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COUNSELLORS AND COMPETENCE: THE COUNSELLING FOR DEPRESSION (CfD) PERSPECTIVE

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Abstract

There has been a rapid expansion in competence-based therapies in response to growing demands for evidence-based practice, greater openness and accountability. The changes have been accompanied by a new theoretical and empirical base for therapist training and practice. Out of this rapidly changing therapeutic world emerged Counselling for Depression (CfD). This competence-based integrated model of person-centred and emotion-focused therapy is intended to standardise counselling work, particularly for therapists working in an Improving Access to Psychological Therapies (IAPT) agency, in the treatment of depressed clients. The change has not been without its critics. Concern has been expressed about the suitability of one model for all modalities. The history of competence based vocational education and training since the 1980s suggests that an uncritical adoption of the competence based approach can have unintended consequences.

This thesis explores competence, in the context of CfD, and the implications for training, practice and assessment based on the perceptions of therapists, trainers and supervisors. Nineteen participants involved in CfD training, from across England, were interviewed for their perceptions of CfD as a manualised, evidence-based framework of integrated person-centred and emotion-focused competences. The interviews were audio recorded and the resulting transcripts analysed using Template Analysis. Therapists were relieved that CfD had become available and thereby secured their jobs as IAPT therapists. Participants unfamiliar with emotion-focused therapy saw CfD training as an opportunity to enhance their practice. The CfD competence-framework provided participants with the means of explaining what they actually do. However, significant tensions emerged concerning the CfD competence framework, the integrative therapy, the CfD training programme and the CfD method of assessing competence. The implications for participants, the competence framework, training, therapeutic practice and assessment are discussed and several recommendations proposed.

Contents

Glossary

ACP	-	The Alliance for Counselling and Psychotherapy
AHPP	-	Association of Humanistic Psychology Practitioners
APA	-	American Psychological Association (Society for Psychotherapy Research Task Force)
APEL	-	Accreditation of Prior and Experiential Learning
BAC	-	British Association for Counselling (1977-2000)
BACP	-	British Association for Counselling and Psychotherapy (2000+, was BAC)
BACBP	-	British Association of Cognitive and Behavioural Psychotherapy
BAPCA	-	British Association for the Person-Centred Approach
BCP	-	British Confederation of Psychotherapists
BPC	-	British Psychoanalytic Council
BPS	-	British Psychological Society
CBET	-	Competence-Based Education and Training
CBT	-	Cognitive Behavioural Therapy
CCT	-	Client Centred Therapy (see also PCT)
CfD	-	Counselling for depression
CHRE	-	Council for Healthcare Regulatory Excellence (post 2012 - NICE)
CORE	-	Clinical Outcomes Routine Evaluation
COSCA	-	Confederation of Scottish Counselling Agencies
CPD	-	Continuing Professional Development
DH	-	Department of Health
DIT	-	Dynamic Interpersonal Therapy
EBP	-	Evidence Based Practice
EFT	-	Emotion Focused Therapy
EMDR	-	Eye Movement Desensitization and Reprocessing
ERG	-	Expert Reference Group
FEU	-	Further Education Unit
GDG	-	Guideline Development Group
GP		General Practitioner
HPC	-	Health Professions Council (changed in 2012 to HCPC)
HCPC	-	Health and Care Professions Council
IAPT	-	Improving Access to Psychological Therapies
ILB	-	Industry Lead Body
IPA	-	Interpretative Phenomenological Analysis
IPT	-	Interpersonal Therapy
MBCT		Mindfulness-Based Cognitive Therapy
MSC	-	Manpower Services Commission
NCVQ	-	National Council for Vocational Qualifications
NDPB	-	Non Departmental Public Body
NHS	-	National Health Service
NICE	-	National Institute for Health and Care Excellence
NOS	-	National Occupational Standards
NTI	-	New Training Initiative
NCVQ	-	National Council for Vocational Qualifications
NVQ	-	National Vocational Qualifications
PCE	-	Person-centred and experiential (therapy)
PCT	-	Person-Centred Therapy (Client-centred therapy)
PCEPs	-	Person-Centred and Experiential Psychotherapy Scale
POS	-	Professional Occupational Standards
PRN	-	Practice Research Network
PSA	-	Professional Standards Authority (for Health and Social Care)
PTSD	-	Post-Traumatic Stress Disorder

PWP   -   Psychological Wellbeing Practitioner
RCT   -   Randomised Controlled Trial
RVQ   -   Review of Vocational Qualifications
SCAC   -   Standing Council for the Advancement of Counselling (start1971, BAC 1976)
SETs   -   Standards of Education and Training
SfH   -   Skills for Health
SoP   -   Standards of Proficiency
UK   -   United Kingdom
UKCP   -   United Kingdom Council for Psychotherapy
UKRC   -   United Kingdom Register of Counsellors
VET   -   Vocational Education and Training

Chapter One

Introduction

Since 2010 the effectiveness of counselling and psychotherapy has been under increasing scrutiny. Alderdice (2010) notes increasing demands over recent decades for higher therapeutic standards and greater accountability, while Cooper (2011) argues that therapists need to address the rising demand for evidence-based practice. This was to ensure that therapeutic interventions are effective and from the taxpayer perspective, value for money. Sanders and Hill argue that the evidence-based paradigm "aims to integrate clinical judgement with the findings of high quality research to ensure healthcare interventions are guided by the best contemporary knowledge of effectiveness in order to maximise outcomes for service users" (Sanders and Hill, 2014, p.6). Both therapeutic expertise and evidence derived interventions / competences are seen as necessary in order to maximise outcomes for clients. This perspective, which constitutes the essence of the evidence-based paradigm, underpins the United Kingdom (UK) healthcare system through the clinical guidelines of the National Institute of Health and Clinical Excellence (NICE) and subsequent decisions on which treatments will be recommended for implementation within the Improving Access to Psychological Therapies (IAPT) service. It was thus believed imperative that the psychological therapies, such as CBT, psychodynamic, family / systemic and person-centred and experiential therapy (PCET), acquire an evidence-base of effective interventions or competences to ensure inclusion within the IAPT menu of therapies.

However, there are therapists who fear that the mechanism to be used in response to such calls, whilst suitable for some therapies, will have a negative effect on person-centred practice and training. The fear is that the competence-based / evidence-based approach to therapy may undermine the core therapeutic assumptions which underpin counselling and in particular person-centred / relational therapy (Chapman, 2012, Folkes-Skinner, 2015, Goldstein, 2011, Johnston, 2011, Rogers, Maidman and House, 2011, Vaspe, 2000). The concept of competence-based practice is relatively new to counselling but of growing importance. Hyland (1994) makes a distinction between competence as a capacity and competence as a

disposition. When using competence in the capacity or holistic sense, we may be evaluating an individual as successful in what they do, for example, a competent electrician, pilot or doctor. The term dispositional competence however refers to the more atomistic competences or particular abilities required when performing a vocation or profession. For instance a pilot has to apply and know about a range of abilities when using the aeroplane controls, taking off, flying and landing, as well as communicating with passengers and adhering to safety procedures. The evidence-based paradigm and the demand for transparency informed CfD's emergence as a competence-based therapy. According to Sanders and Hill a competence-based therapy is comprised of categories of competences which specify the "knowledge and descriptions of the attitude or stance taken by the therapist in relation to the client and descriptions of skill or method" (Sanders and Hill, 2014, p. 28). A competence framework emerged constituted of dispositional abilities / competences derived from research evidence of their therapeutic effectiveness in the treatment of depression. However, these evidence derived abilities or competences associated with the treatment of depression may not represent all the dispositional competences a therapist would associate with their particular therapy. It may therefore be possible to collect evidence of therapist competence in delivering a particular form of therapy without evidence that this therapy is effective. The latter may occur for experienced and qualified therapists as they change to working with CfD therapy. Competence-based and evidence-based therapies are therefore not necessarily the same thing because it is possible for competences to be identified, as they were during the development of National Vocational Qualifications, without the need for evidence of the existence of the competences. However, when a therapy becomes competence-based and evidence-based, the relationship is that the competences within a competence-based therapy have been identified because there is research evidence indicating their effectiveness in the treatment of a condition. I return to the topic of competence in chapter two. I would argue, as a consequence of the rapid development and launch of Counselling for Depression (CfD) as a competence-based therapy, that the concerns of the authors mentioned above could not be taken into consideration, or the implications for practice, training and assessment.

This thesis will explore the concept of competence within the context of counselling through the perceptions of people involved with CfD training, assessment and

practice. For accountability purposes many forms of therapy are rapidly adopting a competence-based approach to practice. But as Hodkinson and Issitt (1995) argue, whilst the concept of competence may appear simple, it cannot be understood without examining the context in which it is introduced. The emergence of CfD, my counselling background, and prior experience of competence-based systems, guided me towards the purpose of this study.

Chapter one contains the following sections:
- Background
- My interest in competence-based training
- The role of events / bodies in the development of CfD, with a focus on the following: National Vocational Qualifications (NVQs) and response from the profession , regulation and standards and therapist competence, the Depression Report and launch of IAPT, the contribution of Skills for Health, NICE and mental health provision and CfD and the IAPT service
- Summary, thesis terminology and structure of the thesis.

1.1 Background

Although a relatively young profession (McLeod, 2003), in recent years client demand for counselling services has been increasing. This demand has been accompanied by increasing political concern for public protection, standards of training and professional accountability. Media stories related to dubious practices and the lack of public protection have fuelled political and professional arguments around how best to improve the situation. This concern was perhaps unsurprising given that there was no legally required therapist training or requirement for therapists to conform to a professional code of conduct (Coe, 2009). What made the situation more complex was the availability of a massive number of trainings, each with its own philosophy, syllabus and standards. Such differences made it difficult for the public and non-counselling services to determine who was appropriately trained, qualified and to what standard (Pointon, 2009; Woolfe, 2006).

In 2005 the British Association for Counselling and Psychotherapy (BACP) and the United Kingdom Council for Psychotherapy (UKCP) carried out a mapping exercise of available trainings supported by the Department of Health (DH). The mapping exercise identified 570 trainings. Of the 570 trainings 63% lacked professional recognition but some counselling and psychotherapy trainings may have been accredited through further and higher education institutions (Postle, 2007). Unfortunately, the exercise did not identify the dominant philosophies or method of trainee assessment. It appears that such decisions were at the discretion of each training organisation. By 2008 the BACP training directory contained 1200 training programmes. Between 1977 and 1992 the number of BACP registered counsellors increased from 1000 to 8556 (McLeod, 2003). By 2011 this number had leapt to 36,000 (BACP, 2012) and by 2020 the number of BACP registrants had grown to 53,000. The growth in both trainings and BACP members appears to be due to the demand for training and, as Folkes-Skinner (2010) found, training is regarded by potential therapists as essential preparation for entry into the profession.

However, the profession continued to be unregulated and differences between the trainings remained. There was a lack of national standards and possible variations in the competence of trainees. The solution to this complex situation, the adoption of a medicalised therapeutic model, incorporating evidence-based competences, was becoming the preferred political solution to the need for clear standards, transparency, accountability and development of a highly skilled counselling workforce (Fonagy, 2010). Examples of research derived competences or national occupational standards include CBT, psychodynamic therapy, family and systemic therapy and humanistic therapy (Skills for Health, 2010). The medicalised therapeutic model has emerged from the growing importance of medical science and specialism in contemporary healthcare and now informs our understanding of mental health and mental illness. Sanders and Hill (2014) refer to this situation as the medicalisation of distress within a framework of health and illness. It is within this health framework that a medicalised means of treating distress follows from diagnosis to a prescribed treatment for the diagnosed medical condition. This healthcare framework now includes CfD, as a NICE recommended treatment for depression. IAPT provides the diagnostic service through which a client is matched

to the appropriate recommended treatment (chapter one, section 1.4 provides further information on this point).

There were fears amongst counsellors and psychotherapists that this was the end of an era of freedom as the state supported the introduction of a medical model of practice into the field of relational / person-centred therapy along with adherence to evidence-based practice (Browne, 2009; Shannon, 2009). However, Cooper (2011) argued that the profession needed to compromise and work within the system if counselling was to survive in the public sector, because it was unlikely that the demand for evidence-based practice would simply go away. The profession had reached a juncture in its development where reform was inevitable. The profession had to respond to what Sanders and Hill refer to as the "threat to person-centred and experiential (PCE) counselling" (Sanders and Hill, 2014, p.2) in order to secure the employment of IAPT / PCE therapists and argue for parity with other therapies within the IAPT service, such as CBT.

Before discussing the emergence and development of the CfD competence model, I want to reflect on personal experiences of competence-based training and assessment. I do so for two reasons. Firstly, my previous experience of a competence system alerted me to what appeared to be similar developments within counselling, in particular CfD. Secondly, as Botts points out, self-reflexivity is an important part of qualitative research, requiring researchers to remain in:

> "flexible 'dialogue' with the research subjects and contexts, in order to preserve a sense of the researcher's own subjectivity within the process…for researchers to constantly locate themselves within their work, and to remain in dialogue with research practice, participants and methodologies"   (Botts, 2010, p. 159-160)

Through the process of self-dialogue I hope to minimise the potential for researcher subjectivity to impact on the integrity of the research, how it unfolds and how it is interpreted. Within this process I attempt to be self-transparent from the beginning to the end of the study, through use of reflection and reflexivity.

1.2 My interest in competence-based training

In the 1980s I was working in a further education college with responsibility for the cross college curriculum. It was at this time that a national reform of vocational education and training began under the auspices of the National Council for Vocational Qualifications (NCVQ). NCVQ was tasked with converting as many traditional vocational courses as possible into competence-based National Vocational Qualifications (NVQs). I, because of my curriculum responsibilities, became involved with introducing into the college NVQs in a wide range of subjects, such as catering, childcare, beauty, teacher education and management studies. Converting traditional further education training programmes into competence-based NVQs was a stressful process for all involved. It was stressful because as Jessup indicates:

> "this shift from an input-led system [based on a syllabus] to an outcome-led system [competence-based standards] has fundamental implications, both in defining the content of education and training and open access to different modes of learning…[and] an assessment led system"   (Jessup, 1991, pp. 11-12).

Jessup was right when claiming that the shift to a standards-based or outcome-led system would make a lot of educationists unhappy as the shift required new kinds of standards, new forms of assessment and new forms of training. The scale of the shift and consequent workload made many college staff unhappy. The meaning behind 'fundamental implications' only emerged following consultations with awarding bodies and reading the numerous NCVQ documents and associated publications. Political and financial pressure required the conversion of traditional courses to NVQs in as short a time as possible. Preparing for the introduction of the new NVQs had to continue alongside normal teaching, which often created resentment, anger and fatigue. During this time my task was to ensure staff had the necessary training and materials so that a range of NVQs became part of the college prospectus.

I became an advocate for competence-based NVQs. I was attracted to the NVQ model by the apparent transparency of the competence specifications, the unit based structure and credit accumulation system, and the separation of assessment from training. The separation of assessment from the mode of training was to have a significant impact on the delivery of training, such as who could assess, where assessment could take place and trainee control over assessment. To be involved in what at the time Burke (1989) called a quiet revolution was educationally challenging and emotionally exciting. However, whilst continuing to promote the NVQ competence model I became more and more concerned as problems began to emerge. For example, new training resources had to be produced for each NVQ unit of competence but staff disagreements arose over what should or should not be included in the resource to enable a trainee achieve the specified performance criteria. The provision of sufficient training opportunities, whether in college or industry, was difficult to arrange and manage. A huge bureaucratic assessment system arose around assessment. The supposed simple 'achieved / not achieved' or 'competent / not yet competent' or 100% achievement of all the performance criteria, often meant that multiple assessments were necessary to ensure coverage of all the performance criteria. Different assessors, be they further education staff or industry personnel, would interpret the competence statements differently. Considerable amounts of time were required for one assessor to remain with one trainee as they performed tasks which included many NVQ competences. The place of knowledge in the assessment process was unclear. Although NVQ range statements included guidance on the knowledge related to each unit of competence staff often had different expectations as to what should be assessed with regard to knowledge when a trainee performed in different locations. Over time I lost my enthusiasm for this quiet vocational revolution. I became less of an advocate and more concerned that, whilst there are some appealing features within the NVQ model, the competence performance criteria became the focus of training and a distraction from learning opportunities and the needs of trainees.

In 2004 I became redundant, following many college re-organisations. Whilst I found redundancy initially unsettling on reflection the availability of time gave me the opportunity to do something I had wanted to do for some time. I trained to be a counsellor. Then, in 2010, having become qualified, accredited and a registered

counsellor, to my surprise and interest, Skills for Health (SfH) launched a number of competence frameworks for the psychological therapies. This ignited my interest in the possible implications for counselling, particularly as the 'culture of competence' (Vaspe, 2000) was gathering momentum and about to embrace person-centred therapy. Amongst counselling colleagues the topic of competence frameworks and competence-based practice was not high on their agenda but if I brought it to their attention they became curious, interested and challenging.

Reflexivity is the capacity to reflect on one's actions and values when producing data, analysing data and writing accounts (Bott, 2010). King and Horrocks (2010) suggest that reflexivity is about the researcher taking responsibility for making visible their role in the production of knowledge. This responsibility Bott argues requires researchers to "constantly locate themselves within their work, and to remain in dialogue with research practice, participants and methodologies" (Bott, 2010, p. 160). As noted above, my experience with NVQs familiarised me with a particular competence-based model and how it was put into practice by different vocational areas. There are positive and negative aspects to this experience, in terms of the competence model, the training model and the either / or assessment model. It is this particular perspective I bring into my research work and interaction with participants. My particular concern was my dual role, being a researcher and a therapist, and the implications with regard to carrying out this qualitative study, as the data I was to gather depended on my relationship with people I considered to be professional colleagues. My research decisions were being made amid the feelings and tensions I experienced during the insider and outsider moments, and my attempts to maintain a boundary between the researcher and therapist identities.

It was not my intention to distance myself from the participants. I was going to be the 'insider' researcher, with a similar therapist background to the participants, but I viewed myself and the participants as having an interactive role in the research. My concern was with the possible impact of emotions and theoretical and political allegiances on this endeavour. DeLeyser (2001) identifies an insider as an 'in-group' member with access to the group or professions historical and contemporary debates. While I shared many commonalities with my participants, such as training and leaning towards person-centred therapy, I was also aware of the need to

maintain an analytical and intellectual distance required of an 'outsider' researcher (Lykkeslet and Gjengdal, 2007). I felt that I had to take a measured approach to the outsider position if I was not to be seen by participants as a critic or looking to undermine CfD.

CfD is an unusual therapy in that for the first time evidence-based person-centred and emotion-focused competences have been integrated within a single competence-based framework. I was interested in gathering the views of experienced therapists, trainers and supervisors on the competence framework and ramifications for the training and assessment programme. CfD was developed in response to a situation which threatened the jobs of person-centred therapists in the primary care sector (Sanders and Hill, 2014). There was an urgent need for CfD. I anticipated that CfD may be a sensitive research topic and wished to avoid causing participants undue discomfort. I was concerned to avoid the danger that prospective participants may be suspicious or concerned as to why I had chosen to research CfD. By being open, transparent and ready to respond to participant questions I hoped to allay such concern.

1.3 The role of key events / bodies in the development of CfD

The CfD model that we see today has its roots in a number of key historical events promoted or supported by various bodies. The launch of the NCVQ national framework for competence-based vocational NVQs required the profession to become involved in the development of competence-based qualifications. Statutory regulation has long been an aim of the counselling and psychotherapy bodies. However, this required the profession to become involved again in the development of national occupational standards / competences if the profession was to achieve its desire for statutory regulation. Similarly, The Depression Report and launch of the Improving Access to Psychological Therapies (IAPT) service, Skills for Health (SfH) and the National Institute for Health and Care Excellence (NICE) have influenced and contributed to the direction of counselling and psychotherapy and ultimately led to development of CfD. While each may be said to have influenced counselling and psychotherapy differently there is one common thread that has remained constant over time. The thread relates to national standards of training and standards of safe

and effective practice. There follows a chronological examination of the twists and turns in the professions journey towards a solution to the standards issue based on the development of the new competence-based integrated CfD therapy that we see today.

1.3.1 National Vocational Qualifications (NVQs) and response from the profession

A new vocational education and training (VET) model began to emerge in the UK following publication of 'A New Training Initiative' (1981). The initiative claimed to be introducing 'standards of a new kind'. 'Standards' in this context refers to a clear specification of the performance, including level of performance, required of an individual. The existing VET model, which was mainly defined in terms of inputs and norm-referenced qualifications, was being changed to one defined by its outputs and criterion-referenced qualifications. 'Inputs' are the syllabuses and specification of learning opportunities, while 'outputs' refers to the standards of performance related to products or services or learning outcomes. This change became known as 'the quiet revolution' because of the far reaching consequences it was to have across the industrial, education and higher education sectors (Burke, 1989).

In 1986 the government established the National Council for Vocational Qualifications (NCVQ). Its aim was to reform the UK vocational education system by developing a new seven level framework of National Vocational Qualifications (NVQs). NVQs are competence-based qualifications. The NVQ statement of competence is expressed in three degrees of aggregation: units of competence, elements of competence and their accompanying performance criteria. NCVQ define competence as "the ability to perform work activities to the standards required in employment" and elements as "the smallest and most detailed specification of competence" (NCVQ, 1988, pp. 12 & 22).

The performance criteria are used, during trainee assessment, to determine whether a trainee is competent or not yet competent, there is no mark, grade or percentage. The stress is on outcomes and preferably observable performance. The NVQ reforms introduced many professions to a variety of novel training features, with the emphasis on competence-based performance, criterion based assessment,

assessment under normal work conditions, modular based credit accumulation and individualised learning. Hyland argues that "NVQs are not primarily concerned with learning, but with the collection of evidence to satisfy competence criteria" (Hyland, 1994, p. 14). In the midst of all these changes one problem stood out, the place of knowledge and understanding when the emphasis was on performance criteria (doing something). Early NVQs relied on the observation method of assessment but later NVQs were modified in recognition that knowledge and understanding were a necessary component to sustained effective performance in different contexts. However, trainees were only required to be aware of the knowledge related to the unit of competence.

In response to the governments NVQ initiative a lead body for advice, guidance and counselling was established in 1994, with the BAC (now the BACP) as a prominent member (Russell and Dexter,2001; Woolfe, 2002). The lead body developed NVQs in counselling skills. From the outset therapists such as Foskett (2001), Frankland (1996) and Lefebure (1996) expressed concern that NVQs were really a hostile attempt to reshape professional activities and ill-suited to therapy dependent on certain qualities of relationship such as empathy and respect. The anticipated major reform of counsellor training and qualifications failed to materialise as NVQs became just another qualification enmeshed in the on-going national argument about how to bridge the vocational / academic divide. The CfD competence model has some similarity to the NVQ model but there are no CfD performance criteria.

For NVQ dissenting therapists this may have been a relief but, as Russell and Dexter (2001) argue, the specificity of the standards reminded therapists of a key purpose of their work, the need and ability to perform to the prescribed standards. Moreover, the process of designing counselling NVQs introduced professionals to the structure and components of the NVQ competence-based model and a definition of competence based on the ability to perform work activities to the standards required in employment. The link between competence and standards required in employment continues through into the competence-based model of CfD. The NVQ model and CfD model are structurally similar but aspects of the NVQ model, such as performance criteria, are missing from the CfD model because it uses a different assessment method. Although the assessment methods are different there is one

similarity with the early NVQs, the reliance on a single assessment method. Early NVQs relied on observation of practitioner performance whereas audio recording is the CfD method. Practitioners were to confront the issue of developing standards of performance and appropriate training programmes again as they sought political support for statutory regulation. The need to make explicit what therapists do, and to what standard, was something a section of the counselling community was willing to address if subsequently they achieved a regulated profession, while others objected to such a move.

1.3.2 Regulation, standards and therapist competence

Statutory regulation has been high on the agenda of professional bodies for some time. It has not been achieved due to political opposition and / or professional differences of opinion related to training and the assessment of competence. Despite continuing political resistance to statutory regulation the profession's desire to obtain statutory regulation has meant that it has had to confront issues such as the multiplicity of trainings and variations in standards of therapist competence.

Mowbray (1995) argues that UK governments have consistently demonstrated a reluctance to introduce statutory regulation for counsellors and psychotherapists. In 1999 the 'Alderdice Psychotherapy Bill' collapsed after two readings because the government favoured an alternative route to regulation, and argued that there was too much focus on employer rather than client interests (Bondi, 2004; Postle, 2007). While professional bodies continued to champion statutory regulation the Alliance for Counselling and Psychotherapy and the Coalition against Over-Regulation of Psychotherapy called on therapists to resist what was considered to be an adversarial system (Browne, 2009).

A glimmer of hope for those promoting regulation was afforded by the White Paper 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century' (2007). The White Paper indicated that counsellors and psychotherapists were a priority for future regulation. In 2008 the Health Professions Council (HPC), the regulatory body at the time, began to consult professional organisations, education providers and service users on standards of training and standards of

proficiency (competences / skills, knowledge and abilities). By 2010 the consultation was struggling to resolve two key issues. Professionals rejected the proposed differentiation between counselling and psychotherapy and criticised the HPC for its focus on generic rather than profession specific standards (McGahey, 2009; Pointon, 2009).

A change of government brought a close to the HPC work on statutory regulation and the development of standards. Voluntary regulation became the way forward under the auspices of the Professional Standards Authority (PSA). Nonetheless, it was more than apparent that the development of standards, linked to safe and effective practice, was going to remain high on the political agenda. This message was reinforced when, in the mid-2000s, the most significant document with regard to mental health, training and standards / competences was published: The Depression Report (CEPMHPG, 2006).

1.3.3 The Depression Report and launch of IAPT

The Depression Report drew the attention of the political establishment to the crippling and tragic effect of depression and chronic anxiety on an individual and the resulting high cost to the taxpayer with regard to unemployment, incapacity benefits and lost taxes. To turn around what was described as 'a very bad situation' the report recommended the establishment of a new service, which became the NHS / Improving Access to the Psychological Therapies (IAPT) service. The new service was to recruit an additional 10,000 therapists and only National Institute for Health and Care Excellence (NICE) recommended evidence-based therapies were to be offered by the service. IAPT service users were to be offered a choice of psychological therapy.

The good news, based on the NICE guidelines, was that evidence-based psychological therapies were available and capable of successfully treating 50% of the one in six of the population diagnosed with depression each year. The report notes that "the most developed of these therapies is cognitive behaviour therapy" (The Depression Report, 2006, p.1). Cognitive behaviour therapy (CBT) was specifically highlighted because it had strong evidence base indicating effectiveness

in the treatment of depression. The bad news for person-centred therapists was that PCT was missing from the report, apparently because PCT lacked sufficient evidence of its effectiveness in treating depression. As a result it was unlikely PCT could become a NICE recommended therapy, which in turn meant exclusion from the IAPT menu of therapies. The situation was described as a serious "threat to person-centred and experiential counselling" (Sanders and Hill, 2014, p. 2).

The recruitment of 10,000 additional therapists may be interpreted as a positive aspect of the report by those wanting to remain as NHS / IAPT therapists or with aspirations of becoming IAPT therapists. However, the report recommendation that "anyone wishing to practise a particular therapy should be required to have the relevant training in that therapy (The Depression Report, 2006, p. 10) meant that any optimism quickly turned to pessimism. The lack of a NICE recommended PCE therapy meant that training in a relevant therapy was unavailable to person-centred therapists. The Depression Report recommendations focused professional attention on this particular issue, but finding a solution raised a number of other issues for the profession. The CBT evidence-based / competence-based model was held to be the exemplar model but no such model existed incorporating the person-centred approach. An award had to be developed and quickly. The challenge facing the profession was finding sufficient person-centred and experiential therapy research evidence from which certain therapeutic abilities / competences could be derived that were effective in the treatment of depression. As a starting point and to expedite the task of identifying appropriate research and competences the profession turned to the Skills for Health (SfH, 2010) humanistic competence framework.

1.3.4 The contribution of Skills for Health (SfH) to CfD

SfH is the Sector Skills Council for the UK healthcare sector. It was established in 2002 with the aim of raising standards in skills and training to maximise quality, productivity and health outcomes. The work of SFH, such as the development of occupational standards, is overseen by the Department of Health. In 2007 SfH started to consult interested parties on the development of National Occupational Standards (NOS) for the psychological therapies. Three years later a digest was published of the NOS / competence frameworks for four psychological therapies:

CBT, psychoanalytical / psychodynamic therapy, family and systemic therapy and humanistic therapy. The humanistic therapy was of particular interest to those preparing to develop what became the CfD therapy. The humanistic framework was important in the development of CfD because it contains competences derived from research reported in Roth, Hill and Pilling (2009), and incorporates approaches particularly relevant to CfD, for instance process-experiential therapy and person-centred therapy.

1.3.4.1 National Occupational Standards / competences

The process of identifying the NOS / competences was overseen by an expert reference group comprised of researchers and trainers selected for their expertise in a relevant therapy. A collaboration between clinicians and researchers produced the evidence from which the NOS / competences are derived (Vincent and Lillie (2010). The development of the NOS / competences helped to establish a national set of standards / competences (Fonagy, 2010). The competences, once identified, were then clustered according to the activities through which therapists conduct therapy. The four SfH frameworks contain clusters that focus on generic, basic, specific and meta-competences. The competences describe what is expected of a therapist, and include the knowledge and skills which underpin a performance (Fonagy, 2010). The competences also present a client with an overview of what they can expect to receive or experience. The comprehensive SfH humanistic competence framework appears to have made a significant contribution to the CfD framework of competences.

1.3.4.2 Counselling and psychotherapy and the SfH humanistic competence framework

Three features of the humanistic therapy competence framework were of particular interest with regard to the development of a new CfD-PCE therapy. The competence-based framework could be used as a template for the new therapy. The humanistic competences were derived from published evidence, as noted in the above paragraph, and this evidence would be a critical component in a future CfD application to become a NICE recommended therapy. Finally, the humanistic

framework incorporated an integrative approach to therapy, based on process-experiential therapy and PCT, a combination that provided a possible solution to the person-centred issue. While these features enabled an expeditious response to the threatening situation one important element was missing: how the SfH competences were to be assessed.

1.3.4.3 SfH competence-frameworks and assessment issues

The scale of the humanistic competence framework created an assessment problem: how to assess the 200+ ability statements contained in the SfH competence framework. This type of problem had previously been acknowledged by the authors of the CBT competence framework (Roth and Pilling, 2009), who suggested that because of the number and varying levels of the competences, it was not suitable for assessment purposes. To resolve the problem Roth and Pilling recommended that competence measures should identify and focus on assessing a sub-set of core competences. It was more than apparent that the new therapy, if it adopted the number and varying levels of the SfH competences, would face a similar problem.

 A new competence measure, based on a sub-set of core competences, would need to be produced. The CfD assessment method and the CfD assessment instrument are discussed in chapter two, sections 2.5.3 and 2.5.4. Reducing the measure / assessment instrument down to the essentials in terms of core competences may create a more manageable approach to assessment but in focusing on a sub-set of the competences is it possible that something in competent practice could be missed**. Sanders and Hill indicate that the SfH humanistic therapy competences "marked the first step in the development of CfD" (Sanders and Hill, 2014, p. 3). The second step, alongside the SfH humanistic framework, involved consideration of two different sets of research evidence. A NICE / Guideline Development Group reviewed five RCT counselling studies (Bedi et al, (2000); Goldman et al (2006); Greenberg and Watson (1998); Simpson et al, (2003); Watson et al, 2003) when considering production of the depression guideline. The GDG concluded that counselling, covering PCT, EFT and process experiential, was effective in the treatment of mild-to-moderate but not severe depression. However, the GDG urged

caution when interpreting the research results because of the small samples and insufficient evidence.

In the second set of research, Elliott et al (2013) conducted a meta-analysis of twenty-seven studies, involving humanistic-experiential therapy, in the treatment of depression. The research indicates that the person-centred-experiential (PCE) approach was found to be broadly equivalent with CBT in the treatment of depression and in other instances there was support for the superiority of PCE over other forms of practice that do not include these methods when working with depressed clients. The Sanders and Hill view was that although the RCT evidence was fairly limited it nevertheless suggested that "of the different areas of practice, included in the humanistic framework, person-centred therapy and EFT had the strongest evidence base" (Sanders and Hill, 2014. P.27)**.** Eventually**,** an expert reference group, composed of practitioners, academics and professional bodies, came together to consider the accumulated evidence and the SfH humanistic framework to oversee the production of the CfD competence framework and roll out of the CfD training programme (Sanders and Hill, 2014). The range of evidence derived generic, basic, specific and meta-competences / abilities, which a trainee needs to demonstrate and eventually be assessed against, is provided under section 2.2. It was this unique evidence based integrated CfD therapy which became a NICE guideline recommended therapy for depression.

1.3.5 NICE and mental health provision

NICE was created a legal entity in 1999 but by 2013, following the Health and Social Care Act (2012), there was a change of status and it became a non-departmental public body 'The National Institute for Health and Care Excellence" (NICE). NICEs remit covers health and care throughout England. NICE addresses the remit by developing guidelines which are designed to help professionals deliver and improve the quality of provision within the NHS / IAPT service. Crucially, the Depression Report indicated that the mental health reforms it had set in motion incorporated the central task of implementing the NICE guidelines. NICE guidelines have the power to shape the provision of mental health services in England for the foreseeable future. In this context it seems reasonable to assume that if NICE were to review the

depression guideline, and a consultation is underway at the moment (NICE, 2017), the profession will need to be ready, with evidence, to argue the case that counselling, and in particular person-centred and experiential therapy, deserves to be a recommended therapy for the treatment of depression. The development and continuing development of CfD has been and continues to be influenced by the role NICE has in ensuring that treatments for specific conditions are based on the best available evidence in order to improve outcomes.

1.4 IAPT, CfD, diagnosis and referral

This section explores how CfD fits within an IAPT service characterized by three things, each of which may have some influence on the development and use of CfD within the service. The IAPT programme began in 2008. It is an ambitious programme of talking therapies, with regard to the target number of clients the service anticipates it will be treating each year. The expectation is that 1.9 million adults will be accessing the service each year by 2024.

IAPT services are usually provided within traditional NHS Trusts but may also be found within the voluntary and private sectors, which suggests there may be variations in level of provision. The IAPT service has three stand-out features. First, the IAPT evidence-based talking therapies are delivered by trained therapists. Therapy is matched to a mental health problem, such as depression, and delivered over a prescribed period of treatment. IAPT claims that this arrangement optimizes client outcomes. Second, therapy sessions are subject to routine outcome monitoring so that both client and therapist have up-to-date information on progress. Third, therapists have regular, client outcome focused supervision. While person-centred therapists may be familiar with these features there are practitioners that see one or more of them as inimical to PCT. This is discussed further in chapter two.

CfD therapists are not expected to make a diagnosis of depression (Sanders and Hill, 2014). A member of the IAPT team with responsibility for making a diagnosis will refer the client, possibly to a CfD therapist. CfD therapists, as an IAPT team member, are expected to be aware of the IAPT diagnostic and referral process. Within an IAPT service a diagnosis is required to ensure a client receives the

appropriate treatment within the stepped care system. The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders – fourth edition) and the ICD-10 (International Classification of Mental and Behavioural Disorders) are the two diagnostic frameworks used within the UK . Each framework discriminates between degrees of symptom severity, duration and content. Sanders and Hill state that "NICE [2009] abbreviates the DSM-IV comprehensive diagnostic instrument in 'Clinical Guidance 90: Appendix C: Assessing Depression and its Severity" which lists the key symptoms, associated symptoms and referral factors (Appendix 1). The instrument distinguishes between mild, moderate and severe depression, the greater the severity the more intense the treatment. It is the diagnostic and referral system that determines which model of therapeutic change is most appropriate for a client. Initially, as intimated in the Depression Report, the IAPT service concentrated on CBT as a high intensity treatment of depression at step 3 in the IAPT stepped care model of provision. While CBT remains the NICE frontline therapy for depression the NICE clinical guideline for depression also includes four other high intensity therapies, one of which is CfD, for use with clients who fail to respond to CBT therapy.

The IAPT one to five stepped care framework aims to provide clients with mental health problems, such as depression, with an appropriate service. This will depend on the diagnosis, as discussed above, plus the clients' personal circumstances. Each step represents increased complexity of interventions. A client can only 'step-up' to more intensive specialist services if it is considered clinically to be the right thing to do.

1.5 Summary

The profession was slow to respond to a political discourse dominated by issues of cost effectiveness and the need for evidence of therapeutic effectiveness. The eventual response was the development of a new therapy, CfD. It may be that therapists are qualified and feel competent in a preferred therapy. However, in this new environment it was now necessary for therapists to retrain in order to demonstrate the particular CfD framework of competences / abilities because they are based evidence of their effectiveness in the treatment of depression. The

Depression Report identified CBT as being at the forefront of evidence-based practice and therapeutic effectiveness. Moreover, and worryingly for PCT therapists, PCT was not mentioned in the Depression Report and the profession was late in realizing that the survival of PCT in primary care was in the balance. Why the profession was late is difficult to explain because the signs of change were clearly visible within various national initiatives. Various publications and events have influenced the direction of counselling and psychotherapy. Increasingly the focus has become therapist competence, training for competence and assessment of competence in response to demands for greater accountability, safe practice and cost effectiveness. To expedite a way out of the threatening situation the profession turned to the evidence-based competences within the SfH competence framework. The relevant SfH competences were integrated into a new person-centred and emotion-focused (PCE) therapy.

Inevitably the profession will need to regularly update evidence of therapeutic effectiveness as bodies, such as NICE, also revise their evidence-based guidelines and in the process determine which therapies, and thereby which therapists, will be part of IAPT and primary care provision. CfD, as a new competence-based PCE therapy, is perhaps particularly vulnerable because as Sanders and Hill (2014) point out, it has a fairly limited RCT evidence base. Recent research, which is discussed in chapter two, suggests the profession is trying to enhance the evidence base.

1.6 Thesis Terminology

- The term humanistic is viewed as an umbrella term for a number of therapies, connected by broad set of theories and models with shared values and philosophical assumptions, such as person-centred and Gestalt (McLeod, 2003).
- The term person-centred or client-centred therapy refers to a therapy which aims "to establish a relationship with a client based on respect, empathy, transparency and equality" (Smith, Collard, Nicolson and Bayne, 2012, p. 224).
- Counselling and psychotherapy are umbrella terms that cover a range of talking therapies (BACP, 2020).

- Emotion-focused therapy refers to a therapy that "systematically but flexibly helps clients become aware and make productive use of their emotions" (Elliott, Watson, Goldman and Greenberg, 2015, p. 3).

- CfD is a person-centred and emotion-focused therapy or person-centred experiential (PCE) model of therapy (Sanders and Hill (2014). Although this title has changed during the study, to PCE-CfD, the original title of CfD has been retained.

- Participant refers to a volunteer in the study and is used rather than trainee, trainer and supervisor

- The word 'profession' is used loosely, because, although there is a body of distinct knowledge, it is not a statutorily regulated profession.

1.7 Structure of the thesis

Chapter one is an explication of my interest in competence-based training and the role and / or influence that certain events and bodies have had and continue to have on the development of what eventually emerged as CfD. The CfD competence framework, the CfD training programme and the CfD assessment method are examined in chapter two. This is followed, in chapter three, by a review of the relevant research literature. My research methodology is discussed in chapter four and my findings considered in chapters five, six and seven. Finally, in chapter eight, I discuss the implications of the findings for therapists, the competence framework, the CfD training programme and assessment of therapist competence. At the end of the chapter eight I record the limitations of the study, areas for future research and my recommendations.

Chapter Two

Counselling for Depression

By the end of chapter one Counselling for Depression (CfD) had been produced and the training programme rolled out. CfD is a new integrated therapy comprised of competences derived from research evidence indicating their effectiveness in the treatment of depression. It is a NICE recommended therapy for depression and one of the talking therapies provided by the IAPT service.

This chapter explores the key features of CfD, such as the model of therapeutic change, the structure and content of the CfD competence framework and CfD as a new integrative model of therapy. This is followed by an examination of the CfD training programme and the accompanying trainee assessment method. The training programme has been designed based on the notion that trainees will be experienced and qualified therapists and therefore best placed to learn about and deliver CfD (Sanders and Hill, 2014). However, the curriculum, as described by Hill (2011), appears to contain many new and possibly unfamiliar features which may present more of a challenge to experienced therapists than has been anticipated. My examination will therefore include the areas of programme entry requirements, the split in time allocated to 'classroom' learning and workplace learning, and the new method of assessing therapist competence using the CfD / PCEPS instrument. Supervision is a key component of CfD training as the supervisor has responsibility for ensuring therapists / trainees "adhere to the therapeutic model described in the CfD competence framework" (Hill, 2011, p. 16). Making this a key responsibility for supervisors could create a problem. Traditionally supervision has not been a management role, where therapists / trainees are given directions or specific tasks. Rather, supervision has been about support, impartial guidance and the provision of a setting in which therapists / trainees can be open with the supervisor "with no fear that disclosures will find their way back to those deciding who will pass or fail the training" (McLeod, 2003, p. 504). But within CfD supervised practice it seems that it could take on a management role.

As well as the aforementioned issues a number of other issues may arise associated with the CfD / IAPT relationship and how trainees may react to the task of integrating the PCT competences with the EFT competences. Assessing trainee performance is a major component of the training programme. However, there appears to be a number of differences between the PCEPS items and the CfD competences and the SfH competences. Such differences (see Appendix 3 for the chart comparing the PCEPS items and the CfD / SfH competences) may create problems for trainees, assessors and supervisors during trainee assessment and / or when trainees are being assessed when working with different clients. The assessment of adherence and competence is likely to be unfamiliar to trainees, particularly the focus on adherence to the CfD therapeutic model. Adapting to this form of assessment may be an issue for trainees who feel that it hinders their professional ability to respond to client need and disregards their knowledge of the client. I end the chapter by discussing the language of competence and defining competence.

2.1 The CfD model of therapeutic change

CfD conceptualises depression as arising from particular types of emotional experience and processes (Sanders and Hill, 2014). It is how the client relates to their emotional experience which can result in either the feeling of psychological growth or a feeling of being 'stuck' due to "incongruences between how they actually are and how they feel they should be" (Hill, 2011, pp. 6-7). Hill (2011) describes CfD as a coherent therapeutic stance, based on the person-centred and emotion-focused theories, with regard to the treatment of depression. The PCT element encompasses communication of empathy, an accepting attitude and maintenance of an authentic relationship. The EFT element provides a more structured and technical approach for focused working with underlying emotions (Sanders and Hill, 2014) with the goal of reducing the emotional distress and 'stuckness' and thus depression.

The CfD conceptualisation of depression may be difficult to accept by therapists with an allegiance to the person-centred approach. The difficulty is that depression in CfD is treated like an illness or medical condition. However, within PCT the belief is that during conversation the client has the ability and sufficient inner resources to effectively deal with distress when the therapist demonstrates the Rogerian core conditions (as noted above) without having to resort to certain skills and techniques

(Smith et al, 2012). While the client / therapist relationship is important in both PCT and CfD the way CfD conceptualises depression suggests combining PCT into the CfD model may present PCT therapists with a challenge. The importance of the process orientation of PCT and the significance of the client role is such that a PCT therapist may, as McLeod (2003) has argued, strongly oppose any attempt to direct, label / diagnose clients. However, CfD seeks to combine what some PCT therapists might consider to be different approaches to resolving depression.

CfD has been designed for the treatment of clients, within an IAPT service, whose symptoms and experiences match the diagnostic requirements of depression (Sanders and Hill, 2014). In this context, the CfD position is that the integration of PCT with a sub-set of EFT practices enhances treatment effectiveness without impairing PCT. The PCT conditions become the means of facilitating a clients' exploration of emotional processes, such as excessive self-criticism, which may be distorting emotional experience and creating conflict between the different aspects of the self. Alternatively, it may be that a clients' 'inner critic' is hostile towards a significant other, leaving the client with unfinished business with regard to unmet needs and unresolved distress. CfD aims to reduce identified self-discrepancies through client work which is based on an empathically attuned relationship and "focal interventions" (Hill, 2011, p. 7), or process guiding interventions.

2.2 Structure and content of the CfD competence framework

CfD is described as a person-centred and experiential (PCE) therapy. The 'and' between person-centred and experiential reflects the integrative nature of CfD in that it was "drawn from person-centred therapy (PCT) and emotion-focused therapy (EFT)" (Sanders and Hill, 2014, p. 4). As it was necessary for the new therapy to become part of the NICE guidelines only those PCT and EFT competences which could be supported by research and clinical evidence indicating therapeutic efficacy and cost effectiveness were considered for inclusion in the CfD competence-framework. As noted in chapter one the CfD knowledge and ability competences are, in the main, derived directly from the 200+ knowledge and ability statements within the SfH humanistic competence framework.

The CfD competence framework is composed of four categories of competences: generic, basic, specific and meta-competences:

Generic Competences

G1 – Knowledge and understanding of mental health problems

G2 – Knowledge of depression

G3 – Knowledge of, and ability to operate within, professional and ethical guidelines

G4 – Knowledge of a model of therapy, and the ability to understand and employ the model in practice

G5 – Ability to work with difference (Cultural competence)

G6 – Ability to engage client

G7 – Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'

G8 – Ability to work with the emotional content of sessions

G9 – ability to manage endings

G10 – Ability to undertake a generic assessment

G11 – Ability to assess and manage risk of self-harm

G12- Ability to use measures to guide therapy and to monitor outcomes

G13 – Ability to make use of supervision

Basic Competences

B1 – Knowledge of the philosophy and principles that inform the therapeutic approach

B2 – Knowledge of person-centred theories of human growth and development and the origins of psychological distress

B3 – Knowledge of the person-centred conditions for, and goals of, therapeutic change

B4 – Knowledge of the PCE conceptualisation of depression

B5 – Ability to explain and demonstrate the rationale for counselling (Ability to initiate therapeutic relationships)

B6 – Ability to work with the client to establish a therapeutic aim

B7 – Ability to experience and communicate empathy

B8 – Ability to experience and to communicate a fundamentally accepting attitude to clients

B9 – Ability to maintain authenticity in the therapeutic relationship

B10 – Ability to conclude the therapeutic relationship

Specific competences

S1 – Ability to help clients access and express emotions

S2 – Ability to help clients' articulate emotions

S3 – Ability to help clients reflect on and develop emotional meanings

S4 – Ability to help clients make sense of experiences that are confusing and distressing

Meta-competences

M1 – Capacity to implement CfD in a flexible but coherent manner

M2 – Capacity to adapt interventions in response to client feedback

M3 – Working with the whole person

M4 – maintaining a person-centred stance

M5 – Maintaining safety in the therapeutic relationship
M6 – Maintaining psychological contact
M7 – Capacity to balance therapeutic tasks
M8 – Integrating the therapist's experience into the therapeutic relationship   (Sanders and Hill, 2014, pp. 201-205)

Each competence contains knowledge and ability statements. The 13 generic competences include the knowledge and abilities common to a variety of therapies, as well as CfD. The 10 basic competences "describe the range of activities that are fundamental to CfD practice" (Sanders and Hill, 2014, p. 33). The basic competences are closely related to person-centred therapy and the associated theories of human growth and origins of distress. The 4 specific competences focus on working with the client's emotions and emotional meanings. The specific competences assume that the therapeutic relationship has been established, based on authenticity, unconditional acceptance and empathic understanding. The framework information, in relation to the specific competences, is spelt out in much more detail when compared with the generic and basic competences. Finally, Sanders and Hill describe the 8 meta-competences as various higher-order skills "which relate specifically to the implementation of CfD" (Sanders and Hill, 2014, p. 36), including clinical judgement and balancing delivery of CfD with responding to client need. Learning this amount of new material may stimulate and / or challenge learners but Sanders and Hill recommend that "the framework as a whole should be implemented to ensure clients receive a coherent therapy package" (Sanders and Hill, 2014, p. 29).

The competence framework contains nine knowledge statements and 52 abilities. This breaks down into 8 knowledge statements and 15 abilities within the generic and basic competences and 1 knowledge statement and 37 abilities within the specific and meta-competences. The CfD competence framework contains exactly the same competences as the SfH humanistic framework but in abbreviated form apart from the specific and meta-competences.

2.3 CfD as an integrative model of therapy

As noted earlier the CfD framework integrates PCT and EFT evidence derived competences. The idea or trend towards integrating different therapies is not new but

the integration process has usually occurred in the context of therapist personal and professional development (McLeod, 2003). As therapists undertake training and develop a career they perhaps are drawn towards new ways of working which they blend into their own inimitable way of working. It is a matter of therapist choice. Faris and van Ooijen, Like McLeod, suggest integrative practice develops "over the course of development of the individual practitioners" (Faris and Ooijen, 2009, p. 25). However, CfD therapists are presented with a 'ready-made' integrated therapy, leaving few choices with regard to what is to be integrated and how.

Hollanders (1999), argues that integrative practice depends upon combining diverse theoretical concepts into a coherent new theory. Similarly, McLeod (2003) suggests that the integration of different therapeutic approaches requires the development of a substantive new theory and common language. It could be argued that PCT and EFT are not so diverse as to present an integration problem for therapists, as both have roots in the humanistic perspective. Nevertheless, Faris and Ooijen (2009) found that integrating supposedly similar therapies was no less problematic. Faris and Ooijen were in the process of developing a coherent integrative counselling model for teaching purposes. Both originally trained as integrative counsellors but subsequently diverged, one becoming a family therapist and the other developed a relational / intersubjective way of working with clients. Many misconceptions arose about each other's current approach to counselling because of different theoretical traditions and differences in the language used to explain an approach. Their counselling identities had changed and now they needed to come together and develop a new shared identity. Before they could develop a shared language on which to build a new integrative model it was necessary to develop a shared understanding of subjects such as the nature of human beings, consciousness, and relational processes. CfD therapists face a similar task as they adjust their existing therapist identity, including knowledge, beliefs, values and practices, to the demands of the new PCE therapy. This task may become all the more challenging if either PCT or EFT is unfamiliar. Nevertheless, by the end of training the expectation is that therapists:

> Should be competent in all areas of the framework…to maximise
> effectiveness it is probably more important to view the framework

holistically, rather than as a collection of unrelated activities, and

implement the entire therapy in a single, seamless, fluid, consistent

and coherent manner   (Sanders and Hill, 2014, p.36)

The CfD training programme has been designed to familiarise experienced therapists with the integrated PCT and EFT competences. Role play exercises with training colleagues provide the opportunity to rehearse delivery of the competences. But it is during workplace practice with **real** clients that therapists produce four audio recordings with different clients which are assessed "for adherence to the practitioner manual using the therapy adherence scale [the PCEPS]" (Hill, 2011, p.17).

2.4 CfD training

2.4.1 Entry to training

Therapists who enter CfD training are qualified and experienced practitioners. They are required to possess a diploma in humanistic or person-centred counselling and hold or be able to produce evidence of working towards BACP accreditation. There is an expectation that therapists / trainees will have a minimum of two years' experience post qualification in brief counselling. Therapists are expected to submit evidence of qualifications and experience prior to commencing training to their host training organisation (Hill, 2011, pp. 8 – 9).

2.4.2 The training programme

The CfD national training curriculum was commissioned by IAPT and developed by BACP (Hill, 2011). At the time of writing this study seven organisations offered CfD training. The training programme (see Appendix 2 for a chart of the programme) is divided into two phases. The first phase concerns a five day taught programme. The second phase consists of 80 hours of supervised practice in the workplace. The workplace is usually the therapists' place of employment.

The syllabus for the taught phase is based on the content of ten modules. Each module is built around a competence or number of competences drawn from the CfD competence-framework. The expectation is that within the five days different modules will be taught morning and afternoon. The modular curriculum consists of:

- Module 1 - Introduction to the IAPT programme and understanding depression (A)
- Module 2 - Introduction to the IAPT programme and understanding depression (B) (Competences are different in A & B)
- Module 3 - Orientation to the competence framework
- Module 4 - Theoretical principles and values
- Module 5 - Working with depression
- Module 6 - Working briefly
- Module 7 - The CfD relational stance
- Module 8 - Working with emotional processes
- Module 9 - Assessment of trainee competence
- Module 10 - Supervision and clinical practice   (Hill, 2011, p. 13).

The five day training intends, because the therapists / trainees are qualified and experienced, to build on their existing knowledge and align practice with the evidence-based competences (Sanders and Hill, 2014). Role play exercises, with a training colleague, are used to provide therapists with formative assessment feedback on skills development. At least one of the role-plays is video recorded and assessed using the CfD assessment instrument, the Person-Centred and Experiential Psychotherapy Scale (PCEPS).

In the second phase of the training programme the workplace provides the setting for a continuation of learning and preparation for assessment. However, the assumption within the CfD programme appears to be, as in NVQ competence model, that the workplace is the best environment in which competence can be evidenced by implementing CfD with actual clients. The workplace has become a self-learning environment for the therapists unless there are work colleagues able to offer support. This may depend on whether workplace colleagues have the relevant knowledge

and experience. The critical task for therapists during this phase is the completion of four audio recordings of sessions with clients for assessment purposes. Therapists have responsibility for selecting, from each recording, a twenty minute segment to be submitted to their assessor (probably their trainer) as evidence of adherence / competence to CfD practice. Hill states that the 80 hours of supervised practice should be completed in "approximately twelve weeks" (Hill, 2011, p. 14).

2.4.3 The CfD method of therapist assessment

Therapists are formatively assessed during the five day training. This may include discussions, group-work, question and answer sessions, and a role-play exercise. The role play of CfD practice with a training colleague is videoed and assessed by the trainer using the PCEPS instrument. Summative assessment is carried out during the second phase of training. Four audio recordings, each with a different client and at least two from later sessions, are assessed using the PCEPS. Should one or more recordings fail to meet the assessment threshold performance a therapist can submit two further recordings. Successful completion of the assessments entitles the therapist to become an accredited CfD therapist.

2.4.4 The PCEPS measure and scale

The PCEPS is a new psychometric instrument. The designers of the PCEPS (Freire, Elliott and Westwell, 2014) refer to it as a new adherence / competence measure of person-centred and experiential psychotherapies. It was developed, the authors argue, in the absence of an appropriate adherence / competence measure of person-centred therapy.

An early development of the measure, described in Freire et al (2014) and Sanders and Hill (2014) contained 15 items, divided into two subscales, 10 items associated with PCT and 5 for EFT. Eventually, after tests had been carried out, certain items were found to be redundant and it became a ten item scale. The ten items of the PCEPS measure are:

- 1. Client frame of reference / track
- 2. Psychological holding
- 3. Experiential specificity
- 4. Accepting presence
- 5. Content directiveness
- 6. Emotion focus
- 7. Dominant or overpowering presence
- 8. Clarity of language
- 9. Core meaning
- 10. Emotion regulation sensitivity

(Sanders and Hill, 2014, pp. 186 –191).

When a therapist is assessed each item is rated, or given a score, of between 1 and 6 on a Likert type scale. An item rating of 4 indicates an adequate level of adherence / competence. A rating of 40 is a 'pass' or overall adequate level of adherence / competence, while 60 is the highest rating or overall excellent standard. Hill (2011) however refers to the PCEPS as an 'adherence scale', rather than an 'adherence / competence' or 'competence' scale, which suggests the focus is on a therapist's ability to adhere. During summative assessment an assessor listens to the therapist's performance and rates each of the PCEPS items. The rating is based on what the assessor hears in the interaction between the client and therapist. There is no requirement for therapist knowledge to be separately assessed.

2.4.5 Supervision within CfD training and assessment

The programme prescribes one hour of supervision per fortnight, or the equivalent group supervision, during the twelve weeks of the second phase of training (Hill. 2011). The supervisor is not an assessor but may be asked to provide a report on a therapist's attendance and participation in supervision. It is anticipated that all clients may be presented for supervision but of particular importance will be those sessions submitted for assessment. Hill states that "the work of supervisors should be informed by the competence framework", with a focus on ensuring "that counsellors adhere to the therapeutic model described in the CfD competence framework as this

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model is closely aligned to the evidence base and so is likely to deliver the best outcomes" (Hill, 2011, p. 16). The supervisor's key priority, as far as possible, is therefore to ensure a therapist is familiar with the competence framework and understands that assessment success depends on adherence to the framework. McLeod argues that supervision in counselling is "not primarily a management role" (McLeod, 2003, p. 507), as in giving supervisee's directions and tasks, but if the priority for a supervisor is as described above, then CfD supervision seems to have taken on a management role.

2.5 Issues and debates related to CfD

2.5.1 The CfD / IAPT relationship

As noted previously CfD was a rapid response to a difficult political situation. Vaspe (2000) expressed concern that professional eagerness to embrace the culture of competence was putting at risk the "very real skills of the accomplished and competent counsellor…[such as] intuition, imagination, and flexibility in response to unpredictable circumstance" (Vaspe, 2000, pp.177 & 180). Nevertheless, the profession had little option but to develop an appropriate competence-based therapy in response to the difficult political situation and the needs of therapists working in an IAPT service. Like Vaspe, House (2009) has argued that competence frameworks could do terminal damage to the subtleties of effective practice. Similarly, Byfield (2012) claims that the reductionist language of competence can lead to a 'one-size-fits-all' model of therapy, a model which may be incompatible with a therapy which celebrates difference, nurturing and responsiveness to client need, such as person-centred. The argument being that it may be difficult to quantify, in terms of competence specifications, such attributes of therapist practice.

From another but similar perspective Proctor and Hayes (2017) argue that the PCE model of therapy may be incompatible with the medical, diagnostically driven model of the IAPT service:

> Contradictions between the values of the PCE approach on which CfD
> Is founded and the medical, bureaucratic and capitalist models that

underlie the current operation of the NHS in the UK…the diagnostically based, symptom focused measures used underline the medical and diagnostic focus of the IAPT agenda.

(Proctor and Hayes, 2017, pp. 1 & 3).

Proctor and Hayes argue that IAPTs bureaucratic, medicalised approach to therapy, where the condition of depression is diagnosed and a treatment prescribed, is contrary to the person-centred values which underpin CfD therapy. It would appear that CfD therapists may find the expectations of the IAPT service at variance with their preferred way of working with clients. For instance, although BACP suggests that some clients may need up to 20 sessions of CfD it seems that CfD therapy will have to be delivered with a focus on alleviating the client's depressive symptoms in as short a time as possible because IAPT may limit the number of sessions to a maximum of 3 or 6 (Proctor and Hayes, 2017). Proctor and Hayes argue that this is symptomatic of a system focused on outcomes or the measure of client progress is a reduction in symptoms rather than the client perspective of what is helpful or not and unconcerned about the values connected with a therapy such as CfD. To comply with the IAPT restriction on the number of sessions a CfD therapist may have to resort to specific therapeutic knowledge and behaviour to achieve a quick outcome but as Hodkinson and Issitt (1995) noted in the context of NVQs, this may draw an assessor's attention away from other aspects of competent practice.

In this world therapies are competitive rivals in that each has to continually demonstrate not only their effectiveness in the treatment of depression but also better recovery rates. If one or two therapies prove more effective than others then it seems reasonable to assume that the service will incline towards those that will deliver cost effective therapy. However, such a strategy may produce unforeseen problems. For example, Perren and Robinson (2010) identified data collection issues within IAPT services, with counselling being categorised erroneously as a low intensity intervention rather than a step three high intensity intervention, when some IAPT counselling services are being reduced and / or moving towards becoming CBT only services.

CBT occupies a commanding position within the IAPT service. As a consequence other therapies have become a 'second line' intervention and then only if a client fails to respond to or refuses CBT (Sanders and Hill, 2014; Perfect et al, 2016). Such a competitive situation was bound to exacerbate professional splits and rivalries in terms of theoretical models and practices. Bueno (2009) referred to the splits as a version of sibling rivalry. Over time this situation appears not to have improved to any great extent. The implementation of local IAPT services may be viewed positively with regard to clients being able to access counselling services. However, Perfect et al found variations in the services offered by different IAPTs and called for commissioners of counselling services to "ensure that all five NICE recommended therapies are available across England and that [client] choice of therapy is embedded in the IAPT model" (Perfect, Jackson, Pybis and Hill, 2016, p. 20). Although IAPT services claim that clients can choose a therapy Perfect et al found that only one of 114 IAPT services offered five therapies (CBT, counselling, IPT, psychodynamic and couples therapy). Client choice it seems is limited to that which is available in their IAPT area. This raises questions as to why IAPT is failing in its commitment to provide a range of therapies when demand for mental health services is predicted to surge (Forrest, 2020). At the same time it raises questions with regard to people retraining in a NICE recommended therapy if the prospect of IAPT employment is limited.

Doubts about the rhetoric of competence had previously been expressed by Hyland (1994). Hyland argued that the behaviourist foundation of competence-based training, as found in NVQs, may be suitable for lower level tasks and skills but at odds with a post-16 education system informed by the cognitive / humanistic tradition based on an experiential approach "to growth, development and progression in learning" (Hyland, 1994, p. 62). Hyland's concern was that in practice competence-based systems reduce the training curriculum, marginalize knowledge, and prioritize assessment of outcomes and the gathering of evidence. Hodkinson and Issitt (1995) were similarly concerned about the focus on assessment and the concentration on technical knowledge rather than learning, and the possibility that competence-based systems ill-prepare practitioners for what Schon (1987) referred to as the indeterminate zones of practice, such as uncertainty and the uniqueness of a situation. Despite these concerns NICE and the NHS / IAPT services, and many

therapies, are adopting the evidence-based / competence-based approach with the expectation that outcomes will improve because therapists are working with competences derived from the best available evidence.

Presently, NICE recommends and IAPT clients can, at least theoretically, access a range of talking therapies besides CBT, such as psychodynamic therapy (DIT), humanistic / experiential, interpersonal therapy (IPT) and systemic family therapy. Also available to NHS patients are therapies such as dialectical behavioural therapy, EMDR, mindfulness-based cognitive therapy (MBCT) and couples therapy. The therapies have adopted the evidence-based competences approach and training and assessment methods similar to that of CfD. They have also developed, like CfD, an instrument such as the PCEPs scale for assessment purposes. Unlike the much used Cognitive Behavioural Therapy-Revised (CBT-R) instrument in CBT research, indicating people have confidence in the CBT-R as a measure of competence in CBT, the PCEPS is a new measure or check on a person's ability to implement the main principles of the CfD approach. However, as Freire et al (2014) point out, although the PCEPS reflects some of the earlier work on scales carried out by Truax and Carkhuff (1967) it nevertheless remains relatively new and the results arising from its development need replicating by researchers / practitioners. CBT training is significantly different in that it is a one year programme rather than twelve weeks, as in CfD training. Why CfD and the other competence-based therapies, such as DIT, chose a shorter training period when compared with CBT is puzzling, particularly when the Depression Report held CBT model to be the prime example of evidence-based practice.

The pre-eminence of evidence-based practice was signalled by the Depression Report and adopted by NICE when constructing its guidelines. Before NICE recommends any therapy for use in an NHS / IAPT service the therapy first has to demonstrate its efficacy, based on RCT evidence, in the treatment of a specific condition such as depression. The reliance on RCT evidence by NICE is an area of concern. Critics such as Mollon (2009) and Barkham et al (2017), argue that RCT evidence alone is limited and call for the large NHS data sets, data sets from routine practice and the voice of patients to be included when decisions are made into the effectiveness of counselling in the treatment of depression and / or when NICE

reviews its guideline for depression. Especially as evidence derived from IAPTs own standardised data set indicates that counselling is as effective as CBT in the treatment of depression (Barkham et al, 2017). However, Barkham et al also expressed concern at the "paucity of high quality head-to-head trials [RCTs] relating to counselling" (Barkham, Moller and Pybis, 2017, p. 263).

Evidence related to humanistic or counselling therapy was, Sanders and Hill (2014) claim, fairly limited at the time CfD was being considered. Two different sets of research into the effectiveness of person-centre / experiential therapy with depression were reviewed. Five studies, incorporating client-centred therapy, antidepressants, CBT, psychodynamic counselling, process experiential therapy (EFT) and usual GP care, with between 6 and 20 session, were reviewed by a Guideline Development Group (GDG) when the NICE guideline for depression was constructed. The GDG concluded that the evidence from these studies supported the effectiveness of counselling for mild-to-moderate depression but not for severe depression. However, the evidence was also seen as limited because of the small size of the samples. In the second set of research Elliott et al (2013) conducted a meta-analysis of 27 studies of humanistic-experiential therapies. Twenty-three studies compared PCE with other therapies, but mostly with CBT. Positive and negative outcomes were evenly spread across the 23 studies, although some support was found for process guiding approaches over other approaches in the treatment of depression. Evidence from both studies indicated that elements of person-centred and emotion-focused were effective in the treatment of depression and could form the basis of a counselling therapy. The SfH humanistic competence framework and the evidence-based interventions from these studies underpin what eventually came to be known as Counselling for Depression (CfD).

The lesson from the period when CfD was developed and its use since 2011 is that to avoid the same threatening predicament again, and because NICE regularly reviews the guidelines, is that research into the person-centred / emotion-focused therapy, or the person-centred experiential approach, needs to be on-going. Just such an example was the large randomised control trial, entitled PRaCTICED, in which CfD / Person-Centred Experiential Therapy (PCET) was compared with CBT in the treatment of depression (Barkham et al, 2021). The hypothesis being that CfD

will not be meaningfully inferior to CBT in the treatment of moderate and severe depression. The RCT was carried out under the auspices of the Sheffield Health and Social Care IAPT service. It is the first trial in the IAPT service to examine the two most frequently recommended psychological therapies. The findings confirm the non-interiority of PCET to CBT at 6 months. This supports the results from the large, non-randomised datasets of the IAPT programme. The findings also suggest that PCET might be inferior to CBT at 12 months but that, given the high demand for psychological therapies, investment in the training and delivery of PCET for improving short term outcomes should continue.

Professional bodies and professionals, as above, are demonstrating that evidence gathering on behalf of each therapy is likely to be an on-going requirement as NICE seeks to ensure its guidelines continue to be based on best available evidence. In this way CfD or whatever it may become will be able to call on evidence in the debate with NICE about its effectiveness in the treatment of depression and thereby maintain CfD-PCE within the NICE depression guideline and on the menu of IAPT therapies.

2.5.2 The brevity of training

The phrase 'top-up training' is used by Folkes-Skinner (2015) to describe CfD accredited training when compared with the longer periods of training required for recognised professional qualifications. However, from a curriculum perspective, the top-up view seems to ignore the scale of the CfD national training curriculum. A five day taught phase may be appropriate where therapists are 'topping-up' existing knowledge and practice but this may not be suitable where therapists are learning a radically new competence-based integrated therapy, such as CfD. Although therapists are qualified and experienced learning a substantive new theory (McLeod, 2003) within the five day timeframe may present a challenge in that therapists are developing a new competence-based approach to practice and adjusting to an unfamiliar assessment method. As Sanders and Hill indicate "in the world of routine practice, adherence to a therapy manual is not common practice" (Sanders and Hill, 2014, p. 21), which suggests therapists may have to learn what it means to adhere to a therapy manual prior to implementing CfD in the workplace with clients.

Nevertheless, it would appear that the 5 day taught phase is considered sufficient for therapists to become familiar with the competences, understand the CfD conceptualisation and treatment of depression, and become accustomed to the PCEPS method of assessing adherence / competence. Then, within the 12 weeks workplace phase, where each therapist appears to be in a self-learning situation, the challenge becomes how to interpret the competences with sufficient understanding that they are capable of implementing them to the threshold standard when working with real clients. Previous research has noted issues associated with the training and assessment programme (Pearce et al, 2013; Drewitt, Pybis, Murphy and Barkham, 2018). Further discussion on this topic occurs in chapter three. While my study will also look at the CfD training programme it will be from a different perspective, that of therapists acquiring, and being assessed against, the CfD competences.

2.5.3 Adjusting to and Integrating PCT and EFT competences

The expectation is that by the end of phase two of training therapists will be able to implement the integrated PCE-CfD therapy. However, Hollanders (1999), McLeod (2003) and Faris and van Ooijens (2009) suggest that therapists need time to develop a new integrative practice which is comprised of a substantive new theory. Without the development of a shared language, based on the new theory, misconceptions or distortions can arise with regard to practice, human development and the alleviation of distress. Moreover, individual therapists, particularly qualified and experienced therapists, may react differently to the way PCT and EFT have been integrated in the CfD model of therapy. CfD therapists may be entering training with established identities derived from an allegiance to a specific therapy. For example, classically trained person-centred therapists may perceive EFT terms such as 'focal interventions' or 'process guided interventions' as CfD therapy taking a more directive and less relational approach. In such circumstances PCT therapists may resist change if change involves a loss of identity.

Traditionally trained therapists are unlikely to be familiar with a competence-based approach to therapy. A therapist may have acquired a competence-based NVQ but this is unlikely to help with their CfD training. The NVQ competence model differs in

a number of ways from the CfD competence model, for instance in the specification of performance criteria related to each of the NVQ competences. CfD training may be the first opportunity for therapists / trainees to study the person-centred and emotion-focused competence-framework and associated categories of competences. Learning a competence based model of therapy may be an issue for experienced therapists, in terms of adjusting to the language of the competence model, adjusting existing practice to the prescribed competences and disciplining oneself to adhere to the CfD competences. For example, whether therapists recognize the CfD competences as characteristic or not of their core approach to therapy, may occasion conflict in adjusting existing practice to the prescribed competences and in disciplining oneself to adhere to the CfD competences. Such conflict could become a serious issue. The CfD competence framework is particularly important to CfD training and this study because, as Sanders and Hill (2014) argue, the competences provide the link to evidence of effective practice and as such "it follows that the assessment of trainees should be based on how far they implement the competences with real clients in therapy sessions" (Sanders and Hill, 2014, p. 183).

Learning to implement the competences in complex real life situations has been criticised by practitioners and educationalists, on practical and philosophical grounds (Hodkinson and Issitt, 1995; House, 2009; Hyland, 1994; Malone and Supri, 2012; Northey, 2011; Sultana, 2009; Wolf, 1995; Vaspe, 2000). The critics suggest that deconstructing a complex, multi-faceted professional activity so that it can be assembled into a competence framework consisting of discrete, recognizable competences is difficult, with regard to quantifying therapist attributes such as empathy, respect and transparency. The challenge for CfD therapists / trainees is how to re-combine the 200 plus discrete competence statements into a coherent therapy and form of assessable practice when implementing CfD with a client. This complicated process has perhaps been made all the more so for therapists as they endeavour to integrate the discrete person-centred and emotion-focused competences of procedural knowledge and skill. During training therapists may recognize, or not, the generic or non-specific and specific competences but the challenge remains, if they want or need the CfD award, is how to combine the

competences in such way that an assessor will recognize it as a coherent form of CfD therapy.

2.5.4 Criticisms of the assessment method

2.5.4.1 The PCEPS items and the CfD / SfH competences

Roth and Pilling (2009) assert that competence-frameworks tend to be too large for assessment purposes. They recommend that a competence measure should be composed of a sub-set of the competences. The PCEPS is based on a sub-set of competences in relation to person-centred and experiential therapy. However, this suggests that it is not the actual CfD competences which are assessed but the items within the PCEPS instrument. The thread that links the PCEPS items, the CfD competences and the SfH humanistic competences is their close association with person-centred and experiential psychotherapy. But, while the CfD and SfH competences are exactly the same, with regard to language and specifications, the PCEPS item specifications appear to be markedly different. My PCEPS, CfD and SfH humanistic Comparison Chart (see Appendix 3) identifies the differences between the PCEPS items and the CfD competences / SfH humanistic competences. The humanistic framework of competences (Roth, Hill and Pilling, 2009) is included in this comparison chart because it was part of the source material in the development of the CfD competence framework and the PCEPS items. Topics in the CfD competence framework which are not explicitly addressed within the PCEPS include, for example, ability to undertake a generic assessment, ability to assess and manage risk of self-harm, ability to make use of supervision, ability to use measures to guide therapy and to monitor outcomes, working with difference and managing endings. CfD theory, for instance, which addresses mental health conditions, depression and models of therapy, may be part of the taught period of training but therapist / trainee knowledge is not tested during the PCEPS rating process. This seems to indicate that therapist response to contextual factors is not taken into account during assessment. This prompts the question "What is the PCEPS being used for?" Could it be about preparing therapists / trainees to adhere to one form of PCE therapy? For instance, when implementing CfD in a randomised control trial (RCT). In an RCT therapist ability to adhere to the therapy protocols is

essential and something a researcher would want to control. Or perhaps it is about a therapist extending their existing practice. However, Sanders and Hill argue that assessment of therapists / trainees should be based on "how far they implement the CfD competences with real clients in therapy sessions" (Sanders and Hill, 2014, p.183). This suggests that there may be variations in the way each therapist / trainee implements CfD with real clients, depending on client need, and thereby more difficult to control and assess.

I developed the PCEPS / CfD / SfH comparison chart as a means of revealing the similarities and potential differences between the PCEPS items and the CfD and SfH competences, and thereby the possible implications for assessment. The PCEPS items differ to such a degree that it is difficult to see what the relationship is, if any, between the items and the competences therapists are expected to acquire and then implement when working with a client. The PCEPS instrument may be a measure of person-centred and experiential therapy, but whether this is the same as the PCE / CfD therapy is uncertain given, as noted above, the Sanders and Hill argument.

2.5.4.2 Adherence / competence and the PCEPS

Freire et al (2014) describe the PCEPS as a new adherence / competence measure of person-centred and experiential psychotherapy. However, Sanders and Hill claim that the driving force behind the development of the PCEPS was "the need for a measure which could be used to assess the competence of therapists in RCTs of person-centred and experiential counselling" (Sanders and Hill, 2014, p. 184). This suggests that the PCEPS may be an inappropriate instrument in a training context. During CfD training therapists are learning to acquire competences and preparing to deliver CfD in a primary care setting rather than a randomised controlled trial (RCT). It may be that RCT methodology requires therapists to adhere faithfully to a treatment manual but as noted earlier "in the world of routine practice, adherence to a therapy manual is not common practice" (Sanders and Hill, 2014, p. 21).

However, Hill describes the CfD assessment instrument as "the CfD adherence scale" (Hill, 2011, p. 58). In this statement competence is not mentioned, although

the PCEPS appears to have been designed to assess adherence and competence concurrently. The focus, from the Hill statement would appear to be on therapist adherence. Therapists may be confused as to which is more important, adherence or competence or both. The challenge for therapists is that they only have four therapy sessions, all unseen by an assessor, in which to demonstrate adequate adherence to the items or competence or both.

Waltz, Addis, Koerner and Jacobson conceptually separate adherence from competence in the following way:

> Adherence refers to the extent to which a therapist used interventions
> and approaches prescribed by the treatment manual and avoided the
> use of interventions proscribed by the manual…
> and competence refers to the level of skills shown by the therapist in
> delivering the treatment (and includes taking into account
> contextual variables   (Waltz et al, 1993, p. 620).

According to the Waltz et al definitions, when contextual factors, such as client condition, particular problems and stage in therapy, are taken into account, competence presupposes adherence but adherence does not imply competence. In some studies, and depending on the research aim(s), adherence and competence may be assessed concurrently or independently (Barber et al, 2006, Hogue et al, 2008, Strunk et al, 2010, Branson, Shafron and Myles, 2015). However, Muse and McManus (2013) argue that although adherence and competence are conceptually distinct that in practice there is much overlap, so competence is not sufficient without adherence and vice-versa. As CfD therapists will be working with different clients at different stages in therapy the Waltz et al (1993) definitions suggest context could significantly influence therapist adherence and competence. If this was to occur, and for the purpose of assessment feedback, it may be that an assessor will need to consider whether to assess adherence and competence concurrently or independently.

2.5.4.3 Knowledge and competence

The CfD method of assessing therapist competence does not require the assessment of knowledge during summative assessment. It may be that knowledge is formatively assessed during the five day phase, but Sanders and Hill (2014) argue that it is the application of knowledge to complex real-life situations, rather than essays and role-plays, which defines competence. The list of CfD competences contains eight knowledge statements, all of which appear to underpin the long list of CfD competences / abilities. Sanders and Hill state that " a central premise of competence frameworks is that therapists need background knowledge relevant to their practice, and it is the ability to draw on and apply this knowledge in therapeutic work that marks out competence" (Sanders and Hill, 2014, p. 23). As this appears, in the context of CfD training, that this is how competence is to be defined, it seems that therapists are expected not only to know the 'how' of therapy but the 'why', but without having to explain the 'why' or how they have applied CfD theory and therapeutic model of change.

2.6 Defining competence

Despite therapist calls for a definition of competence at the moment there is no professional consensus as to how to define competence. Previously, Egan (1990) has called for counsellor training to be competence based and Kazantis (2003) has called for an operational definition of competence, one which delineates the behaviours, techniques and strategies indispensable to a particular model of therapy. Likewise, Hill and Knox argue that, given the growing demand for competency benchmarks "we need better definitions of expertise and competence…and also to develop psychometrically sound means of assessing them" (Hill and Knox, 2013, p.802).

In the context of CfD, competence is referred to as "the judicious combination of knowledge and skill" (Sanders and Hill, 2014, p. 31) when implementing the competences with real clients. This appears to be a straightforward statement but it is not difficult to see that a therapist may need help in understanding exactly how 'the judicious combination of knowledge and skill' is to be demonstrated or made known

during assessment. To clarify how others have attempted to unambiguously define competence the profession could review and draw inspiration from the many existing definitions (Beauchamp and Childress, 2001; Earut and Hirsh, 2007; Further Education Unit (FEU), 1984; McLeod, 2003; NCVQ, 1988; Schroeter, 2008). However, Hyland (1994) and Cowan (2005) offer a cautionary note, claiming that there is much imprecision, ambiguity and confusion around the language of competence. Hyland argues for a distinction to be drawn between competence as a capacity, the evaluation of an individual in the performance of a professional activity, such as a doctor or builder, and disposition, a narrower more atomistic term to label particular abilities, for example, building a stone wall or a piece of writing. Some of the definitions reflect this type of distinction. For instance, the NCVQ definition narrowly focuses on the abilities required "to perform work activities to the standards required in employment" (NCVQ, 1988, p. 22), while the FEU (1984) and Eraut and Hirsh (2007) definitions are much wider with regard to what is expected of competent people in their professional and life roles.

Although person-centred therapists now have a competence framework which delineates the prescribed behaviours, knowledge and techniques, I would argue that this is only be the first piece in a jigsaw that will eventually, when all the pieces are in place, depict competence-based practice, training and assessment. The other pieces of the jigsaw are solitary items which appear to have a place in the jigsaw but at the moment the issue is whether they will all fit together into a coherent whole. My PCEPS/CfD/SfH comparison revealed certain issues and, as Bond (2010) cautioned, any method of determining therapist competence will need to accommodate the inevitable tensions between standardisation and innovation, the theoretical orientation of the therapist and the contextual and cultural variations and the needs of particular clients.

Summary

In this chapter I have examined the CfD competence framework structure and content, the training programme, the assessment method and the lack of an operational definition of competence. At the end of training the expectation is that a therapist will implement the framework as an integrated whole so as to ensure the

client receives a coherent therapeutic package (Sanders and Hill, 2014). I have looked at the CfD model of therapeutic change and its focus on alleviating a client's emotional problems as the means of reducing a client's depressive symptoms. If a client enters into the IAPT programme they have usually had a diagnosis of depression and been referred to an appropriate level within the IAPT stepped care model. While therapists are required to be aware of the diagnostic and referral system they are not responsible for undertaking a diagnosis. Within the IAPT system CBT has been designated as the frontline therapy, leaving other therapies, including CfD, in the 'second line' of treatments (Perfect et al, 2016).

I was particularly interested in how the different aspects of the CfD training and assessment programme fit together, especially as workplace hours contribute approximately 75% of programme time. A number of issues emerged during my examination. It appears that therapists only have a five day taught phase in which to learn a substantive new theory and develop a new form of integrative practice before undertaking 80 hours of workplace practice. The workplace appears to have become a self-learning environment, in that therapists' may have to continue to learn the theory and practice of CfD, while also preparing for and carrying out summative assessments. Implementing the new CfD integrative model of therapy may present a challenge for experienced and qualified therapists who have an allegiance to and identity based on their preferred therapeutic model. During training therapists are adjusting to a new means of assessing adherence / competence in person-centred and experiential therapy. As adherence to a therapy manual is not common practice in a routine counselling setting therapists may find it difficult adjusting to the CfD method of assessing adherence / competence. During training therapists are introduced to the evidence-based CfD competences and effective practice, but then assessment requires that they focus on the PCEPS items and reaching a threshold standard if they are to become an accredited CfD practitioner. However, the CfD curriculum indicates that assessment should be based on how far therapists implement the competences with real clients. My PCEPS / CfD / SfH comparison suggests that assessing a therapist against the CfD competences is different to assessment against the requirements of the PCEPS items. It seems that there may be a mismatch between what the PCEPS items require of a therapist and the Sanders and Hill (2014) statement that therapist assessment should be based on

how far and well therapists implement the CfD competences with clients. Although the list of CfD competences includes the knowledge and abilities a therapist needs when implementing the competences it seems that therapist knowledge is not to be tested as part of judging therapist competence.

Chapter Three

Literature Review

3.0 Research on therapist training

The focus of much research in counselling and psychotherapy has been on 'what works best', or the effectiveness of certain therapies in the treatment of specific conditions (Antonious, Cooper, Templer and Holliday, 2017; McLeod, 2019; Paintain and Cassidy, 2018; Strunk, Brotman, DeRubeis and Hollon, 2010), with very little research attention given to other significant issues within the field.

Some research attention has been given to issues such as the client / therapist alliance and outcome (Bedi et al, 2005; Watson and Geller, 2005; Crits-Christoph et al, 2006; Horvath and Bedi, 2002), cultural competence (McKenzie-Mavinga, 2005; Powell, Dada, Yaprak, 2015) and the relationship between competence and outcome (Barber, Sharpless, Klosterman and McCarthy, 2007; Branson, Shafran and Myles, 2015; Collyer, Eisler and Woolgar, 2020). The research suggests that it is important to develop a strong therapeutic alliance in the first few sessions, as the quality of the alliance has been found to be positively related to therapeutic outcome. There is also growing research interest into the relationship between therapist competence and client outcome. The evidence for a relationship is inconclusive but nevertheless interest in therapist competence continues particularly as counselling / psychotherapy becomes competence-based.

However, it has been remarked that therapist training has received less than adequate research attention (Ronnestad and Ladany, 2006: Roth and Fonagy, 2006) and Hill and Knox (2013) questioned why so little is known about the effects of training on trainees / therapists from a personal and professional perspective. The question is important for students of counselling and psychotherapy, trainers, training institutions and therapists' clients. In the period since these publications this situation has not markedly improved, with only a small number of research studies specifically on training being published, particularly for benchmarked competence-based person-centred and emotion-focused therapy.

Folkes-Skinner (2010) found that therapists consider training to be essential preparation for entry to the profession, with the perception that completion of training indicates an ability to work competently and safely. However, Hill and Knox (2013) claim that "training might influence trainees in different ways, rather than having uniform effects" (Hill and Knox, 2013, p. 801).

My database search for empirical research relevant to this study was undertaken based on the key words competence, adherence, person-centred therapy, emotion-focused therapy, counselling, psychotherapy and training. The references included in the publications identified provided information about further potentially useful publications. Research in this area, as Sanders and Hill state is "fairly limited" (Sanders and Hill, 2014, p. 27) and, as Hill and Knox (2013) argue, gaps remain in our knowledge with regard to how to define and measure competence, the effective components of training and how abilities are incorporated over time.

My review of the empirical literature was undertaken with the intention of focusing on studies relevant to CfD as a competence-based therapy. I have reviewed a small number of CfD studies but due to the paucity of research in this area I have reviewed research that is not specifically on CfD or competence-based programmes. I searched for and reviewed literature on a number of generic issues because they all have relevance to the particular case of CfD. The generic issues include specific versus non-specific interventions, psychotherapy trainees' conceptions of the learning process, workplace learning, re-training in new approaches, implementing competence frameworks and assessment of competence. I considered these issues to be of relevance to the CfD programme for the following reasons. CfD has adopted a manual or competence framework composed of basic / non-specific, generic, specific and meta-competences. The relative contribution of specific and non-specific factors is considered in the context of training and development of therapist ability to develop and maintain a working relationship with the client. Becoming a CfD practitioner requires therapists to undertake training. It is a training programme which incorporates a number of new features, which may challenge how those involved conceive of counsellor training, training for competence and their relationship with the new learning. The workplace within CfD training has become a key learning and

assessment environment. Learning and assessment in this environment is likely to be unfamiliar to traditionally trained and experienced therapists. My literature review includes studies which have looked at the workplace in terms of it becoming a learning environment and learners preparing for assessment. Therapists undertaking CfD training are being re-trained in terms of changing to a new therapy and a new competence-based approach to therapy. Literature was reviewed which addressed the prospect of and issues around re-training in a new therapy, implementing competence-frameworks and the assessment of therapist competence.

After locating the literature for this chapter and reviewing it I decided to divide this chapter into six sections. The studies in the first section are concerned with the difference in opinion pertaining to specific versus non-specific factors in relation to effective therapy. In the second section I discuss time allocation for learning and the issues that can arise for learners if there is insufficient of it. The way the CfD training programme has been designed suggests that there may be insufficient 'classroom' time for learners to internalise all that is new about CfD. Third, workplace studies are reviewed because of its importance within the CfD programme. Fourth, CfD trainees may be experienced therapists but CfD contains much that is new, with regard to a new integrated PCT and EFT therapy, new competence framework and new assessment method. Studies that explore potential conflicts when new learning is involved are reviewed. Fifth, CfD requires a therapist to change their existing practice to a competence-based approach. Studies, which explore this type of change, are discussed. I have included the few CfD studies in this fifth section because the findings may be of direct relevance to my research. Finally, in the sixth section, my focus is on studies which incorporate adherence and competence, and the assessment of these entities, as CfD has, for the first time in terms of person-centred and emotion-focused, introduced a new method of assessing adherence and competence.

The chapter ends with a summary of the key issues and challenges and a statement of the aims of this study.

3.1 Specific versus non-specific factors - contribution to outcome

There is a debate surrounding whether training should emphasise specific or non-specific (factors common to all modalities) factors. Stein and Lambert's (1995) meta-analysis on graduate and postgraduate training and therapy outcome studies found that more experienced therapists of any modality were better equipped to continue working with clients with long term conditions on a long-term basis than inexperienced therapists. This ability was apparently due to common factors rather than specific model interventions. Clients of the experienced and trained group improved more than clients of less trained and experienced group. As a result Stein and Lambert suggest that training should concentrate on common factors, such as interpersonal skills and the facilitative conditions as found in the client centred tradition because this was the best predictor of the therapeutic outcome. Asay and Lambert (1999) came to a similar conclusion. Following a review of research findings on the general effects of psychotherapy with particular attention directed to research on common factors, they estimated that non-specific factors accounted for 85% of variance in therapeutic outcomes. The non-specific factors included client factors and relationship variables, for instance positive about therapy and willingness to collaborate. Only 15% of the variance was attributable to the therapeutic model or specific techniques. The present day drive towards using only authorized evidence-based therapies, treatment guidelines and manual based therapy seems to be at odds with this view. The Asay and Lambert finding suggests that training should be based on non-specific factors, particularly as evidence continues to emerge indicating that non-specific factors have a considerable effect on the symptoms of depression, with specific factors having a limited impact (Cuijpers, Driessen, Hollon, van Oppen, Barth and Andersson, 2012). However, caution is needed about this suggestion because the research is relatively old. Nevertheless, the Cuijpers et al research, because of the positive link between non-specific factors and depression, is highly relevant to this study.

However, Beutler et al (2004) found that training which focuses on specific, manualised tasks and concepts enables therapists to produce better outcomes than non-specific training. Nevertheless, a note of caution has been sounded with regard to training in specific techniques by Crits-Christoph et al (2006). Five participants

from different theoretical backgrounds and up to 3 years postgraduate experience undertook manualised training in specific alliance fostering techniques. The techniques included a collaborative stance, positive regard and agreement of tasks / goals, in combination with interpersonal psychodynamic interventions in the expectation it would improve the therapists / client alliance. The evidence was inconclusive, with only a marginal improvement in the therapist / client alliance. The authors suggest that manualising alliance fostering is problematic as the alliance can be influenced by both the therapist and client. The contradictory research findings concerning the relative effectiveness of specific versus non-specific interventions is hard to explain**.** However, Cuijpers et al (2012) suggest that it is not easy to disentangle the relative contribution of specific and non-specific effects in the different therapies. Nonetheless, it seems likely that the specific versus the non-specific debate will continue especially now that contemporary competence-frameworks include both non-specific and specific factors (competences). The effectiveness of specific interventions, especially where these are manualised, is clearly relevant to the proposed research since CfD has adopted a manualised competence framework approach to therapy (BACP, 2010).

In a major review of quantitative and qualitative evidence for the effectiveness of training, Hill and Knox (2013) carried out a manual search for empirical studies within seven journals, which addressed training for novice therapists (undergraduates and graduates) and training for practicing therapists, over the period 1998 - 2013. They suggest there is a need to know more about specific skills training and whether prior training in non-specific factors (empathy, paraphrasing and reflecting) enables trainees to more effectively learn specific skills. Nevertheless, the contemporary solution to overcoming the specific versus non-specific factors issue has been the development of standardised instruments and prescribed benchmarks (minimum thresholds) and construction of manuals related to specific models of therapeutic practice. Hill and Knox question the value of benchmarking and the idea of training to for certain skills because "therapy is complex and relationships differ with every therapist-client dyad, so no one can ever be completely trained or prepared for such inevitably varied experiences" (Hill and Knox, 2013, p. 801). There is the opportunity within my research to explore the benchmark issue because CfD therapy is founded on the client / therapist relationship and benchmarked specific competences.

The CfD competence framework, and thereby the training, incorporates both generic therapeutic competences (a set of common and non-specific factors that underpin all modalities), which person-centred therapists may recognize, and specific therapeutic competences (modality specific competences) related to person-centred and emotion-focused therapies which therapists may or may not recognize as characteristic of their core practice. Therapists may need training support in terms of any struggle with competences they perceive as uncharacteristic of their core practice and therefore an impediment to a coherent implementation of CfD. Evidence from a study into how therapists construe generic competences "in relation to the theoretically consistent elements of their therapy" (Roth, 2015, p.5) provides support for the applicability of generic competences across CBT therapy, psychodynamic therapy and humanistic approaches. However, the author also found that some generic items were perceived as inimical by both psychodynamic and humanistic therapists, for instance, the 'explicit structuring of sessions' was judged as uncharacteristic of these therapies. It may be that CfD therapists / trainees with a classical person-centred background may find this issue a particular difficulty.

3.2 Time allocation and learning

The amount of time designated to learning may be expected to affect the amount of learning but few studies have addressed this issue directly. However, the research suggests that certain issues may emerge if insufficient time is devoted to learning. As a result trainees may take longer than intended to complete training and / or they may be unable to integrate new learning with their core practice (Bein et al, 2000; Drewitt et al, 2018). The length of time for a therapist to feel competent in the delivery of a therapy has been found to vary considerably. For instance, Najavitis, Weiss, Shaw and Dierberger (2000) explored how helpful treatment manuals are for psychotherapists. A 56 item survey was carried out with 47 CBT therapists, which explored their perceptions of manuals, in terms of number read, favourite manuals, descriptions of the ideal manual and reaction to adherence scales. This sample was chosen to limit the potential confound of orientation and because therapists of the CBT orientation were most likely to have been exposed to the use of a manuals. The therapists were positive about the use of manuals but found that it takes longer to

feel competent in psychodynamic therapy than cognitive, interpersonal and supportive-expressive therapy. This suggests that trainers of experienced therapists may need to take into account that some manual based therapies may require a longer period of learning than others.

Moreover, Nerdrum and Ronnestad (2002), in a qualitative study into trainee therapists' conception of the learning process, found that internalizing learning takes time and effort, which suggests that those planning a training programme need to carefully consider how quickly learning can take place. Time for formal learning within CfD training is limited to one week or approximately 25 hours. The expectation appears to be that because CfD "will be familiar territory to experienced PCT practitioners" (Sanders and Hill, 2014, p. 4) internalizing the learning related to the concepts and principles associated with the new competence-based integrated therapy may present little challenge to the learners. However, as the above studies suggest, internalizing learning is a complex process. This suggests that although CfD trainees are experienced therapists they may need training to be spread over a longer period of time if they are to internalize, or understand, adjust to and be able to apply, the principles and concepts related to CfD therapy.

3.3 The role of workplace learning

Practice is a regular feature of training programmes within course role-play exercises, which trainees find useful (Bennett-Levy et al, 2009), but little is known about inexperienced / experienced therapists learning to deliver therapy with real clients in the workplace. There is an absence of research explicitly addressing the blend of workplace and course learning within counselling / psychotherapy training, an issue clearly relevant to CfD because the workplace occupies almost 80% of CfD training time. The workplace offers the opportunity to work with real clients, a factor which trainees have identified as having a positive influence on their development (Folkes-Skinner, et al, 2010; Hill and Knox, 2013; Orlinsky, Botermans and Ronnestad, 2001)).

However, Orlinsky et al (2001) recommend work with real clients should only commence if the trainee has been trained to a certain standard in a relevant model

of therapy. The authors arrived at this recommendation after identifying, from an analysis of therapist responses to a questionnaire, those features of training that facilitate or impede professional development, in particular the positive influence of working directly with clients. As workplace learning with real clients is now a major component within CfD training programmes there is the opportunity to explore how therapists are prepared for and then undertake workplace practice. Trainees may value 'on-the-job' training with real clients but Eraut, Alderton, Cole and Senker (1999) suggest that learning in the work environment is dependent on how work is organized and allocated, and that this determines whether learning can take place 'on-the-job'. On-the-job training and assessment of practice under normal work conditions is considered by Jessup (1991) to offer the most 'natural' form of evidence of competence. This may be the case within CfD training as assessment evidence will be gathered when a therapist is working with a real client.

However, there is evidence indicating that this may not always be the case. The findings from the mixed methods research of Drewitt et al (2018) and Pearce et al (2013) into practitioners experiences of learning CfD and implementing CfD in the workplace indicate that the demands of the workplace may conflict with the demands on the trainee to implement therapy as decreed by their training. Nevertheless, data from a longitudinal study, over three years, concerned with the early career professional learning of newly qualified nurses, graduate engineers and trainee chartered accountants is positive about learning from other people in the workplace. There were three research questions: What is being learned? How is it being learned? What factors affect the level and direction of learning efforts? Data was gathered from observations of participants at work with follow-up interviews. The findings suggest that "formal learning contributes most when it is both relevant and well-timed, but still needs further workplace learning before it can be used to best effect" (Eraut and Hirsh, 2007, p. 149). The impression is that a blend of formal and workplace learning can significantly help a learner prepare or hone their skills in readiness for a workplace role. However, Eraut and Hirsh (2007) suggest that support and feedback from someone on the spot may be essential if workplace learning is to make a meaningful contribution to the overall learning programme.

Therapists in the real world of routine practice settings have been found to have large caseloads and multiple roles within their organisation or service (Proctor and Hayes, 2017; Robbins et al, 2011). As CfD trainees are both learners and employees this is a situation with the potential to impede their learning as they strive to deliver CfD within the constraints of the workplace. Participants in a qualitative study into the ethical conflicts faced by IAPT therapists as they try to deliver the therapy they had been trained to deliver found them feeling stressed, exhausted and under pressure as they endeavoured to work according to their professional and ethical standards within a service which is focused on outcome measures and recovery rates (Jackson, 2019). The coherence of CfD training may rest on how well the components of training logically and consistently fit together, especially as the workplace component is by far the largest training element.

3.4 Conflicts in new learning

Research indicates that therapists with a preferred way of working or an established mode of practice find learning a new therapy disturbing and difficult (Bein et al, 2000; Folkes-Skinner, Elliott and Wheeler, 2010; Lowndes and Hanley, 2010; Owen-Pugh, 2010; Byrne, Salmon and Fisher, 2018). Therapists learning to deliver CfD are not only learning a new therapy but face the additional challenge of learning to deliver CfD therapy based on a new framework of competences related to person-centred and emotion-focused practice. Hollanders (1999) and McLeod (2003) argue that learning to integrate therapies is difficult because integrative practice brings together possibly competing ideas with regard to distinctive theories and practices. There is the opportunity in my research to explore how therapists adjust to this new therapy and the impact the competence-based approach has on the process of adjustment.

There appears to be two aspects to the challenge of new learning, one which involves adapting to the new therapy and a second which involves the therapist's self-concept. Lowndes and Hanley (2010) explored with seven newly qualified therapists their perceptions of training in integrative counselling. A key finding was that therapists needed to be able to tolerate discomforting feelings as they confronted theoretical ambiguity. The therapists found it difficult to navigate their way or "find a pathway between the firm ground inherent in purist models, and maintain

the autonomy and flexibility of integration" (Lowndes and Hanley, 2010, p. 169). However, in a case study, a qualified integrative therapist also experienced similar navigation difficulties when learning a single approach to therapeutic practice, meta-cognitive therapy (Byrne et al, 2018). The difficulties included learning to adhere to the new therapy and resisting previous ways of working with clients.

It seems that if new learning requires therapists to change their core practice it may also be interpreted as a challenge to their counsellor identity. Owen-Pugh (2010) in a qualitative study of 12 therapists investigated counsellor identity in the context of qualified psychodynamic therapists undertaking a top-up degree in counselling that included a compulsory CBT module. Owen-Pugh found that therapists with an allegiance to their core training experienced difficulties integrating psychodynamic therapy with the principles of CBT. The participants initially felt deskilled and developed a resistance to learning as they endeavoured to integrate the therapies and focus on thoughts rather than feelings. Bein et al (2000) describe this problem as participants experiencing divided loyalties between existing practices and the new therapy. In Bein et al.'s research, 16 participants with backgrounds in psychiatry and psychology and prior training in psychodynamic therapy were given a year-long training in time-limited dynamic psychotherapy (TLDP). The assumption behind the training programme, given the participant's prior experience, was that they would only need to make a technical adjustment to their customary practices. However, the assumption was incorrect as the participants felt the change required more than a technical adjustment to existing practice. TLDP practice was perceived as quite different to their existing practice and that they would need additional time devoted to learning TLDP theory and rehearsing TLDP practice in order for them to understand how their existing practice and TLDP could be combined. CfD therapists / trainees, because of their prior experience and training, are in a similar position to the TLDP trainees. There is the opportunity in this study to explore whether CfD therapists / trainees experience a similar issue or will the integration process proceed unimpeded.

Folkes-Skinner et al (2010) suggest that in such situations training needs to incorporate strategies which help trainees make the transition from resistance to adoption of the new learning. The process of transition is described by Folkes-

Skinner et al as the deconstruction of an existing self to allow for the emergence of a new self-identity. In their case study Folkes-Skinner et al investigated a trainee's experience at the start of training in integrative practice and found that it challenged the trainee's self-concept, with regard to their organised set of perceptions, beliefs and values. The trainee is reported as experiencing fluctuating levels of confidence and self-esteem, most notably when implementing the new learning in the context of client work. This trainee eventually overcame resistance to the new learning and integration improved. As this is a case study involving one trainee further research is needed into how other trainees respond to new learning.

Overcoming resistance to new learning may be impossible for some therapists. A study into the experiences of 10 counsellors undertaking training in person-centred experiential therapy (PCET) within an IAPT service suggests that participants who are unable to overcome resistance to new learning may not complete their training (Nye, Connell, Haake and Barkham, 2019). The participants came from a variety of different backgrounds, for instance, four with a single core model and six with an integrative background. The 5 participants who completed their training in PCET experienced similar feelings to those experienced by participants in the Owen-Pugh and Folkes-Skinner et al studies but eventually overcame any inconsistencies between PCET and their single or integrative practice through perseverance and willingness to adopt the new model. The authors suggest that the 3 participants who did not complete the training were unable to resolve such inconsistencies, and two were still in training. Resistance to new learning appears to arise whether trainees are compelled to undertake training or do so voluntarily. For instance, while it was compulsory in the Owen-Pugh study in research by Mackay, West, Moorey, Guthrie and Margison (2001) participants from a variety of therapeutic backgrounds were invited to learn about and apply a new therapeutic approach, the psychodynamic-interpersonal (PI) model. Training gave rise to feelings of uncertainty, fear and stress as therapists struggled to "come to an accommodation between their previous identity and identity as a PI therapist" (Mackay et al, 2001, p. 36). Participants felt restricted by the new therapy and wanted to use proscribed interventions. For some participants resistance to the new learning was such that they chose not to apply certain interventions, therefore defeating the point of the training. If CfD therapists

were to behave in this way it may be that they would find it difficult to complete their PCEPS assessment.

It seems that resistance to new learning depends on the perception of individual trainees. In a qualitative study, conducted by Atherton (1999), semi-structured interviews were carried out with a total of 124 participants in three different kinds of in-service training in social work, plus a participant observation study on a short course. Although most participants experienced some form of resistance minor and major factors were found to trigger resistance and triggers varied from person to person. Participants experienced a loss of certainty as the training required "the active renunciation or (passive) loss of patterns of practice" (Atherton, 1999, p. 85) which, up until the new learning, they had used confidently in routine practice. The suggestion is that individuals experience new learning as 'additive', in terms of adding to their repertoire of skills, or 'supplantive', in which case the new learning is perceived as replacing rather than complementing existing skills. It seems that if the new learning is perceived as 'supplantive' the likelihood is that resistance may be more difficult to overcome. Although the Atherton research concerns social worker training the general principle of individual resistance to new learning might also apply to trainees in other vocations. CfD therapists may be undertaking training by choice or because they need the award in terms of securing employment. Either situation may colour their perception of the competences. However, it may be that it is only when therapists / trainees delve into the detail of the competences that they will be able to determine whether the competences reflect their core practice, and therefore acceptable, or so contrary that they induce resistance.

As noted earlier by Roth (2015) in a study into the validity of competence frameworks, therapists were able to recognise competences from their own competence framework (CBT, humanistic or psychodynamic) as characteristic of their approach to therapy. Roth asked 111 experienced therapists to rate, using a Likert type Q-sort instrument, the concordance between items contained in the three competence frameworks. While there was broad support among trainees for the general applicability of generic competences, psychodynamic and humanistic therapists found some generic competences, such as those related to the use of monitoring measures and explicit structuring of sessions, as inimical or

uncharacteristic of their approach to therapy. This is an issue CfD therapists / trainees may have to confront as they endeavour to implement the integrated competences.

The counselling and psychotherapy research samples quoted are mainly small (1 - 12 participants) so I have to be cautious in drawing conclusions. Further research is needed. However, the findings suggest that the CfD therapeutic model and training may involve therapists / trainees in a number of new learning situations which may challenge their 'self-concept', counsellor identity and possibly trigger resistance to the new learning.

3.5 Changing to a competence-based approach

Training based on national competence frameworks for a number of counselling / psychotherapy modalities is a relatively recent development. Since 2010 an increasing number of competence frameworks have been developed but research based on these national frameworks is limited. Sanders and Hill argue that changing the existing practice of experienced therapist to the CfD competence model will require "only an adaption of existing skills and practices" (Sanders and Hill, 2014, p. 27). However, trainees may find changing their existing way of working with a client to a competence-based approach requires more than an 'adaption'. Practitioners, such as House (2009) and Vaspe (2000) argue that a therapy based on attributes, such as empathy, and ability to be non-judgemental and authentic, are not amenable to becoming competence-based. McLeod similarly argues that "many of the essential abilities of the counsellor refer to internal, unobservable processes…and that the skilfulness of an intervention can rarely be assessed by dissecting it into smaller micro-elements" (McLeod, 2033, p. 479). But the CFD competence framework contains such attributes, essential abilities and dissected competences. Trainees, and perhaps the trainers and supervisors, who hold such views may find changing to the CfD attributes and essential abilities difficult to accept. Two CfD studies present an insight into those aspects which may have helped trainees change or made changing to a competence-based approach more problematic.

Pearce et al (2013) conducted an evaluation of the first phase of the roll-out of CfD. Thirty participants, mainly employed within an IAPT service completed a CfD training questionnaire about their expectations of training, experience of the training, impact on practice, the workplace component and programme supervision. Six participants were selected for a follow-up telephone interview, which provided an opportunity for participants to expand on their questionnaire responses. Trainees were positive about the competence framework, in that they felt it accurately reflected the person-centred and emotion-focused therapy. They also felt the competence-framework was compatible with their way of working. However, although participants were positive about the competence framework, and 60% reported that their practice had changed, it seems that 40% reported it had not or did not comment. Perhaps the 40% felt that it was unnecessary to change their practice but this may also be why some participants encountered difficulties in adhering to the competence framework and completing the training in the course timeframe. This difficulty was attributed to the difference between the therapists' professed orientation, as disclosed on the entry to CfD training application form, and the way they routinely work with a client. It would appear that the implications of changing to the competence based approach only became fully clear to the participants when they tried to carry it out with clients. The impression is that participants faced a number of obstacles related to the competence framework, implementing the competences and adhering to the competences as they attempted the change to CfD.

Similar findings emerged from a study by Drewitt et al (2018). This suggests that not much had changed since the Pearce et al study. Drewitt et al conducted a mixed methods study into learning and implementing CfD in routine practice settings with 18 participants. Sixteen participants reported that CfD training had had an impact on their practice and two indicated it did not change their practice. A majority of participants (n = 13) found the CfD model compatible with their way of working with clients, while some found it had had a positive effect on their sense of self and skill set. Despite this half of the participants found changing to a new form of integrative practice was a challenge, particularly those who had "completed training in modalities additional to the person-centred approach (Drewitt et al, 2018, p. 11). This suggests that trainees with an existing eclectic / integrative approach may find it particularly difficult changing to another integrative therapy, such as CfD, if it conflicts

with their existing practice. This difficulty was attributed to the wide range of skills and approaches deemed suitable for entry to a CfD programme and therapists not currently practising in PCT. Further challenges emerged which may impede or mean that change becomes almost impossible. One challenge concerns what this study refers to as the unrealistic expectations of qualifying in the specified timeframe of three months. Drewitt et al found that participants are taking an average of nine months to complete the CfD course. It seems that some trainees require more than three months to make the change to CfD practice, which then presents them with the issue of how to access to additional assessment opportunities in the workplace. It may be that in these circumstances some trainees will decide not to continue with the task of changing to CfD. Especially as they found it difficult to Implement CfD in the IAPT setting because of service constraints and CfD practitioners regularly faced "with a lack of support" (Drewitt et al, 2018, p. 11). The lack of workplace support suggests that the training programme may need to incorporate support additional to that, such as supervision, to help them overcome issues.

Research by Liness et al. (2019) suggests that such challenges can be overcome and the change to competence based practice attained with the aid of additional support. Liness et al. evaluated a one year IAPT / CBT competence-based training course during which trainees (n=252) with different experience and qualifications were changing how they would normally work to the CBT competence-based approach when working with depressed patients. The 252 compromised of 168 mainly clinical and counselling psychologists plus 69 psychological wellbeing practitioners (PWPs) and 15 non-accredited counsellors / psychotherapists. Trainees attended the course for two days per week, with three days spent in the workplace. Participants submitted audio recordings for assessment of competence. This study indicates that trainees who normally work with a specific modality can successfully attain CBT competence within the set timeframe provided trainees have ready access to in-course additional support in overcoming any obstacles to change. It seems that whatever the educational attainment of trainees they all needed some additional support. The additional support comprised of different amounts of intensive training. If a trainee was experiencing difficulties in making the change to CBT practice and attaining the benchmark assessment requirement they could access support which focused on those areas where help was required. The study

suggests that identifying trainee needs early in training may help trainees achieve competence by tailoring supervision and additional support to those who need it. Although CfD therapists / trainees have access to one hour of supervision support per fortnight over the twelve week CfD training programme there is no planned additional learning and practice support for those who may struggle with the change to a competence-based approach to therapy and / or the assessment of competence method. This lack of additional support, particularly once therapists / trainees are in the workplace, may hinder their ability to make the change from their existing practice to the competence-based model.

The research suggests that therapists will face a number of challenges as they endeavour to change their existing practice to the CfD competence-based approach. However, the Liness et al (2019) research suggests that the provision of additional support is one way of helping trainees with different levels of experience and qualifications, as may arise with CfD trainees, change to a new form of practice and attain competence.

3.6 Assessing adherence and competence

CfD training introduces therapists to a new method of assessing their practice. Assessment of therapist competence focuses on practice with real clients. However, Sanders and Hill (2014) argue that adherence to a therapy manual is not common practice in routine practice settings. This suggests that learning to adhere to and skilfully utilize the CfD competences for the purpose of assessment may be a significant issue for experienced therapists who are more familiar with working autonomously and in a client centred way.

CfD is based on categories of competences derived from empirical evidence, albeit limited, of their effectiveness in the treatment of depression. The goal is that the empirically derived competences and interventions should be implemented whenever a CfD therapist is treating a client with depression. Achieving this goal requires therapists to demonstrate within 4 / 6 performance assessments with real clients that they have reached a benchmark standard for adherence / competence. A performance is audio recorded and assessed for adherence / competence using the

PCEPS instrument. Findings from two CfD studies confirm that participants struggled to adhere to the competence framework, despite positive comments related to CfD training and use of the adherence scale (Pearce et al, 2013; Drewitt et al, 2018). The CfD assessment method, using a single standardized instrument, may have the potential to reassure trainers and RCT researchers that therapists are implementing the CfD model to the prescribed standard, and therefore that outcomes could be attributed to the therapy, but the above evidence, albeit limited, suggests that adhering to a particular therapeutic model is a problem for therapists and an area for further research. Additionally, there is evidence which suggests that the CfD method of assessing competence may produce a less than comprehensive picture of therapist competence (Keen and Freeston, 2008; Muse and McManus, 2013).

An investigation into how reliably a well-established CBT course assessed the standard CBT competences found substantial difficulties arose during assessment of knowledge and skills because therapist performance differed considerably across situations and problems (Keen and Freeston, 2008). This university course consisted of a 5 day training followed by 35 days of training on a day release basis over 10 months. Assessment of trainees (n=52) included two 60 minute video recordings of work with real clients, three essays (4000-8000 words) and two case studies (4000 words). The three assessment methods addressed the practical aspect of work with clients, reporting and reflecting on the course of therapy and therapists views on the link between theory and practice. Assessors used the Revised Cognitive Therapy Scale (CTS-R), which consists of 12 items, to assess a therapist's client work and two examiners marked the case studies and essays. Trainees had to score 50% on all assessments to complete their training successfully. Substantial difficulties emerged in the assessment of knowledge and skills considered to be important in cognitive behavioural therapy. Essays were better than case studies in the assessment of therapist knowledge but skills assessment proved to be problematic. This issue arose because some participants scored low on video 1 and high on video 2, while the reverse happened for other trainees. It seems that therapist ability to demonstrate the competences was dependent on the course of events within a session. The authors calculated that in order to improve the assessment reliability for each competence, assessors would need to evaluate 19 videotapes. This has

implications for CfD assessment in that therapists only have four opportunities, and with different clients, to demonstrate the PCEPS items / CfD competences.

A further complication, Roth and Fonagy (2006) argue, is that it is harder to assess competence than adherence because it usually rests on judgements about what constitutes a skilled performance. Such a complication may arise during CfD assessment. Within the CfD training curriculum adherence and competence are presented as separate entities. Therapists are expected to adhere to the competence framework while therapist competence concerns the way in which the competences (knowledge, skills and techniques) are implemented in practice with real clients (which is how Waltz et al (1993) define these two entities).

However, a CfD assessor, using the PCEPS scale, judges therapist adherence and therapist competence concurrently rather than as two distinct entities of a therapist's performance. There is one further consideration. Alongside the Waltz et al separation of these entities, Barber et al (2007) indicate, that adherence is context independent but competence is context dependent, meaning that therapists require knowledge of when, or not, to intervene. It seems reasonable, in the context of training, that therapists may want their acquisition and utilization of the competences to be assessed independently so that they are aware of where improvement is needed. The issue of how best to assess competence has been investigated by Muse and McManus (2013), who conducted a systematic review of 64 peer-reviewed studies from between 1980 - 2012 into methods for assessing competence in CBT. This study was carried out because there was a lack of consensus as to how CBT competence should be assessed. The existing multiple methods of assessing CBT competence had been widely criticised (Barber et al, 2007: Perepletchikova and Kazdin, 2007; Sharpless and Barber, 2009; Webb et al, 2010). Muse and McManus suggest that the numerous different assessment methods emerged due to a lack of consensus about how best to assess CBT competence. The systematic review was carried out to evaluate the strengths and weaknesses of methods of assessing CBT competence in order to make recommendations about the most effective assessment methods and thereby the means of assessing the training of new CBT practitioners and the quality of treatment in routine practice settings.

Muse and McManus identified a wide range of assessment difficulties and issues, for instance: the use of non-standardised tests and scales, the need for trained assessors, role plays that over simplify the therapeutic situation, a lack of a validated competence threshold, ambiguous competence statements and uncertainty over whether adherence and competence should be assessed independently or concurrently. The CfD programme may overcome some of these issues, because trainers undertake two days of training, a competence threshold of 67% is specified for each PCEPS item and adherence / competence is assessed concurrently. Therapists may question why there is a 67% threshold for each item rather than performance criteria, as in the NVQ competence model, but as Barber, Sharpless, Klosterman and McCarthy (2007) found, although adherence and competence are conceptually different not all assessment instruments have been designed to clearly separate them. There may be occasions where adherence and competence can be assessed concurrently but there may also be occasions, for instance when responding to client need, when adherence to a manual without taking context into account could be construed as incompetent (Sharpless and Barber, 2009). The Muse and McManus (2013) study indicates that perhaps more than one method of assessing therapist competence may be needed, particularly if context needs to be taken into account.

Muse and McManus examined ten methods of assessing competence using the Miller (1990) hierarchical framework for assessing therapeutic skill to organise skills assessments into four levels: knowledge (knows), practical understanding (knows how), skills (shows how) and therapeutic practice (does). Different assessment methods were used by the various researchers in the papers reviewed to gather evidence at each level. By the time a therapist reaches level three, skills (shows how), therapist application of knowledge is also taken into account. At the fourth level, the 'does' level, assessment focused on a therapist's ability to use independent judgement and critical thinking to effectively deliver therapeutic interventions within a cultural and organisational context. The authors concluded that a multi-method approach to assessment provides the means by which sufficient evidence can be gathered to address the "domains outlined in the Miller (1990) competence assessment framework in order to provide adequate assessment and feedback on all aspects of therapist competence" (Muse and McManus, 2013, p. 498). This

conclusion suggests that the CfD method of assessment (listening to a therapist perform) may be missing aspects of therapist competence, such as independent judgement and critical thinking when working with different clients.

In addition assessment may be compromised if variables, such as therapists selecting which sessions to submit for assessment and assessors assessing someone they know, are not taken into account (Fairburn and Cooper, 2011). In the case of CfD training the curriculum makes clear that therapists are responsible for selecting which audio recording to submit for assessment, possibly in conjunction with their supervisor, and assessment of therapist performance is undertaken by their trainer / assessor. These curriculum arrangements are perhaps reflective of training in general. However, they may also, perhaps unwittingly, introduce bias and partiality into the assessment process.

Methods of assessing therapist competence need to be capable of assessing the requisite knowledge and skills during therapeutic practice, preferably when working with a real client (Fairburn and Cooper, 2011; Orlinsky, Botermans and Ronnestad, 2001). If this is to be achieved the research indicates that a multi-method approach to assessing competence is needed. This suggests that the CfD assessment method may be less than adequate in terms of producing a comprehensive picture of therapist competence in the implementation of CfD with real clients. For instance, a therapist may want to explain how contextual factors influenced their delivery of CfD, particularly if they fail to achieve the assessment benchmark. However, CfD assessment is performance based. Therapists are required to achieve a benchmark level of performance when implementing each of the items / competences. Such an assessment method means the conditions can be replicated, so the same assessment can be administered to different therapists, and therapist performance evaluated in the same way. However, while treatment integrity, or implementing a model of therapy as specified, is fundamental to empirical testing (Perepletchikova, Treat and Kazdin, 2007; Owen and Hilsenroth, 2014; Sharpless and Barber, 2009; Webb, DeRubeis and Barber, 2010) the Muse and McManus (2013) evidence suggests there are other domains, as well as performance, which need to be assessed when therapist competence is being tested.

3.7 Summary of the issues and challenges

The research has highlighted issues in the following areas: time needed for learning, difficulties in workplace training, conflicts in new learning, issues in competence-based training and adherence / competence issues.

3.7.1 Time needed for learning

If training time is insufficient for trainees to internalize new learning the research suggests experienced therapists may find it difficult to integrate the new learning with their core practice and feel competent in the new approach. This may result in therapists taking longer than anticipated to change to the new mode of practice or therapists being unable to complete the training. The CfD training programme has been designed for experienced therapists. However, internalizing the learning associated with the new CfD therapy and the new competence based approach to therapy within the five day training and prior to the workplace phase of the programme may present a significant challenge. Particularly when additional / trainer support in the workplace for therapists who may be struggling with the theory or competences does not appear to be part of the training curriculum.

3.7.2 Difficulties in workplace training

Work based learning, in combination with training, offers trainees the opportunity to develop the skills, knowledge and understanding, in a real work environment, in readiness for a work role. However, the research indicates that learning in the work environment is dependent on how work is organized and allocated as it is this which determines whether learning can take place 'on-the-job'. As the workplace has become the major component (80%) within CfD training time it is likely that therapists may be learning alone for most of the time in an environment where they are both learner and employee and coping with the demands and constraints of the workplace. While the research indicates that therapists find working with real clients one of the most influential factors in their development there is also research which argues that work with real clients should only commence once a trainee has been trained in a relevant model of therapy. CfD therapists have five days to learn the

theory and practice of a new integrated competence-based therapy before returning to the workplace to deliver CfD with real clients and prepare for assessment. There is the potential for the demands of the workplace to impede learning and put therapists under pressure as they strive to acquire the competences and complete their assessments within the allocated twelve weeks. The coherence of the CfD training programme may rest on how well the training component prepares therapists for the workplace component.

3.7.3 Conflicts in new learning

Learning a new therapy can be disturbing and difficult for experienced therapists if the new learning conflicts with a preferred mode of practice. The difficulty may arise if therapists perceive the new learning to be a challenge to their self-concept and / or professional identity. Integrating existing perceptions, values and beliefs with new learning may result in a mix of competing therapeutic ideas, which generate divided loyalties between existing practices and the new therapy / learning. Therapists in this situation have to be able to tolerate theoretical ambiguity otherwise resistance to the new learning may develop. Making the transition from resistance to adoption of the new learning has been described as the deconstruction of an existing self to allow for the emergence of a new self-identity. If therapists are unable to overcome resistance to the new learning they may not complete the training or need longer to adjust to the new learning. CfD training introduces therapists / trainees to a new therapy, with a number of new features. Each of these features, such as the integration of the person-centred approach with emotion-focused therapy, the mix of person-centred and emotion-focused competences and having to adhere to the CfD model of therapy, may present a challenge to an existing self-concept and / or professional identity. Learners in this situation may require the provision of additional support if they are to overcome such challenges.

3.7.4 Issues in competence-based training

Since 2010 an increasing number of competence frameworks have been developed for the psychotherapies. Some practitioners have argued against such a development. Critics claim that an approach such as person-centred is not amenable

to becoming competence-based because of difficulties in quantifying factors such as empathy, authenticity, and the subtle dyad interactions, while others are worried that this development is taking place without therapists being convinced it is the right thing for them and their clients.

The frameworks deconstruct complex, multi-faceted professional activities into discrete competences. The assumption behind the CfD model of therapy is that experienced therapists will only need to make an adaptation, possibly a technical adaptation, to existing skills and practices. This would seem to be a reasonable assumption but a competence framework consisting of more than 200 discrete person-centred and emotion-focused competences, which inform the CfD training modules, may pose a significant learning issue because of its scale. If therapists find the competence statements ambiguous or uncharacteristic of their approach to counselling they may struggle to implement CfD. The identification of a prescribed set of empirically based competences may ensure that therapy is standardised but traditionally trained therapists may find the notion of adhering to the competences contrary to the person-centred approach and being responsive to the needs of a client.

3.7.5 Adherence / competence issues

The issues concerning adherence and competence revolve around the CfD assessment method. Experienced therapists / trainees may find it difficult to accept that achievement of CfD accreditation is based solely on how well they adhere to and deliver the CfD competences in the context of four sessions with real clients. They may be confused to find that knowledge is not part of PCEPS assessment. The challenge of achieving a prescribed statistical score with regard to adherence / competence may be something unusual and daunting for experienced therapists / trainees. The research suggests that a multi-method approach to assessment provides the best means by which sufficient evidence can be gathered in order to provide adequate assessment and feedback on all aspects of therapist competence. Methods of assessing therapist competence therefore need to be capable of assessing the requisite knowledge and skills during therapeutic practice. This suggests that the CfD assessment method may be less than adequate in terms of

producing a comprehensive picture of therapist competence. Therapists have to achieve a 67% benchmark for each item and they have 4 – 6 audio recorded opportunities with different clients at different stages in therapy to achieve an overall pass. Therapists may find this process and scale rather limited and unable to reflect what happens during an assessed session, particularly as the client and contextual factors may not be taken into account and / or the assessment judgement on whether a therapist has performed an item is based on an assessor's interpretation of an audio recording.

The recent and significant growth in the application of the competence-based approach across a number of counselling and psychotherapy modalities has now encompassed person-centred and emotion-focused therapy. This is in response to political pressure and calls for professional accountability. The change has been so rapid for person-centred and emotion-focused therapy that there has been little time to reflect on and understand what it may mean for practitioners, practice and training. In all likelihood the advance of this approach will continue into many more areas of counselling. Many therapists, experienced and novices, will be encountering the language and process of competence and competence-based training for the first time. This is especially the case for those with an allegiance to the person-centred approach and / or emotion-focused therapy in the context of a new competence-based CfD-PCE therapy. There are gaps in our knowledge and understanding about the effect of the competence-based approach on therapists, their competence, training for competence, including the integration of competences from different modalities, and how therapist competence in this new context is to be assessed. To gain an understanding of these areas I plan to solicit the views of trainees, trainers and supervisors involved with the CfD-PCE competence-based programme.

3.8 The aims of this study are:

1. To explore therapists', trainers' and supervisors' understanding of competence in the context of Counselling for Depression therapy
2. To explore therapists', trainers' and supervisors' perceptions and feelings about training to the CfD competence framework

3. To explore therapists', trainers' and supervisors' perceptions of and feelings about being assessed for adherence and competence

4. To identify the implications of the findings for training, practice and assessment of therapist competence.

In this chapter I discuss my methodological approach and research design under the following sections:

- Epistemological position.
- Design and the sub-sections: sampling and recruitment, participants and the semi-structured interview
- Pilot study
- Topic guide
- Data collection
- Ethical considerations and the sub-sections: anonymity, confidentiality, participants and right to withdraw
- Reflexive statement
- Data analysis

4.1 Epistemological position

The clarification of a theoretical position is essential to the development of the conceptual framework employed by the researcher. Willig (2001) suggests that it is important to be clear about the aim of a study or what it is the researcher wants to know, as this guides subsequent consideration of an epistemological position and accompanying data collection method. Epistemology is concerned with the nature of knowledge and the processes by which it can, or cannot, be acquired (Willig, 2018). McLeod (2003) suggests it is the kind of knowledge that is considered valid, useful or acceptable, as opposed to ideas or beliefs about something. As indicated in chapter two I embarked on this research to explore, from a therapist, trainer and supervisor perspective, the change to a competence-based approach to therapy to see if it has implications for practice, training and assessment of therapist competence. Two key epistemological orientations need to be considered when undertaking research. The first is positivism, which posits that we can know the true nature of the world and we can do this by direct observation or experimentation. This is the only knowledge acceptable to science. Robson (2011) indicates that scientifically based research

employs quantitative data, as it relies on strict rules and regulations, with the aim of developing scientific laws.

An alternative to the scientific approach is based on the interpretive tradition. The epistemological belief behind this tradition is that "the social world is interpreted by those involved in it" (Robson, 2011, p. 24). So there may be as many realities as there are people. Research which uses the interpretive tradition endeavours to understand human behaviour based on the meaning individuals attach to it rather than explain it in terms of the results or truths emerging from scientific experimentation. King and Horrocks (2010) argue that interpretive research is idiographic, meaning that participants provide researchers with a detailed description of their world in terms of setting, relationships, work and interests.

The knowledge I seek is not based on precise measurement, rather I am seeking knowledge from insiders, the participants involved in the phenomenon being studied (Blaikie, 2000). Probable differences in participant histories, cultures and philosophies, including mine, led me to anticipate I would need a research approach which acknowledged that one person's view was as valid as that from another person. The likelihood was that there would be multiple realities. I considered a number of ways of gathering useful knowledge on my research topic, such as postal questionnaire or on-line interview. However, such strategies seemed a little impersonal and I anticipated I would need to ask questions face-to-face with an interviewee, and talk in some depth with participants, about their perceptions as I was seeking rich, nuanced data on the phenomenon under investigation.

Therefore my epistemological position is that different people, because of their individual differences with regard to feelings, principles and understandings, will perceive a phenomenon idiosyncratically. This belief influenced my decision to base my study on qualitative methodologies rather than the quantitative or scientific approach with its focus on hypothesis testing and data measurement, which seemed contrary to my aim of exploring the meaning people attach to the phenomena being studied. A mixed design may have been possible but I had to question whether I as the sole researcher could carry out such a design. I anticipated that my research may evolve as I began to gain experience and an understanding of the phenomenon

from the participant's perspective. Robson suggests that this is a typical feature of qualitative research in that "the design of the research emerges as the research is carried out and is flexible throughout the whole process" (Robson, 2011, p.9).

However, as an inexperienced researcher and having found some of the literature on approaches to qualitative data analysis difficult to understand I began looking for a straightforward set of procedures to guide my analysis, particularly as my questions would also bring some structure to the interview. Although I wanted to remain as open as possible to the perceptions of the participants my questions would inevitably focus their and my attention on the substance of each question. Such a focus, with the flexibility I needed to meet my needs and yet remain open to participant perceptions, I found within the King and Brooks (2017) template approach to thematic analysis and the Braun and Clarke (2006) / Thomas (2006) approach to analysing qualitative data. Thematic analysis offers a flexible approach to analysing qualitative data while retaining concise guidelines around the steps to the identification of themes and sub-themes.

Having read the available CfD literature and reflecting on my prior knowledge of competence based training I realised that both were informing my starting position with regard to data gathering and my early thoughts on data analysis. At the same time I had to remember my aim was to explore with therapists, trainers and supervisors their perceptions of competence and competence-based therapy, in the context of CfD, and the possible implications for practice, training and assessment of therapist competence. While there are practitioners who have argued vehemently against person-centred becoming competence-based (House, 2009) I hoped that my design would enable me to remain open-minded during my interactive approach to knowledge production. Therefore, I prepared research documents I hoped participants would find interesting, and perhaps re-assuring, in that I planned to explain my research position, and include being a part-time research student and a working counsellor. Where interviews were to be held was at the discretion of the participants. This might, I reasoned, help them feel more at ease and in control, so that if they wanted to challenge me, or ask for clarification related to the research or CfD, they would do so.

4.2 Design

To explore the perceptions of those participating in a competence based counselling for depression programme I have employed a qualitative approach. Robson (2011) suggests that a weakness of a fixed quantitative design is its inability to capture the complexities and subtleties of participant's behaviour and views. As the participant perspective was precisely what I was hoping to capture, so my quest to find a research design which would facilitate this task became increasingly important. The role of 'I', as an instrument within the research, and possibly shaping the research, is also missing from within the quantitative approach (Robson, 2011). Therefore, 'I' will be used to locate myself within this research and acknowledge that I had a role in shaping it.

King and Horrocks (2010) point out the qualitative approach is applicable where the researcher's purpose is to capture the complexities and subtleties of participant's behaviour and views on a particular phenomenon. As noted earlier qualitative research encompasses a flexible approach to design and the changes that may occur during the research process. It was likely that my design would need to change as I gained research experience and familiarity with the topic from a participant perspective.

My target recruitment number was twenty participants. I considered that the number of therapists / trainees was likely to be greater than the number of trainers and supervisors, primarily because few organisations offered CfD training. As a result a mix of interview methods was considered, focus groups for therapists and individual interviews for trainers and supervisors. However, the two participating training organisations suggested this may prove difficult to implement. It became apparent that because of the geographical spread of the prospective participants that organising focus groups would be difficult due to interviewee commitments, travel issues and costs. It also became apparent, because of my research topic that it would be possible to use the same questions with all participants. Therefore, I decided to conduct individual, face-to-face interviews, with all participants. While this increased my costs, by negotiating a mutually agreeable interview location and time

with participants, costs could be held down, for instance, by travelling to and from an interview in a day.

Prior to selecting the face-to-face interview consideration was given, due to the geographical spread of participants, to the use of email interviewing. Meho (2006) suggests that email interviews provide a number of benefits and challenges. It is possible to conduct multiple interviews using a standard interview guide, irrespective of interviewee location, and data requires little editing or formatting prior to analysis. Interviewees can take their time in answering, they are in a familiar environment, and this may help with regard to expressing themselves. However, a serious drawback may be fluctuations or delays in responses. Although reminders can be sent out a response cannot be guaranteed. Crucially, the lack of face-to-face contact means that it is not possible to monitor non-verbal behaviour or voice modulations. I eventually rejected this strategy for the reason that face-to-face interviews offered the prospect of immediate access to more nuanced data in an environment where the interviewer and interviewee are better able to interact.

Observing and making notes during the interaction between a participant and a client was not an option because of client privacy and organisational constraints. Video recording of interviews was a possibility. However, the practical issues around use of video equipment in a variety of locations and the possibility I may need access to technical support presented too many problems. A small, easily transportable, digital piece of audio equipment became my most appropriate option. By audio recording an interview I could focus on the participants, rather than being distracted by making a written record. Audio recording also allowed interviews to be spontaneous, free-flowing and yet remain focused on the research questions.

Semi-structured interviews were used to gather data. Robson (2011) and Runswick-Cole (2011) identify three categories of interview: structured, semi-structured and non-structured. Structured interviews are controlled by the interviewer, with a focus on ensuring all interviewees are asked the same questions in the same way. This was not how I anticipated I would conduct my interviews. Robson claims the unstructured approach tends towards informality as the direction and content of the interview is controlled by the interviewee. However, as Runswick-Cole (2011)

argues, no interview is completely unstructured, because the interview topic has usually been chosen, as in this instance, by the researcher in advance. Although I had chosen the research topic and prepared a series of prospective questions I did not want to entirely control the interview or leave the direction of the interview to participants. The semi-structure interview offered an interactive, fluid, conversational and yet focused approach to data generation. Mason (2002) and McLeod (2003) suggest, the semi-structured interview provides researchers with opportunities to explore meanings, the relevance and depth of the data, and, by using supplementary questions, explore participant understanding of their responses. While the interactive element allows interviewees to present their particular perspective, the interactive element also allows for the interviewer to ensure the interview remains topic-centred and focused on relevant issues.

4.2.1 Sampling and recruitment

Recruitment was a difficult process. Two training organisations declined to be involved and trainers in another organisation also declined. I sensed their reluctance to participate was based on political and professional concerns. Counselling for Depression, as a new evidence-based IAPT therapy, was in a sensitive position with regard to demonstrating its effectiveness in the treatment of depression. It was important, for therapists generally but particularly for person-centred therapists, that CfD should become an established and effective therapy alongside other therapies such as CBT. My perception was that organisations and prospective participants had reservations and as a result did not want to be associated with this study. Consequently, my high priority became participant safeguards and rights such as anonymity, confidentiality and consent.

I considered that a purposive sample would be appropriate because, as Robson (2011) suggests, eligible participants were to be drawn from a homogeneous group with a narrow range of experience. King and Horrocks (2010) point out that this strategy is appropriate where participants have to be knowledgeable, through involvement with and experience of the research subject.

When considering sample availability I drew on guidelines from academic literature (McLeod, 2003; Robson, 2011) and my existing knowledge of CfD training organisations, professional networks and the availability of an on-line research surgery provided by a professional body. I planned to recruit twenty participants, a number that was guided by the need, as Mason (2002) suggests, for sufficient data with the right focus to enable me to address my research aim and questions. I hoped that this number of participants was going to be large enough to make a meaningful analysis of their perspectives on the topic, yet not so large that, as Mason cautions, a detailed and nuanced focus becomes impossible. At the time of the research seven organisations across England offered CfD training. The number of participants that could be recruited was therefore limited to the number involved in CfD training within these seven organisations.

Two organisations volunteered to participate in this study. The two organisations nominated a person to liaise with me. Each organisation was sent a copy of the 'Letter of Invitation' (Appendix 4) and, for information only, the 'Research Information Sheet' (Appendix 5). The liaison nominee took responsibility for forwarding the letter of invitation to prospective participants. I was unaware of how many prospective participants received the letter of invitation. The letter of invitation included my email address at the university should a prospective participant want to express an interest in the study. Once a prospective participant made direct contact with me to discuss the study, and depending on whether they wanted to continue, I would then send them via email the research information sheet.

Originally, my aim was to recruit sufficient participants through the two organisations but it soon became apparent that the response rate was going to be lower than my target number. An alternative recruitment route had to be considered. I contacted a professional body and obtained consent to post my letter of invitation on its CfD practice research network site. Prospective participants who responded to my post and expressed an interest were sent the research information sheet.

4.2.2 Participants

All the participants who requested the research information sheet volunteered to participate in this study (Appendix 6). The information sheet provided prospective participants with details of the research, my details, what is required of participants, confidentiality information and participant rights. The participants were geographically widely spread across England, from the north east to the south west. Nineteen participants were interviewed, fifteen females and four males. Nobody withdrew. All are qualified therapists with between 2.5 and 24 years post qualifying experience, three with trainer experience and four with supervisory experience.

All the participants had some experience of working for an IAPT service. Two identified as self-employed, with additional experience as volunteer counsellors. Although there is one essential entry requirement for CfD training the background of the participants was much more varied. Four participants identified as 'pure' therapists (2 person-centred, 1 psychodynamic and 1 gestalt) with the remaining 15 identifying as integrative / eclectic therapists, being a mix of person-centred, systemic, existential, gestalt, CBT, transactional analysis, psychodynamic and solution-focused. All the participants were unknown to me. As the participants are drawn from a small world, in terms of the CfD / IAPT world, and to preserve their anonymity, I decided not to identify participants in the findings as trainees, trainers or supervisors.

As I considered my actual interviews and reflecting on Robson's suggestion that a dummy run or pilot study may assist a researcher become aware of the "inevitable problems of converting your design into reality" (Robson, 2011, p. 405), I decided to carry out a pilot study.

4.2.3 The semi-structured interview

My research questions were open-ended, because my interest was in the participants' accounts and points of view concerning my research topic. The interview questions were driven by my research topic, which Braun and Clarke (2006) refer to as a top-down rather than bottom-up approach. My reading of articles

/ books and research related to competence and competence-based training (Bates, 1998; Cain et al, 2003; Dearden et al, 2004; Grugulis, 2003; Hodkinson and Issitt, 1995; House, 2009; Hyland, 1994; Mulder et al, 2007, Vaspe, 2000; Young, 2011) and my experience of competence-based programmes within further education gave rise to my topic guide. For instance, I was aware of the major revisions that further education vocational training programmes had had to implement as they changed to a competence-based approach and a new method of assessing student competence. The competence-based approach to education and training is much criticised by Hyland (1994), who argues that the approach is mechanistic and cumbersome because of its focus on assessment and the gathering of evidence indicating the competences have been implemented. Hyland also notes that the competence approach lacks a coherent account of the place of knowledge and understanding within competent practice. Similarly, Mulder et al (2007), in a critical analysis of competence-based training across four EU countries, identified issues within the areas of competence and performance, competence and knowledge, competence and the curriculum and learning during training and learning in the workplace. Jessup, a strong proponent of the standards / competence-based approach, argued that the traditional but inefficient past education and training system, needed to be revised in terms of "predetermined statements in the form of competences or attainments, which serve as targets and guide the course of learning" (Jessup, 1991, p. 134). The assumption was that the competences made assessment more transparent and explicit and learning more relevant to the needs of individuals. But Jessup's predicted dramatic overhaul of education and training never really emerged but neither has it not gone away, as we can see with the proliferation of competence-based frameworks amongst the psychotherapies.

4.3 Pilot study

As I was new to research I thought I would benefit from the experience of managing and conducting some form of pilot study. My pilot was not a miniature of the actual study, or about hypothesis testing, or a feasibility study. However, the experience provided an invaluable insight into aspects of research practice prior to initiating my longer study.

It was not going to be possible to recruit local CfD trainees as no local organisation was delivering CfD training. Therefore, I decided to test my questioning technique and interview approach with counselling trainees from a local counselling and training organisation. I approached the management of this organisation, in which I have a role as a counsellor, for permission to interview trainee counsellors. They gave permission after we discussed the purpose of the interview: counselling and competence. A trainer explained to trainees the purpose of my interview and asked for volunteers. Five trainees volunteered to participate. They were all adult trainees, in the final year of training. The impression I had was that the trainees were well disposed towards a run through of my questions and quite willing to provide feedback on the process and questions. As an insider I was pleased not to be involved with the recruitment of the trainees and considered that perhaps the trainees volunteered out of interest in the topic. I did not know any of the volunteers. Time constraints and difficulties in getting the trainees together meant that a group interview became their preferred option.

I prepared five questions, to be used flexibly, depending on interviewees' responses:
1. How did you come to undertake counsellor training?
2. What's the journey been like in becoming a competent counsellor and what did you like / dislike about it?
3. What in your opinion does it mean to be a competent counsellor?
4. Think back to any previous training you might have had and compare it with your counsellor training, what's different about counsellor training?
5. How would you feel if all counsellor training became competence-based?

My questions focused on counsellor competence, my area interest, rather than their training experiences. However, they referred to their training when needing to illustrate what they were talking about. For instance, developing specific skills and feeling competent prior to working with clients. I planned that the interview would last for one hour and the trainees were informed of this time limit. The interview was audio recorded. I kept brief written notes on the interview, trainee responses and feedback. Prior to the interview I was surprised at how nervous I was at the prospect of conducting the interview. It had been some time since I last spoke in front of a group. There was also the possibility of a power imbalance in that I was a qualified counsellor within their place of training. As a consequence, if I was to develop a

rapport with the trainees within the short period of the interview I had to prepare myself for the give and take of what I hoped would be a conversational approach to the interview.

I arrived early in the interview room and arranged the seating in a semi-circle in the hope this shape presented an open, inviting interview approach. After a brief explanation of my study and a discussion on points of interest all five gave their consent to proceed. I explained that I hoped we could hold a conversational type of interview. The conversational approach enabled some interesting views to be discussed but also meant that there were occasions where we wandered away from the point of the question. When this happened I had to find a way, without upsetting an individual or undervaluing what someone was saying, of bringing the conversation back to the point of the question. I found this a helpful rehearsal because, as McLeod argues, "it gives the researcher some practice in controlling the research situation" (McLeod, 2003, p. 34).

The interview hour passed very quickly, and highlighted the need, in this short time period, to remain focused on the area of interest. The trainees were, in the main, unfamiliar with the topic, apart from one trainee who had had experience of a competence-based social care NVQ. However, they were more than able to define competence and provide examples from their practice. My analysis of the data was limited to reading my brief notes and listening to the audio recording. Writing notes during the interview distracted me from the conversation and at times I felt it could be interpreted by the interviewee as not paying attention. I therefore kept it to a minimum. Listening to the recording was often difficult because interviewees sometimes talked over or interrupted one another. Competence was perceived as something which developed over time and probably in stages, such as certificate, diploma, and degree level. Trainee responses indicated that, apart from when they asked me to clarify a question, that they had understood the point of most of the questions. Question five proved to be difficult for the interviewees because the concept of 'competence-based' was unfamiliar to them. This required a rather long explanation from me, taking up precious interview time and something I would need to avoid within the actual interview. The interview included some humour, which helped 'break the ice', and facilitated the conversational approach. This was

particularly noticeable when discussing the formal assessment of competent practice in that, apart from feedback on role play exercises, this was unfamiliar to them.

At the end of the interview the group wanted to know about my background and why I was interested in this subject. I had considered that the trainees might want to ask some personal questions but they were more curious that I had anticipated. Perhaps I should have anticipated this as they are being training to be curious and authentic. As Riach points out participants' ideas of why we, as researchers, research certain subjects is therefore of key importance when considering who we interview, and why they might want to be interviewed" (Riach, 2009, p. 363). Such a consideration prompted my thoughts on how much information I might disclose during my research when responding to participant interest in my thoughts and experience concerning competence-based practice. Although, during the interview I felt my responses satisfactorily answered trainee questions, I still felt the need to reflect on what may happen when carrying out the actual research. However, I also felt, because of the trainee's interest in the topic that it would also be of interest to the wider counselling and psychotherapy community.

The pilot study provided an insight into a form of interview schedule I might use in my research. In the debriefing the trainees provided feedback on both the questions and sequencing of the questions. The feedback suggested that I need to think about the length, number and focus of my questions taking into consideration the data I was hoping to generate in the time available. King and Horrocks (2010) suggest that formulating full questions helps a researcher to think carefully about the research topic and minimizes the possibility of leading the interviewee. However, following my pilot study I decided to remain with short open questions and avoid complexity (as in pilot questions 2 and 4) so that participants could remember the point of the question. Trainees found my supplementary questions helpful, in terms of keeping to the topic, but I had to remember not to lead interviewees in a particular direction.

Mason (2002) suggests that researchers, when considering the methodology, need to avoid being overly optimistic, rather be realistic, particularly with regard to the basics, such as time, cost and personal abilities. Replicating all aspects of my actual study within the pilot was not possible as there were notable differences with regard

to sample size, type of interview and research aim. The pilot interviewees lacked knowledge of CfD, so the concept of competence could only be addressed in the widest sense rather than the idea of discrete competences. However, the pilot experience suggested where I might need to adjust my behaviour and/ or my questions, for instance:

- Listening closely to what interviewees say, noting words which may provide an insight and using supplementary questions appropriately, for instance, to clarify relevant data or return the conversation to the point of a question.
- In light of my pilot I found some questions worked well and so retained them, and made changes to others. For instance I retained an introductory / non-threatening question 1 and a closure question, question 5 in the pilot and question 6 in my topic guide. Questions 2, 3 and 4 of my topic guide had to be changed to reflect my research aims, in particular the areas of CfD competence, CfD practice and the competence framework. The topic of assessment was not addressed in the pilot. Question 5 in my topic guide has been inserted to address the CfD method of assessing therapist competence.

4.4 My topic guide was revised to comprise the following 6 questions

1. Please could you say a little about your counselling background and then how you came to be involved in a CfD training programme?
2. If someone is described as CfD competent, what in your understanding does this mean?
   Linked to **AIM 1**.
3. What do you like / dislike about the CfD competence-framework?
   Linked to **AIM 2.**
4. What is it like putting CfD / PCE into practice?
   Linked to **AIM(s) 2 and 3.**
5. What are your thoughts on the CfD assessment method?
   Linked to **AIM 3**

6. If you could talk to counselling's professional bodies about the future for the competence-based approach in relation to counselling what would you say or ask them?
Linked to **AIM 4**

Alongside each question I prepared a list of points in anticipation that I might have to ask some supplementary questions for a more conversational style, in-depth, explorative interview, which would allow the emergence of the rich data I sought. Seidman (1998) suggests that there are three phases in the conduct of in-depth interviewing. I have drawn on the notion of phases. In the first phase I asked participants to provide information on their background as a means of putting their experiences in context. In the second phase the emphasis becomes participant perceptions and the meanings they attach to the research topic areas. Words such as 'how' and 'what' have been used in the questions, rather than 'why', with the intention of gaining as much information as possible. Finally, participants have the opportunity to reflect on the points they have raised and those they might want to raise with professional bodies.

My plan was to use the topic guide flexibly. Rather than taking a prescriptive approach to interviewing, if an interviewee, while responding to one question also incorporated a response to another question, then I had to be ready to adjust to a change in the questioning sequence. The sequence of questions moves, as Robson (2011) suggests, from an introduction to the main body of the interview and finishes with a question which I hoped would diffuse any tension that may have developed during the interview. The interview starts with a 'warm-up' question (Mason, 2002), which gives interviewees the opportunity to talk about their existing competence, qualifications and how they came to be involved in a Counselling for Depression programme. All the participants were asked the same topic guide questions. Question one gave each participant the opportunity to talk about their core approach to counselling, initial training, how they came to CfD training, and their current role. Invariably I needed to ask further questions to clarify points. In response to these follow-up questions, participants provided further information about their core background or role in training / supervising. The form of my questions gave trainers and supervisors the opportunity to spontaneously comment on their experiences of

training / supervising CfD trainees, but they were not directly asked about these. My focus, through the topic guide questions two to five, was on participant perceptions, in the context of CfD, of competence, training for competence and assessment of competence. The final question asks interviewees to consider what, given the opportunity, they would like to say to or ask of the professional bodies about the future of competence-based practice and training. One or more of my research aims has been linked to the relevant question.

4.5 Data collection

Participants were interviewed in a quiet location, such as an office or teaching room. The interview was our first face-to-face meeting and to help develop a rapport, I endeavoured to use accessible, professionally familiar language, particularly in relation to the CfD programme. However, Holloway and Jefferson (2000) caution that there are no guarantees that different people will share the same meanings. I disclosed to interviewees I had not undertaken CfD training but was familiar with the CfD curriculum and textbook. So, although I had shared with participants that I was a counsellor I also felt my lack of CfD training had to be made known if a trustworthy relationship was to be maintained and questions of meaning explored.

Prior to the interview I thanked participants for their interest, answered any questions and checked that they wanted to continue with the interview. The consent form was reviewed with participants and then signed. Although my research information sheet indicated that interviews were to be audio recorded I was concerned that some participants may be intimidated by the thought of being recorded. Therefore, audio recording was discussed prior to the interview to allay any concerns, particularly in areas such as who would have access to the recording, why, and that I was responsible for the long term security of the data. Following the interview participants were thanked again for their participation and signposted to sources of support if it was needed. Interviews lasted between 1 and 1.5 hours. It took a year to complete the interviews. The interviews were subsequently transcribed verbatim by a transcriber. My information sheet informed participants that a transcriber would be producing the transcripts. I discussed this arrangement with the participants prior to the interview and signing the consent form.

Organisations invariably gave consent for interviews to be held on site. If this was not possible, due to interviewee commitments, a different location and time was arranged with the interviewee. This enabled me to check that the physical environment was appropriate for the interview, because as King and Horrocks (2010) indicate, an environment which lacks privacy, comfort and quiet, can have a detrimental impact on the progress of the interview. I had, as King and Horrocks recommend, rehearsed using the audio recorder to ensure familiarity with the equipment and where to locate it so that the microphone clearly picked up both voices. Prior to the interview participants were requested to speak clearly, not to rush statements and advised that I may ask supplementary questions for additional information or clarification on certain points.

After an interview I updated my records to indicate it had been completed. As soon as possible I listened to a recording to check it was satisfactory. Recordings were kept in a lockable cabinet until I delivered it to the transcriber. The transcriber contacted me as soon as a transcript was ready for collection.

4.6 Ethical considerations

The research was given ethical approval by the Research Ethics Panel of the University of Huddersfield (Appendix 7). A risk analysis was carried out and recorded on the risk analysis and management form of the university. The legal obligations derived from the Data Protection Act (1988 / 2018), the General Data Protection Regulation (2018) and the ethical framework of my professional body informed my ethical considerations. An interview is a moral enterprise (Kvale and Brinkman, 2009) because the intention is to place in the public arena that which emerges from delving into participant's work / life experiences. My focus was therefore to protect from harm those willing to participate in my research.

4.6.1 Anonymity

My research information sheet informed prospective participants that their anonymity and privacy would be respected. This was confirmed prior to starting an interview.

Where necessary, within transcripts, material which might identify a participant has been removed and each participant has been assigned a pseudonym. Participants were assured that identifying material would be removed from data that was to be published and / or might be used in a presentation. Protecting participants from possible identification was a particular concern given the relatively low number of prospective recruits across the seven CfD training organisations. Each participant consented to the use of quotes within my data analysis but their privacy / identity was protected through the use of a pseudonym.

4.6.2 Confidentiality

Confidentiality concerns the means by which the researcher protects the information provided by the participants (McLeod, 2003). As indicated above material in the transcripts that might identify participants, such as locations and names, was either removed and / or altered. The Data Protection Act (1988 / 2018) requires that appropriate and practicable methods must be implemented to protect privacy, and this applies to both electronic and manual data. Accordingly, a password protected electronic file of participant's names and contact details was established and kept separately from their numbered individual files. Individual files are kept in a lockable cabinet. I kept a list of names should a participant want to view their file or withdraw their data. Participants were informed that I will securely store data for a period of five years.

4.6.3 Participant consent

McLeod (2003) indicates that the competence of an individual to give informed consent refers to that person's capacity when s/he has to make a rational decision on the matter in question. To aid this process the research information sheet provided participants with details on the research topic and confidentiality. Prior to commencing an interview I checked that participants understood what my research involved, their role and how I intended to protect the interview data. Subsequently, participants were asked to sign an eight point consent form (Appendix 8). Prior to signing the consent form the eight points were discussed.

The giving of consent did not imply, as Robson (2011) points out, that a participant is consenting to their privacy being infringed. Participants were informed that interviews were to be recorded, transcribed by a transcriber and anonymised during transcription. The transcriber signed a confidentiality agreement and deleted the file of transcriptions once the file had been forwarded to the researcher.

4.6.4 Right to withdraw

Participants were informed that they could withdraw at any time before or during the interview without giving a reason for the decision and without any consequences. Participation in the research was voluntary and not a requirement of the CfD training. Participants could request withdrawal of data provided the request came within two months of the interview. No participant made such a request. A list of support contacts was prepared should anyone experience distress as a result of participating in the research.

4.7 Reflexive statement

Within qualitative research it is becoming increasingly important for a researcher to reflexively appraise their personal involvement in the research and connection with the participants. King and Horrocks suggest that reflexivity invites the researcher to "look 'inwards' and 'outwards', exploring the intersecting relationships between knowledge, our experience, research roles and the world around us" (King and Horrocks, 2010, p. 125). My experience with competence-based NVQs in the further education sector and the publication of four competence-based frameworks for the psychotherapies by Skills for Health (2010) provided the initial stimulus for this study. My NVQ experience and a review of the NVQ / academic literature (Bates, 1998; Cain et al, 2003; Dearden et al, 2004; Grugulis, 2003; Hodkinson and Issitt, 1995; House, 2009; Hyland, 1994; Mulder et al, 2007; Vaspe, 2000; Young, 2011) led me to my research topic and areas of interest. During my early considerations of the research my willingness to critique and take responsibility for my decisions became an exploration of intersecting relationships. Horsburgh (2002) suggests that the researcher can demonstrate reflexivity by use of the 'first person' when describing aspects of the research where there was personal involvement. The use of the first

person, the 'I', has been used to give voice to my ownership of the decision to use a qualitative approach within my research.

It was not my intention to distance myself from the participants. However, as an 'insider' researcher, with a background similar to the interviewees, the issue of maintaining a research boundary came to the fore early in my deliberations, for instance, when considering how to avoid bias in the recruitment of participants. The placement of a liaison person between me and the prospective participants helped to remove me from recruitment of participants. I viewed myself and the participants as having an active and interactive role in the research, with all that this implies in terms of the possible impact of emotions and theoretical and political allegiances on this endeavour. Bot argues that "central to maintaining reflexivity is the need for researchers to constantly locate and relocate themselves within their work, and to remain in dialogue with research practice, participants and methodologies" (Bott, 2010, p. 160).

 I anticipated that constantly locating and relocating myself would be a real challenge given my 'insider / researcher outsider' status and role ambiguity. Jenkins (2000) identifies an insider as an 'in-group' member, with access to the past and recent history of the group / profession. Certainly I shared a number of commonalities with my research group, such as language, educational and training experiences, and professional work roles and responsibilities. I considered such commonalities could be to my advantage. For instance, when making contact with training organisations or endeavouring to develop a rapport with participants. However, DeLyser (2001) and Hewitt-Taylor (2002) caution that such familiarity can also be a disadvantage. I may feel comfortable being with other therapists but the familiarity and feeling close to participants may challenge my ability to separate my therapist and researcher roles. I wanted to establish a trusting relationship with participants but at the same time maintain what Lykkeslet and Gjengdal (2007) refer to as the analytical or intellectual distance required of an outsider researcher.

I considered the insider / outsider dichotomy would be an ever present challenge. Robson (2011) suggests that there is always a need to anticipate where conflict may arise, such as during challenges or asking probing questions. So when it came to

writing my research questions, not only was the content important, but also the way it was presented, such that participants would be willing to talk freely on the topic and perhaps reflect on it in a way they had not previously. The essential ethical factor was not to harm or cause distress to the participants.

When planning this research I decided to make reflexivity an integral aspect of the research process. The insider / outsider dichotomy, together with the accompanying ethical issues, emerged as soon as I entered into the process. My preference for person-centred therapy and dislike of competence-based NVQs could not be ignored as I reflected on how these factors may influence my research aims, questions and the recruitment process. As a novice researcher I was aware of the importance of clarifying researcher motivations when using qualitative methodologies. I found I could quite easily relate to the insider position because the research involved the field of counselling and other therapists. The outsider position was less clear, as I had a degree of familiarity with training for competence and a partial understanding of CfD. However, Breen's comment "the role of the researcher is better conceptualised on a continuum, rather than as an either / or dichotomy" (Breen, 2007, p.163) provided some consolation. This suggestion resonated with how I felt at the time of planning the research and reflecting on the insider / outsider dichotomy. I hoped that it allowed me to maximize the advantages of being an insider and outsider researcher while minimizing the disadvantages.

 I sensed, as a person-centred therapist with certain values and beliefs, that this was informing my decision to take a qualitative approach to my research. I take the view that the individual is the expert on their world (ontology) but given the right conditions (in counselling this would involve factors such as congruence and acceptance) I invite a client to explore the thoughts, feelings and meanings they attach to their experiences of the world (epistemology). However, while I might be comfortable, to a degree, with the qualitative approach, in terms of listening and questioning a participant, I have to remember the aim is not to counsel participants but to subsequently analyse and interpret the data they provide.

4.8 Data analysis

The transcripts contain, as far as possible, pauses and some aspects of non-verbal communication, such as laughs and sighs, but not voice intonation or pitch. I was aware that when a transcript is produced the transcriber has the opportunity to start the process of becoming familiar with the data. As I had used a transcriber I therefore had to wait until transcripts became available to start this process but I hope that in my reading and rereading of transcripts this difference has been overcome. Transcripts contain numbered lines with a left and right margin for comments.

Template Analysis (King and Horrocks, 2010; King and Brooks, 2017) was used to thematically analyse the transcripts. The analysis involves two processes, defining themes and organising themes into some form of structure (King and Brooks, 2017). The focus is on a coding structure, the template, which may be based on a sub-set of the data, which is then applied to further data and revised until it has captured the themes / patterns within the data which present as full a picture as possible of the research topic. This allowed me to develop particular themes more extensively with regard to the richest and most relevant aspects of the data. A theme captures something important about the research topic. Braun and Clarke (2006) argue that a researcher needs to retain some flexibility when considering whether it is the prevalence and / or the importance of something in the data which makes it a theme in relation to research topic. Retaining such flexibility places a researcher in a position of responsibility for decisions during the analysis because of their active role in the identification of themes and selection as to which are of particular relevance.

I adopted a six step iterative approach to my analysis that involved the identification of themes or patterns within the data and point to something interesting about my research aims. As soon as was possible I started reading transcripts to become familiar with the data (Step 1). Although Template Analysis allows for the use of a-priori codes, I did not use a-priori codes as I wanted to take an inductive approach to the data analysis. When I felt sufficiently familiar with the data I commenced the initial coding process (Step 2). I began by highlighting portions / 'chunks' of text within the first four transcripts, my sub-sample of the data, and inserting comments

within the margin. The sub-set consisted of two male and two female interviewees with different training backgrounds. I did not code all the text, my focus being on coding text that was relevant or captured something thought provoking in relation to my research aims. As I began to review and number my notes in the margin I started to group them together into clusters that seemed to work or make sense of the data. However, these clusters were just ideas at this stage.

My preliminary coding gave rise to a possible hierarchy of themes. However, King and Brooks suggest that "it is important not to rush to tidy up the clusters" (King and Brooks, 2017, p. 9) as it may be necessary to explore different ways of clustering themes and establishing hierarchical relationships between themes, where sub or narrower themes nest within a broader theme. This process reduced a significant amount of text into small' chunks of manageable meaning, which eventually became my initial template (step 3):

1. Reasons for undertaking CfD training
    1.1 support / encouragement
        1.1.1   employer / employment
        1.1.2   IAPT
        1.1.3   funding
    1.2 Additionality
        1.2.1   CfD competences
        1.2.2   experiential competences

2. Competence, CfD competences and the competence-framework
    2.1 the competence model
    2.2 the competence framework
    2.3 knowledge and competent CfD practice
    2.4 PCEPS and the relationship with the competence framework and recognizing competent practice

3. What now for competence and counselling
    3.1 counselling and the competence model
    3.2 competence for conditions v. competences for different approaches

My initial template was used to code my subsequent transcripts as they became available. As I read these transcripts I identified text that addressed my research

questions and assigned a code from my initial template. If the identified text did not fit with an existing code I would reconsider my codes and amend if necessary. King and Horrocks (2010) suggest that within template analysis there is no fixed number of hierarchical coding levels, the coding priority is to capture and organise the meanings identified. I found that rather than restating what participants were saying that in the clustering process I began to take a more interpretive approach to the data. A new iteration of the template emerged with the analysis of each successive interview. As the iteration process progressed codes were modified and / or new ones generated, particularly if my codes, based on the increasing data, failed to encapsulate the range of participant perceptions and feelings (Step 4).

Frequently, it was possible to interpret the data in such a way that it could be associated with more than one theme or sub-theme. For instance, interviewees reported that CfD could be used with psychological conditions other than depression. I interpreted this is a serious claim or 'meaning' as it seemed contrary to the Counselling for Depression title. It had the feeling of being a top level or broad theme because it was very pervasive in the data. However, it could also be a sub-theme representing a distinct manifestation of a broad theme, for instance as a critical comment on the credibility of the CfD evidence-based competences in relation to depression. Eventually, I interpreted it as a sub-theme of my broad theme 'tensions in the CfD model', where there was a possibility of relating it with other sub-themes, such as the relationship between the PCT and EFT competences in the treatment of depression. However, it was an iterative process, in that early transcripts were revisited as I acquired and analysed subsequent transcripts (Step 4). I continued to read the data associated with each theme, asking myself if the data supported it. Where themes overlapped I had to take an active role when deciding which to identify as a broad theme or sub-theme. For instance, there was so much overlap in the coding related to assessment practice and knowledge testing that I decided to put both sub-themes under the top level theme of 'tensions within the CfD model'. My final template is based on multiple revisions, reflecting my re-interpretations of the data (step 5). When I reviewed my final template I considered the themes / sub-themes in the context of the entire data set. The final template conveys the essence of each theme and the hierarchical relationship between the themes, which I was then able to take forward into my 'write-up' (Step 6).

1. **CfD: A threat or an opportunity**

     1.1 Having no choice: jobs under threat

     1.2 Accountability and good practice

     1.3 Auditability and good practice

2. **Tensions in the CfD model**

     2.1 Tensions between PCT and EFT

     2.2 I can't be fully me

     2.3 Is 'Counselling for Depression' just 'counselling'?

3. **Tensions in CfD training**

     3.1 training is the wrong way round

     3.2 Limitations of the assessment method

          3.2.1   inadequate measures

          3.2.2   absence of therapist voice

     3.3 The CfD competence framework and competence as understood by

          participants

(See Appendix 9 for the final template themes / sub-themes and example quotes).

Chapter 5 – Findings 1

CfD: A threat or an opportunity

The NICE (2009) guideline for depression recommended cognitive behaviour therapy (CBT) as a frontline therapy for depression within IAPT provision. Other therapies were only to be used if an IAPT client failed to respond to CBT. This established the CBT model, a model based on evidence derived competences, as the standard for good practice with the message that therapists need to hold such a NICE recognized award to continue to be employed or become employed in the primary care sector. No such award existed for person-centred / humanist therapists. Without a training and award, comparable to the CBT model, the jobs of experienced person-centred / humanist therapists in the NHS / IAPT psychological services were at risk. As a consequence person-centred therapists working in an IAPT service, or hoping to do so, needed access to such an award as soon as possible to secure jobs and ensure the person-centred approach remained on the menu of IAPT therapies and thereby available to clients. This chapter explores participants' reported need for Counselling for Depression and the ensuing issues. Participants felt that CfD was needed to protect their jobs and potentially provide a way of ensuring accountability to others and the means of auditing practice. Although participants were broadly in favour of accountability and auditing in some form, they showed concerns about using the competence framework for these purposes.

5.1 Having no choice: jobs under threat

Participants concede that a situation had arisen where counsellors with an allegiance to the person-centred and humanist approach found their IAPT / NHS jobs at risk. They describe the situation as desperate and insecure, where the "powers that be", the decision makers, had decided that participants, although qualified and experienced NHS counsellors, needed to retrain to prove they held an award in an approach approved for use in the treatment of depressed clients. Participants fear that without an award, such as CfD, it would be unlikely they could retain or apply for employment within an IAPT service. Dorothy claims that "we weren't in a position

that was secure" and Caroline, Ann and Joan confirm that they would no longer be able to work in the NHS without CfD:

> I changed jobs and then I, to have that job I had to do the CfD training, and that's the way it's going I think…so you need an additional training on top of whatever you trained in…I had to do this, the CfD, to have this job. If I don't complete it, I can't stay. (Caroline)

> Working in the NHS it's become very clear that you have to be, in order to continue working short term within the NHS, you need to be IAPT compliant…so I felt that we were being told, whether this is true or not, that unless you did a course within the next couple of years you would no longer be able to work, do short term work in the NHS. So I felt I needed to do something and the CfD was available. (Ann)

> The powers that be decided that all counsellors needed CfD training in order to tick off the box from the commissioners (CCG), erm, and that I guess, is how we were asked to do the CfD training. (Joan)

The seriousness of the situation, with regard to accountability and employment prospects, is quite apparent. The participants' comments convey a sense of powerlessness. It appears that Ann and her fellow participants sensed, rather than their employer making it explicit, that they would have to undertake a stipulated training in order to be IAPT compliant, otherwise job losses would ensue. Joan and her colleagues are in a similar position. The "powers that be", like some monolithic unseen administration authority have decided that CfD is the award Joan and her colleagues need if they hope to continue in IAPT employment. However, in Joan's comment "tick off the box from the commissioners" there appears to be an awareness that IAPT is also under pressure, to ensure participants in its employ are appropriately qualified, so that it can tick a CCG box to ensure the continuation of funding for its counselling services. Participants seem to be in a situation where they

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have little choice but to comply if they need a job. There is a sense of qualified participants under pressure and frustrated by demands to undertake additional training for an award in which they are already qualified. The impression, in Joan's comment, is that CfD is not necessarily a positive choice for the therapists but a convenient means by which the local CCG could hold therapists accountable. No matter how experienced and / or qualified a therapist might be, the message is brutally clear. If therapists want to work in the NHS / IAPT then CfD was the accountability standard. Similarly, Ann conveys a sense of having no option but to retrain despite being qualified and developing therapeutic competence over many years:

> That's what I'm struggling with, that is, this is a huge five, six
> and ten years of competence that you've worked through, but
> it seems like oh, but now we have to start again and jump
> through another list of competences that may or may not be
> connected to what you've already competently passed.   (Ann)

The impression is that Ann is upset and feeling under pressure to prove once again that she is a competent practitioner. Ann appears unsure as to the usefulness of the competences in terms of her actual practice. It is as though Ann is an outsider, an observer, of something that is being imposed on her. In what appears to be quite a dictatorial process any sense of participant autonomy is apparently a low priority. It seems that a quite radical, and perhaps political, change is underway for participants working in an agency, such as IAPT, and for reasons which have yet to be made explicit and / or understood by therapists.

The picture Lucy paints in the quote below suggests that the professional bodies were in a 'catch-up' situation, in responding to the NHS / IAPT, with no option but to develop a competence based person-centred / experiential therapeutic framework if counselling was to survive in the NHS and "the status" of therapists was to be protected:

> I think counselling needed a way to be able to survive within
> the NHS to provide what it was doing for clients anyway and

therefore it had to tick all these boxes and go through this
process [produce CfD] to do it…but I guess it is a way of
framing what **counsellors** do…they've [professional bodies]
got a job to do, which is to preserve the profession and keep
the status and that's just one of the games people play to do
that…everything was just going downhill rapidly and, in terms
of the NHS culture… and more constraints on how everyone
could work with IAPT, erm, and I could see the writing on the
wall.   (Lucy)

It seems that for Lucy the "writing on the wall" foretold of the progressively worsening
working environment for therapists within IAPT. Not only are participants facing a
changing NHS culture and workplace constraints but, in addition, a more ominous
issue was about to descend on person-centred practitioners that had deliberately
been initiated by the CCG, NHS and IAPT. The impression is that this is an issue
designed to bring person-centred / experiential therapy into line with the competence
/ evidence-based model that had been adopted by the other IAPT therapies. Lucy
refers to the task of resolving this issue as "one of the games people play to do that",
so that the CCG and IAPT can "tick all these boxes" as a means of checking that the
task has been completed, and a product, a certain style of evidence / competence
based framework has been produced. However, referring to this as a tick box
exercise can often mean the process becomes more complex than can be evidenced
by the specific things that can be audited, such as the auditable material produced in
support of CfD. In some instances it may be that auditing (ticks / checks) would help
to identify where something could be improved but if the perception becomes that it
is a perfunctory exercise then participants may become cynical about it. Lucy
suggests that "they", in terms of those who devised CfD, voluntarily entered into a
political game, where "they" recognized that the rules and outcome of the game had
been set by the NHS / IAPT. Nevertheless, "they" recognized that if they were to
protect IAPT therapists a new competence based framework derived from evidence
of effectiveness in the treatment of depression had to be produced. Participants were
already doing an IAPT job for which they were qualified and experienced but, as
Lucy points out, there was a need for CfD in order to maintain their "status" or
professional standing in relation to the other IAPT therapists.

There is in Lucy's awareness of the profession taking responsibility for the development of CfD some disquiet with regard to the profession being under pressure to act quickly and in a certain way. Like Lucy, Dorothy expresses awareness of the professions' need to act quickly because therapists were in an insecure position. For this reason, and perhaps with some reservations, Dorothy has decided to support this "Counselling for Depression project". There is a feeling of anxiety about what may emerge from the project because of unresolved professional arguments, which Dorothy refers to as professional "shenanigans", related to "what works and what doesn't".:

> I was just aware that we weren't in a position that was secure…all these arguments going on with BACP about, you know, what works and what doesn't and the importance of RCTs and all this shenanigans. So for me it was a matter of if counselling is actually going to have a future we've got to be in there, so it was a political decision to support this Counselling for Depression project.   (Dorothy)

Dorothy's use of "shenanigans" creates a feeling of professionals acting in a rather dubious way with the aim of pursuing an equally dubious agenda. One aimed at casting doubt on whether it is possible, even when using RCT evidence related to person-centred therapy, to identify what works and what doesn't. In the meantime the other IAPT therapies have moved on and accepted that RCTs present the most logical and convincing method of determining the effectiveness of different approaches. While not ignoring the professional arguments, or shenanigans, Dorothy argues that the profession has "got to be in there", working alongside other stakeholders as decisions are made on the development of CfD and its future in the primary care sector.

It is apparent that participants felt that any delay in responding to the NHS / IAPT stance jeopardised the future of person-centre / experiential counselling. Dorothy appears to be rehearsing the form of debate that probably took place within the political game as the professionals sought to find an answer to the NHS / IAPT issue. Nevertheless, Dorothy pragmatically puts this discussion to one side and offers her support for CfD in recognition of the need for such a therapy. It seems that the

profession and participants had to suppress any negative feelings if CfD was to be developed as a model which eventually would place it on an equal footing with other competence-based therapies within the IAPT menu of therapies:

> But there was a pressure there to say look, person-centred and even humanistic approaches are going to disappear in a mire of medicalisation of the whole of counselling… if we don't do something about it…the CfD approach might be an interesting way to go because it was designed, evidenced, for briefer work than perhaps a classic person-centred might be designed for… there was a kind of, it almost feels like a kind of we'd better do it [develop CfD], even though it rankles because otherwise we'll be lost. A bit like we'd better set up some RCTs because if we don't do that, we're never going to be believed. So yeah, I think it was, it was chasing before we lose sight of the competition.   (Steve)

Steve, like Lucy, senses that the profession was in a 'catch-up' situation, one where the profession was under pressure to find a solution to the "medicalisation" of counselling as precipitated by the evidence-based / competence-based approach of IAPT. Without such a response Steve feels that "we're never going to be believed" or taken seriously, particularly as the competition, in terms of other therapies, had already shown that they could work with the competence-based approach to therapy. Although Steve is concerned that classically trained person-centred therapists may find CfD contentious because of the way it is portrayed within a therapy "designed, evidenced, for briefer work" with depressed clients he nevertheless argues "we'd better do it". It seems that Steve, like other participants, is undertaking a delicate balancing act, understanding the need to act but fearful about the outcome.

On the other hand, participants could see the value of being accountable, and of the potential for the competence framework to constitute a way of achieving this. However, this was not perceived as unproblematic.

5.2 Accountability and good practice

A key ethical question for counselling agencies and therapists concerns the issue of being accountable to someone, for instance, a client, a colleague, a supervisor, the NHS and training inspectors. Accountability requires agencies and the employees to take responsibility for their actions. It requires demonstrating the existence of measures designed to prevent harm to users of their services, which may be in the form of written procedures of all the agency activities. This accountability encompasses an obligation to answer questions on the activities in order that others may understand how the agency plans to address risks. Up until the development of the CfD competence framework person-centred therapists, unlike their CBT colleagues and other IAPT therapists, lacked a manual documenting their activities.

Participants appear relieved that in the CFD competence based therapy they now have a manual they can refer to should a situation arise where an explanation of their actions is required. They all have the same, single point of reference, if they have a need to explain their distinctive, evidence-based, integrative therapy. However, there is concern that the framework may be deficient in its coverage of the person-centred approach, making any explanation difficult and possibly distressing. Barbara, a supervisor, thinks "it's useful to be able to say this [the competence framework] is what we do, err…because of the world we live in we need to be accountable" but on reflection declares that:

> It goes against the grain for me to have it all written down
> like that [the competence framework] because I think it can
> be such a subtle skill, a subtle exercise, a subtle
> engagement between two people…and I don't think
> those things can be written down.   (Barbara)

The suggestion is that it is impossible to spell out, as competences, the subtle, intricate and not immediately obvious interactions that occur between a client and the therapist. This is particularly important when the client's potential to self-determine is at the centre of the person-centred therapeutic process. It seems that participants are torn between delivering the CfD form of person-centred therapy

when they know that something else is possible, something that better reflects the person-centred approach. Dorothy, a trainer, argues that "it's unfortunate that it's a world that wishes to prescribe and sort of somehow minimize the potential which can happen between two people…it's a massive compromise". There is a sense of a world, a political and professional world, imposing on therapists a model of therapy purporting to incorporate the person-centred approach, which, from an accountability perspective, is unable to convey all that a person-centred therapist may regard as essential to good practice.

Should this be the case participants argue it will be difficult to explain sessional events, particularly the more subtle and delicate exchanges that occur between therapist and client. Such a situation may place responsible participants in a difficult position, one where they nevertheless remain liable for their actions. However, as Annette states "I'm guessing it's something to do with standardisation, making sure that everybody is singing from the same hymn-sheet". This suggests that the competence framework will only provide therapists with security provided all participants keep to the framework competences when explaining what they actually do. Nevertheless, the competence framework may not provide the anticipated security. Participants who feel obligated to explain their actions may also be aware that some therapeutic events, as noted earlier, may lie outside the scope of a competence framework which focuses on their behaviour. However, participants seem to be aware that the political and professional world in which therapists counsel has an expectation that therapists will be liable for their actions. The accountability issue is one that presents participants, in particular those with an allegiance to or leaning towards the person-centred approach, with the need for a language in harmony or reconcilable with that of the person-centred approach:

> I do believe in accountability…we're learning a language [the
> language of competences] so that we can talk to people about
> what we do, we can actually communicate that we do x and y
> and these are the reasons why we do it…the bit I struggle with
> …it's that sort of scientific, the more scientific approach, I don't
> believe we shouldn't have any evidence or research, you know,
> we do need to be accountable and professional.   (Carol)

Carol suggests that all participants within the CfD programme were not only learning a new therapy but one that has a language of its own, which enables them to explain to non-CfD therapists exactly what it is they do. However, Carol's commitment to the new therapeutic language appears to wane because of the way it has been incorporated into a "more scientific" approach to therapy. It seems that Carol wants to disassociate herself from the scientific approach and the assumption that good quality evidence mainly comes from randomised controlled trials. Although Carol acknowledges the need for research and evidence as part of being accountable, the impression is that Carol has reservations. Carol appears to be struggling to reconcile the need for evidence-based interventions with awareness that it may be the intangible and unconscious dynamics which may be just as efficacious as the evidence-based interventions in bringing about therapeutic change. It seems that it is difficult to balance the need to be accountable, which Carol feels is part of her professional responsibilities, with the discomfort she feels may arise if she has to use the more scientific CfD model of therapy when explaining her practice.

Nevertheless, participant accountability to an IAPT service depends on acquiring CfD accreditation, otherwise jobs are on the line. Participants may not want to undertake CfD training, for the reason discussed above, but having to train in order to retain a job. For participants working within a service, such as the NHS / IAPT, there is a feeling that accountability not only acts to assure the service provider that they are delivering an ethical service but that there is a personal commitment to delivering the best possible service for clients. However, there is a tension when training is what 'the powers that be' want a therapist to do and not what the therapist believes is best practice and / or the need for accountability is acknowledged but the means by which a participant may be held accountable is perceived as inappropriate in the context of the person-centred approach.

5.3 Auditability and good practice

Participants acknowledge that the world around counselling and psychotherapy is rapidly changing in response to calls from various agencies for greater openness, transparency and accountability. There may have been some transparency and

openness associated with initial counsellor training and the checking of a trainee's ability to counsel but thereafter counselling becomes a private process, almost hidden and unseen, except for what might be discussed during supervision. This is changing as a counsellor's therapeutic activities must be accounted for in an auditable, transparent and measurable way. Participants perceive that the CfD competence-based model of therapy presents the means by which their work with IAPT clients can be transparently scrutinized and measurably audited. It seems that participants expect that they will be answerable for what they do and responsible when things go wrong. However, as Francis indicates, the auditing of sessions will be a new, and therefore an unfamiliar process, because historically it has not been routine practice for sessions of experienced therapists to be audited:

> I have been particularly impressed actually that somebody has
> written these competences in a way that means humanistic
> psychotherapy can be audited, which it traditionally has not
> been able to show itself in the past.   (Francis)

Francis appears pleased that someone understood how to write the CfD competences in a way that they are useful not only for training and assessment but also as a means of auditing practice. However, Francis is also pragmatic about why the competences may be used for audit purposes:

> It's also about getting accepted with the politicians and
> people that make these decisions to employ and finance
> the work that I do.   (Francis)

The impression is that competences may have multiple uses, for instance during training and assessment, but also in terms of auditing and reassuring certain people, particularly IAPT managers, that the people they have employed and pay for their counselling skills are consistently delivering a quality service. As Joan acknowledges "it has to do with focus and quality…a framework for doing this particular kind of therapy as opposed to other versions of therapy…it has to do with securing a level of quality to the therapy we deliver" in the context of working with real clients.

While it appears that participants are resigned to being audited in order to convince others of the quality of the service they offer in the workplace some participants have concerns about subjecting therapists to this sort of pressure. Dorothy argues that the workplace may be an inappropriate auditing environment because of the constraints and demands of the workplace:

> It's a real clash of values between what's being, what the
> evidence has said about the approach and the context
> within which it's being delivered…I think people are put
> under pressure by managers, I think their employment
> environment is critical, you've got people who are paid
> by outcome.   (Dorothy)

Dorothy appears to be talking for all therapists in the sense of knowing about the workplace challenges that confront participants as they strive to deliver CfD therapy with real clients. The suggestion is that therapists, who have been instructed to adhere to a CfD model of therapy based on certain values, may find it difficult to implement this model when faced with the constraints and demands of the workplace. In such a situation the CfD model may be an inappropriate audit instrument, especially as participants may be delivering a quality service but just not what an auditor might expect when checking performance against the CfD competences.

This is perhaps a particular tension for person-centred participants. The CfD competences highlight the abilities and knowledge expected of a person-centred / emotion-focused participant. But for person-centred trainee this appears to disregard what the client may contribute to their recovery. It may be that some person-centred therapists will be able to ignore this tension, if, as Lucy suggests, the competences, rather than clarifying what therapists do and should know is actually "an interpretable feast" and open to different translations and multiple meanings:

> There's lots of varied understanding of what CfD means…so
> having to call it a manual is nonsense, it's an interpretable
> feast really…this is trying to put competence into a reliable

measure, because the competence framework, I mean I do

kind of know about it, even though I think it's fairly irrelevant,

erm,…but it's very vague, you know, how you would measure

any of those items on the competence framework, I've no idea.

(Lucy)

The possibility of multiple interpretations presents a challenge to the notion of the competences as clear statements of what a CfD therapist needs to know and do. In such a situation it may be that to incorporate the competences into an auditing instrument would be inappropriate. However, Lucy's perception of the competences as "fairly irrelevant" contradicts the more positive view of the competence framework expressed by other participants. Participant concerns with CfD assessment are discussed in chapter seven.

As noted earlier Francis suggested that it is only with the emergence of CfD as a competence-based model that the auditing or checking of practice has become possible. This is a significant change, because as Francis points out, the monitoring of therapist practice by audit has not been custom and practice within the profession. It may be argued that supervision provides a way of monitoring participant practice but scrutiny by audit raises the monitoring to another, higher and more transparent level. This may raise ethical issues around confidentiality and privacy but participants are also concerned about what is to be audited, how and the possible variations in the interpretation of the competences / PCEPS items. While there is support for the auditable standards there is anxiety in relation to the audit process. Asha argues "I would recommend to carry on with the standard approach to training" but then worries that "it's always going to be the question of measuring it, isn't it, which comes up everywhere". It seems that there is support for the incorporation of specified standards or benchmarks into therapist training, as a means of ensuring therapists attain a certain level of performance. However, it also seems, based on Asha's comment, that there is concern over how such standards or benchmarks are to be measured. Varied understandings casts doubt on CfD as a standardised approach to counselling work. Participants may view as positive the varied understandings of the competences, in that CfD could be implemented differently by different participants. However, the growing awareness amongst participants that sessional work will have

to be audited as part of monitoring the quality of the service, particularly for those employed within an agency such as IAPT, suggests they remain open to solving any problems around how best to conduct an audit. If, as Lucy argues, CfD is open to different interpretations, the auditable standards may have to be something other than those expressed in CfD if a reliable and consistent audit process is to be established.

Summary

It seems the situation for therapists working in the NHS / IAPT could not have been worse. The perception amongst participants was that a certain amount of 'political game playing' took place, involving various agencies and the profession, in order that the end product of the game satisfied each of the players. Person-centred therapists were not going to be able to retain their IAPT jobs if they could not demonstrate IAPT compliance, which required a therapist to hold accreditation in a NICE approved evidence-based / competence-based award. As no such award existed it was with some rapidity that the profession developed one, much to the relief of participants. However, there is a sense of participants being under pressure and frustrated by, in their view, having no option but to undertake additional training for a job they were already doing and for which they were already qualified. There is an appreciation that the CfD competence framework offers participants, for the purpose of accountability and auditability, the means of explaining and monitoring what they do. However, participants felt that the CfD competence framework, because of its focus on adherence to a particular mode of therapy, may be an inappropriate accountability and auditability instrument for the person-centred approach and practice in the workplace. In the following chapter the focus moves from the need for CfD to tensions in the CfD model.

Chapter Six - Findings 2

Tensions in the CfD model

This chapter explores the tensions in the CfD model, as perceived by participants. The tensions include the challenge CfD presents to a participant's self-concept with regard to the values and beliefs which underpin a participant's way of being with clients, the difficulty of integrating the person-centred approach with emotion-focused therapy and CfD as a therapy designed specifically for depression. Participants feel 'I can't be fully me' when therapy takes a more manualised approach and minimizes those personal attributes which may be so influential in a client's recovery. While CfD proclaims to be a therapy based on the person-centred / experiential approach participants found that in practice they have to compromise, on their previous person-centred counsellor training, qualifications and experience, as they adjust to a more directive approach which mandates the use of special techniques with a goal in mind. The problem appears to be rooted in the style of EFT but CfD training seems to assume that experienced therapists will have no problem in comprehending the theory and practice of CfD. However, problems arose where EFT is new to a participant or contrary to their existing way of being. Although the CfD framework competences were derived from evidence indicating their effectiveness in the treatment of depression participants found that they could also be used to effectively treat a variety of conditions as well as depression. This raises questions related to the evidence base for CfD, whether depression can be diagnosed as a discrete condition and importantly which model of therapy participants are using to treat clients, for instance their own or the CfD model.

6.1 tensions between PCT and EFT

The combination of person-centred and emotion-focused therapies is not one that participants have found easy to accept and / or implement. CfD presents person-centred participants with a challenge, one that appears to have affected some more than others. Some person-centred participants consider the two therapies, PCT and EFT, to be totally incompatible while other therapists, who were intrigued by the emotion-focused aspect CfD, engaged in CfD training with the intention of

developing EFT as a component of their practice. However, participants who are striving to integrate PCT and EFT, and successfully complete the training, are finding it difficult to maintain the person-centred approach alongside EFT when there is an expectation that the participant will take an active lead in a task focused therapeutic relationship. The nature of the participant / client relationship changes from one based on equality to one which emphasises the role of the participant.

Lucy is adamant:

> That's the difficulty with this model for me, it's putting classical client centred therapy together with emotion focused therapy, which is much more directive and much more, has ideas of techniques and what to do to help people deal with their emotions…so that's where it diverts from classical person-centred practice.   (Lucy)

For person-centred participants the more directive or therapist led approach of the emotion-focused competences presents a challenge to the type of relationship they associate with being a person-centred practitioner. Lucy sees putting these two together as a 'difficulty for me'. This suggests Lucy sees the attempt to combine PCT and EFT is something of a 'sticking point' for her. Her use of "much more" twice gives emphasis, signalling the gulf Lucy perceives between these two approaches. Nevertheless, it is a problem participants with a variety of therapeutic backgrounds are confronting as they undertake CfD training, conduct CfD therapy with clients and prepare for assessment.

Bibi suggests that the more structured and disciplined CfD therapy fundamentally changes her person-centred client / therapist relationship. Bibi's argument is that the EFT items within CfD practice require a participant to take a controlling lead in the therapy and positions the client as the respondent rather than as an equal partner in the relationship. This Bibi finds "restrictive", in that the CfD requirement to adhere to the competences means that she has to be conscious or "aware" of this all the time and constrains what she can contribute to her work with a client:

> Person-centred is about letting the client lead the session…this [CfD] is
> you leading the session more, because you're taking, you've got a
> framework, yeah, like CBT, you've got a framework…this is where
> the therapist takes the lead and this is where there's a conflict with
> me. I like the client to take the lead, I love the fact clients are free
> to talk…this is much more structured and disciplined…I find it
> restrictive in a way that you've got to be aware of it…I just feel
> that person-centred works so much better.   (Bibi)

When Bibi says she loves that clients are free to talk, this seems to signal that she places a great deal of value on this aspect of PCT. Like Lucy, she draws contrasts between CfD and PCT in order to demonstrate what she feels are the strengths of PCT that she values so much. Such an offer of freedom contrasts sharply with a therapy she regards as "structured and disciplined" and restrictive. There is a sense of a structure that is pre-planned, that the therapist has a plan of action in mind as they enter the session. But for Bibi whatever the client talks about during a session becomes the focus of the session, which means there can be no plan. It appears that CfD practice changes the client / participant interaction in a way which directs Bibi to take the lead and focus client attention on their emotions by using particular therapeutic methods. Bibi's comment "you've got to be aware of it" conveys not only a sense of the pressure she feels she is under to keep to the required model of practice but also a sense of loss and a certain amount of sadness that she is unable to offer her PCT way of being with a client which she considers works so much better alone. Asha too seems attracted to EFT but despite her initial enthusiasm appears to have found EFT draws her away from her non-directive PCT approach.

Asha wanted to develop the EFT component of her practice but worries that integrating PCT with EFT will have disadvantageous consequences for her person-centred approach to therapy. Her concern illustrates how difficult adjusting to the EFT approach to client work can be when a therapist is also trying to maintain a person-centred approach:

> Because I've always worked in a person-centred way, but maybe
> In terms of, erm, working more with emotion and kind of bringing

It, erm, out more and erm, I suppose that, that was the difference,
I've never had, err, a pre-planned focus of work…for me a
personally challenging bit was how to be doing it without, erm,
without stepping out of, erm, of client, clients', you know, point of
reference, reference framework, erm, how to do it and still in a way
that I am not, erm, I wouldn't say directive, but still very respectful
of where the client is because in terms of my own work, I believe
I am kind of, erm, I would, I call it the oh what's the, erm, what's
the expression, the err, it's the principle non-directivity.   (Asha)

Asha may want to work in a more emotion-focused way but has found that if she
does so her client work takes a more directive rather than non-directive approach,
like Lucy and Bibi. However, there is no outright rejection of this integrated model,
rather a willingness to try and find a halfway position, where she can deliver CfD and
minimize the impact on her person-centred practice. Asha, like Lucy and Bibi, seems
to find the combination of PCT and EFT challenging to accomplish, without losing
what she values, in her case maintaining focus on the client's frame of reference.
She talks of being 'respectful' of the client, which seems to contrast with the
directivity that she sees in EFT – and non-directivity is a principle for her, again
suggesting its high value for her. From Asha's perspective as an experienced
therapist, the uncomfortable feeling she conveys, in terms of struggling with "how to
do" CfD while upholding her principle of 'non-directivity', appears to be one that
remains with her.

This sub-theme is concerned with the tension confronted by participants as they
endeavoured to adapt to the process guiding stance of emotion-focused practice,
which they felt intrigued by, but felt that it does not fit with their PCT orientation.
Participants with a belief in the non-directive stance of the person-centred approach
were disturbed by what they perceive to be the more directive stance of emotion-
focused therapy. However, participants with gestalt, psychodynamic and integrative
backgrounds also experienced a similar difficulty.

6.2 I can't be fully me

Participants found that CfD practice presents a challenge to their way of being with a client during therapy. In this study most participants claim to be person-centred or lean towards the person-centred approach, even when they identify as eclectic or integrative practitioners. There is a feeling that CfD practice makes it difficult for a participant to be themselves during therapy, to be spontaneous, intuitive and sensitive in response to a client. It is a way of being which has developed over time and with experience. At its centre are the values and beliefs they associate with a 'way of being' rather than a way of doing. For participants inclined towards a 'way of being' client change is as result of being listened to, understood and cared for rather than the use of special techniques intended to stimulate emotions.

Bridget's claim that "I don't feel fully me in a session when I'm working with this model" conveys her sense of frustration at not being able to be "fully me",' or way of being with a client, because of the demands of CfD practice. There is Bridget the CfD therapist but this is not the Bridget as she would ideally like to be. It appears that on her first day of training those with a person-centred background were told they would have no problem with CfD, presumably because of its person-centred component, but Bridget argues that when therapy "is pushing for something", in terms of probing for the client's emotions, there is a problem:

> We don't always get emotion [from a client] and if I was pushing for
> emotion I would be being directive because people don't always want
> to give emotion…I think what it is, it's addressing your client's way of
> regulating it, I can see that, but if it's not there in the first place and we're
> pushing for something that's not there, then we're moving into directiveness,
> aren't we…I feel it is a bit manualised because we're actually working to
> something aren't we, you know, I don't feel fully me in a session when
> I'm working with this model…we were told on the first day [of training]
> that if you are very person-centred you won't have a problem with it [CfD]
> because you'll just be doing it anyway, erm, but there are times when I
> just don't feel very person-centred because I'm pushing for these
> competences.   (Bridget)

Bridget gives the example of being with a client who doesn't always want to give emotion, or talk about his / her emotions, for whatever reason. Rather than waiting until the client is psychologically ready to discuss emotions Bridget feels that "there are times when I just don't feel very person-centred because I'm pushing for these competences". Bridget's use of the word "pushing" suggests therapy is driving the client in a certain direction, perhaps in a direction the client does not want to go, and making Bridget behave in a certain way, which Bridget appears to recoil from because it is inimical to how she conceives of herself as a person-centred therapist. Bridget suggests that "pushing" is the participant controlling the therapeutic interventions in a way which focuses the client attention on a particular emotion or behaviour. This is an approach to therapy which is at variance with her person-centred approach and the potential for client self-realization during therapy. It is as though, Bridget claims, the manualised CfD therapy is "actually working to something", a goal to be achieved by following a number of steps. Bridget is obviously concerned that therapy as a process, wherein the inner resources of the client are central to resolving their distress, is changing to a more therapist directed approach with the aim of focusing on the client's emotions. Bridget is obviously concerned that her way of being with a client, with regard to what her 'self' can contribute in the service of the relationship and alleviating distress, is at odds with the CfD manualised model of therapy.

Similarly, Andrea, although apparently relieved that CfD seems to advocate participants take a more pro-activate approach to client work, is concerned that the competences constrain her practice. This, Andrea argues, creates a personal tension, as the model takes her attention away from what may be best for her client:

> One of the things that I found a really big relief when I did the training
> was that it was very pro-active and so that came as a relief and actually
> there are elements of that that have definitely helped my practice…having
> the competences in mind, it takes my attention away, it feels like it takes
> me away from the range of things that I could be referring to in order
> to best work…I suppose that's what the tension is… it kind of feels
> like you, you're not getting it right, when actually doing those kind of

> things is a big part of where I need to be right now in terms of my
>
> own learning and my understanding of how I can best help people.
>
> <div align="right">(Andrea)</div>

It appears that the "big relief" experienced by Andrea arose because CfD takes a pro-active stance towards client work. The impression created by her expression of relief is that Andrea incorporates a pro-active approach, in terms of therapist led approach, in her therapy if she senses it would help the client. It appears that Andrea found elements of CfD helpful, with regard to developing her practice. As she says this is "where I need to be right now", in terms of CfD providing an opportunity for professional development. There is a strong sense that she feels she needs to be allowed to draw on a wider range of practices, including the new elements from CfD, in order for her own development as a therapist and helping her understanding of how clients are best helped. However, unlike Bridget the tension for Andrea appears not to be the pro-active directivity of CfD but the way the competences place limits on what she can offer clients in order to do her best for them. It seems that she feels her autonomous self, in terms of sensing how best to help a client, has to be restrained in CfD therapy because the competences constrain "the range of things that I could be referring to in order to best work". In effect a client is being denied what Andrea would like to offer in terms of responding to the client's need.

Moreover, as Andrea admits, there is a fear that should she respond to a client's needs in a way she perceives as appropriate "It kind of feels like you, you're not getting it [CfD] right". Andrea's comment indicates the feeling that performing CfD correctly requires a trainee / participant to adhere to certain behaviours, even when they believe this might not be helpful at the time. This is probably correct because the CfD assessment method specifies what an assessor will be looking for in terms of trainee behaviour. The use of any non-CfD interventions could not therefore be taken into consideration even if they appeared to help the client. There is a sense in Andrea's statement of some resistance to meeting specific criteria and frustration at being unable, based on her prior learning and experience, to work with her client in a way that she feels will best help her client.

In the following quote Andrea says "I feel I'm being pulled in two directions", which conveys her sense of struggle with the need for CfD accreditation and being the therapist she wants to be. Andrea appears to have doubts about successfully finishing the course when there is a tension around meeting the specific competence criteria for a new model of therapy which cannot accommodate her new learning, prior learning, and practice experience even though it may help the client:

> It feels like I'm struggling with the concept of meeting specific criteria. It feels like it's, the training itself I really found helpful to my practice… but since then I feel like there's obviously kind of resistance in me because I left the course feeling like I was going to crack straight on with recordings and I haven't…and I think, I've been thinking quite a lot about why that is and I think there is a sort of I feel I'm being pulled in two directions and the part of me that wants to finish the course can see the value in having something like CfD, to bring some evidence into what we do and a way of measuring and showing what we do feels really important, but at the same time my practice is growing and that my, the influences on me are widening and the CfD feels like it's trying to narrow it again.   (Andrea)

There is a sense of, although Andrea has given much thought to her resistance to CfD, Andrea's internal debate is almost outside of conscious awareness, something deep down that is stopping Andrea from fully embracing CfD. However, there is a sense of rapid forward momentum as her enthusiasm for the training made her anticipate that she would 'crack on' with her audio recordings. But this did not happen and she reflected on this. She identifies her resistance to 'cracking on' as due to a tension. She seems to value the evidence base CfD promises, but this comes at a personal cost. As in her previous quote, she mourns the loss of her personal development as a therapist. She says her practice is growing, and this sense of professional growth is also expressed as she goes on to say the influences on her are widening. We get a strong sense that she feels this is really a good thing but that the narrowing CfD represents just pulls her in the opposite direction to her direction of travel. So CfD feels like a straight-jacket, something that is stopping her

developing as a therapist and as a person. She feels she cannot be fully herself with a client when adhering to the CfD model of therapy.

Carol set out on her CfD training with the intention of developing the emotional-focused aspect of her work. However, Carol has also found adjusting to CfD practice a less than smooth journey:

> So I've had to sort of really dig deep and sort of been pushed to say come on you need to do this if you're going to complete this, you know, you need to get on with it and it does feel at each stage, is a push…I am finding that it's not a smooth journey…I think those ten [PCEPS] areas are the ones that are more in mind because those are the ones that are being thought about and assessed. They rather daunt me in a way, that there's part of me that can feel quite threatened by this expectation that they are to be achieved or, you know, held on to is some way…so no, there isn't really a huge amount of flexibility, and that's probably part of the struggle that I have…so where adherence causes me problems as a word or as a concept, is being told how to be, either through a model or through an expectation, you know, when for me the whole point of counselling is that everybody is different…so I, I need to have some autonomy, as a practitioner, to offer whatever is, whatever feels required at that moment…but I think it does feel quite rigid, you know, it does feel quite, that the round hole with the square peg has got to fit into, it feels quite tight.   (Carol)

Carol's comments paint a picture of someone in turmoil over what is expected of her when implementing the CfD model of practice. There is a sense that it has been incredibly difficult for Carol to accept aspects of PCT / EFT practice. Her response has been to "dig deep" or make a substantial effort to reconcile her way of working with the CfD model of working with a client. Her comment "I think it (CfD) feels quite rigid" conveys a lack of flexibility in the modality with regard to her ability to respond flexibly to the needs of different clients. This inflexibility makes it extremely difficult for Carol to adjust to CfD, because, as Carol points out, "the whole point of

counselling is that everybody is different", and working with those differences requires a therapist to be as flexibly responsive as possible. Carol describes this difficulty as trying to fit a square peg, the therapist and their practice, into the round hole that is the CfD therapy. It seems that adherence to the PCT and EFT competences, or the ten PCEPS items Carol refers to, change Carol's relationship with her client because, rather than offer "whatever feels required at that moment" she has to consciously keep in the forefront of her mind the ten PCEPS items and rigidly adhere to them if she hopes to achieve assessment success. The implication is that there is little room for Carol to be herself with her clients.

Barbara suggests that therapists may be experiencing the above implementation problems and personal issues if the new learning, learning the new therapy, is perceived as undermining or supplanting their current, familiar and cherished approach to therapy. It is their own peculiar therapy, something they have pride in as they have nourished and refined it and developed a sense of ownership:

> I think that that's a real problem for some people and I think with CfD
> is that, erm, most people are coming from to that training [CfD] after
> years and years of practice and developing their own style and, erm,
> and mostly calling it integrative, because you know, that's
> what it is, you have brought bits in and then to, erm, to be
> asked to modify that or change it, erm, sort of quite, in some
> cases quite dramatically I think, it has been really, really hard
> …they've been judged as failing in their practice and some
> have stopped at this point because they just sort of emotionally
> can't carry on with it…and I've seen quite a lot of anger around it.
>
> (Barbara)

Barbara clearly feels that there is always going to be a problem where training requires fundamental changes to a therapist's own way of being with a client. There is a sense of a deeply rooted and developed way of practising that has been rehearsed and refined, and then to be asked to make "dramatic", fundamental changes to their "own style" is extremely challenging. It must be, as Barbara says,

"really hard" to feel you are being asked to renounce something you have developed based on a great deal of experience and reflected upon over a long period of time. Some therapists, based on Barbara's observation, are so angry when their CfD practice is assessed as incompetent that they are willing to go as far as withdrawing from training. To withdraw appears to reflect a trainees / participant's commitment to certain values and preparedness to take a step which may result in the loss of a job.

Terry is also struggling to understand whether he can be himself within CfD practice:

> I think this is my principal difficulty, is actually, is defining that, am I
> competent as a counsellor and competent as a, err, CfD-er…
> adhering to the competences, does that make me more competent
> as a counsellor…I'm not sure, that's my, it might make me more, does
> it make me less of what I, what I bring as a counsellor…I'm bringing a
> a lot of my own self to counselling, to that particular role…my own
> experience, which is not covered by the competences.   (Terry)

Terry, in one breath defines himself as a competent counsellor but then begins to doubt or question whether adherence to the competences makes him more or less competent or just a competent CfD practitioner. The training appears to have confused Terry. He is concerned that a therapy based on the competences is an underestimation of what he brings to counselling. Terry feels that training in the competences fails to recognize him as a competent therapist. Terry argues that his counselling is based on "a lot of my own self" and it is this aspect of his work which is not covered by the CfD competences. There is a feeling that being a CfD practitioner is something different to being a competent therapist. There is a shared feeling amongst the participants that what they bring to counselling and their client work, in terms of the self, and their beliefs, values and experience, has to be suppressed

Moreover, Francis suggests that even when a participant has willingly tested out various techniques or ways of being within CfD practice it is unlikely the above dilemma will be easily resolved or that the debate within oneself will be less troubling:

I think it is good to adhere to the model, to the competences, but I think there's also good therapy that could be outside that…if you're sticking strictly to the competences then too much relationality is not on model, for example, if I self-disclose, tell the client something about my own experience, or some of my own feelings, something from my own frame of reference, that could be seen as off model, It's not adhering to the competences and I will be marked down. So I've learnt to turn that part of my practice to fit into this model…I'm constantly evaluating, you know, how much relationality and how much person-centred and staying in there for reference, I think it's an interesting and on-going debate that's on-going.   (Francis)

Francis has shown a willingness to reflect on what may happen if he combines some familiar counselling strategies with CfD practice. However, his comment "something from my own frame of reference" suggests that Francis holds a set of beliefs and values on which he judges things are at odds with the model. This seems to imply that his values and beliefs are not consistent with this model, or at least need to be shoe-horned or made to fit with the model. Francis seems aware that if he introduces something from his own experience into CfD practice it may be interpreted by a trainer / assessor or supervisor as going "off model" or nor adhering to the competences and therefore "marked down" during an assessment. The message, not to go "off model" has obviously made a strong impression on Francis. Despite this message there is a sense of Francis 'game playing' here. He seems to be trying to 'get away with' retaining relationality in some form, but in a form that will not be picked up by an assessor as 'off model'. He says he has learnt "to turn that part of practice to fit the [CfD] model", but use of the word "fit" conveys a less than positive feeling for having to change to a form of practice he would rather not. The loss of autonomy he feels, in terms of his inability to choose how to be with a client, is quite apparent. However, Francis seems less personally disturbed by this tension when compared with other participants, as he refers to it as a debate, which feels quite intellectual rather than emotional.

Therapists who enter CfD training are experienced and qualified. In this study participants have between 2.5 and 25 years of therapeutic experience in a diverse

range of therapies. As noted earlier therapists were told that with this experience, particularly the person-centred experience, they would find adjusting to a combination of person-centred and emotion-focused practice relatively straightforward. However, participants found that it is less than straightforward. The feeling is that their autonomy or freedom to act in a way they perceive as person-centred is at variance with that expected when implementing the CfD competence-based integrative model. Participants claim that changing practice they have developed, refined and added to over many years is extremely difficult, and all the more so if the changes contradict practice that is significantly meaningful to them. The moral principle of therapist autonomy, in terms of freedom of choice and freedom of action, appears to lie at the heart of participants' therapeutic practice. It primarily concerns control over their work. In what appears to be quite a dictatorial process any sense of therapist autonomy is apparently a low priority. Some participants perceive that freedom of choice and freedom of action is restricted by the requirements of the CfD model of therapy.

The outcome is that participants are finding that CfD presents a challenge to their sense of self and their cherished values and beliefs. When participants perceive the 'self' to be so important to the therapeutic process the thought that it might not be or that a participant, as Barbara says, cannot be "fully me" in a session, is unthinkable. The struggle to be 'fully me' creates a palpable CfD tension.

6.3 Is 'Counselling for Depression' just 'counselling'?

Participant comments indicate there is a tension between CfD as an evidence-based therapy for depression, which is what it was designed for, and their experience with CfD as a successful treatment with a wide range of conditions. The competences were selected for inclusion in the CfD competence framework because there is evidence indicating that they are effective in the treatment of depression. This suggests that perhaps the competences are not particular to depression and / or the diagnosis of depression covers a range of conditions and / or other factors are influencing the therapeutic outcome. Based on their experience of using CfD with different clients participants argue for a change to the title. Their suggestions, which include a return to the generic title of 'counselling', indicate there is some agreement

on the need for change but also awareness that the challenge is finding a title others would understand and that fits within the NICE depression guideline.

Both Caroline and Francis point to CfD as something of a 'tick box' or political exercise:

> When the economists got involved and said that people are,
> are losing you know, they're staying at home from work, they're
> not working because they're depressed, so then the state, the
> Government rolled out Counselling for Depression because they
> wanted to keep people in work, you know, but of course, you know,
> people come to [counselling] because they have relationship problems,
> or they're being bullied at work, or, and that's not depression, you
> know, but we can call it that[CfD] in order to give the clients
> counselling, so the GPs, they tick the box…I think the idea of
> Counselling for Depression is good but maybe it should just be
> called, you know, counselling for living.   (Caroline)

> I don't like this Counselling for Depression, I think there is
> some political reason why they came up with that but I don't
> like the title because it's not counselling for depression…
> they need to drop the last bit because I think this approach
> probably works with most psychological difficulties, so you
> don't really need that bit on the end…we talked about it quite
> a lot when we did our training, it's the, erm, emotion-focused
> angle of this approach that is particularly powerful. Some
> people were making suggestions that the title should include
> the emotional focus…it [CfD] actually treats more than that
> condition [depression].   (Francis)

Caroline's comment conveys a degree of cynicism with regard to conducting CfD with a client so that someone else can tick a box and place it on record that the client received CfD. However, participant comments indicate they are treating clients with a range of conditions, as well as depression, and in Caroline's comment there is a

sense of wanting this to be recognised. There is a feeling of frustration in having to deliver the therapy, as prescribed during training and assessment, to a particular group of clients because this is what is expected of therapists in a service such as IAPT:

It seems that Caroline and Francis consider that counselling became Counselling for Depression for political reasons. By implication, they seem to be saying that responsibility for what they see as a questionable title arose for reasons counsellors were unable to control. However, Francis seems unsure as to the political motivation behind the title 'Counselling for Depression' while Caroline appears sure it was about keeping or getting depressed people back into work. Francis and Caroline suggest, but for different reasons, that the title should be changed. Francis says that the title was much discussed during training, which indicates that others shared his concern about the title. It seems their shared view was that CfD has a particularly powerful element, the 'emotion-focused angle', which they recommend should be incorporated into the title. But Francis also thinks that 'depression' could be removed from the title because CfD appears to work with most psychological difficulties. Caroline seems to feel that by calling it Counselling for Depression it is much easier for people, such as GPs, to prescribe it for patients, even when the problem may be something other than depression. The impression is that without depression in the title prescribing counselling and client access to counselling becomes a problem. It seems that 'counselling' is too nebulous a term, but, as Caroline points out, CfD provides the means by which therapists can give clients counselling. Despite this problem with the title problem Caroline suggests the CfD title should be changed to one she feels can encompass a range of conditions, including depression.

For qualified participants, with considerable experience of working with clients, this situation becomes a balancing act between adhering to CfD as an evidence-based therapy for depression and knowing, from experience, that they can use it with conditions for which it was not designed. Iris says:

> I completely understand this, that it had to go, if they can get it into
> NICE guidelines, yeah, it can't just hang around saying this is good
> counselling, way of counselling, it's got to hook itself on a medical

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condition, so its hooked itself on depression, but it's also good for

trauma, it's also good for anxiety and it's also good for bereavement

…I have found it [CfD] really useful, particularly, you know, funnily

enough working with people with depression, but with all sorts of

things I've found it useful.   (Iris)

Iris, like Caroline, seems to accept that for political reasons CfD had to be designed with NICE in mind, the motive being the need to gain access to the NICE guideline for depression. The issue for proponents of counselling, as Iris says, is that it isn't enough to simply claim that counselling is effective therapy, it has to be demonstrated. Iris suggests that if counselling was to overcome this problem it was necessary to "hook itself on a medical condition". Iris's use of the "hook itself" phrase suggests that by fair means or foul, and possibly in desperation, that counselling had to attach itself to depression knowing that here was a condition for which they could provide some evidence of the effectiveness of counselling interventions. Iris seems to feel that hanging CfD on depression is almost random, it could just as easily have been 'hooked' on trauma, anxiety or bereavement. Depression was perhaps just a handy 'hook'.

Dorothy regards the introduction of CfD as part of medical 'game playing':

I think it's a shame it got called Counselling for Depression, you know,

I think it would have been better to just be called counselling. I think

for me, the argument I make is, you know, depression is descriptive,

it's not prescriptive, so if somebody can be diagnosed, then that's

prescriptive…they're making it more and more that it [depression]

is an illness…it's coming from a medical view, because they actually

believe these things exist as discrete illnesses, and in the person-centred

approach, don't actually recognize them as illnesses…it's all about

evidence, you know, being able to do randomised control trials, it's all

about statistics and number crunching and treatments, so that's, that's

the game.   (Dorothy)

Dorothy conjures up an evocative image of a group she refers to as 'they' who are making it (depression) into an illness, which she challenges and clearly positions herself against the medical model of depression. She says, rather incredulously, they 'actually believe' depression exists as a discrete illness, as if anyone with experience of treating people with depression would understand that it cannot be helpfully viewed in this way. The 'more and more' in her quote suggests she feels there is an increasing movement towards medicalisation. Her final remark about statistics and number crunching, which she links to evidence, but then rather ironically refers to this as 'the game', in which she regards the number crunching as per the phrase 'there's lies, damn lies and statistics'. The 'game' or use of statistics to bolster weak arguments seems to be the sentiment that Dorothy is communicating here. But, as participants have argued, depression can mean many things, which is perhaps why the CfD link with depression is now being questioned by these participants.

Lucy is also of the opinion that:

> The CfD approach can be applied to anybody with any problem…they
> just have to say it's depression because they had to prove there was
> enough studies for people who had a diagnosis to say this approach
> has helped… and to get it through NICE.   (Lucy)

Lucy makes the bold claim that CfD can be used with anybody with any problem. The claim is made despite Lucy's awareness that CfD was derived from studies on the treatment of depression. However, there is a rather cynical feel to Lucy's comment "they just have to say it's depression because they have to prove there was enough studies for people who had a diagnosis to say this approach helped" Lucy appears to be suggesting that the game professional bodies played to get CfD accepted by NICE produced evidence derived competences, perhaps unwittingly, which can be used with a range of conditions, including depression.

Participants may be calling for a change in the title based on their experience with CfD but it is the issues raised in their quotes which capture the essence of what they feel and dislike about CfD. For instance, the medicalised approach to therapy, linking therapy to a specific condition and therapy as conceived of by various non-

counselling agencies. There is an understanding that something like CfD had to be developed in response to a rapidly changing political context. However, the response became what some participants disparagingly refer to as a 'tick-box' exercise, in that CfD had to address the expectations of bodies such as NICE and IAPT if person-centred and experiential therapy was to survive in primary care. There is a sense that much of what participants appreciate about the person-centred approach is being sacrificed in the rush to embrace a medical approach to client work and the treatment of discrete conditions. Inherent in this medical model is the need for evidence-based interventions, so they can be replicated and tested. But this is contrary to a relational based therapy, such as person-centred, where the process of therapy is considered to be essential to client development rather than any prescriptive form of treatment. While title change may be an issue it would seem that it was, for the participants, only a starting point to or the means by which they could introduce topics that really worried them about the CfD model of therapy.

Summary

Three significant tensions have been identified within the CfD model. Participants feel that they are unable to counsel in a way they describe as 'fully me', or way of being with a client based on cherished values and beliefs, but finding this to be difficult when working with CfD. Participants struggled to integrate the classic person-centred approach with emotion-focused therapy. Person-centred participants found it difficult to maintain a working relationship with the client based on equality and the potential for client self-determination while trying to deliver the EFT expectation that the therapist will take a more active, more direct role, in a task focused therapeutic relationship. To participants, the CfD model is perceived to be at variance with the person-centred concept of client self-determination. Although CfD was designed for the treatment of depression participants found that it was also effective in the treatment of other conditions. The profession had little time to develop a person-centred / emotion-focused competence based therapy which complied with NICE guidelines but in the rush to do so it seems that, in the view of participants, the outcome, the CfD mix of PCT and EFT competences, is a therapy which can be used to effectively treat several conditions. They recognized that for political reasons, and perhaps scientific reasons, it was necessary for CfD therapy to

be associated with a condition such as depression. However, participants worried that this appears to signal acceptance, by the profession and some with a feeling for the person-centred approach, of a more medicalised approach to therapy in terms of making a diagnosis and dispensing a prescribed treatment. While this chapter has focused on participant perceptions of the CfD model the following chapter, chapter seven, considers participant perceptions of CfD training.

Chapter Seven - Findings 3

Tensions in CfD training

Introduction

Participants perceive CfD training to be the 'wrong way round'. They are expected to implement CfD in the workplace with real clients before they have had time to digest and understand the theoretical and practical implications of carrying out this new integrated competence-based therapy in the workplace. The 'wrong way round' training leaves participants lacking sufficient familiarity with the many new features of the new CfD model of integrative therapy before they start to treat real clients with depression. The workplace then becomes a self-directed learning environment, and, although supervision is available they feel disconnected and isolated from the training programme, unless someone in the workplace is familiar with CfD and available to provide support.

Participants disapprove of the CfD method of assessing therapist competence. Their concern is that the CfD method of assessing therapist practice produces a less than comprehensive picture of their competence. They have misgivings about their competence being judged based on just four twenty minute audio excerpts of sessions with different clients, where the assessor is using a scale which appears unable to capture the subtle interactions that occur between two people and where contextual factors are not taken into account.

7.1 training is the wrong way round

Therapists found that the training is not preparing them for what is expected of them. Training is the wrong way round, in that therapists commence practical work with clients in the workplace before they have had sufficient time to become familiar with CfD theory, practice and assessment. Participants felt that this did not prepare them for the workplace, and feeling they must undertake self-directed learning, as a means of developing some understanding of new material, such as the theoretical

underpinnings of CfD, the framework competences and the method of assessing adherence / competence.

Several participants argue that their lack of CfD understanding arose because the CfD training programme is "the other way round", with practice before theory, leaving therapists low in confidence as they try to remedy this situation in the workplace by reading the CfD textbook:

> You do the course and then you start reading about it because that's
> when you have the time and that's when you record and you take it
> to supervision, but really you need to, as we know, you need to do the
> theory before you do the practice. But here it's been the other way
> round, or you have to do the theory and the practice on your own,
> whilst it would be better six months in advance…so you can read up
> on it…but I hardly had any time and neither did the other people on
> the course.   (Caroline)

> I didn't feel and I don't feel looking back that five days could
> give me enough of an immersement in the person-centred
> approach to the point that I felt it was in me…I didn't feel
> confident in [my] knowledge of the [CfD] approach to be
> able to move slightly away from those ten things. I remember
> reading the book that comes, that you read alongside the course,
> and by about the third tape I'd got myself completely tied up in
> knots because I'd read the book again because I started to
> feel like I was not holding it and then you read much, it was a
> much broader understanding of the approach and techniques
> that we hadn't done on the training and I thought oh I'm just
> getting lost here and that I remember the supervisor saying
> just put the book to one side, forget the book, focus on
> what you know, that you can hold on to and do your next two
> assessments…but I didn't feel I knew enough about it.   (Ann)

Caroline suggests that in CfD training, rather than theory before practice, that participants are conducting CfD practical sessions before they have had time to become familiar with the theoretical underpinnings of the approach. Caroline says "you can read up on it…but I hardly had any time and neither did the other people on the course", implying that she was not alone in that experience. Ann got herself "completely tied up in knots" when trying to absorb the theory by reading after the five day taught phase of training, suggesting that this was confusing rather than enlightening for her. She felt she needed to be immersed in the approach, to the extent that it was "in her", implying an intuitive knowledge that is "to hand", but says that she remained under-confident about her knowledge after her training and when attempting to apply it in practice. The workplace feels like a lonely, solitary learning environment, a form of distance learning, because of the lack of support apart from that provided through the fortnightly supervision. For Caroline and Ann CfD training needed to be the other way round so that CfD theory, and its implications for practice, could be sufficiently addressed and rehearsed in advance of workplace practice and assessment of therapist competence. Terry says of the distance learning aspect:

> The experience of, of the distance learning aspect of the, the training, is, erm, I'm finding it a little bit difficult. It's a bit, err. It's a bit solitary, it's a bit erm, it seems a bit disconnected, but you know, I can see that it needs to be done, so I will complete it…within twelve months. (Terry)

Before Terry made the above comment he took a deep sigh, almost as though this was a difficult admission for him to make. His comments with regard to distance learning, feeling a bit solitary and disconnected from any structured learning convey his sense of isolation as he grapples alone with learning about CfD and how to perform it. His latter comments suggest that, in spite of the difficulties, he is trying to remain positive but facing the probability it will take him much longer to achieve CfD accreditation than expected at the start of training.

The problem, as Lucy sees it, even for people who leave the five day taught phase of training feeling positive about CfD, is that without support in the workplace

participants may find it difficult to sustain this feeling and make progress. Lucy suggests that:

> The problem is of course there's very little support when people
> get back to their workplace…unless there's lots of people who
> have trained and there's some kind of peer support within in it
> …and supervisors are coming, are not necessarily coming from
> the same page as trainers, so that's the support counsellors
> have when they go back into the workplace…but there's lots
> of varied understanding of what CfD means.   (Lucy)

Participants in the workplace, Lucy suggests, will not be able to access support unless they are in the fortunate position of working alongside therapists who have undertaken a similar training. So some participants may be lucky and others not. One area of support participants can expect is that provided by a supervisor. However, Lucy suggests that trainers and supervisors "are not necessarily coming from the same page", implying they may have conflicting CfD views because there are many variations in peoples understanding of what CfD means. So the best participants / trainees can expect is perhaps confusing supervisor advice because of differences in how they interpret CfD theory, practice and assessment. It seems that the quality of the support available to a participant may well determine their rate of progress on the training programme.

CfD training, from a participant perspective, is the wrong way round. They are trying to implement CfD in the workplace before they understand CfD. Although there is a five day taught phase of training participants feel that their knowledge of CfD is incomplete and therefore need to continue learning the new material while resuming their normal workplace routine and working on their CfD assessment recordings. Participants find themselves alone in the workplace, with minimal support and inconsistencies in supervision, endeavouring to understand CfD and under pressure to complete a minimum of four practical assessments with different clients. At the same time participants perceive the assessment method as unsuitable for the purpose of assessing their competence.

7.2 limitations of the assessment method

Participants generate the evidence for assessment by audio recording sessions with real clients in their place of employment. Participants know that they have to select and submit four audio recordings for assessment, and that each will be assessed by an assessor using the PCEPS measure / items. All the participants chose to focus on the ten PCEPS items, and not the framework of competences, because of the importance of the items in the assessment process. Ray, Bridget and Andrea provide insight into why they chose to focus on the PCEPS:

> In terms of the detailed [competence] framework I don't know
> anybody who's, you know, used it in practice…in practice,
> I guess it is [the PCEPS], because I guess that's, that's what
> the lecturers are using when they listen to the recordings
> and understand us, yeah, and that's what supervisors
> are kind of using to advise whether people put forward,
> you know, their twenty minute excerpt of recording.   (Ray)

> We looked at the [competence] framework, I mean we've
> obviously had all that stuff on the course, but now that I'm
> actually doing it and looking for the right tapes to send in,
> these are what I'm actually working with [the PCEPS items]
> and I mean I won't say that that's [the framework] gone out
> of the window but it's not, it's not familiar, it's not tattooed in
> my brain.   (Bridget)

> To be honest, since I did the training, this is probably quite
> interesting in itself, I haven't got much of an awareness
> actually of the competences in my head in that they're there
> and I'm aware I enjoyed learning about them when I was on
> the course, but I guess I've, there's probably something in
> that, in that I haven't really tried to keep hold of them.   (Andrea)

The impression is that the framework of competences or "that stuff" as Bridget perhaps dismissively refers to them, is not at the forefront of her consciousness. There is a sense that she feels it ought to be but admits that although the framework had been "looked at" - "it's not familiar, it's not tattooed in my brain". It seems, as Bridget says "now that I'm actually doing it", in terms of the training and "actually working with" the PCEPS, that she realised the PCEPS items are what she needs to remember rather than the framework. Andrea too, although she says she "enjoyed learning" about the competences, says she had little awareness of them, which suggests she had little use for them. Ray appears to be defending his own lack of use of the framework by framing himself as just one of many who take the same approach. The use of 'we' and 'don't know anybody' in two of the above quotes suggests that the lack of awareness and use of the framework was perceived as common amongst the trainee colleagues of Ray and Bridget.

Lucy appears convinced that the competence framework, while useful as a manual in response to a threatening political situation, is irrelevant in the context of participants working towards accreditation as a CfD / PCE practitioner:

> I ignore the competence framework entirely…I'm not really
> interested in the competences at all, I kind of, I think they're
> just really a historic thing to tick a box politically, to make it
> look like a manual…I think it's fairly irrelevant.   (Lucy)

The lack of focus on the competences is understandable in the context of CfD assessment. However, it is not understandable in the context of a ten module training programme based on new learning encompassing the person-centred and emotion-focused competences and an unfamiliar assessment method. The assessment method may be unfamiliar in terms of the competences and the audio recording of sessions with real clients but, for the first time, participants are learning to adhere to the therapeutic model described in the CfD competence framework, as this is the model which is closely aligned to an evidence base for the treatment of depression. This is an intriguing situation because, as noted in the PCEPS and competence framework comparative chart (Appendix 3), the PCEPS as a measure of person-centred / experiential practice does not appear to cover all the person-

centred and emotion-focused competences. The PCEPS items continue to be the means by which participant practice is assessed, but it is not clear which competences are being assessed, particularly as participants have admitted to ignoring the CfD competences. This discordance, as a comment on competence and competences, is especially important to this study and is discussed further in chapter eight.

In terms of the structure and content of the assessment itself participants feel that the method of assessment provides a less than comprehensive picture of their competence. They are concerned that competence is being judged solely on what an assessor can glean from listening to four twenty minute audio excerpts of their practice with different clients. The impression is that this sample is too few, more audio tapes should be assessed, or longer samples from recordings should be assessed, or both. At the same time the 'absence of therapist voice' in this assessment process worries participants. The PCEPS rating scale is considered to be limited. Therapists' feel that the narrow numerical scale is an inadequate method of assessing all that competence embodies.

7.2.1 Inadequate measures

Participants feel that four twenty minute audio excerpts, and perhaps up to six recordings should they fail any of the four, is inadequate with regard to an assessor gathering sufficient evidence of each and all the PCEPS items and producing a comprehensive picture of a therapist's competence. The 1 to 6 scale is considered too limited to capture the essence of the therapeutic relationship and, in particular, attributes such as genuineness and warmth.

Andrea is clearly disturbed by the reliance on audio recordings and what she feels is a rather "crude" way of assessing competence:

> I suppose what I'm not sure about is how an assessor does that when
> they listen to a twenty minute recording. I mean that's what we're talking
> about when we talk about assessment, it's a twenty minute recording…
> it doesn't quite feel enough to me…the problem is, it [the feedback] came

so much at the time after I'd done that session I couldn't remember

what the assessor was referring to in the feedback…I think we're

all struggling with this particular way of measuring our work, that can

feel a bit crude at times and so I don't, and I think there's a part of me

that resists…resists conforming to what's expected as a way of

showing that we're competent, because we feel competent, but

not necessarily wanting to evidence it in this very specific way,

it feels, it feels a bit crude.   (Andrea)

Andrea seems appalled that an assessor will judge her competence based on the content of a twenty minute recording. Her comment "that's what we're talking about when we talk about assessment, it's a twenty minute recording", conveys her sense of disbelief that it is only the content of a twenty minute recording, a very minimal amount of data, will be used to determine whether she is competent. Andrea is also concerned about the way her work is to be measured. She says "I think we're all struggling with this particular way of measuring our work", implying that her concerns are shared by all her course colleagues. She feels that this particular way of measuring her work is "a bit crude", leaving "a part of me" that wants to resist conforming to "this very specific way" of "showing that we're competent". The use of "crude" suggests that Andrea feels the assessment method has been thrown together or is unrefined, such that it may be an inaccurate method of assessing participant competence. However, her statement "because we feel competent", conveys a sense of willingness to be assessed provided it is not "in this very specific way". The implication being this "very specific way" cannot encompass all that is required of a competent participant. Perhaps Andreas' admitted resistance is also a response to a fear of being rated as incompetent.

Andrea is apparently reflecting not only her own concerns but the concerns of others in relation to what they see as the problems with the assessment method. They might feel competent, having acquired a qualification and therapeutic experience, but now they have to demonstrate or be re-tested for competence with an assessment method they consider to be unfair. They know little about the assessment method and feel the specific assessment items fail to reflect, from their perspective, what therapist competence entails. There is a sense of disbelief that the measure of

someone's competence is dependent on what an assessor may or may not hear within a small segment of an audio recording. The implication being this specific way of measuring competence produces an incomplete and possibly inaccurate picture, leaving competent participants bemused, frustrated and angry.

Caroline considers the rating scale as "a bit small" and "a bit limited", which suggests some disquiet over the prospect of having the complexity of her work reduced to a single low number:

> I suppose the scale [PCEPS] felt a bit small, one to six, you
> know, if it was a percentage then you could be, you know
> forty-five or seventy-three, but it's a bit limited… I found it
> quite difficult because I've never been measured on a, on a
> number or with a number before. I've had obviously lots of
> supervision, but that's been verbal…but for somebody to
> say well that's a four or a three or a six, it's you know, I
> suppose the scale felt a bit small…a bit limited.   (Caroline)

Caroline says her therapeutic practice has "never been measured" numerically previously and is obviously disturbed by the thought that her practice will be assessed numerically with a scale she says is rather limited. There is a sense of unease as Caroline grapples with the idea that her work will be judged as 'a four or a three or a six' by an assessor using a scale which perhaps restricts the ability of the assessor to measure her skills in a more refined and sophisticated way. The stark contrast she seems to draw with her previous experience, when she's had 'lots of supervision' and verbal feedback, suggests feedback in terms of a single score perhaps looks paltry and uninformative to her.

Lucy, like Caroline, thinks that the scale is limited:

> I mean the problem with this as well is that me, as an outside
> observer [assessor] am trying to measure something that's
> going on between two people, you know…people
> can do it [CfD] quite idiosyncratically…people express this

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way of working in very different ways…when I'm listening to
recordings from people, I guess the bits that are more , yeah,
it's all, it's all part of how, for me, all of it measures how well
 a therapist is demonstrating empathic understanding with
openness and genuineness and with an accepting attitude
and it's kind of…which is why then it's coming to these discrete
things and you know, I think it's limited, it was a fifteen measure,
item measure originally and that was better for me because
there was a lot more about acceptance and warmth and
genuineness, that was a bit more, whereas it's reduced to
one thing in this one [the ten item PCEPS]. So it means
that, like the techniques behind emotion focused have
got a much bigger part in it than the warmth, genuineness
and acceptance, for example, because there's three of them
and only one of acceptance…I don't like that…but yeah, I
think it's hard to measure because there's three of them
and only one of acceptance, but yeah, and I think it's hard
to measure…it's very subjective though.   (Lucy)

Lucy recalls that a fifteen item version of the PCEPS scale was changed to a ten
item scale. Lucy says that the fifteen item scale was 'better for me' because there
was a lot more about acceptance and warmth. She feels that acceptance and
warmth, important aspects of PCT competence, have been neglected in the shorter
number of items on the scale, and the 'techniques' of EFT seem to have taken over.
Lucy suggests that the lack of discrete PCEPS items related to acceptance, warmth
and genuineness, makes it "hard to measure" such qualities within the reduced
items. Her point 'it's very subjective' appears to question the supposition that
objectivity accompanies measurement. By implication much of what a participant
does in their work with a client may be lost in this process.

Ray, when thinking about twenty minute excerpts and the assumptions that may be
made about what's happening between two people suggests, as noted earlier, that
an alternative or additional assessment strategy may enhance the process of judging

whether a participant is PCT / EFT competent. By incorporating video alongside audio recording of participant practice the assessment process would be:

> Much, much, much better, you could get much more out of it if you videoed it… to video recording therapy sessions, to demonstrate that people aren't just talking a good story, that they're actually demonstrating that, you know, they don't just know what they ought to be doing, but they're actually intelligently, effectively putting into it into practice.   (Ray)

Ray's enthusiasm for the type of additional evidence that may emerge from video recorded sessions is quite apparent. He seems confident that video recordings would present assessors with much more data than audio recordings. He seems to feel that participants, who may be "talking a good story" or simply 'going through the motions' rather than doing something that would really demonstrate competence, would be under pressure to visually demonstrate they can implement the therapy intelligently, effectively and competently.

Based on the perceptions of participants, the PCEPS as a means of measuring participant adherence / competence to the CfD model presents a less than comprehensive picture of their performance and competence. Participants are concerned that their competence is assessed based solely on a few audio excerpts and with a scale they perceive as too narrow numerically and limited in terms of communicating all that occurs between client and participant. Furthermore, participants also reported that the therapist 'voice' is absent from this process.

7.2.2 Absence of therapist voice

Assessors are not required to seek evidence other than what a participant presents in an audio recording. Participants are concerned that relevant contextual factors are absent when their competence is being judged. The absence of the participant voice means that they are unable to explain to an assessor the reasons for how they worked with the client as they did.

Therapists are concerned that at no point within the CfD assessment method can they argue their case or explain events which occur during therapy. Bridget is frustrated because the assessment method only requires an assessor to listen to excerpts from audio recordings when judging her competence. In this situation Bridget is worried that assessment will only pick up the obvious:

> These are kind of the things that get picked up on by tutors [assessors] when they're doing the marking, but it's a bit infuriating because, you know, we know the client and we know what we've worked with beforehand, so there are things that come up that we're bound to place to one side, for want of a better word, because we've already worked with it, we've covered it, we've worked through it…I feel that unless the listener [the assessor] knows what's gone beforehand, how can they possibly pick up on what you're missing and what you're not missing…I think what would help more is if we could present a case study with that recording, even if it's only five hundred words and maybe some background information …just so we don't get slated for those things we're not picking up on, that we have reasons for not picking up.   (Bridget)

Bridget's sense of frustration in not being able to explain the context behind what is happening in the session and the excerpt is quite apparent. Her comment "get slated" conveys her anger when an assessor has picked out something she was not doing, but, if Bridget had simply been asked to explain what she was doing she feels the assessor may have reviewed the judgement. She considers that her knowledge of the client and what has gone on "beforehand" with a client are factors the assessor needs to be aware of before judging her. There is a sense of Bridget naturally setting aside some issues from a session because they have been attended to previously, but the assessor won't know this and may think Bridget has neglected them. Nevertheless a CfD assessor is not required to ask for an explanation.

Dorothy, who is a trainer, appears at first to be less concerned than Bridget about this type of assessment method but then goes on to say "I think it is difficult when it's borderline":

> I think it comes across in the tone of the voice, the quality, you know, originally there has been a video that's made here [at the end of the five day training] and obviously I've met people and everything. I think it is difficult when it's borderline and then what happens is that a colleague will listen and they'll make their assessment and then we'll collaborate to see if, you know, if there's a sort of cohesion between the decisions. (Dorothy)

Dorothy's comment indicates that this form of assessment can also be a problem for a trainer / assessor. Difficulties arise when "borderline" decisions have to be made and there is uncertainty around how to interpret something in the audio tape. Dorothy suggests that in this instance another assessor could be brought in for a second opinion but then indicates there may still be variations in the interpretations. So, now there may be two assessors, each with a different view, and no other evidence which they can take into consideration before coming to a conclusion. It appears that even trainers consider the assessment method may present them with difficult situations, where they will have to infer that a therapist has performed an item or not and yet the participant still has no voice in this process.

Ray suggests that video evidence could help assessors in situations where there is uncertainty interpreting and rating what they hear within an audio recording. He feels that an assessor could "get much more" out of a video recording. However, Ray acknowledges that this is not the current position and that "we are where we are", meaning that assessment will continue to be based on assessors inferring or making assumptions about what occurs in a session based solely on what they hear. Ray appears to feel the assessment situation could easily be improved but recognizes that this is just not going to happen:

> It would be much, much better, you could get much more out of it if you videoed it and nowadays you can more cheaply do it, it's not

like ten years ago, where you had cumbersome cameras and stuff

…it would be better if you videoed it, you could get more data, having

said that we are where we are and I suppose yep, you are making

some inferences.   (Ray)

But Ann is worried by the idea of assessors basing judgements on inferences when therapists could simply be asked for what may be relevant evidence. Ann is reflecting on an instance where therapeutic activity paused, as the client and Ann sat in longish silences. Ann admits she worried about this situation, with regard to how it may be interpreted by an assessor. Ann puts herself in the position of the assessor and can see how it might seem, that she had "lost the holding of it", but she is emphatic that wasn't the case, "I simply don't believe that". Ann is convinced, based on her understanding of item nine on the PCEPS assessment scale, concerning 'psychological holding', that she was maintaining a good, solid, emotional and empathic connection with the client even when perhaps the client was in pain or feeling overwhelmed. Ann appears to feel that she calmly and securely held the client as the client processed experiences. At the same time Ann seems to feel that reasonable eye contact was maintained with the client. She is adamant that she was following "those ten things" and can, if asked, provide a cogent explanation for a sessional event and why it was in line with one or more of the ten PCEPS items.

I think they need to hear, they need to hear from me, that I can do,

that I am following those ten things…I do feel it's very hard in a

tape because there are a couple of longish silences, which I felt

when hearing it, that I lost the holding of it, but I simply don't

believe that, I just don't feel that was the case in the room. I

could hear in the silence them [the client] kind of processing, I

think we still had eye contact, but I think in just listening to

something that gets a bit lost.   (Ann)

Ann is convinced that she had been right to just sit with her client during "longish silences" as she sensed the client was working through and perhaps developing a new understanding with regard to what they had been discussing. Ann talks of the important things that "get lost", such as the eye contact, her connection with the

client, and her interpretation of an event, when an assessor makes an assessment decision based on inference or conjecture when something, such as a long silence, could be clarified simply by asking the participant for their view of the event.

The issue of important things getting "lost" also frustrates Annette:

> I don't know what they're assessing it [the audio] against…
> you have to assume they have sight of that [the PCEPS /
> competence framework], don't you, I don't know…so the
> session is fifty minutes but [assessors] listen to twenty
> minutes, because it doesn't just, just because you didn't
> do it in that 20 minutes doesn't mean that you haven't done
> it, you know, through the course of counselling .   (Annette)

> In terms of an expectation of knowledge of person-centred or
> emotion-focused theory I guess, I would say that was kind of
> taken for granted, certainly I wasn't aware of it being assessed
> …it's inferred, but it's only inferred to a degree…somebody
> could practice and you could have a whole number of audios
> and it wouldn't be obvious and one might suddenly go, "What's
> that? What were they doing then? What's that based on?"   (Steve)

Annette appears unsure about the actual assessment method but doubts that it reflects a participant's practice over the "course of counselling". There is a sense that she has to take 'on trust' that assessors are using the PCEPS, so we feel a lack of confidence in the assessment method in Annette. Annette seems anxious about a process within which an assessor is only going to listen to a twenty minute excerpt, and would be unaware of all that has transpired in the rest of the 50 minute session. We get a sense that Annette feels this is unfair. She seems to be making a plea for a different method of assessment to be used when assessing participant competence, one that might incorporate opportunities to find out what the participant has done, and why. Like Annette, Steve, seems to be taking on trust that knowledge was assessed. He says he "wasn't aware" of therapist knowledge being assessed , rather it's 'inferred', suggesting that assessment of the audio recording might be a matter of

conjecture when there may be moments wherein what a therapist is doing is not obvious. This reflects Ann's concern about "something gets a bit lost" if an assessor does not have to ask the participant for clarification. But, Carol says:

> I remember all the different people that were on the course. I
> remember thinking oh we still all do it differently, so there was
> still some space for, you know, we're not robots, you know, but
> it's interpretation isn't it?   (Carol)

CfD training may seek to standardise counselling work with depressed clients but Carol's comment suggests each therapist will interpret CfD differently. Carol seems to have had a revelatory moment, proclaiming "we're not robots" who will simply accept the CfD manual of instruction without question. The image of robots mechanically following a manual is quite evocative. She clearly is saying something quite damning about manualisation – or at least expressing a view about its limitations. The idea of accepting the instructions without question is also evocative. She seems to suggest therapists ought to interpret the manual in their own way and not just follow it to the letter. The realization "oh we still all do it differently" suggests that perhaps within CfD practice there is "still some space", or room to manoeuvre, for therapists to be able to interpret CfD in a way they find fits with their identity as a therapist. However, such a situation suggests that assessment of participant competence may require an assessor to be open to multiple interpretations. This is perhaps why therapists feel they need to have a voice in the assessment process.

Participant comments convey distrust of a method of assessment where they have no voice and are therefore are unable to explain the contextual factors at the time of the audio recorded session with a client. They dislike the idea of assessors basing competence judgements on inferences, conjecture and assumptions, when, if they had a voice, they could make known their knowledge of the client and the influence of contextual factors on the conduct of a session.

7.3 The CfD competence framework and competence as understood participants

Participant understanding of competence, having implemented CfD and the assessment method, appears to be different to the way competence is interpreted within CfD. The impression is that Bridget **is** struggling to accept the CfD interpretation of competence. She finds it "infuriating…how can they [assessors] pick up on what you're missing and what you're not missing" because the focus is solely on how far she implements the CfD competences. Her understanding of competence, as an experienced therapist, is that competence incorporates not only what she does, but, just as importantly, her reasoning as to why she does or does not do something. For Bridget competence encompasses much more than how well she can adhere to the CfD competences.

Ray, Ann and Iris also expressed disquiet with the CfD assessed form of competence. Ray suggests that the CfD assessment method "doesn't measure competence… a beginner might adhere to something but they're totally insensitive". Ray seems to feel that adherence to the CfD model without the element of therapist sensitivity is something less than competence. Similarly, Iris says that adhering to the framework "may not reflect a competent therapist because I may not be responding to my client's needs". It seems that responding to the needs of her client, being sensitive, is something she perceives to be an important element of competence. From Ann's perspective CfD competence means adherence "to those ten things" but she reports that when she does this "I don't feel competent" in that it restricts her ability to be 'genuine', or be with a client as she would be when using her core practice. Meanwhile Terry argues that adherence is not the same as competence but acknowledges that adherence to the competences can mean that you are CfD competent. However, he also argues that this "doesn't perhaps recognise other aspects of competence" which are outside" of the CfD version of competence, particularly those aspects related to "my own experience…my own self". Terry seems to feel that he has to restrict what he considers to be part of competence because it is not part of CfD competence. As Lucy identified, within the PCEPs there is only 'acceptance', which makes it difficult for trainees to incorporate

those aspects of competence they consider important, such as 'genuineness', into their assessed practice because they are not required.

From the participant perspective it seems that competence entails more than adherence to the CfD competences. They have identified where they consider the CfD version of competence is a less than complete picture of their actual competence.

Summary

Participant perceptions have highlighted a number of tensions within the CfD training programme, including the assessment method. Participants perceive CfD training to be the wrong way round, such that it failed to adequately prepare them, in terms of CfD theory, practice and assessment, for undertaking client work in the workplace. As a result the workplace became a self-learning, self-development environment where they have to rely on their own endeavours as they strive to come to terms with CfD theory, practice and method of assessing their CfD practice. Therapists become disconnected from the training programme. Supervision is the therapist's main source of support, particularly as assessment feedback, although welcome and helpful, was not always timely. Participants consider that the CfD assessment method presents a very limited picture of therapist competence. From a participant perspective the picture with regard to competence is lacking because assessment fails to take into account therapist / trainee considerations with regard to why they did, or did not, do something, the timing of interventions and how the context / client influenced the course of therapy. Factors such as responding to client need and being sensitive are seen by participants as important when their competence is being judged. Such a view is contrary to the CfD method of assessing competence. The CfD training modules appear to contain material relevant to the participant conception of competence but the modular material appears not to be taken into account when assessment takes place. From a participant perspective it seems appropriate to ask why these factors are not assessed when determining CfD competence.

The use of the one to six PCEPS scale to measure therapist adherence / competence is considered to be too narrow to reflect all that a therapist does, and neglects those attributes a person-centred therapist considers important, and is therefore a less than adequate means of assessing participant competence. Assessors are judging participant competence based solely on what they hear, interpret or can infer from the material within four twenty excerpts from audio recordings. The absence of a therapist voice in this assessment process means that they are unable to explain to an assessor how contextual factors influenced the therapist / client interaction, which they feel is unfair. They fear their actual competence may be overlooked, in terms of knowing when to, or not, do something, the timing of interventions, responding to client need and particular contexts, and being able to justify their approach to therapy.

Chapter Eight

Discussion

Introduction

As the competence-based approach to therapy gathers momentum across counselling and psychotherapy this study sought to explore therapists, trainers and supervisors perceptions of competence in the context of Counselling for Depression (CfD) and the implications of the findings for training, practice and assessment of therapist competence. The launch of the CfD competence based model provided an opportunity to explore competence in the context of a new integrative therapy incorporating evidence-based person-centred and emotion-focused competences and training programme designed specifically to prepare people as CfD therapists.

8.1 Summary of research findings and contribution to knowledge

The rapidly changing political environment presented a threat to the employment prospects of person-centred participants employed in the NHS. Participants felt that the professional response to this threat, the production of CfD, became a matter of expediency and as such a 'tick box' activity in order to achieve the goal of becoming a NICE recommended therapy for depression. Nevertheless, participants were thankful, and perhaps relieved, that CfD had become available as it meant that jobs in the NHS were secured and employment prospects enhanced. Some participants considered that the person-centred aspects of the competence framework reflected their way of working but struggled to integrate PCT with the emotion-focused component. Those participants who were unfamiliar with emotion-focused therapy welcomed the prospect of new learning and blending emotion-focused practices into their existing practice. Participants thought the CfD competence-framework could be useful if they needed to explain to the public, colleagues and bodies such as NICE, precisely what therapists do. However, for the purpose of becoming a CfD therapist the competence framework was considered to be irrelevant or could be ignored.

Despite welcoming CfD for the reasons outlined above, participants felt that they were unable to be 'fully me' in the context of CfD. They were worried that their

concept of self in terms of the values, beliefs and experience they take into their therapeutic work with a client was under threat. Participants were intrigued by the new learning opportunities that CfD offered, in terms of additions to their therapeutic practice, but anxious to remain as autonomous practitioners, with a choice as to what to aspects of CfD to accept or not when working with a client. Participants perceived that the person-centred approach was significantly undermined by certain emotion-focused competences that require a participant to take a more task focused orientation or directive approach towards client work. As a result some participants considered the CfD therapist-led approach to client work to be incompatible with a client centred approach to therapy. Participants perceived the CfD training programme to be the 'wrong way round' in that they were carrying out sessions in the workplace before they had had time to digest CfD theory, practice and the method of assessing therapist competence. Participants expressed reservations about an assessment process where competence is judged on a few audio excerpts, where contextual factors are not taken into account, and a narrow 1 to 6 scale is used to rate the complexities of a client / participant interaction. They felt that aspects of competence they consider important, such as the timing of interventions, sensitivity to client needs and context awareness, could be missed during the CfD method of assessing competence. As such their understanding of competence is different to the CfD version of competence. There were largely no differences between the views of trainees, trainers and supervisors, but differences in trainer and / or supervisor experience are discussed below. Participants found that, although CfD is an evidence-based treatment for depression, it can be used just as effectively with other conditions.

This study contributes to and extends our knowledge of competence and a competence-based approach to training and assessment from the perspective of people involved in a CfD-PCET competence-based programme as follows:

- contribution to our understanding of how competence is perceived and how competence-based training is received and experienced

- contribution to our understanding of how CfD training, the development of competence and the assessment of competence specifically is received and experienced

- contribution to our understanding of the needs of trainees and the challenges trainees face in combining the competences of the person-centred approach and emotion-focused therapy

- contribution to our understanding of the difficulties trainees experience with the assessment of competence

8.2 The irrelevance of the CfD competence framework

Participants suggest that the competences can be ignored or are irrelevant in the context of CfD training and assessment. This view is shared by trainees, trainers and supervisors. It is a view that appears to have arisen because the focus during assessment is on the PCEPS items. While this is perhaps understandable it is also confusing given that trainees are learning a new competence-based therapy and, as Hill (2011) points out, the training modules are linked to the sets of competences from the CfD competence framework. The perception of the competence framework as irrelevant is at variance with the findings from the CfD research of Drewitt et al (2017), Goldman et at (2016) and Pearce et al (2013). The lack of competence framework awareness limited participant ability to discuss the competences in any depth. This raises questions as to how participants can achieve CfD accreditation without reference to the competences. Particularly as Sanders and Hill (2014) argue that CfD assessment is primarily concerned with how far a trainee implements the competences with real clients. The research suggests that working with real clients can have a positive influence on trainee development (Folkes-Skinner et al, 2010, Hill and Knox, 2013) but Orlinsky et al (2001) argue that work with real clients should only commence if trainees have been trained to a certain standard in a relevant model of therapy. Although a video recording of participant practice is assessed at the end of their five day training it is not clear what standard of performance is expected of participants before they commence working with real clients. This is a particularly challenging situation for participants unfamiliar with the emotion-focused component of CfD. In such a situation Nerdrum and Ronnestad (2002) found that

learners require time to internalize the new learning. However, the CfD 'wrong way round' training presented participants with challenges in terms of opportunities to learn new material, preparedness to counsel and be assessed with real clients.

Nonetheless, this did not appear to hinder participant ability to achieve CfD accreditation. As participants are not referring to the competences the question is which and / or what competences are participants demonstrating to a standard an assessor judges to be worthy of an adequate or higher rating on the PCEPS scale. The impression is that experienced participants enter the CfD assessment process with the competences required to achieve CfD accreditation. It seems that this may be a situation where it may be possible to introduce an accreditation of prior learning system, as in the NVQ model (Fletcher, 1992), for experienced therapists / trainees so that their training fits well with their needs. The primary concern for CfD assessors appears to be with collecting evidence to satisfy the PCEPS items, which, as Hyland (1994) argues when discussing competence-based NVQs, separates such a process from and is rather different from the development of learning. Participants appear to have recognized that this was the situation and therefore focused their efforts, not on learning the new competence material, but what they needed to do to address the PCEPS items. Participant knowledge and skills is such that, irrespective of modality orientation, they were able to complete the four assessments. Participant comments suggest that the CfD competence framework and training programme may be more suited to less experienced therapists, or indeed novices, provided training was the right way round. This would allow trainees time to digest and internalize the new learning and acquire those competences closely aligned to the evidence base for effectiveness in the treatment of depression. However, it seems that experienced participants also needed more learning time if the CfD competence framework is to be perceived as relevant with regard to understanding and working with the CfD model. Like other recent competence based therapies, such as on-line and telephone counselling and children and young people counselling, CfD training appears to be more concerned with preparing people for a specific work role rather than the development of the person and practitioner. Participants may be grateful for CfD in order to survive in IAPT but as House (2009) and Vaspe (2000) argue, the imposition of externally imposed performance criteria, and the demands of audit and evaluation, may force therapists / trainees into a situation where they have to make

sacrifices and compromises. This appears to be happening to CfD therapists / trainees, particularly in the areas of autonomy and way of working.

8.3 Therapist way of being: 'self' and professional

CfD practice had a negative effect on the participant sense of self. Participants reported that they were being pulled in different directions and unable to be 'fully me' when working with a client. This was the view of trainees. However, one supervisor had worked with trainees struggling to balance PCT with what they perceived to be the more directive approach of CfD. Trainee concern was that in order to become a CfD practitioner they would have to relinquish or compromise those values and beliefs which underpin their way of being or 'fully me' when working with a client.

Previous research by Byrne et al, 2018, Folkes-Skinner et al, 2010, Lowndes and Hanley, 2010 and Owen-Pugh, 2010 suggests this is a common experience amongst trainees and therapists as one 'self' faces the prospect of becoming another 'self'. It would appear that for all the participants the self-concept represents, as McLeod (2003) argues, the many dimensions of 'what is me' and that while each person may want to prevent conflict with the self-concept it is nevertheless inescapable. Such a situation is described by Folkes-Skinner et al (2010) as a potentially disturbing personal journey but, as McLeod (2003) and Hill and Knox (2013) point out, few studies have been carried out on the evaluation of the effects of training programmes. The finding from this study contributes to our knowledge on the effect of CfD training on participants' sense of self. The findings also have far-reaching implications for trainees, novice or experienced alike, and trainers / supervisors, when training requires the integration of different therapies with different philosophies and / or a change to a therapist's core orientation. A study into the dilemmas faced by trainee counsellors, by Owen-Pugh (2010), recommends the incorporation of various strategies into training programmes so that trainees / therapists are appropriately supported as they work through personal dilemmas. While supervision support has been incorporated into CfD training it seems that other strategies were not considered necessary for experienced practitioners, leaving CfD therapists / trainees unable to access additional support at times of difficulty and dependent on whatever resources may be available in the workplace.

CfD training was described by participants as a brave thing to do, to expose one-self to change and wrestle with the pressure to change when one wants to resist. Atherton (1999) and Mackay et al (2001) found that such situations gave rise to difficult feelings and resistance to new learning, particularly when learners are expected to renounce existing patterns of practice, which up until this point they had used confidently. For some participants, such as those intrigued by emotion-focused therapy, the struggle to be 'fully me' may have been less of a struggle, because, as Atherton (1999) proposed, the new learning may be perceived as adding to rather than supplanting or replacing existing practice.

The 'I can't be fully me' dilemma created a personal tension for participants but the difficulty participants faced when integrating the person-centred approach with emotion-focused therapy created a professional tension. It seems reasonable to assume experienced and appropriately qualified therapists might find developing an integrative approach relatively straightforward. CfD therapists are working with an integrated therapy in which the PCT / EFT therapies have similar theoretical roots. Therefore, one might reasonably expect little conflict as person-centred participants adjust to the PCT / EFT orientation of CfD. Moreover, Ronnestad and Skovholt (2003) argue that more experienced therapists are better equipped to deal with theoretical ambiguities than less experienced learners. However, in this study experienced participants found the CfD theoretical ambiguities particularly difficult to deal with. Participants found the therapist led EFT task focused approach of CfD difficult to reconcile with the person-centred approach to therapy. This suggests that these experienced participants are less willing to tolerate therapeutic ambiguities and remain loyal to their established, familiar and well developed practice. Like participants in the studies of Owen-Pugh (2010), Lowndes and Hanley (2010) and Byrne et al (2018), CfD participants are finding it difficult to navigate a path between, as they perceive them, dissimilar theoretical orientations. This confirms the Bein et al (2000), McLeod (2003) and Byrne et al (2018) argument that in a situation where there are competing therapeutic philosophies and divided loyalties practitioners may struggle if the change to a new therapy significantly challenges their existing, trusted and effective practices.

Participant sense of being a therapist, in which is embedded the values of person-centred counselling, made tolerating the theoretical ambiguities within the CfD model especially problematic. For some participants such ambiguities rendered the two therapies incompatible. As they endeavoured to resolve this issue therapists felt that they had had to make a massive compromise as they tried to reach a balance between their cherished person-centred approach to client work with the need to become a recognised CfD practitioner. Owen-Pugh (2010) found that participant ability to cope with conflicting therapeutic theories improved as they worked on clients and reflected on such issues. This finding emerged from a traditional counsellor training programme, where trainees are allowed a genuine choice in developing their own integrative practice. However, Owen-Pugh also suggests, that when the training curriculum, practice and assessment are tightly controlled, as in IAPT programmes such as CfD, therapist choice with regard to style of integrative practice is likely to be restricted. This study confirms the Owen-Pugh suggestion because genuine choice, in terms of participants choosing how they will implement CfD, is restricted, as adherence to the CfD model / PCEPS items is the assessment priority. Participants have to adhere to the CfD model if they hope to achieve CfD accreditation. Such tight control of participant practice may ensure assessment success but restricts participant autonomy, participant responsiveness to client need and the potential for client involvement in their path to recovery.

The findings from this study, for instance, the 'I can't be fully me' tension, the PCT / EFT issue and the problem trainees, trainers and supervisors had with the competence framework are at variance with findings from the CfD research of Drewitt et al (2018), Goldman, Brettle and McAndrew (2016) and Pearce et al (2013). Drewitt et al found that participants had a predominately positive CfD training experience with an overall positive impact on sense of self, practice and skill set. Implementing CfD in the service setting was problematic due to a lack of support and other workplace constraints. Goldman et al found, based on the client perspective of the effectiveness of CfD, that it had been beneficial for them. Counsellors were perceived to be using skills reflecting the specific CfD competences. Clients reported that CfD therapy had been hard work but this finding perhaps reflects something that is inherent within any model of therapy. Goldman et al argue that the findings reaffirm that the core values of counselling were being delivered, in that the person-

centred non-directive stance is being maintained. However, this is the client view and not that of the CfD counsellors. Most participants in the Pearce et al study viewed training in a set of competences as positive, useful and compatible with their way of working. However, some participants encountered difficulties with the assessment process, for instance in adhering to the competences, while others felt there was not enough training on EFT.

The finding from this study that the competence framework could be ignored or was irrelevant to becoming a CfD practitioner is at odds with the positive view of training in the competences expressed by participants in the Drewitt et al (2018) and Pearce et al (2013) research. Participants in this study felt that the task focused stance of CfD set in motion a more directive and less person-centred approach to client work which contradicts the Goldman et al (2016) finding that CfD counselling remained with the person-centred non-directive approach rather than a therapist led or more directive stance. Participants in this study found that training in the CfD challenged their sense of autonomy as a professional therapists, which contradicts the Drewitt et al (2018) finding that training had a positive impact on the participants sense of self, practice and skill set. A key difference between this study and the other CfD studies is the inclusion of trainer and supervisor perceptions, which reinforce the trainee concerns related to the irrelevance of the competence framework and their concerns with regard the method of assessing therapist competence. This may be one reason why the findings from this study differ from the other CfD studies. Further research into the views of trainers and supervisors is recommended.

8.4 Wrong way round training

None of the previous CfD studies identified CfD training as being the 'wrong way round', or the learning problem this creates. However, they did identify challenges in the areas of adapting to a new model of practice and assessment, training being too short, not enough training input on EFT and balancing coursework demands with workplace constraints and learning to adhere. The finding in this study, that training is the 'wrong way round', and the problems this creates for participants with regard to learning new material related to the competences and new integrative therapy,

suggests this issue may be the source of the challenges identified by Drewitt et al (20180, Goldman et al (2016) and Pearce et al (2013).

The CfD training programme is described by participants as being the 'wrong way round'. Participants find themselves in the workplace implementing CfD before they have had time to digest and reflect on the theoretical underpinnings of CfD as a competence based integrated therapy. The greater part of participant learning and activity occurs within the 80 hours of workplace practice. The assumption appears to be that experienced participants will not need to be taught all that is contained within the programmes' ten modules. This runs counter to the Orlinsky et al (2001) recommendation that work with real clients should only commence once the trainee has been trained to a certain standard in a relevant model of therapy. It is acknowledged that working on real clients can have a positive influence of therapist development (Orlinsky et al, 2001) and that 'on-the-job' learning can be successful but depends on how work is organized and allocated (Eraut, Alderton, Cole and Senker, 1999). Such considerations do not appear to have been part of CfD planning. As a result participants return to the workplace, commence working on clients, needing to continue work on the theoretical underpinnings of the model and preparing to be assessed but feeling isolated and disconnected from the training programme. Participants have access to one hour of supervision per fortnight but this appears to be insufficient. Moreover, one participant voiced concern that different supervisors interpret CfD differently, which suggests that participants may be receiving mixed messages or do not have access to dependable and / or impartial advice. This reflects the mixed response to CfD supervision expressed by participants in the Drewitt et al (2018) and Pearce et al (2013) studies. However, the different interpretations of CfD, and thereby the mixed messages dilemma, point to serious problems with meaning and definitions with regard to the CfD model, which may then jeopardise the aim of CfD training, which is to "standardise counselling work with depressed clients" (Hill, 2011, p.8) in order to align interventions with the CfD-PCE evidence base.

The workplace has become a significant learning environment within CfD training but appears to have received little attention with regard to what a participant can expect with regard to support. As noted above, Eraut et al (1999) argue, that successful 'on-

the-job' learning is dependent on how work is organized and allocated. The authors suggest that responsibility for this environment rests with management, who, in this instance is likely to be the participant's IAPT line manager. However, within CfD training it seems that this responsibility rests with the lone participant as they try to blend course demands with the demands of the workplace. This may be an unworkable expectation, because as participants in this and the Drewitt et al (2018) study found, learning and completing the assessments within the three month training timeframe is difficult. The average time to complete training and achieve CfD accreditation has become nine months (Drewitt et al, 2018). It appears that additional support strategies need to be made available if participants are to complete training or complete it within the allotted timeframe, but particularly during the workplace phase of training so that personal and professional issues connected with CfD can be resolved.

CfD was designed as a particular PCE treatment for depression. The link with depression is challenged by this study. No previous research has questioned this link. Participants claim that CfD can be used to treat a range of diverse conditions, such as anxiety, bereavement and trauma. This suggests that the CfD competences, which were derived from evidence indicating their effectiveness in the treatment of depression, are also effective in the treatment of other conditions. However, as admitted by participants, when delivering therapy with real clients and selecting tapes for assessment they focused on the PCEPS items rather than the CfD competences. It appears that IAPT clients, who have been diagnosed with depression, are successfully being treated by participants but not with the CfD competences. This is hard to explain but the research of Stein and Lambert (1995), Asay and Lambert (1999), Crits-Christoph et al (2006) and Cuijpers et al (2012) suggests that non-specific factors, such as client factors, therapist factors and relationship variables, may be influencing the therapeutic outcome irrespective of the condition. Alternatively, it may be, as participants have intimated, that depression is not a diagnosable, discrete condition, as the medical model suggests, but a term used commonly to cover the highly complex interaction clients experience between social, emotional, environmental and biological / physical factors.

While this study has highlighted new issues, such as the wrong way round training, the PCT / EFT integration issue and negative impact on self, when compared with the studies of Pearce et al (2013), Goldman et al (2016) and Drewitt et al (2018), it is apparent that little has changed over time because trainees / participants continue to identify some similar training issues. CfD is described as 'top-up' training (Folkes-Skinner, 2015), or continuing professional development, but such labels fail to convey the extent of new learning, with regard to the new therapy, new competence-based approach and new method of assessing practice, that participants are presented with during the five day phase of training. Findings from this study indicate that in its current form the training is inappropriate to meet the needs of experienced participants. It leaves experienced participants feeling disconnected from the training programme, wrestling with challenges to their sense of self and professional identity, and in need of appropriate support, in the workplace, as they strive to understand CfDs theoretical underpinnings while implementing CfD with real clients and preparing to be assessed.

8.5 Frustration with the assessment method

Participants in this study spoke of their frustration with the CfD assessment method. The overall impression is that it presents a rather less than comprehensive picture of their competence generally and in PCE. Assessment based on four audio excerpts is perceived to be a rather crude way of assessing competence. They argue that as knowledge is not assessed the assessor is therefore unaware of the contextual factors influencing the process of therapy. Although the ten modules of the training programme incorporate generic and basic knowledge competences, this aspect of their learning is not part of the assessment of competence.

It seems that assessment of competence has become detached from the person. Participants in this study felt that assessment should reflect their actual PCE practice with real clients. That the actual practice is not assessed seems incongruent with the Sanders and Hill (2014) claim that competence requires not only knowledge but its application to complex real life situations. Confusingly, Sanders and Hill also claim that therapist competence "can only be truly assessed using real sessions with clients" (Sanders and Hill, 2014:183), which suggests, as it was in early NVQ

assessments (Jessup, 1991) and is now happening in CfD, that it is only necessary to assess practical work to determine therapist competence. The impression is that assessment of other domains of competence, such as participant knowledge in relation to the therapy, the client and contextual factors, is unnecessary. CfD assessment does require participant knowledge to be tested. Therefore, although participants are required, for assessment purposes, to work with different clients at different junctures in the treatment of depression, an assessor is not required to question participants, or ask for any other form of explanation as to the sessional events and / or contextual factors. But, if a more complete picture of competence is to emerge, as participants' desire, then perhaps such strategies could be included in the assessment process as part of communicating the knowledge that only they have with regard to the client and contextual factors. Jessup (1991) suggests that while the workplace brings a sense of realism to assessment the task for the assessor becomes more difficult because of what may be occurring naturally for the trainee in this context. This is the point of concern for participants. Participants are concerned that their competence is being judged by an assessor without the need to take into account what has been or is occurring naturally in a real life session.

This issue has previously been noted by Keen and Freeston (2008). Keen and Freeston found that 'content specificity', or the likelihood of considerable differences in therapist performance depend on the situation and condition, create reliability problems when measuring competence. From the CfD perspective the 'content specificity' issue is important because participants in the workplace have to select four different clients for audio recorded sessions, with two clients from the late phase of counselling. So the situation and client condition may be different in each case and yet only one method of assessment is being used to assess competence in complex real life situations. A later study into methods of assessing therapist competence in the delivery of CBT found that it is difficult to assess skills-based aspects of competence (Muse and McManus, 2013). The authors stress the importance of avoiding simplifying the process or adopting a limited focus on aspects which are most easily assessed. To counter the limited focus, which perhaps reflects what participants found with CfD, Muse and McManus suggest the use of a multi-method approach to the assessment of competence. They suggest that the range and complexity of the work can cause problems in making valid and reliable

assessment judgements. The apparent advantage of a single method approach to judging CfD competence is challenged by the Muse and McManus findings on the grounds of oversimplifying the complexity of sessional events and the client / participant relationship. While the PCEPS may provide assurance of participant ability to adhere to a model for the purpose of accreditation the CfD participants are less than confident in its ability to produce a comprehensive picture of their competence.

The driving force behind the development of the PCEPS was the need for a useful instrument in clinical trials research and counselling training / supervision (Freire et al, 2014), where the instrument would be used to ensure CfD-PCE was being delivered faithfully to the manual. While the measurement of adherence and competence is new in the context of CfD-PCE it is not uncommon for these entities to be investigated during research into the possible relationship between adherence and outcome and / or competence and outcome of therapy (Barber et al, 1996; Branson et al, 2013; Strunk et al, 2010; Trepka, Rees, Shapiro, Hardy and Barkham, 2004). However, participants have noted, within the context of a training programme, that the PCEPS method of assessing competence is limited. In this context combining different kinds of evidence may improve the reliability and validity of the CfD assessment process and assure participants that it is their competence that is being judged.

8.6 Reflexivity and reflections

My research was, by design, qualitative. My aim was to explore with therapists, trainers and supervisors their perceptions of competence in the context of training for a new, competence-based integrative therapy known as Counselling for Depression. It took one year to complete the nineteen interviews. My relationship with the interviewees positioned me as an insider researcher in terms of studying my own 'tribe', the counselling world, with its specialised language and culture. The challenge this familiarity created for a practitioner researcher like me, as Arber (2006) and DeLeyser (2001) point out, is one of becoming an outsider in order to maintain distance, not get too close to or distracted by events, with the aim of remaining objective. However, there were times when I felt I was an insider, using

the specialised language and intrigued by what participants had to say, but also outsider with no experience of their world as IAPT therapists.

The reflexivity process calls upon researchers to constantly locate and relocate themselves within their work (Bott, 2010) or, as King and Horrocks (2010) suggest, by looking inwards and outwards throughout the process. This I have tried to do through the use of 'I' and 'my', as I considered my position, values and beliefs, and how these might impact on my design, process and analysis. Now that the research is at an end, and I can look back over a long process, I feel that my chosen research design enabled a balance to be struck between closeness, familiarity and distance such that I could address the aim of the study and maintain as much objectivity as possible. However, as a novice researcher I was learning 'on-the-job'. For instance, I was concerned that my insider familiarity might blind me to events and comments I should not be taking for granted. I had to learn that distance meant I had step back in order to cast an objective eye over the events and issues that participants may take for granted, such as their view of competence and person-centred therapy.

Unlike the interviewees, I was neither a CfD practitioner nor an IAPT therapist. Nonetheless, the commonalities we shared as therapists helped facilitate my acceptance during the early contact with training organisations and the interviewees. There was a feeling of familiarity and sameness because of shared commonalities, such as educational experiences, work roles and responsibilities, and an awareness of some of the issues troubling the profession. I was aware that CfD was a sensitive issue. It was being rapidly introduced, mainly for therapists working for a particular agency, but many outside this sector were unaware of its unique framework. The few who were aware began to voice concerns related to its medical model approach. Not all organisations were receptive to my request for help. This was difficult to deal with because it came early in the research process. Initially I was surprised and perhaps a little annoyed. The rejection felt personal, but for those willing to speak about this as a sensitive issue, it became apparent they had concerns about my motivations for this study. After a tentative introduction, related to therapist competence and the development of competence, I felt that people became more interested and willing to discuss participation in the study. I met people in their working environment, enjoyed cups of tea with them, and in some trepidation tried to gain their trust. Eventually,

when discussing how possible interviewees could be contacted, while allowing me to remain at a distance, we made decisions on who I would send paperwork to within an organisation, and who would then forward documents, such as my letter of invitation, onwards to prospective interviewees.

In the early interviews I uncritically assumed that interviewees knew much more than me in certain areas, that they would be as open as possible and that I could just let them talk. However, occasionally the interviewees needed focused supplementary questions in order to get to the point of the original question. This may have been due to misunderstandings on their or my part but more importantly I think it reflected my need to quickly learn the language of CfD and IAPT. This was not any deliberate attempt on my part to enhance my insider position, although this may have happened, but I needed to be able to communicate more effectively with the interviewees. As an experienced therapist I thought I had some skills I would find useful in one-to-one interviewing but this was a steep learning curve. Interviewees appeared to assume that I knew what they were talking about, even though I had admitted I was not CfD trained. Hence they kept their comments relatively brief. During conversations interviewees would say "you know", when they thought I should know something, but I didn't, and I would have to belatedly admit I didn't know and then ask a supplementary question which I hoped made sense to the interviewee. On occasions I felt I empathised or entered into the interviewees' world to such a degree that parts of our conversation, which may have contained points of relevance to this study, were either neglected or went unchallenged by me. Balancing the insider / outsider positions was a constant challenge.

DeLeyser (2001) suggests that when interviewees are eager to talk it may be difficult for the researcher to stop the conversation when striving to balance maintenance of rapport with an interviewee with the need to evaluate the data as the interview progresses. This was my experience, particularly in situations where, from an insider perspective, what the interviewee was talking about was of interest to both of us but not really relevant to the study. I would be wavering between letting the conversation continue to see where it led or to interrupt this person, someone I don't really know and may upset, in order to focus our conversation on the point of the question. On occasions the conversations were so informative I lost track of time but mostly I was

aware that I needed relevant responses from interviewees in the time we had together.

Although, as a counsellor, I was an insider I really knew little of the counselling world of the participants. I wanted to know about the participant perspective of competence based on their involvement with the CfD competence-framework and implementation of the competences. This I planned to do by asking open questions, listening to participant responses and, when necessary, asking supplementary questions. This was not always easy as it was sometimes difficult to separate my knowledge from that of the interviewees. As an insider researcher I brought to the interviews my own knowledge and experiences with regard to competence but seeking to know about the interviewee's perceptions and experiences of this subject. The challenge, during interviews, became one of ensuring I kept to questions that mattered to my research rather than following an interviewee's lead, even though it may have provoked my interest. When the topic of the CfD competence-framework was discussed, although interviewees admitted not remembering much about it, I would deliberately probe and in this way allow participants further time to reflect and perhaps access some memories of the competences. While my insider knowledge was to a degree similar to the interviewees it soon became apparent where their knowledge and experiences were different to mine. Their perception of the competence framework, that it could be ignored or was irrelevant, shocked me, as I was aware that the training modules specify which competences are to be addressed. My initial reaction was one of dismay as this seemed to make my research meaningless. However, after reflecting on why they came to this conclusion it made sense, although my surprise at this conclusion probably came out in my supplementary questions as it was unexpected. However, it was a significantly positive contribution with regard to competence in the context of experienced participants learning to adhere to the PCEPS items and successfully completing the assessments. This struck me as a pragmatic response to the assessment situation and an insight into their existing level of competence.

The interval between the interviews was usually sufficient for me to reflect on my progress and if possible commence reading transcripts. On reflection I am now aware that relevant points were missed because I had not maintained the outsider distance. During my research I felt that the boundaries between insider and outsider

researcher became blurred or unclear, and perhaps this is what happens as part of the process of re-locating me within the research process. For practitioner researchers like me, the choices I made with regard to detached outsider and involved insider are described by de Laine (2000) as a moral passage, involving questions of self-identity and moral decision making. Such decisions arose when data gathering, in that I was anxious not to lead the interviewees but interested in getting data related to each of my topic questions, and during data analysis, when, although I had a plan to work to, the challenge was to remain as objective as possible in the analysis of all the data. I felt clear about my insider researcher position but I was less clear about my position as an outsider researcher. I was clearly a member of the group I was studying, so the notion of not belonging to the group or being an outsider was difficult to accept. The way I was feeling resonated with Breen's (2007) argument that the researcher role, rather than being an either / or dichotomy, is better conceptualised as being on a continuum. Rather than berate myself for perhaps getting too immersed in a conversation or worrying about whether an interviewee would be cooperative I had to learn to relax, see both sides of what I was trying to do, and try to maximise the insider and outsider advantages while minimising disadvantages.

8.7 Limitations

More therapists volunteered to participate than trainers and supervisors. It may be that if more trainers and supervisors had been recruited different themes or additional themes may have emerged because each will be considering CfD from a different vantage point.

My volunteers may have come forward because they had strong (possibly negative) views they wanted to be heard. In retrospect, as my intention was to gather the perceptions of competence from as diverse a range of participants as possible, perhaps my Letter of Invitation and Information Sheet could have been rewritten to explicitly invite those with both positive and negative experiences. Future research may take these points into consideration.

I was aware given my background, as a qualified counsellor and experience within the further education sector related to competence-based vocational training, that this may bias my data analysis / interpretation. To minimize this happening I incorporated actions, such as reading and re-reading the transcripts, line by line coding to ensure my focus on what participants are saying rather than on issues I might be expecting to find, theming and re-theming, within my analysis and interpretive approach as a means of minimizing both conscious and unwitting bias.

This study recruited a homogeneous group of participants from two training organisations and a practice research network. Trainees, trainers and supervisors from other training organisations might feel differently about competence, the CfD training programme and assessment of competence because their programme is in some way different and different people with different experiences are on or managing the programme.

As this was a volunteer group with an interest in CfD the findings from this study may not represent the views of groups such as those who failed to complete training. It would be useful to know whether those who gave up training did so because of the kinds of experiences participants in this study relate.

8.8 Future research

Participants in this study were dissatisfied with the CfD method of assessing competence. They identified particular issues and suggested changes. Further research is required into how best to assess therapist competence in PCE within the training context (formative assessment) and workplace context (summative assessment).

Support during the twelve weeks in the workplace is limited to six supervision sessions and feedback from an assessor. Further research is required to understand what level of programme support therapists need in the workplace to facilitate completion of the assessments and change to the CfD model within the prescribed timeframe. As self and professional autonomy appear to be a recurring issue for people on counsellor training programmes further research is needed into what type

of strategies could be included in the CfD training curriculum to support learners as they endeavour to make the change to CfD.

Trainers and supervisors have now had (since 2011) considerable experience with CfD. Further research, involving trainers and supervisors, perhaps as separate groups, would bring a specialist focus to CfD research and the opportunity to see if their issues differ from those already identified.

8.9 Recommendations

The assumption behind the CfD competence based model of therapy is that experienced therapists only need to adapt existing skills and practices to become an accredited CfD therapist (Sanders and Hill, 2014). It is a programme the authors claim to be one of continuing professional development. Although participants found aspects of the training familiar, such as the PCT content, or stimulating, such as the EFT content, the brevity of the 'classroom' period of training was such that learners felt insufficiently prepared for what was expected of them in terms of learning in the workplace and preparedness for the process of assessment. A curriculum review is proposed, to examine the impact on learning from what participants referred to as a 'wrong way round training'.

Assessment of therapist competence is a major component of the CfD curriculum. However, participants expressed concern about the method of assessment. Their concern is that the current assessment method fails to capture a comprehensive picture of therapist competence. This concern arose because assessment focuses solely on that which an assessor can infer from a short audio recording. As Sanders and Hill (2014), in the CfD textbook, define competence as the judicious combination of knowledge and skill when working with clients in complex real life situations, it seems reasonable to ask, as the participants asked, why therapist knowledge and judicious use of that knowledge in complex situations is not tested. A review of the current assessment method is recommended in order to reconsider whether it is actually assessing therapist competence.

Those involved in a CfD programme are encountering many new phrases, for example, framework of competences, competence-based practice and adherence to a therapeutic model. Many participants had their own ideas on the meaning competence but considered the competence framework as irrelevant or could be ignored in terms of becoming a CfD accredited therapist. There is a need for a profession wide debate to clarify definitions and the development of a shared understanding of the culture of competence as more and more therapies adopt the competence-based approach to therapy.

Conclusion

Most participants in this study were supportive of CfD and / or relieved that it had become available as it meant NHS jobs were secured. The identified tensions indicate the need for modifications to the existing training programme or the development of a new programme if such tensions are to be avoided in the future. As a training programme it ill-prepares therapists for what is expected of them in the workplace and during assessment. The participants view of competence, what it means, how it should be developed and then how therapist competence should be assessed is at variance with the CfD competence-based training and assessment programme. They have suggested changes to both CfD training and the assessment method which would address their expectations as to what it means to undertake competence-based training and becoming a competent practitioner. Integrating the person-centred approach with emotion-focused therapy was a particularly difficult challenge. The overall impression is that it is not a training programme in terms of new learning and equipping people with the competences which underpin a new integrated therapy. Rather it appears to be an assessment programme aiming to ensure experienced participants adhere to a particular PCE model of therapy. The PCEPS has been challenged in terms of its ability to measure participant competence. The participant's prior experience is acknowledged by Hill (2011) to be an essential component within CfD training and assessment. Therefore, it may be possible that another form of training could be adopted, one that incorporates an Accreditation of Prior Experiential Learning (APEL) process as a means of recognizing existing competences, plus, if necessary a 'top-up' training programme. Alternatively, the detail and scope of the competence framework suggests that it

could form the basis of a training curriculum for people new to PCE therapy. However, this may require a more traditional longer period of training, including the integration of workplace experience, together with a multi-method approach to the assessment of participant / trainee competence.

There are areas where a wider professional debate on the direction that CfD and the other competence-based therapies are taking counselling and psychotherapy would help therapists when reflecting on their own career path. Like the medical, legal and nursing professions, counselling and psychotherapy is establishing competence-based specialisms, for instance, depression therapists, child counsellors and on-line counsellors. While in the past becoming a specialist was a matter of choice, following initial training, it now appears that trainees will have to focus on a particular competence-based training route. The on-going SCoPEd project, with its focus of the competences and practice standards for counsellors and psychotherapists when working with adults seems to be just another step in the process of identifying particular role competences and acceptance that this change will continue for the foreseeable future. However, what is unclear is whether training in a specialism, such as becoming a depression therapist, based on prescribed competences, will handicap or enhance the career prospects of primary care therapists.

The culture of competence and the language of audit and evaluation are relatively new concepts within counselling and psychotherapy. The competence-based model is transforming the field of counselling and psychotherapy. The CfD curriculum presents an initial competence and training model designed specifically for person-centred and emotion-focused therapy. However, the findings suggest that aspects of the CfD competence-based training model require further development, and in order to avoid the confusion and ambiguity which surrounds competence there is a need to address questions of meaning and definition.

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Appendices

Appendix 1 – DSM-IV Clinical Guideline 90

Appendix 2 – The CfD Training Programme

Appendix 3 – Chart comparing the PCEPS items/CfD competences/ SfH humanistic competences

Appendix 4 - Letter of Invitation

Appendix 5 – Research Information Sheet

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Appendix 1 – DSM-IV Clinical Guideline 90. Appendix C (NICE, 2009)

Key symptoms

- persistent sadness or low mood and / or
- marked loss of interests or pleasure
- at least one of these, most days, most of the time for at least two weeks.

If any of above present, ask about associated symptoms:

- disturbed sleep (decreased or increased compared to usual)
- decreased or increased appetite and / or weight
- fatigue or loss of energy
- agitation or slowing of movements
- poor concentration or indecisiveness
- feelings of worthlessness or excessive or inappropriate guilt
- suicidal thoughts or acts

1. Factors that favour general advice and active monitoring

- four or fewer of the above symptoms with little disability
- symptoms intermittent, or less than two weeks' duration
- recent onset with identified stressor
- no past or family history of depression
- social support available
- lack of suicidal thoughts

2. Factors that favour more active treatment in primary care:

- five or more symptoms with associated disability
- persistent and long standing symptoms
- personal or family history of depression
- low social support
- occasional suicidal thoughts

3. Factors that favour referral to mental health professionals:

- inadequate or incomplete response to two or more interventions
- recurrent episode within one year of last one
- history suggestive of bipolar disorder
- the person with depression or relatives request referral
- more persistent suicidal thoughts
- self-neglect

4. Factors that favour urgent referral to specialist mental health services:

- actively suicidal ideas or plans
- psychotic symptoms
- severe agitation accompanying severe symptoms
- severe self-neglect

Appendix 2 - Counselling for Depression - Training programme

Pre-training Entry requirements	On-training – Part one 5 day taught programme – Divided into 10 half days for 10 Modules	Assessment (formative) at the end of the 5 days	On training – Part two 3 months (approx.) of supervised practice Completion of 80 hours (from which 4 audio recorded sessions with different clients will be assessed).	Assessment (summative) leading to CfD status
• Qualified Humanist Practitioner • Be accredited or registered with a professional or regulatory body • 2 years post qualification providing brief therapy for clients with common mental health problems, inc. depression. • Self-assessment (optional)	Modules: 1 & 2 - Induction to IAPT / Depression 3. Competence-framework Orientation 4. Theoretical principles & Values 5. Working with depression 6. Working briefly 7. The CfD relational stance 8. Working with emotional processes 9. Assessment of therapist competence 10. Supervision and clinical practice.	20 minute video / DVD recorded session with a training colleague.	Completion of 80 hours (within an IAPT service). Minimum 4 sessions to be audio recorded for assessment purposes – with different clients & two from the latter phase of counselling. Supervision to be provided either individually or in groups of 3 – 4. Supervision to be at least every two weeks – individuals to have a minimum of 1.5 hours per month (or the equivalent group supervision). Supervisors to provide a report on each trainee evidencing their engagement in the supervisory process.	4 audio recorded sessions to be assessed against the Person-Centred Experiential Psychotherapy Scale (PCEPS) - + two opportunities to resubmit for recordings failing to meet the threshold for therapy adherence.

Appendix 3 – Comparison of PCEPS

	Appendix 3 - Comparison of PCEPS, CfD Competences and the Humanistic Framework Competences			
No.	**PCEPS item**	**CfD Competence**	**Humanistic Competence**	**Comment**
1.	**Client frame of reference / track** How much do the therapist's responses convey an understanding of the client's experiences as the client themselves understands or perceives it? To what extent is the therapist following the client's track? Rating: 1 = no tracking 6 = excellent tracking	There is no reference to 'tracking' in the list of CfD competences. However, there is a CfD competence G7 which states 'ability to foster and maintain a good therapeutic alliance and to grasp the client's perspective and world view'. The CfD list of competences also has 'ability to work with the client to establish a therapeutic aim'	There is only one reference to 'track' in the 200+ statements within framework under 'ability to work with the client to establish a therapeutic aim' This framework also includes 'ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and world view'.	Therapists would have to search across the PCEPS, CfD competences and Humanistic competences to make sense of the PCEPS item. The CfD and humanistic competences are the same but a therapist would have to look at the humanistic competence to find out what is expected under 'ability to foster..' and 'ability to work with the client…'.
2.	**Psychological holding** How well does the therapist metaphorically hold the client when they are experiencing painful, scary, or overwhelming experiences or when they are connecting with their vulnerabilities?5 Rating: 1 = no holding 6 = excellent holding	There is no reference to 'psychological holding' in the CfD competence framework. A therapist would have to search for something that looked apposite e.g. 'G8 'ability to work with emotional content in sessions' and S4 'ability to help clients make sense of experiences that are confusing and distressing'	G8 and S4 (the same wording) appear in the humanistic framework – plus more detail on what is expected or not of a therapist.	The difference in wording between the PCEPS and CfD competences is confusing and requires the therapist to make assumptions about which competences are covered by the item.

3	**Experiential Specificity** How much does the therapist appropriately and skilfully work to help the client to focus on, elaborate or differentiate specific, idiosyncratic or personal experiences or memories, as opposed to abstractions or generalities? Rating: 1 = no specificity 6 = excellent specificity	The CfD competences make no reference to experiential specificity but the CfD competences S1 (ability to help clients to access and express emotions), S2 and S3 seem close to what a therapist has to be doing when demonstrating this item.	The humanistic competences are the same as those expressed in the CfD competence framework – but in a lot more detail.	The language of the item means that therapists would have to search and compare the item with the CfD competences, and probably more importantly, the humanistic framework (because it is so much more detailed) to find which competences may be being addressed during assessment.
4	**Accepting Presence** How well does the therapist's attitude convey an unconditional acceptance of whatever the client brings? Rating: 1 = explicit non-acceptance 6 = excellent acceptance	The CfD competence B8 'ability to experience and to communicate a fundamentally accepting attitude to clients' is similar to the item apart from differences in language e.g. presence rather than attitude. B3 = Knowledge of the person-centred conditions for, and goals of, therapeutic change. B7 = Ability to communicate empathy B9 = Ability to maintain authenticity in the therapeutic relationship	The same (B8) competence appears in the humanistic framework – but in significantly more detail.	Considering the textbook and CfD competences place such stress on the person-centred stance of CfD practice it seems strange that, apart from acceptance, aspects of P-C practice, such as empathy, warmth, positive regard, being genuine, transparency and being authentic (CfD B3, B7 & B9) are either missing or appear less important in the PCEPS which might disturb person-centred therapists. CfD meta-competence M7.1 is 'an ability to balance the need for warmth and acceptance with the need to be congruent and transparent with clients' but how is 'balance' to be interpreted or is everything subsumed under acceptance?

5	**Content Directiveness** How much do the therapists responses intend to direct the client's content? Do the therapist's responses introduce explicit new content e.g. explanation, guidance, teaching, advice etc. Rating: 1 = 'expert' directiveness 6 = excellent non-directiveness	The CfD competences make no reference to 'content directiveness' except within the meta-competence M4 'maintaining a person-centred stance'. M4.2 states - 'an ability to maintain a balance between directive and non-directive dimensions of the therapeutic process'.	The humanistic framework contains the same meta-competence.	It seems that therapists will get a higher assessment rating if they behave in a more non-directive way and yet the CfD and humanistic competence seems to suggest that it is the balance between directive and non-directive which an assessor needs to look at (as in meeting the client needs e.g. G6 'ability to engage client' and G7 'ability to foster and maintain a good therapeutic alliance..'
6	**Emotion Focus** How much does the therapist actively work to help the client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit? Rating: 1 = no emotion focus 6 = excellent emotion focus	The title of this item is very close to the CfD competences S1, S2, S3 and S4.	The humanistic and CfD competences are the same.	This is perhaps the best match between an item and the CfD competences. Perhaps this says something about where the therapeutic emphasis is to be found in CfD therapy and how CfD conceptualises depression i.e. that depression results from particular types of emotional experience, emotional processes and ways of construing the self.
7	**Dominant or Overpowering Presence** To what extent does the therapist project a sense of dominance or authority in the session with the client? Rating: 1 = overpowering presence	The wording of this item does not appear in the CfD or humanistic competences. Perhaps the nearest CfD meta-competence is M5.2 = Ability to hold authority and contain the therapeutic process while sharing power appropriately with the client, but how is this to be	**The humanistic framework contains the same meta-competence as CfD M5.2**	This item may be included within a number of CfD competences but a therapists / assessor would have to search through the list of CfD competences to identify where this item may be covered – which are the relevant competences – this could lead to many confusing interpretations.

	6 = empowering presence	interpreted?		
8	**Clarity of Language** How well does the therapist use language that communicates simply and clearly to the client? Rating: 1 = no clarity 6 = excellent clarity	There is no such CfD competence but this item is perhaps covered by many competences e.g. were therapists are required to explain, helping clients articulate emotions, use of imagery / metaphor and verbalising key concepts etc.	Same as the CfD comment across the humanistic competences – however, they contain so much more detail with regard to what is expected of a therapist (than the CfD competences and PCEPS item).	The PCEPS makes no reference to CfD competence 'ability to work with difference (cultural competence)' which may be a major omission when participant competence is considered.
9	**Core Meaning** How well do the therapist's responses reflect the core, or essence, of what the client is communicating or experiencing in the moment? Rating: 1 = no core meaning 6 = excellent core meaning	'Core meaning' is not a term found within the CfD competences. There are a number of competences which may cover 'core meaning' e.g. G7 which contains the phrase 'client's world view' or S3.1 – ability to help clients explore…assumptions	'Core meaning' is not a term used within the humanistic competences.	**Unless trainers explain what 'core meaning' or 'essence' means or suggests which of the competences therapists should perform to cover this PCEPS item then participants would have to make this decision on their own when working with clients in the workplace. May lead to different interpretations.**

| 10 | **Emotion Regulation Sensitivity**
How much does the therapist actively work to help the client adjust and maintain their level of emotional arousal for productive self-exploration?

Rating:
1 = no facilitation
6 = excellent facilitation | There is no such CfD competence which uses this item terminology but at least two of the competences may address this item e.g. S1.5 'an ability to help clients achieve a level of emotional arousal that is optimal for exploring their feelings' and S4 'ability to help clients make sense of experiences that are confusing and distressing'. The words 'regulation' and 'sensitivity' are not used in the CfD competences. | The wording of this item does not appear in the humanistic competences. | The 'regulation' of emotions is an important aspect of emotion-focused therapy but within the CfD competences the nearest comment is within S1.5 or S4 'ability to help clients make sense of experiences that are confusing and distressing'.

Once again participants would have to work out which CfD competences they would need to demonstrate to address this PCEPS item - or just focus on the PCEPS item and disregard the competences / not be concerned with interpretations. |

Appendix 4

Counselling and competence: the CfD perspective

Letter of Invitation for CfD Trainees / Counsellors / Trainers / Supervisors

Dear Counselling for Depression Trainee, Counsellor, Trainer and Supervisor,

My name is Reg O'Brien. I am a qualified, accredited and registered counsellor on the Professional Doctorate programme in the School of Human and Health Sciences at the University of Huddersfield. I am carrying out a study exploring the concept of competence, competence-frameworks and the CfD competences from the perspective of people involved with, or have been involved with, a Counselling for Depression programme.

I would like to invite you to participate in my study. If you are willing or interested in taking part in the research please email me at the address below.

Participation would involve attending for a single face-to-face interview lasting between 1 and 1.5 hours.

A mutually agreeable date, time and location for the interview will be arranged once contact has been established.

If you are willing to take part or would like to receive further information prior to deciding whether to take part please contact me at u0420845@hud.ac.uk

Thanking you for your time,

Reg O'Brien.

Information Sheet for
Counselling for Depression Counsellors (Trainees), Supervisors and Trainers

Introduction

My name is Reg O'Brien. I am a Professional Doctorate counselling student at the University of Huddersfield.

You are being invited to take part in a research study. You have received this information sheet because I am interested in exploring how competence is being interpreted within the context of the Counselling for Depression (CfD) programme. I want to explore counselling and competence, competence frameworks and the CfD competences from the perspective of CfD trainees, counsellors, supervisors and trainers.

Before deciding whether to take part, it is important that you understand why this research is being carried out and what participation will involve. Please read the information carefully as it gives an explanation of the research study. This information sheet has been produced to help you decide whether you would like to participate in the research.

The Research

This Professional Doctorate research aims to explore counselling and competence, competence frameworks and the CfD competences from a CfD perspective. To do this, I would like to talk to trainees, counsellors, supervisors and trainers, who are participating in or have participated in a CfD programme.

The Researcher

This study is being conducted by Reg O'Brien from the School of Human and Health Sciences of the University of Huddersfield. The research is being conducted for the purpose of producing a Professional Doctorate thesis exploring counselling and competence frameworks from a CfD perspective and in particular from your perspective. I am independent to your CfD training.

What does taking part involve?

If you decide that you would like to participate, you will take part in one face-to-face interview with the researcher. The Interview will last between 1 and 1.5 hours and held at a date, time and location convenient to you and be arranged if you decide to go ahead with the study.

The interview is designed to help you explore your thoughts with regard to the CfD competences and the CfD framework. In the interview you will be asked to talk to the researcher about what you feel is important and why.

Before the interview begins you will be asked to sign a form giving your agreement to participate, and you will be asked to confirm that you are still willing to take part. You will not have to answer any questions that you do not feel comfortable with. Interviews will be recorded and typed up word for word to enable an analysis of the content.

Why have I been chosen?

You have expressed an interest in taking part in this study and contacted me for further information.

Do I have to take part?

Providing your contact details, or responding to this request for participation, does not put you under any obligation to take part in the study. It is not a requirement of a CfD programme that you should take part, so deciding not to take part will have no consequences for progression on your CfD programme or practice.

What if I change my mind?

You may withdraw at any time before or during the interview without having to give any reason for your decision. You may also ask me to withdraw your data from the study within two months of the interview. Withdrawal from the study will have no consequences for you.

What happens to the information I give you?

Interviews will be recorded and transcribed (written-up, word-for-word), but your name will be anonymised during transcription, and you will not be identified in any reports or presentations produced from the study. All identifying information, such as names and locations will be altered or removed. You will be able to check the transcript to ensure you are satisfied with the level of anonymity. Your name and contact details will not be stored together with your recordings or transcripts. All data will be securely stored with the researcher for a period of five years. The audio recording will only be available to the researcher, research supervisor and transcriber. The transcriber will sign a confidentiality agreement and delete the file of transcriptions once they have been forwarded to the researcher. The information collected during the interviews will be analysed and presented in a Professional Doctorate thesis. The Professional Doctoral thesis will be made available through the University of Huddersfield Repository.

What will you do with the results of the study?

The results of the study will be written up in a doctoral thesis, research journal articles and disseminated at research conferences.

Who has approved the study?

The study has been approved by the University of Huddersfield's Human and Health Sciences School Research Ethics Panel (SREP).

What will I do if I become distressed as a result of participating in the research?

This is very unlikely. However, if you do not have access to supervision, personal therapy or university / institute counselling service and wish to discuss any issues arising from participating in the research, the researcher will provide you with a list of contacts for such support.

Further information
For further information, to ask any questions about the study, or to register your interest in participating, please e-mail Reg O'Brien within seven days at u0420845@hud.ac.uk

No.	M	F	Therapist	Trainer	Supervisor	Years of experience post qualification	Modality	Comment / additional background information
							Appendix 6 – Participant Chart	
1	x		x			3	P-C / Integrative	Volunteer and private practice
2		x	x			3	P-C and relationship counsellor	IAPT experience
3		x	x		x	15	Integrative	NHS experience
4	x		x			20	Gestalt	IAPT / NHS experience
5		x	x			6	Integrative – psychodynamic + humanistic	IAPT experience
6		X x	X x		x	8 12	P-C /systemic + psychodynamic P-C	IAPT experience IAPT experience
7		x	x			13	P-C / humanistic	IAPT experience
8		x	x			2.5	Integrative – P-C, existential and Gestalt	IAPT / NHS experience
9		x	x			6	Psychodynamic	IAPT / NHS experience
10		x		x		24	P-C + other modalities	IAPT / NHS experience

11	x		x			15	Multi-modal approach	NHS experience
12		x	x	x		20	P-C	NHS experience
13	x		x	x		20	P-C	NHS experience
14		x	x			2+	Integrative – P-C, humanistic, CBT, Gestalt, existentialism	IAPT experience
15		x	x			3	Integrative – P-C, TA, Gestalt	IAPT and Private
16		x	x		x	19	Integrative – P-C, CBT + solution-focused	IAPT experience
17		x	x			8	P-C, CBT + other modalities	Private practice
18		x	x		x	18+	P-C, TA and some CBT	NHS / IAPT experience
Totals	**4**	**15**	**18**	**3**	**4**	**Average 11+ years counselling experience**	**A mix of modalities inc. P-C, psychodynamic, TA, CBT Gestalt and solution-focused**	**17 with NHS/IAPT experience 2 Private practice**

Appendix 7 – Ethical Approval

From: Dawn Leeming <D.Leeming@hud.ac.uk> on behalf of Dawn Leeming
Sent on: Monday, December 7, 2015 12:34:19 PM
To: Reginald O'Brien U0420845 <Reginald.O'Brien2@hud.ac.uk>
CC: Kirsty Thomson <K.Thomson@hud.ac.uk>; Viv Burr <v.burr@hud.ac.uk>
Subject: Revisions

Hi Reg,

This looks fine - SREP can approve your revisions. Approval is based on the understanding that you will gain any necessary permissions to post your letter of invitation on the research network and that you and your supervisor will review management of any risks in traveling to interview unknown participants e.g. arranging to contact someone on return. (No need to redo risk assessment form - seems safe to assume there isn't too much risk in interviewing trainee counsellors though!)

Good luck with the research, Dawn

Dr Dawn Leeming
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From: Reginald O'Brien U0420845
Sent: 05 December 2015 15:00
To: Dawn Leeming
Cc: Kirsty Thomson
Subject: amendments

Hi Dawn, please find attached amended documents a) my Letter of Invitation and b) my Information Sheet. Following your queries and after a discussion with Viv I have decided to stay with just face-to-face interviews, no focus groups, and so the only change in recruitment is through my professional body's research network. I will post an email on this network and attach my Letter of Invitation. If someone then wishes to follow-up they can contact me via my student email address and I will then send them to Information Sheet.

There is a change to my research title. I have removed the word 'framework' from the title as I think this better reflects the focus of my research. This has had a knock-on effect with regard to the wording within the Information Sheet and Letter of Invitation. Reference to focus groups or alternative interview techniques has been removed from both documents.

Reg O'Brien

Counsellors and competence: the CfD experience

Consent Form.

Title of Project: Counsellors and competence: the CfD experience.

Name of Researcher: Reg O'Brien, Professional Doctorate student at the University of Huddersfield.

Please tick box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any consequences for me. ☐

3. I understand that I may request my data be withdrawn from the study, within two months of the interview , without consequences for me. ☐

4. I understand that the interview will be audio recorded ☐

5. I understand that all information I provide will be treated as confidential, and will be anonymised. ☐

6. I agree to the use of anonymised direct quotes in the thesis, publications and presentations arising from this study. ☐

7. I understand that the findings from this study will be published in the form of a Professional Doctorate thesis, journal articles and conference presentations. ☐

8. I agree to take part in the above study. ☐

_____   _____   _____
Name of Participant   Signature   Date

_____   _____   _____
Researcher   Signature   Date

Appendix 9 – Final template and example quotes

1. **Theme: CfD: A threat or an opportunity**
   - I think counselling needed a way to be able to survive within the NHS to provide what it was doing anyway
   - Need to be IAPT compliant
   - If that's [the competence framework] going to be a contender in the marketplace, then I think it's important we start to articulate clearly to funders and other people what it is we do and why it works
   - If counselling is actually going to have a future we've got to be in there, so it's a political decision to support this CfD project
   - I chose CfD for two reasons… to keep my accreditation and our service pays more for someone that is IAPT trained
   - If you don't attempt some sort of measures to get people to a certain level of competence…if you just call it counselling… then counselling is never going to be taken seriously [by NICE, NHS and IAPT]
   - It feels like we'd better to do it [produce CfD], even though it rankles, because otherwise we'll be lost
   - Everything was just going downhill rapidly in terms of the NHS culture and everyone being a number and cuts and more and more constraints on how everyone could work within IAPT. I could see the writing on the wall for any kind of ethical counselling
   - Every team member was given the opportunity and I would say more quite strong encouragement to train in a NICE approved model

   ## 1.1 Having no choice: jobs under threat
   - You would no longer be able to work, do short term work for the NHS
   - It's necessary and, understood, I think that's where we are these days, it's necessary and err, that's why I agree to do things like this [CfD], it's necessary to keep the humanistic side of therapy alive and available
   - If we don't complete it [CfD], we won't have our job
   - I knew it was important to have some sort of qualification [CfD] for the work I'm doing, the step three that I'm doing [in IAPT]
   - It looks like that's the way it's going [in IAPT], so you need an additional training on top of whatever you trained in, I had to do this, the CfD, to have this job, if I don't complete it I can't stay
   - Working in the NHS it's become very clear that you have to be, in order to continue working short term in the NHS, you need to be IAPT compliant…I felt we were being told…that unless you did a course within the next couple of years you would no longer be able to do short term work for the NHS
   - It's really a brave thing to do, to kind of expose yourself [to the training], and a lot of people haven't got a choice if they want to keep their job
   - The powers that be decided that all counsellors needed CfD training in order to tick off the box from the commissioners
   - I think it was, err, the NHS asked me to re-train, erm, to make sure that I was compliant with IAPT recommendation

   ## 1.2 Accountability and good practice
   - It's unfortunate that it's a world that wishes to prescribe and sort of minimise the potential which can happen between two people
   - So I need to have some autonomy as a practitioner to offer whatever is, whatever feels required at any moment
   - It's useful to be able to say this is what we do…because of the world we live in we need to be accountable
   - I do believe in accountability…there is something important about not just doing whatever you want to, and not having any sense of accountability…we're learning a language so that we can talk to people about what we do, we can actually communicate that we do x and y and these are the reasons why we do it, so that it can be more accepted and more understood…we do need to be accountable and professional
   - It's a means to an end and it's good to see something like CfD in the NICE guidelines

1.3 Auditability and good practice

- I have been particularly impressed actually that somebody has written these competences in a way that means humanistic psychotherapy can be audited…which it traditionally has not been able to show itself in the past
- It has to do with focus and quality…a framework for doing this particular kind of therapy as opposed to other versions of therapy…it has to do with securing a level of quality to the therapy we deliver
- The movement towards a competence approach is really good…it's a way of assessing who can and who can't [do CfD] and providing evidence
- There's lots of varied understanding of what CfD means…so having to call it a manual is nonsense, it's an interpretable feast really (making it difficult to use for auditing CfD practitioners)
- I would recommend to carry on with the standard approach to training…but then it's always going to be the question of measuring it, isn't it, which comes up everywhere
- I' guessing it's [the competence framework] something to do with standardisation, making sure everybody is singing from the same hymn sheet

2. Theme: Tensions in the CfD model

- There's lots of varied understanding of what CfD means, so having to call it a manual is nonsense, it's an interpretable feast really
- I don't have a problem really with the content of the competences and the framework…it's just the concept…something about feeling like I have to channel my attention towards working in a particular way
- I guess the bit I struggle with is the more scientific approach, the more evidence based approach and how much further down the spectrum to go
- I think it [the CfD model] does feel quite rigid, it does feel quite, that the round hole with the square peg has got to fit into, it feels quite tight
- For me a personally challenging bit was how still to do it [CfD] without stepping out of the client's point of reference, how to do it and still in a way that I'm not, erm, I wouldn't say directive, but still respectful of how the client is, because in terms of my own work I believe in, I call it the principle of non-directivity
- I bought the EFT book…the thoughts I had afterwards was that I would prefer to have more of that…I don't recall having a lot been said in training, how do we assess suitability for CfD
- They really want to be hearing a lot of the process guiding [EFT] and that's the new stuff, and that's very controversial isn't it for pure person-centred counsellors

2.1 Tensions between PCT and EFT

- The difficulty with this model…it's putting classical PCT with EFT which is much more directive
- It's a massive compromise…modifying years of practice and developing their own style
- Feels like I'm being pulled in two directions
- Part of me kind of was starting to kick back in and I was finding it hard
- I will not compromise
- That directivity…I think that's a real problem for some people
- It goes against the grain for me to have it all written down like that [the competence framework] because I think it can be such a subtle skill, a subtle exercise, a subtle engagement between two people, and I don't think those things can be written down
- I found I was kind of guiding my clients towards what I needed…I felt I was being pushy and digging [rather than being person-centred]
- I ignore the competence framework entirely…the competence framework I think is fairly irrelevant

2.2 I can't be fully me

- I don't feel fully me in a session when I'm working with this model
- There are times when I don't feel very person-centred because I'm pushing for these competences / items
- I'm bringing a lot of myself to counselling…my own experience, which is not covered by the competences
- This is where the therapist takes the lead and this is where there's a conflict with me
- This is much more structured and disciplined…I find it restrictive in a way

- CfD feels like it's trying to narrow it [my practice]
- It feels like it takes me away from the range of things that I could be referring to in order to best work
- I found it very difficult to move away from the way I work

2.3 Is 'Counselling for Depression' just 'counselling'
- Can be used with just about anybody
- Shame it got called CfD – better to just call it counselling
- All sorts of things I've found it useful for
- Just have to say it's depression – to get it through NICE
- You can apply the same model, it seems to me, to a whole lot of other things
- The idea of CfD is good but maybe it should just be called Counselling for Living
- No two people are the same, and this model [CfD] won't fit everybody with depression
- It's got to hook itself on a medical condition…but it's also good for trauma, …anxiety and bereavement
- It's a medical model but it's not a medical approach
- This is the difficulty when it's coming from a medical view because they actually believe these things exist as discrete illnesses but the person-centred approach doesn't actually recognize them as illnesses, full stop
- From my point of view I don't particularly look at somebody in terms of their diagnosis, I find that quite alien
- I mean I didn't expect it [CfD] to be as useful as it has been…funnily enough, for working with people with depression, but all sorts of things, so although it's called counselling for depression, I think it can be counselling for other things as well

3. Theme: Tensions in CfD training
- It's [the competence framework] has been read and acknowledged but it's kind of gone out of the window and this [the PCEPS] is my focus
- In terms of the detailed [competence] framework I don't know anybody who's used it in practice…in practice it is the PCEPS
- That makes sense [the PCEPS], this is what I understood…this stuff [the competence framework] doesn't make a lot of sense
- I think I assumed that competence meant the PCEPS and actually when I was reading a bit more about it I then questioned that
- It's just words [the competence framework], it doesn't really mean anything really it…it's all so subjective, they're trying to make really subjective things objective
- You might be good technically with all those ten things [the PCEPS] but actually not connecting with the client
- It seems that adherence to these competences can mean that you are, or have one aspect to your counselling practice that is recognized as competent, but it doesn't perhaps recognize those other aspects of competence which are outside that framework

3.1 Training is the wrong way round
- Really you need to, as we know, you need to do the theory before you do the practice, but here it's been the other way round
- You have to do the theory and the practice on your own
- The experience of the distance learning aspect of the training is, erm, I'm finding it a little difficult…it's a bit solitary…a bit disconnected
- The problem is of course there's very little support when people get back to their workplace to continue that idea [working with CfD] unless there's places where lots of people have trained and there's some kind of peer support…it's trying to hold on to what they already know in light of all the other stuff that's being thrown at them in the workplace
- How the hell do you learn to be a person-centred practitioner, even if it's a person-centred emotion-focused practitioner, in five days
- The training was very, very condensed and so these things take a lot of practice and you need to observe them in action to really know well

3.2 Limitations of the assessment method

- From a practical point of view we're limited to the number of sessions we have because that's what the recordings are going to be measured against
- It's not actually measuring my competency as a therapist, it's measuring whether I, to all extent, I meet that particular criteria at that particular time…but there is something then that becomes quite arbitrary about the grade, why grade it at all…I haven't got any faith in it
- The language I guess may set up an expectation that there's a band of acceptability or something is required, which does sort of rub up against [my previous training] training…and whether I'm doing enough sort of refined CfD to meet the requirements of assessment, that's where I sort of struggle
- I suppose it's almost like you're kind of hearing a stretch of recording because it's rarely possible to listen to a whole recording or it's impossible actually…almost kind of working out what proportion of responses, erm, adhere to a particular, err, particular descriptors in the PCEPS…I kind of get a feeling for it

3.2.1 inadequate measures

- The scale felt a bit small… a bit limited
- Not sure how an assessor does that [assess] when they listen to a 20 minute recording…it doesn't feel enough
- It can feel a bit crude
- Trying to measure something that's going on between two people
- You can be a competent practitioner and not adhere to a CfD approach
- Generally it's [assessment] by audio tapes, so they're listening in on a session with me and my client, erm, have to guess at whether I'm actually meeting those competences
- We're only given a 15/20 minute window of the tapes
- This number [the scale] represents the degree to which you meet the criteria, it feels quite primitive
- I think that's what benchmarks are for, they're to move people in certain directions

3.2.2 absence of therapist voice

- Taken for granted [knowledge]
- Wasn't aware of it being assessed
- Need to hear from me
- How can they possibly pick up on what you're missing or not missing
- You could have knowledge but not demonstrate it
- It's inferred
- I don't know enough about it [how knowledge is assessed]
- It would help if we could present a case study with the recording
- It's sort of implicit you're doing that, even if it's not in your 20 minute portions
- It feels like I'm being assessed on something really specific that doesn't take account of all that I do
- It's bit infuriating because we know the client and we know what we've worked with beforehand
- We're not robots, but it's interpretation isn't it
- Just because you didn't do it in that 20 minutes doesn't mean that you haven't done it through the course of counselling

3.3. Participants' understanding of competence

-.I ignore the competence framework entirely…assessed by your adherence to this scale
- I'm not really interested in the competences at all
- I suppose its like fulfilling all the kind of competences in the framework
- I guess it's more than kind of having skills that are taught really
- there's much more to competency than perhaps what you can measure
- the competences…they're just for information…I wonder if there is a confusion about terminology
- I suppose the competence-framework does more than explain what's in the PCEPS scale as a measure of whether you're actually working within a CfD modality.
- I don't know (response when discussing whether adherence means competence)
- There's still this little bit of tension between what they want you to do ans your previous training
- This is where the therapist takes the lead and this is where there's a conflict with me (as a person- Centred therapist).