factors, such as culture, patient-doctor relationships, health policy, stress etc. In the same line, in United Kingdom health psychologists need to be able to develop theory and conduct research, assess and intervene in order to improve health care and health outcomes even in complex situations, use ethical awareness to develop best

practice, train other health professionals, as well as consult health care personnel and managers (Michie et al., 2004).

Alcorn (1998) proposed an integration of certain courses with the core curriculum in counselling psychology. These courses are: introduction to health psychology, medical aspects of disability, psychopharmacology, medical terminology, neuropsychology, and community health. He also stressed the importance of the integration of science and practice (which, nevertheless, is common ground among counselling psychologists), as well as the necessity for training in the multidisciplinary nature of the work in medical health settings.

Equally, if not more, important are the internship experiences in medical settings and hospitals for the counselling psychologists interested in health psychology. Well-designed internships in different medical clinics, rehabilitation centres, pain clinics, medical schools or similar settings, under the supervision of experts, are essential for a good practice. Internships should be designed in a way to help young trainees adapt their knowledge and skills in the health setting, as well as prepare them to deal with a variety of difficulties and problems. It should also be noted that internship in specific settings (e.g., pain clinics) is a possible pathway through which professional specialization can be achieved.

The specific form that training in counselling health psychology should take depends on many factors: the educational system of each country, the form of the health care system, history, needs, and special conditions. For instance, in the USA to qualify for board certification in clinical health psychology, a doctoral degree in psychology (e.g., in Counselling Health Psychology) is needed, among other requirements regarding training, internship, continuing education and current professional work (ABPP, 1999). Counselling psychologists seem to applaud the development of health psychology as a post-doctoral specialty field (Alcorn, 1998). Likewise, a post-doctoral training in health psychology-related issues might be a solution for British counselling psychologists. (It should be noticed here that also the European Association for Counselling Psychology (EACP) accepts as full members only those counselling psychologists who are qualified at a doctoral level (see the Statuses of the EACP, http://www.counselling-psychology.eu). Alternatively, as the British educational system is flexible, the establishment of a 'joint' counselling (and) health psychology training program could be an answer to the question. A first step might be the establishment of a special interest group within the Division of Counselling Psychology of the BPS, which will encourage the development of these efforts. Such a group is already operating within the Division of Clinical Psychology since 1998 (http://www.bps.org.uk/dcp-facchp/). On the other hand, in countries like mine, Greece, where PhD is strictly an academic title that requires no professional training, other solutions appear to be more appropriate: the inclusion of health psychology-related courses in the counselling psychology post-graduate curricula, or internship in health settings and on-the-job training might fit better.

It should be stressed, however, that post-graduate and doctoral training programs in Health Psychology, as a specific applied field of Psychology, has been established across Europe (e.g., in United Kingdom, The Netherlands, Portugal, Greece) for many years (for relevant information, http://www.ehps.net). The experience gained from these programs could be useful for the development of counselling health psychology training programs. After all, health psychologists and counselling psychologists can both work within the same medical settings in a complementary way.

Conclusion

Counselling health psychology, which refers to the science and practice of counselling psychology in the medical health related context, is a promising area for psychologists. As society and health care policy makers become more and more familiarized with the biopsychosocial perspective on health and illness, and as our work in medical settings becomes more effective, the opportunities for counselling psychologists in health care services will also grow (Layard, 2005). Counselling psychologists will eventually become an integral part of health care provision and, more important, patients will benefit from their presence and services. However, for a successful integration to take place, counselling psychologists must be properly educated. It is a challenge for training programs in counselling psychology to satisfy the emerging needs.

With continuing education and increased advocacy for integrated health care services, counselling health psychologists will meet their goals in providing improved services.

Besides the existing opportunities and difficulties, counselling health psychology is a field with a great future. Health care will be faced with a number of challenges in the near future. Changes in education and training, research and practice (e.g., in the areas of behavioural genetics, telehealth, women and minorities issues, organ transplantation) are already taking place. Within this context, counselling health psychology has a lot to offer and a lot to gain.

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