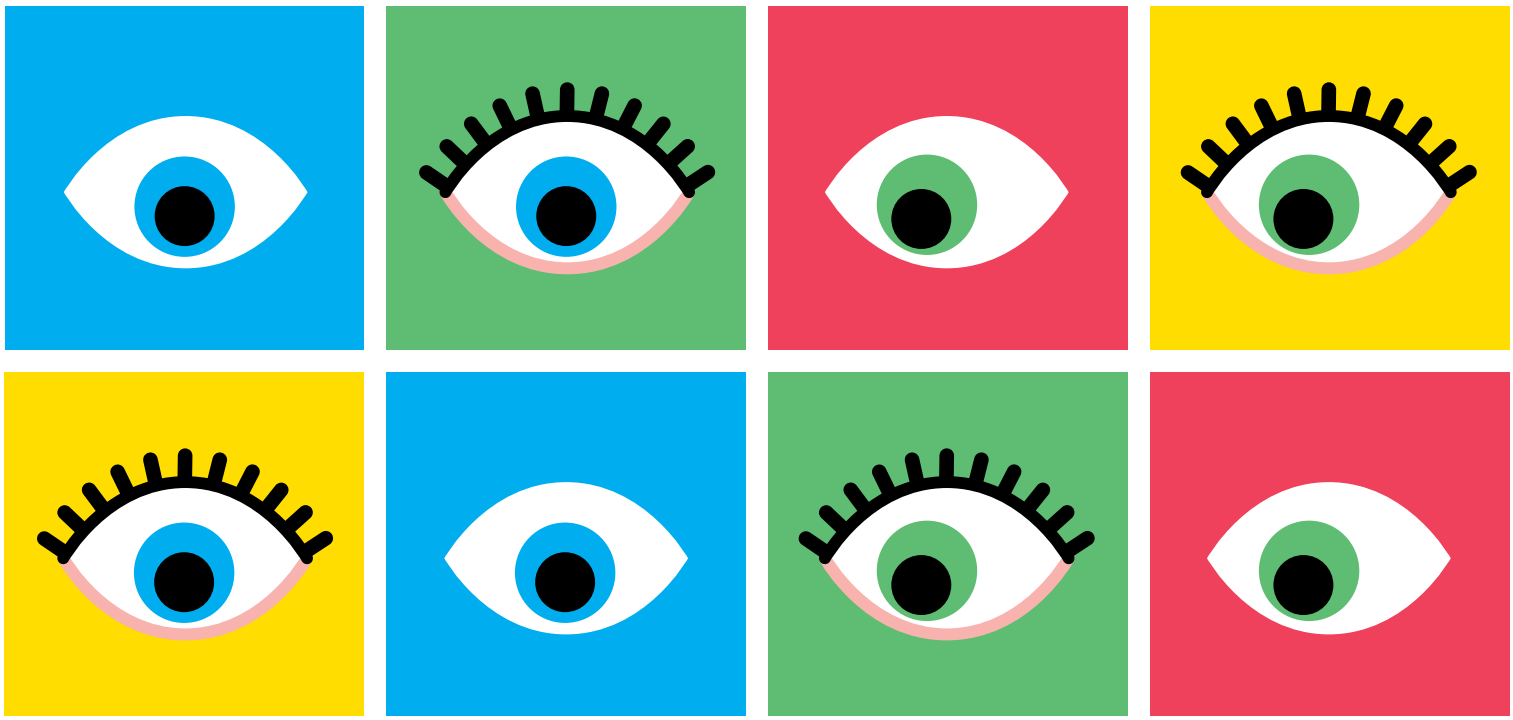
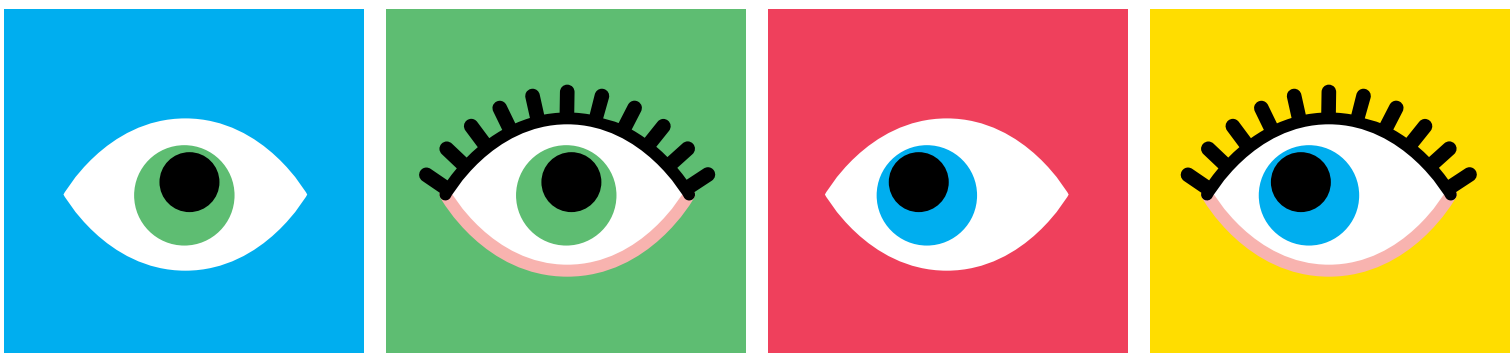
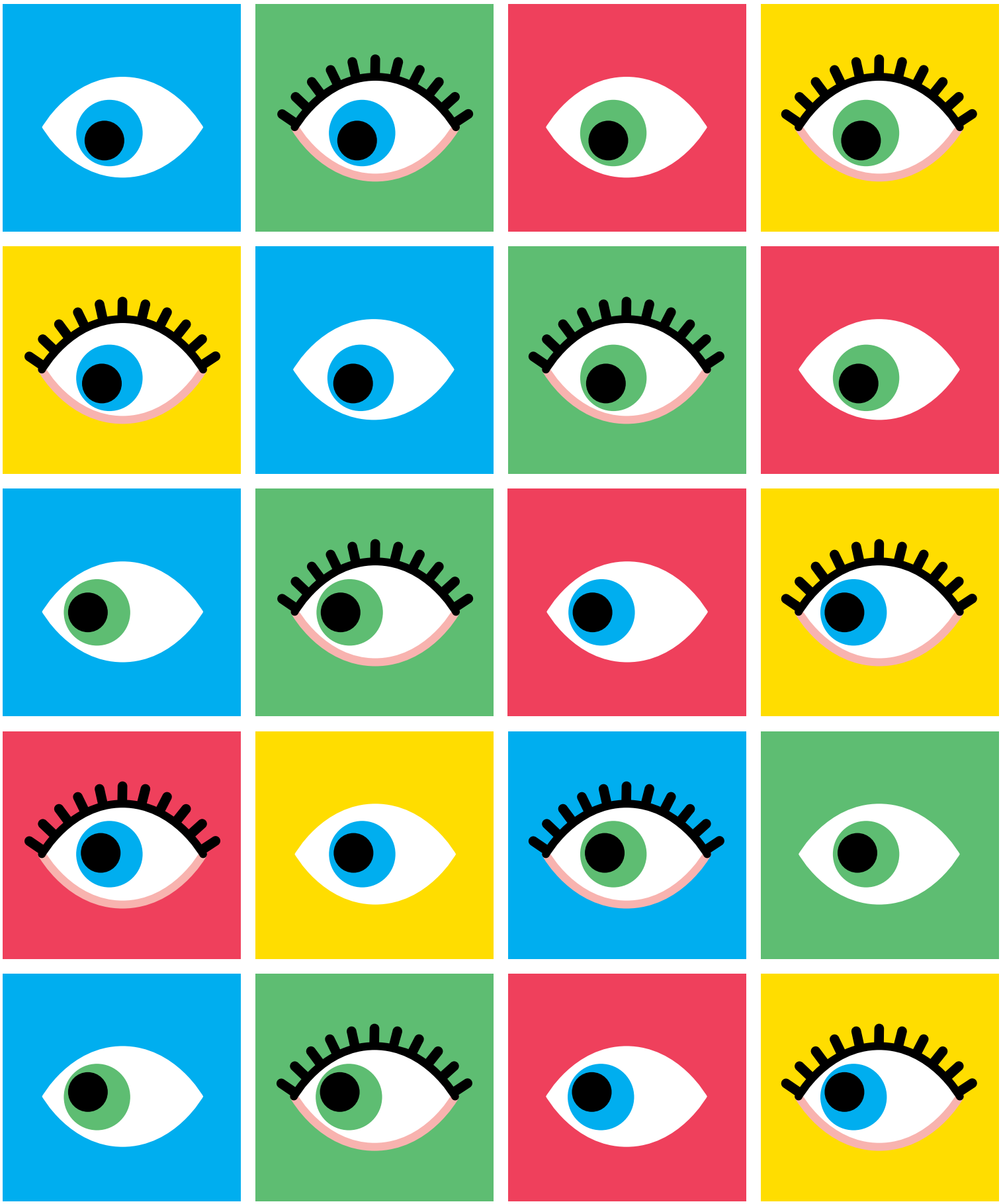


COUNSELLING FOR DEPRESSION: THE PERCEPTIONS OF TRAINEES

AN EVALUATION OF THE FIRST PHASE OF TRAINING BY *PETER PEARCE, ROS SEWELL, ANDY HILL, HELEN COLES, JO PYBIS, JANE HUNT, MAGGIE ROBSON, LYNNE LACOCK* AND *TRISH HOBDAY* ELICITED PRACTITIONERS' VIEWS ON THE INITIATIVE SO FAR





As reported earlier this year[1], together with partners in the higher education sector, BACP has developed a continuing professional development (CPD) training programme for counsellors working in the IAPT programme. The training continues its roll-out and we now have a network of accredited providers covering most of England[2]. The significance of this initiative is that it secures the provision of counselling in IAPT, ensuring that counselling is provided free at the point of access to NHS patients and that the status of counsellors in IAPT is recognised. The training programme qualifies experienced counsellors who already have an initial qualification in person-centred or humanistic counselling/psychotherapy in a competence-based person-centred/experiential (PCE) therapy for people with depression. Counselling for Depression (CfD) is a form of psychological therapy, recommended by NICE as a high-intensity intervention for persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention[3]. It is recommended that between 10 and 20 sessions are offered according to the needs of individual clients.

AN EVALUATION OF THE FIRST PHASE OF TRAINING

The CfD Competency Framework and its associated training programme, together with the Person-Centred and Experiential Psychotherapy Scale (PCEPS)[4], which is used to assess adherence to the CfD model, are important steps on the journey towards PCE counselling being recognised as an evidence-based therapy. Future developments include a CfD textbook to support the training programme, and a randomised controlled trial (RCT) comparing CfD with CBT, both funded and commissioned by BACP. The development of strong links between research, training and practice will help to secure evidence-based status and support choice for users of NHS psychological therapy services.

So far, the number of CfD training places funded by the NHS has been increasing annually; 52 in 2011; 111 planned for 2012; and further training places being negotiated for 2013. Geographical coverage has been variable, with some strategic health authorities investing heavily and others less so. Estimates indicate that up to 30 per cent of IAPT therapists are counsellors[5], and it is vital that this section of the workforce is funded to complete CfD training to increase their own job security and to ensure a continuing choice of therapies in IAPT.

CfD has been generally well received in the counselling field although, as with any new initiative, there are improvements to be made. As it is a new initiative, BACP, and tutors delivering the training, deemed it vital to evaluate the programme and to elicit detailed and structured feedback from trainees in order to better understand their experiences and to make necessary adjustments to the training in the light of such feedback. This article reports on an evaluation of the first year of CfD training, assessing trainees' responses both to the training programme and to the Competency Framework itself.

METHODOLOGY

The evaluation consisted of a questionnaire about experience of the training, and follow-up interviews with some participants. The questionnaire asked about a number of themes: sense of self as a practitioner pre-training; expectations of the CfD training; experience of the five-day taught CfD training programme; the CfD Competency Framework (Generic, Basic, Specific and Metacompetences); experience of supervised practice; experience of the assessment of 80 hours of counselling practice; and the impact of CfD training on practice. All 60 of the counsellors who had taken part in the first round of CfD training were contacted by email with an invitation to complete the questionnaire online and 30 counsellors did so. The majority of the counsellors worked as high-intensity therapists within an IAPT service, many in part-time roles, and all had a minimum of two years' post-qualification experience and had completed a person-centred or humanistic initial training.

Those completing the survey were also asked if they would be prepared to take part in a follow-up telephone interview and a total of six were selected, two participants from each of the three, phase-one, training cohorts. The interviews were intended to give participants more opportunity to talk in-depth about their experience of training as a CfD counsellor. They were audio-recorded, transcribed and analysed by two of the authors for themes that emerged[6,7].

... where supervised clinical practice forms part of the assessment process, the availability of a team of appropriately trained supervisors is a prerequisite to rolling out a training programme

FINDINGS

QUESTIONNAIRES

The questionnaire responses revealed that most participants felt that they had a good understanding of PCE theory and practice pre-training, but very few felt that they had equal status to therapists from other modalities (eg CBT) within their service context. Most participants viewed training in a set of competencies as positive and useful and identified enhancing their status as a significant motivator for participating in the training. There was broad agreement that the CfD competencies accurately described both PCE therapy and how to work with depressed clients from a PCE perspective. A large majority of participants agreed that the CfD supervision provided as part of the training throughout the assessed practice period helped them to align their practice with the CfD Competency Framework. Opinion was more divided about participants' experience of the evaluation of their assessed practice recordings. This more divided response was anticipated, as external assessment of competence is always going to raise anxiety levels, and a number of participants' practice recordings struggled to meet adherence to the Competency Framework. However, interestingly, despite this, there was still very high agreement that the feedback received on assessed practice was clear and supported participants' development as CfD therapists.

Half the participants felt that participating in CfD training had enhanced their status as a therapist, and around three quarters felt that using an adherence scale had been a positive experience. For 60 per cent of participants, CfD training had changed how they practised and had deepened their understanding of how to work with depressed clients. Opinion was again more divided about whether their practice had become more PCE as a result of the CfD training. Nearly half reported that it had, a quarter reported that it had not, and the remaining quarter didn't comment. Sixty per cent of participants, however, reported feeling more confident to work with depressed people since completing the training.

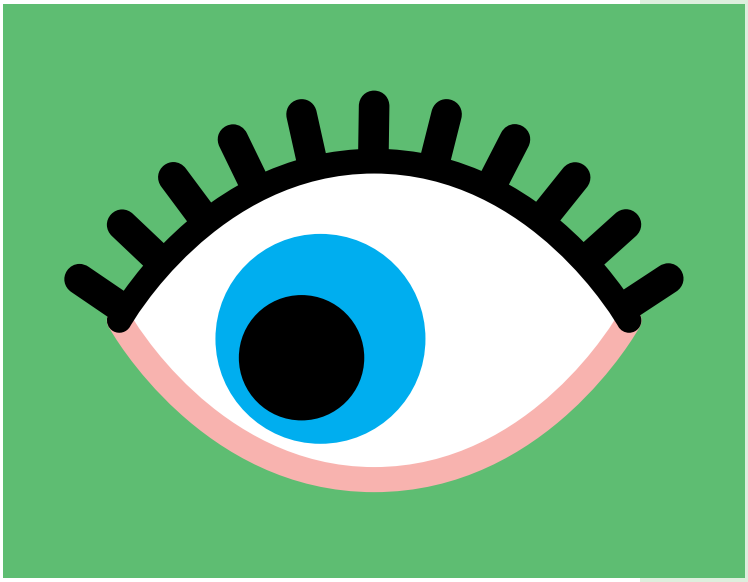
There was a section at the end of the questionnaire that invited open comments from participants. The range of responses is typified by the following two responses:

'In my organisation, I am more valued and this has had an impact on my practice.'

'I don't think the training improved my practice. What it did do was to allow me to re-affirm what I have been doing and what I continue to do.'

SEMI-STRUCTURED INTERVIEWS

The interviews, conducted by two of the authors, produced rich material that both supported and elaborated on the information from questionnaires. Four major themes emerged from these interviews: perspectives on training course delivery; service delivery tensions; the personal and professional impact of undertaking the training; and requirements for further research.



Perspectives on training course delivery: during the interviews, participants were asked to reflect upon their reasons for undertaking the training, their experience of the five-day training programme, and how they felt about the CfD Competency Framework. Respondents identified a mixture of reasons why they undertook the training. These included seeking professional recognition for their counselling work, developing therapeutic skills, and ensuring job security.

Participants talked about a number of strong elements of the training: working again with like-minded people; excellent teaching and tutors; reconnecting to earlier practices; challenging complacency in practice and receiving feedback on their client work; and experience of person-centred supervision. Some of the less satisfactory elements of the training programme were seen to be: the course being too short; difficulties encountered with the assessment process; not enough training input on emotion focused therapy (EFT); and supervisors not being familiar enough with the CfD framework.

Participants were initially cautious about working within a Competency Framework, expecting it to be directive and prescriptive. However, in practice, they found the Competency Framework to be compatible with their way of working and descriptive (rather than prescriptive) of what they already do in their practice. This was typified by one respondent who felt that the framework captured well the essence of what counselling is really all about:

'...the competences about the articulation of emotions and developing emotions... getting to the essence of what counselling is all about.'

Service delivery:

Participants talked about a number of tensions between being trained in the CfD model and then trying to offer this model in their IAPT service settings. The CfD model recommends up to 20 sessions for clients

presenting with depression, and some counsellors found that their service would not allow them, either during or post-training, to offer this many sessions. This lack of flexibility with regard to offering clients more sessions has led to some of the CfD counsellors feeling frustrated in their attempts to implement what they have learnt on the course.

'It was pretty much, the minute the course was finished, it was back to normal, back to try and get clients... patched up in four or five sessions and that sort of thing, so straight away I was... clicked back into having to go back to how I worked before, so I didn't really get a chance to... really engage in what I'd learnt, in some ways.'

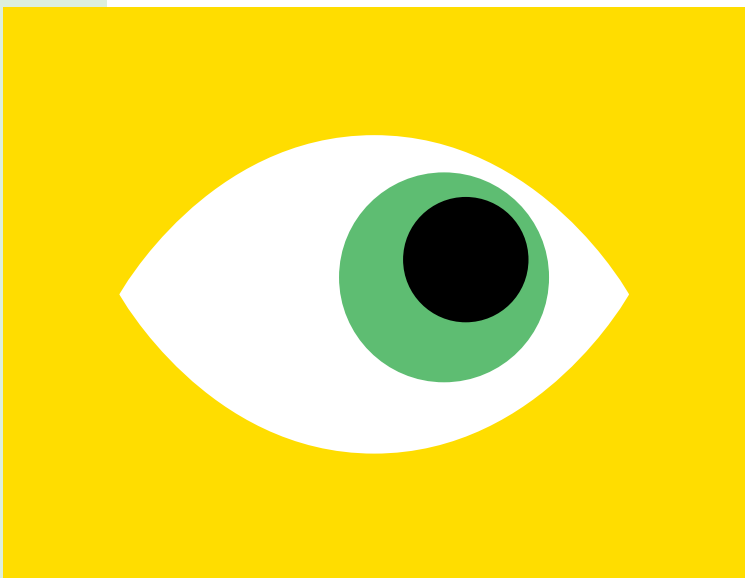
Personal and professional impact:
The training impacted on the counsellors involved in a number of personal and professional ways. Several of the counsellors felt the training had reconnected them with their earlier person-centred practice and values, and one participant stated that it felt like returning home:

'It was going home to a way of working that I had somewhat, not strayed from, but somehow, because of working in a very pressurised environment, I'd actually lost some of it, the spirit of it.'

For one participant, this reconnection was so profound that she experienced it as a healing process:

'A lot of it has got lost in ... more sort of CB... which is fine, and that has its place, I'm not knocking that, but sometimes it does detract from the actual essence of the work, so it was really nice to be able to go back into that, and to really look at how you work with people on a deeper level. And I found... [this] quite healing in a way... It kind of reminds you of why you started out on this process in the first place.'

Several of the counsellors talked about how the training had deepened their ability to work at a greater emotional and relational depth with their clients, particularly within a time-limited framework.



'I target clients more on an emotional level and I'm still doing a six-session model.'

'I had already, obviously... looked at emotions with clients and sat with them in distress. But it has given me an increased confidence in dealing with that area.'

Four of the six participants reported that the training had increased the respect counsellors experienced from their work colleagues and provided them with an increased status level. This left them feeling more skilled, competent and empowered in the therapeutic work they were doing with clients.

'I think it's quite important that we feel empowered and this training has empowered me... and in the setting of our Trust, I'm now respected more.'

However, it is important to note that some of the counsellors felt that a longer course may have given them more status; and they had a sense that, in their locality, CfD was not as professionally recognised as a CBT or IPT (interpersonal therapy) training programme.

Further research required:
A number of participants felt that there was a need for stronger guidelines around who the most suitable client/s are for CfD counselling. By way of comparison, it was felt that CBT had much stronger guidelines with regard to appropriate clientele for CBT interventions. Therefore further clarification with regard to client characteristics and suitability for CFD would be beneficial. Counsellors also felt that more evidence-based research was required to support what they do in their CfD practice.

CONCLUSIONS

The evaluation provided evidence that high-intensity counsellors in IAPT services often do not feel they have equal status to their CBT colleagues. This can be reflected not only in attitudes and perceptions but also in levels of pay. It would appear that training in CfD may help to address some of these perceptions and help, in the future, to reduce this lack of equity by putting all high-intensity interventions on a more equal footing.

It also seemed to affirm that counsellors viewed working with a Competency Framework in a positive light; that the training helped them to return to 'aware practice' within the orientation they were trained in, often after having lost contact with their core in trying to follow the demands of their IAPT context, and that the framework is a valid and accurate articulation of the PCE model. Also noteworthy is the fact that not all trainees found it easy to adhere to the competences, suggesting that, in some cases, there may be a gap between a counsellor's professed orientation and how they actually practise. The CfD training appears to provide a useful means to realign these two areas. The significance of this for the PCE community is that it provides a basis for clarity about PCE counselling in terms of its theory and practice, and a method of ensuring the model is implemented in an adherent fashion by individual counsellors. There are also

...high-intensity counsellors in IAPT services often do not feel they have equal status to their CBT colleagues

implications here for clients in terms of having an informed choice about the type of therapy they receive. As IAPT services roll out a wider range of therapies, it is important that clients can receive clear and concise descriptions of the approaches available and that therapists are accountable for delivering the therapy as described. Without this, there is no real choice for clients.

The evaluation highlighted a number of problem areas in relation to the training. Some felt that, at five days' duration, the course was too short and they needed more time to integrate the material presented. Practical problems were encountered by some in relation to the assessment process, where recording therapy sessions and sending these to assessors outside of their Primary Care Trust presented issues of confidentiality and data handling. In some cases, supervisor expertise was also raised as a problematic issue. It is a statement of the obvious that where supervised clinical practice forms part of the assessment process, the availability of a team of appropriately trained supervisors is a prerequisite to rolling out a training programme. During this initial phase of the CfD training, it may well be that having to train supervisors very rapidly in the CfD model prior to delivering the counsellor training courses was not ideal, and led to instances of critical feedback from some CfD counsellors. As the training is becoming more established, it is likely that this issue is being addressed, with a nationwide network of CfD supervisors being built. Further critical feedback related to the teaching of the more experiential competences which derive from EFT. There seemed to be quite an interest in this aspect of the training, which, for many counsellors, represented a 'developing edge' to their practice. Perhaps predictably in a brief CPD training programme, some trainees felt that the course didn't allocate enough time to this area of theory and practice, and trainees were left wanting more. A final negative point highlighted in the evaluation related to a sense of frustration among trainees at not being able to implement what they had learned on the training programme when they returned to practise in their services. The key issue here seemed to relate to the number of sessions counsellors were permitted to contract for with clients. CfD is recommended in episodes of eight to 10 sessions for mild to moderate depression, and up to 20 sessions for more severe presentations. Despite this, some services seemed to restrict the number of sessions to a maximum of six which, as a high-intensity intervention, runs counter to the recommendations of NICE and those of the central IAPT team. Understandably, trainees who found themselves in this situation experienced a serious mismatch between what they had learned on the CfD programme and how they were being asked to practise within their services. This points to a wider problem of some services not implementing NICE guidelines, nor complying with IAPT therapeutic protocols.

On a more positive note, from the evaluation, there are clear indications that a number of trainees experienced the training as empowering, as helping them to reconnect with the PCE model and, interestingly, being able to work with clients at greater emotional and relational depth. Challenges for the future involve adapting the training in the light of further feedback from trainees, lobbying the Department of Health for more funded CfD training places, evaluating the model, and improving access to CfD training while maintaining quality standards. ■

This article was written as a collaboration between representatives from BACP, Metanoia Institute and the Universities of Keele and York St John.

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READER RESPONSE

The authors welcome feedback on this article; please email peter.pearce@metanoia.ac.uk. To contact the journal, email hcpj.editorial@bacp.co.uk.