NHS Talking Therapies

Curriculum for Counselling for Depression

CONTINUING PROFESSIONAL DEVELOPMENT FOR QUALIFIED THERAPISTS DELIVERING HIGH INTENSITY INTERVENTIONS

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for anxiety and depression

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Revisions

December 2023

1- References to IAPT amended to NHS Talking Therapies
2- Updated to NHS Talking Therapies Curriculum Template
3- Amended entry requirements to align with those in NHS Talking Therapies Manual

Contents

Curriculum for Counselling for Depression 1
Note to trainers 7
How to use this curriculum 7
Introduction 7
What is Counselling for Depression (CfD)? 8
What does the training entail? 9
What are the entry/accreditation requirements? 9
Aims of Training 10
Key Texts 10
Teaching and Learning Methods 13
Supervised Clinical Practice 13
Assessment of Competence 15
Accreditation 16
Learning Outcomes 16
The Modules 19
Module 1: Induction to the NHS Talking Therapies programme and understanding depression (A) 21
Module 2: Induction to the NHS Talking Therapies programme and understanding depression (B) 24
Module 3: Orientation to the Competence Framework 29
Module 4: Theoretical principles and values 31
Module 5: Working with depression 35
Module 6: Working briefly 39
Module 7: The CfD Relational Stance 41
Module 8: Working with emotional processes 46
Module 9: Assessment of trainee competence 51
Module 10: Supervision and clinical practice 53
1. Appendix A Counselling for Depression Adherence Scale 55

2. Appendix B Exemplar Programme for the Five-Day Training 62
3. Appendix C Exemplar Course Evaluation Questionnaire 64
4. Appendix D Exemplar Teaching Materials 68
5. Appendix E Key Person-centred/experiential (PCE) supervision competences 75
6. Appendix F Humanistic Supervision Competences 77

Note to trainers

This training curriculum provides continuing professional development for counsellors who are already trained in Person-centred or Humanistic approaches and who have significant clinical experience. Hence the training described here intends to both build upon existing knowledge and, more particularly, to align counsellors' practice with a competence framework which has strong links to research evidence. It is important for trainers to affirm those areas of existing knowledge and skills which map onto the competence framework and to facilitate the learning of new competences where trainees show indications of lack of familiarity. Effective practice in counselling and psychotherapy is underpinned by good-quality training and supervision, both of which help to ensure that therapists adhere to a model of therapy which is supported by evidence of efficacy. This curriculum, together with the Counselling for Depression (CfD) competence framework aims to ensure competent practice in counselling, which in turn should deliver good outcomes for users of NHS Talking Therapies services.

How to use this curriculum

This document sets out the overall aims of the national curriculum for CfD and provides a model training programme based on the CfD Competence Framework. The training is divided into modules, each with aims, lists of competences, indicative content and suggested reading. It includes background information for some of the modules and guidance in the delivery of the training and assessment elements. Exemplar materials to support the training are provided in the Appendices and a PowerPoint presentation is available on the NHS Talking Therapies website. Trainers must ensure they are familiar with all elements of the curriculum, recommended reading and the CfD Competence Framework.

Introduction

This curriculum describes a programme which trains counsellors to provide a depression-specific therapy for individual clients in an NHS Talking Therapies setting where a client has not responded to CBT or actively opts for counselling. The CfD competences are drawn from a number of NICE-endorsed research studies and from key texts identified by the Humanistic Psychological Therapies Expert Reference Group which describe the modality and underpin its effectiveness. These studies and associated literature are of Person-Centred Counselling and Emotion-Focused Therapy3. These two areas of therapeutic work have much in common both theoretically and in terms of their methods.

When used in combination they are often referred to as Person Centred/Experiential Therapy.

What is Counselling for Depression (CfD)?

CfD is a form of Person-Centred/ Experiential (PCE) therapy derived from *The competences required to deliver effective humanistic psychological therapies* (Roth, Hill and Pilling, 2009). CfD is drawn from those humanistic approaches with the strongest evidence for efficacy, based on outcomes of controlled trials. It is specifically designed to address depression and for delivery within the context of the NHS Talking Therapies programme.

The aim of CfD is to help patients access underlying feelings, make sense of them, and draw on the new meanings which emerge to make positive changes in their lives. It has a particular focus on 'self-discrepancy' – incongruences between how a person feels they actually are and how they feel they should be – which has been shown to be associated with depression. Self-discrepancy can emerge from, and lead to, a variety of difficult and distressing emotional processes, such as internal self-conflict, excessive self-criticism, unresolved loss or trauma, and the distortion or interruption of emotional experiencing. The identification of such processes provides opportunities for focused work with clients, aimed at reducing the intensity of the focal processes and, in turn, the degree of self-discrepancy. The net result of this is a reduction in emotional distress and depressed mood.

The CfD competences provide a rationale and framework for this work. The Basic Competences describe the therapists' relational stance and associated therapist actions, including the communication of empathy, unconditional acceptance and personal presence or authenticity. This stance enables the depressed client to explore and clarify depression-related experiences, helping them develop a more accurate, experientially-based awareness of self. The Specific Competences provide the basis for the identification of, and focal interventions with, the various emotional processes associated with self discrepancy. Such interventions help clients to access underlying feelings, reflect on their emotional experiencing and replace self-criticism with self compassion.

This combination of a coherent therapeutic stance with more specific focal interventions enables counsellors to work effectively with depression. As a form of psychological therapy recommended by NICE for the treatment of depression, it is

particularly appropriate for clients with persistent subthreshold depressive symptoms or mild to moderate depression where 6 to 10 sessions are recommended over a period of 8 to 12 weeks. For more severe or complex presentations, up to 20 sessions of counselling are recommended.

What does the training entail?

Counselling for Depression (CfD) is one of the NICE-recommended psychological therapies for depression made available within NHS Talking Therapies services to support patient choice and ensure there is a range of therapies to meet patients' needs. Although counselling has long been available in NHS primary care, approaches to practice are variable. This training seeks to standardise counselling work with depressed clients and align interventions with the evidence-base underpinning NICE guidelines.

The training consists of a five-day taught programme, followed by a period of supervised clinical work, during which a minimum of 80 hours of practice must be completed.

What are the entry/accreditation requirements?

NHS TTad specified counselling or psychotherapy accreditation / Health and Care Professions Council (HCPC) registered practitioner psychologist.

Experience

Applicants must also be able to demonstrate that they have at least two years' post qualification experience of providing brief counselling to clients with common mental health problems, particularly depression. This experience will need to be evidenced through references prior to being accepted onto the training.

Because the five-day course is at an advanced level and assumes prior competence in counselling, the training will only accept applicants who are able to demonstrate core professional skills. These include general therapeutic competences such as an ability to form therapeutic relationships with clients, effective listening and communication skills.

Applicants will be invited to complete a self-assessment tool (available on the NHS Talking Therapies website) prior to coming on the course. This self-report system enables practitioners to reflect on the extent to which they feel that they have attained

the breadth and level of the competences on key elements of the competence framework. This can then be used to identify training and development needs.

Aims of Training

Overarching Metacompetence

• Ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context

Generic Elements integral to the practice of Counselling for Depression

- Knowledge of depression
- Ability to undertake a generic assessment
- Ability to assess and manage risk of self-harm
- Ability to use measures to guide therapy and to monitor outcomes

Key Texts

American Psychiatric Association (1994) The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC: American Psychiatric Association

Bager-Charleson S and Van Rijn B (2011) Understanding Assessment in Counselling and Psychotherapy. Exeter: Learning Matters

Barrett-Lennard GT (1998) Carl Rogers' Helping System: Journey and Substance. London: Sage

Bazire S (2003) Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing

Bor R, Gill S, Miller R, Parrott C (2004) Doing Therapy Briefly. Houndmills: Palgrave Macmillan

Cooper M, O'Hara M, Schmid PF, Wyatt G (2007) The Handbook of Person-Centred Psychotherapy and Counselling. Houndmills: Palgrave Macmillan

Elliott R, Watson JC, Goldman RN, & Greenberg LS (2004) Learning emotion- focused therapy: The process-experiential approach to change. Washington DC: APA

Embleton Tudor L, Keemar K, Tudor K, Valentine J, Worrall M (2004) The Person-Centred Approach: A Contemporary Introduction. Houndmills: Palgrave Macmillan

Greenberg, L.S. and Watson, J.C. (2006) Emotion-Focused Therapy for Depression. Washington DC: APA

Hill A (2010) The competences required to deliver effective Counselling for Depression http://www.ucl.ac.uk/clinical-psychology/CORE/Counselling_for_depression_Framework.htm

Mearns D and Thorne B (2007) Person-centred counselling in action (3rd ed). London: Sage

Rennie D (1998) Person-centred counselling: An experiential approach. London: Sage

Reeves A (2010) Counselling Suicidal Clients. London: Sage

Rogers CR (1951) Client Centred Therapy. Boston: Houghton Mifflin

Rogers CR (1957) The Necessary and Sufficient Conditions of Therapeutic

Personality Change. Journal of Consulting Psychology, Vol. 21, No. 2: 95-103

Cooper M, O'Hara M, Schmid PF, Wyatt G (2007) The Handbook of Person-Centred Psychotherapy and Counselling. Houndmills: Palgrave Macmillan

Roth AD (2006) Using Measures and Thinking about Outcomes. Lutterworth: British Association for Counselling and Psychotherapy

Roth AD, Hill A, Pilling S (2009) The competences required to deliver effective Humanistic Psychological Therapies http://www.ucl.ac.uk/clinical-psychology/CORE/humanistic_framework.htm

Roth AD and Pilling S (2008) Using an Evidence-Based Methodology to Identify the Competences Required to Deliver Effective Cognitive and Behavioural Therapy for Depression and Anxiety Disorders. Behavioural and Cognitive Psychotherapy, 36: 129-147

Tudor K (2008) Brief Person-Centred Therapies. London: Sage

Tudor K and Worrall M (2004) Freedom to Practise: Person-Centred Approaches to Supervision. Ross-on-Wye: PCCS Books

Watson N and Bryan BC (2010) Relations of Self-Discrepancies to Anxiety and Depression in the Change Process in Psychotherapy. Paper presented at the meeting of the Society for Psychotherapy Research, Pacific Grove http://www.wm.edu/research/watson/

Winter D, Bradshaw S, Bunn F, Wellsted D (2009) Counselling and Psychotherapy for the prevention of suicide: a systematic review of the evidence. Lutterworth: British Association for Counselling and Psychotherapy

World Health Organization (1992) ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization

High Intensity Curriculum: Counselling for Depression Structure of The Training

The five-day training is divided into ten half-day teaching modules. These introduce candidates to the NHS Talking Therapies programme and address key areas that need to be covered to ensure that participants are familiarised with core features of CfD.

Module 1: Induction to the NHS Talking Therapies programme and understanding depression (A)
Module 2: Induction to the NHS Talking Therapies programme and understanding depression (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

Teaching and Learning Methods

As candidates are already qualified in humanistic or person-centred counselling/psychotherapy they will be familiar with a proportion of the curriculum. However, adhering to a specific competence framework and offering time-limited therapy to clients with particular levels of depression within an NHS Talking Therapies context are likely to be new areas of practice. The training should emphasise these less familiar areas. Wherever appropriate, didactic tutor input should be supplemented with widespread opportunities for experiential and interactive learning. Groupwork and role play should be used to support skills development. The CfD competence framework and therapy adherence scale should be used as reference points for good practice.

Supervised Clinical Practice

Supervision requirements

Supervision is a central component of the training. The five-day training includes opportunities to practice counselling and to practice relevant skills in role-play sessions within the training group. However, full competence can only be evidenced by implementing the therapy with actual clients.

Following the five-day training counsellors are expected to undertake 80 hours of practice with clients in the NHS Talking Therapies programme. All clients within this period of practice should be presented for supervision. Counsellors should receive a minimum of one hour's individual supervision per fortnight (or the equivalent group supervision7). It is envisaged that the period of supervised practice could be completed in approximately 12 weeks. Supervision may be provided individually or in small groups of three to four trainees.

Supervision of counsellors

As the CfD training contains an element of supervised clinical practice, a prerequisite for the training of counsellors is the availability of suitably-qualified supervisors. In the first instance supervision will be provided by the team delivering the initial five-day training programmes. After the first cohorts have completed their training and have qualified as CfD counsellors, supervisors

7 Please use the following calculation for group supervision (which is the same for the counsellor/psychotherapist accreditation scheme). Calculate based on the total number

of supervisees contracted to your group, regardless of attendance at particular sessions. Do not count your supervisor.

- Group of four supervisees or less = claim half of the time;
- Group of five supervisees or more = divide the number of hours by the number in the group and claim the resulting time.
- may be recruited from this trained workforce. Selection of supervisors should be based on the following criteria:-

Qualifications

Essential:

- Diploma in humanistic or person-centred counselling or psychotherapy and evidence of working towards BACP Counsellor/Psychotherapist accreditation or equivalent.
- Qualification as a CfD counsellor

Desirable:

- Post-graduate qualification in humanistic or person-centred counselling or psychotherapy.
- Qualification to provide clinical supervision to counsellors and psychotherapists (for example, Certificate or Diploma in Supervision)

Experience

- A minimum of two years' post-qualifying experience of providing brief counselling for clients with common mental health problems, particularly depression.
- Experience of providing counselling in organisational settings (for example, primary care services).

Following recruitment supervisors will attend a two-day top-up training programme comprising the following elements:-

- Supervision within the NHS Talking Therapies programme
- Monitoring adherence to the CfD Competence Framework
- Key PCE Supervision Competences
- Supervision skills practice

Following the two-day training programme, in order to qualify as CfD supervisors, candidates will complete a minimum of six supervision sessions with CfD counsellors. Sessions should be audio-recorded and two of these submitted for assessment. These will be assessed by the trainers delivering the two-day programme using the Key PCE

Supervision Competences (see Appendix E). Where necessary, one opportunity to resubmit will be available. Supervisors would then be qualified to provide supervision to both qualified CfD counsellors and those undertaking the clinical practice element of the CfD training programme. They should have responsibility for monitoring counsellor adherence to the CfD Competence Framework and providing written reports on their supervisees where appropriate.

Supervision within the NHS Talking Therapies programme supports ethical and effective practice. A key priority is to ensure that counsellors adhere to the therapeutic model described in the CfD Competence Framework as this model is closely aligned to the evidence base and so is likely to deliver the best outcomes. The self-assessment tool provides a means by which counsellors can reflect on their level and breadth of competence as a basis for reflective discussion in supervision. The purpose of such discussions should be to identify gaps in skill and knowledge and plan for further training and opportunities for development.

The work of supervisors should be informed by the competence framework for the supervision of psychological therapies (Roth and Pilling, 2009) which describes generic competences relevant to all supervisors. Additionally, the modality-specific supervision competences (Roth and Pilling, 2009), located in Appendix F, should be used to orient supervisors to working more specifically with counsellors as this suite of competences is most closely aligned to the theory and practice of CfD.

Assessment of Competence

How is competence assessed?

Participants joining the training course will bring established skills and experience of counselling clients with a range of mental health problems.

The assessment of competence reflects the professional aims of the training and includes the following:

i. At the end of the five-day training course competence will be assessed by means of a 20 minute demonstration of skills with another member of the training group taking the role of client. These role-plays will be videorecorded and rated by one of the trainers using the therapy adherence scale (see Appendix A).

ii. Following the five-day training course, and during the supervised practice component of the training, competence will be assessed through:

a. Regular attendance of supervision sessions and engagement in the supervision of all cases which make up the 80 hours of practice.

b. The submission of four audio-recordings of counselling sessions each with a different client and at least two from the late phase of counselling (i.e. from the last three sessions with a particular client). Each recorded session will be rated by a member of the training team for adherence to the practitioner manual using the therapy adherence scale (see Appendix A).

iii. In cases where audio-recordings fail to meet therapy adherence, trainees can resubmit a maximum of a further two audio-recorded sessions (i.e. six in total). In such cases opportunities for further training and development may be considered appropriate. At least four of this maximum of six audio recordings need to meet the threshold for therapy adherence for the candidate to have passed the training.

Accreditation

BACP Accreditation

Successful completion of an appropriately commissioned course, including the practice hours, can be counted towards the training and practice criteria for an application for accreditation as a counsellor/psychotherapist with BACP. For counsellors who are already accredited members of BACP, successful completion of a commissioned course would be accepted as evidence of CPD requirements towards their annual renewal of accreditation. A new category of sector specific Senior Accreditation in NHS Talking Therapies High-Intensity Counselling is being developed by BACP, details of which should be available from March 2011.

Continuous Professional Development (CPD) Endorsement

BACP has developed a Quality Assurance procedure for CPD training programmes. This award is designed to reassure commissioners and trainees about the quality standards and relevance of the CPD activity on offer. This award would be applicable to the training programme.

Learning Outcomes

General

The training course will provide opportunities for participants to develop and demonstrate knowledge, understanding and skills as follows:

Participants must demonstrate competency in:

i. The knowledge, skills and techniques of CfD as a development of their existing skills and abilities

ii. Working in accordance with Local and National NHS Talking Therapies Service policy including risk management and outcome monitoring

iii. Sensitively adapting the CfD competences to the needs of individual clients

iv. Working with a range of depressive presentations and taking personal responsibility for clinical decision-making in complex and unpredictable situations

v. Acting as an expert resource to Psychological Wellbeing Practitioners, so ensuring appropriate referrals to CfD practitioners

vi. Cultural competence in work with individual clients and colleagues. This will include developing the ability to recognise their own reaction to people who are perceived to be different and values and belief about the issue of difference. The competence criteria will include

a. Developing an ability to recognise one's own reaction to people who are perceived to be different, values, and belief about the issue of difference.

b. Understanding a definition of culture, related values and factors effecting culture e.g. age, disability, marital status, ethnicity, parental status, sexual orientation, gender, education, language, socio-economic status, and religion or belief.

c. Capable of taking responsibility for responses and actions taken with people who are different or are perceived to be different

d. Developing ability to accept ambiguity of not knowing what to expect or what to do initially during an inter-cultural situation.

e. Risk taking in order to communicate effectively with people from diverse cultures.

f. Working effectively with interpreters, establishing ways of working together and considering clinical implications.

g. Raised awareness of one's reaction to people who are different and the implications of these reactions during sessions.

Specific

Trainees will:

1. Understand the rationale for the NHS Talking Therapies programme
2. Understand the principles of stepped care
3. Appreciate how NHS Talking Therapies seeks to address the needs of those with common mental health problems
4. Appraise how their own practice fits within this service model
5. Describe the range of symptoms commonly used in the diagnosis of depression
6. Describe the treatments recommended by NICE for the various levels and types of anxiety and depression
7. Understand the prevalence, types and levels of depression
8. Understand how to assess severity of depression
9. Demonstrate the ability to undertake a generic assessment
10. Assess levels of risk within depressed populations
11. Identify risk indicators for suicide and self-harm
12. Use the NHS Talking Therapies minimum data set to monitor outcomes and discuss therapeutic progress with clients
13. Demonstrate a critical understanding of evidence-based practice in the context of psychological therapy.
14. Understand the relationship between therapy adherence and positive outcomes for clients.
15. Critically appraise the role of supervision in the delivery of evidencebased psychological therapy.
16. Critically analyse the philosophy and the principles which underpin person-centred practice.
17. Critically appraise person-centred theories of human growth and development and the origins of psychological distress.
18. Critically evaluate the person-centred conditions for therapeutic change in the client/counsellor relationship.
19. Articulate the rationale for counselling, in clear and accessible language.
20. Demonstrate an ability to develop formulations for depression based on particular cases.
21. Understand emotion theory and theories of emotional processing
22. Appreciate the need for emotional regulation in healthy psychological functioning
23. Understand the relationship between conflict splits and depression

24. Understand the relationship between depression and self-discrepancies
25. Identify therapeutic approaches to working with different presentations of depression.
26. Understand the rationale for time-limited psychological therapy in a public healthcare service.
27. Appraise the main characteristics of brief therapy.
28. Demonstrate an ability to collaborate with the client to establish a therapeutic aim or focus.
29. Critically appraise strategies which help the client reinforce their therapeutic progress in the time between sessions.
30. Conclude therapeutic relationships in ways which support the client's therapeutic progress.
31. Understand empathy as a subtle interpersonal process.
32. Appraise the impact of empathy on therapeutic process.
33. Work empathically with both explicit and implicit feelings and experiences.
34. Understand the theoretical importance of maintaining an accepting and non-judgmental therapeutic attitude with clients.
35. Critically appraise the significance of authenticity in the therapeutic relationship.
36. Reflect on their own ability to maintain contact with their emotional experience.
37. Articulate their own emotional reactions to the client in ways that are therapeutically constructive.
38. Appraise a range of emotional processes and their effects on the client's therapeutic progress.
39. Implement strategies which help the client access and express their emotions.
40. Facilitate the client's process of articulating emotions (for example, by the use of imagery and metaphor to capture subtle meaning).
41. Facilitate the client's process of developing new meaning and a revised sense of self, arising from the emergence of newly-experienced feelings.
42. Understand the requirements for supervision and the assessment of clinical practice
43. Reflect on their learning
44. Critically appraise the training programme

The Modules

Module descriptions

Each module represents a half-day training session and so would be somewhere between 2.5 and 3 hours duration. Modules are linked to sets of competences from the

CfD framework providing a focus for the teaching and learning activities. Some of the competences are quite broad-based and general, indicating that the module may be addressing the framework as a whole. Other competences are more detailed and specific indicating that the module is focused on the learning of particular areas of knowledge and skill. The assumption has been made that counsellors need both a conceptual understanding of how the framework is structured and the ability to apply the particular competences. Relevant reading is indicated at the end of each module description. At this point in time, a single text describing CfD is not available. However there are two core texts: Mearns and Thorne (2007) describes the CfD relational stance and Elliott et al (2004) gives a detailed account of how to work with emotional processes. Modules 1 and 2 cover the generic induction to the NHS Talking Therapies programme, whereas modules 3 to 10 focus more particularly on the CfD competence framework.

Module 1: Induction to the NHS Talking Therapies programme and understanding depression (A)

Aims of the module

CfD is a Level 3 intervention within NHS Talking Therapies Services. Hence counsellors need to have a good knowledge of the aims and methods of NHS Talking Therapies Services, including stepped-care and the role of other mental health workers within it. In order to effectively deliver a depression-specific intervention, a sound understanding of depression is necessary, including its origins, course, phenomenology, range, incidence, and prognosis, as well as its impact on the client's functional abilities.

Competences covered in this module

Knowledge of depression

An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:

- depressed mood most of the day
- marked loss of interest or pleasure in daily activities
- sleep problems
- loss of appetite and significant loss of weight
- fatigue/exhaustion
- difficulties getting to sleep or excessive sleep
- psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- feelings of worthlessness or excessive guilt
- low self-confidence
- difficulties in thinking/concentrating and/or indecisiveness
- recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

An ability to draw on knowledge:

- that a diagnosis of depression is based on the presence of a subset of these symptoms

- that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
- that symptoms need to be present consistently over time (for example, DSM-IV criteria specify two weeks, ICD-10 criteria specify one month)

An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthymic disorder and bipolar disorder) and to be able to distinguish between these presentations

An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression

An ability to draw on knowledge of the patterns of remission and relapse/recurrence associated with depression

An ability to draw on knowledge of factors which are associated with an increased vulnerability to depression, for example:

- developmental risk factors (for example, temperament)
- quality of early experience with parents or significant others
- quality of relationships with partner, family and significant others
- quality of current social relationships
- social isolation
- major adverse life-events (for example, childhood abuse or neglect, financial loss, unemployment, separation from a partner, bereavement, retirement)
- major life-transitions (for example, becoming a parent)
- acute and chronic physical illness (both in the client and in significant others)

An ability to draw on knowledge of the impact of depressive symptoms on the client's functioning (for example, in interpersonal and work domains), and the fact that difficulties in functioning can (in turn) contribute to depressive symptoms

An ability to draw on knowledge of the evidence for the effectiveness of psychological and psychopharmacological interventions for depression, and their effectiveness in combination

An ability to draw on knowledge of the ways in which depression is conceptualised within the model of therapy being adopted

Indicative content

Background to NHS Talking Therapies

- Implementation of NICE guidelines
- 900,000 people accessing psychological therapies
- 50% of attendees approaching recovery
- 3600 extra therapists
- Stepped care
- Training of therapists

Depression

- Prevalence
- Symptomology
- Types of depression and recommended treatments
- The role of medication

Suggested reading

American Psychiatric Association (1994) The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC: American Psychiatric Association

Bazire S (2003) Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing

World Health Organization (1992) ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization

Module 2: Induction to the NHS Talking Therapies programme and understanding depression (B)

Aims of the module

Assessment of clients' suitability for counselling is a key activity, particularly within a stepped-care model where a range of treatments are offered for particular types and levels of problem presentations. Counsellors need to appraise a clients' suitability for psychological therapy, generally, and to appraise the clients' suitability for particular types of therapy. This work needs to be conducted collaboratively with clients, taking on board their treatment preferences. Elevated levels of risk of suicide and self-harm in depressed populations highlights the need for these levels to be identified, monitored and managed, hence the importance of risk assessment skills for counsellors training in CfD. Routine outcome monitoring is an important aspect of work in NHS Talking Therapies services. This provides not only data on clients' therapeutic progress but also an opportunity to encourage clients to engage in a process of reflection and self-monitoring which can support recovery.

Competences covered in this module

Ability to undertake generic assessment

An ability to obtain a general idea of the nature of the client's problem

An ability to elicit information regarding psychological problems, diagnosis, past history, present life situation, attitude about and motivation for therapy

An ability to gain an overview of the client's current life situation, specific stressors and social support

An ability to assess the client's coping mechanisms, stress tolerance, and level of functioning

An ability to help the client identify/select target symptoms or problems, and to identify which are the most distressing and which the most amenable to intervention

An ability to help the client translate vague/abstract complaints into more concrete and discrete problems

An ability to assess and act on indicators of risk (of harm to self or others) and the ability to know when to seek advice from others

An ability to gauge the extent to which the client can think about themselves psychologically (for example, their capacity to reflect on their circumstances or to be reasonably objective about themselves)

An ability to gauge the client's motivation for a psychological intervention

An ability to discuss treatment options with the client, making sure that they are aware of the options available to them, and helping them consider which of these options they wish to follow

An ability to identify when psychological treatment might not be appropriate or the best option, and to discuss with the client (for example, the client's difficulties are not primarily psychological, or the client indicates that they do not wish to consider psychological issues) or where the client indicates a clear preference for an alternative approach to their problems (for example, a clear preference for medication rather than psychological therapy)

Ability to assess and manage risk of self-harm

An ability to draw on knowledge of indicators of self–harm, and to integrate research/actuarial evidence) with a structured clinical assessment and the exercise of professional judgment in appraising risk

An ability to draw on knowledge that individuals with a history of prior suicide have a markedly elevated risk of self-harm

An ability to draw on knowledge of factors associated with an elevated risk of self-harm that apply across the population:

- childhood adversity
- experience of a number of adverse life-events (including sexual abuse)
- a family history of suicide
- a history of self-harm
- seriousness of previous episodes of self-harm

- previous hospitalisation
- mood disorders
- substance use disorder
- a diagnosis of personality disorder
- anxiety disorder (particularly PTSD)
- a psychotic disorder (for example, a diagnosis of schizophrenia or bipolar disorder)
- presence of chronic physical disorders
- bereavement or impending loss (where psychological problems preceded the bereavement)
- relationship problems and relationship breakdown
- severe lack of social support
- socio-economic factors for example,:

o people who are disadvantaged in socio-economic terms
o people who are single or divorced o people who are living alone
o people who are single parents

An ability to draw on knowledge that individuals with depression have a significantly elevated lifetime risk of suicide

An ability to draw on knowledge that hopelessness (negative expectations of the future) may be a more important marker of risk than the severity of depression

An ability to draw on knowledge that the risk of suicide is particularly elevated in the three months following attempted suicide, and that this risk remains elevated in the longer-term

An ability to draw on knowledge of local and national protocols (for example, NICE 2004) for the management of self-harm, and an ability to ensure that actions taken comply with these protocols

An ability to maintain a clear and detailed record of any assessments and of decisions regarding plans for managing risk, in line with local protocols for recording clinical information

An ability to communicate (verbally and in writing) with relevant clinicians and services in order to ensure that all individuals or services involved in the management of risk are appropriately informed

Ability to use measures to guide therapy and to monitor outcomes

An ability to draw on knowledge of commonly used questionnaires and rating scales used with people with depression

An ability to use and to interpret relevant measures at appropriate and regular points throughout the intervention, with the aim of establishing both a baseline and indications of progress

An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress

Indicative content

Making a generic assessment

- Use of NICE depression guideline and stepped-care model to judge suitability
- Consideration of client treatment preferences
- Modality-specific considerations: are the communication and receipt of therapeutic conditions optimal?

Risk of suicide and self-harm

- Factors predicting suicide and self-harm in depressed clients
- Judging levels of risk
- Managing and monitoring risk
- Written records relating to risk

Use of the NHS Talking Therapies minimum dataset

- Discussion of measures used
- Scoring of measures: levels of severity
- Involving clients in the monitoring process

Suggested reading

Bager-Charleson S and Van Rijn B (2011) Understanding Assessment in Counselling and Psychotherapy. Exeter: Learning Matters

Reeves A (2010) Counselling Suicidal Clients. London: Sage

Roth AD (2006) Using Measures and Thinking about Outcomes. Lutterworth: British Association for Counselling and Psychotherapy

Winter D, Bradshaw S, Bunn F, Wellsted D (2009) Counselling and Psychotherapy for the prevention of suicide: a systematic review of the evidence. Lutterworth: British Association for Counselling and Psychotherapy

Module 3: Orientation to the Competence Framework

Aims of the module

This module aims to introduce trainees to the CfD competence framework, describing its links to The competences required to deliver effective Humanistic Psychological Therapies (Roth, Hill and Pilling, 2009) and the NICE depression guideline. The distinction between generic, basic, specific and metacompetences is described and how these areas of competence are assembled into a coherent model of practice. Trainees are introduced to the therapy adherence scale and given opportunities to apply it to counselling role-play exercises. The importance of therapy adherence as a means of ensuring the delivery of evidence-based interventions is emphasised. It is noteworthy that the competences covered in this module are the “headline” ones taken from the map as opposed to the more detailed ones. This emphasises the module’s focus on gaining a general, broad-based understanding of the framework. Subsequent modules address the more detailed competences.

Competences covered in this module

Knowledge of the basic assumptions and principles of counselling for depression

Ability to initiate therapeutic relationships

Ability to maintain and develop therapeutic relationships

Ability to conclude the therapeutic relationship

Approaches to work with emotions and emotional meaning

Capacity to use clinical judgement when implementing treatment models

Indicative content

The development of the CfD competence framework

- Research evidence supporting CfD
- Competence development
- The role of the Expert Reference Group

The structure of the CfD competence framework

- Generic competences • Basic competences
- Specific competences
- Metacompetences

Therapy adherence

- The structure of the CfD adherence scale
- Applying the CfD adherence scale

Suggested reading

Roth AD, Hill A, Pilling S (2009) The competences required to deliver effective Humanistic Psychological Therapies http://www.ucl.ac.uk/clinical-psychology/CORE/humanistic_framework.htm

Roth AD and Pilling S (2008) Using an Evidence-Based Methodology to Identify the Competences Required to Deliver Effective Cognitive and Behavioural Therapy for Depression and Anxiety Disorders. Behavioural and Cognitive Psychotherapy, 36: 129-147

Hill A (2010) The competences required to deliver effective Counselling for Depression

http://www.ucl.ac.uk/clinical-psychology/CORE/Counselling_for_depression_Framework.htm

Module 4: Theoretical principles and values

Aims of the module

To provide effective CfD trainees need familiarity with the theoretical knowledge that underpins the therapeutic approach. Despite the fact that all trainees will have completed initial training in Person-centred or Humanistic approaches, variations in the curricula of training courses means that familiarity with underpinning knowledge cannot be assumed. This module therefore covers key elements of person-centred theory, in particular: values and principles, theories of growth and development and the facilitative conditions characterising the therapeutic stance. Emphasis is also placed upon developing trainees' ability to explain their therapeutic approach to clients in ways that are succinct and non-technical. This increases levels of collaboration in therapeutic work and supports client choice.

Competences covered in this module

Knowledge of the philosophy and principles that inform the therapeutic approach

An ability to draw on knowledge that the person-centred model assumes:

- the centrality of 'experiencing' (i.e. thinking, perceiving, sensing, remembering, and feeling, along with the inherent meanings and actions associated with these modes of experience):
- that people are essentially relational beings and are best helped through authentic, person-to-person relationships
- that human beings are free to act in relation to their worlds, and consequently therapeutic change will be largely founded on self determination and self-direction
- that the diversity of human experience is to be valued and treated equally
- the centrality of the assumption that people are motivated towards self maintenance, psychological growth and development, and hence the realisation of their potential
- that the process of psychological growth and self-development operates throughout the life span

An ability to draw on knowledge that human experience can be viewed from multiple perspectives (for example, intrapersonal, interpersonal, contextual, cultural and

spiritual) and that as a consequence the sum of a person's experience is greater than each of these parts

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

An ability to draw on knowledge that healthy functioning involves experiencing in an integrated, holistic manner (and hence the focus of counselling is on the person as a whole (rather than particular symptoms or specific areas of functioning))

An ability to draw on knowledge that a capacity for integrated experiencing (and hence the fulfilment of one's potential) can be affected by conflicts within the self

An ability to draw on knowledge that psychological growth will be influenced by and takes place within a social context.

An ability to draw on knowledge that people have a fundamental capacity to sense whether an action contributes to growth and that emotional experiencing plays a key role in this awareness

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

An ability to draw on knowledge that responding empathically to clients increases their self-understanding and reduces their sense of isolation and alienation

An ability to draw on knowledge that to offer a warm, accepting and nonjudgemental attitude reduces defensiveness in the client and increases contact with the experiencing self

An ability to draw on knowledge that being genuine and transparent increases levels of trust and models psychological health

Ability to explain and demonstrate the rationale for counselling

An ability to provide a concise and coherent description of the therapy for clients:

- an ability to communicate the central belief in the client's capacity to discover inner resources for growth and problem-resolution

An ability for the counsellor to convey the position they intend to adopt in relation to the client:

- to develop a collaborative relationship with the client that aims to share power equally
- to hold an accepting attitude
- to be genuine and open
- to engage with the client in a deeply relational manner

An ability for the counsellor to describe what they hope will emerge from the process of therapy:

- that discussing problems can lead to a sense of emotional relief and a reduction in feelings of isolation
- that therapy is likely to increase contact with feelings and that at times this may be experienced as difficult and upsetting
- that therapy can lead to the development of new awareness and understanding, and to new forms of action and behaviour

An ability to help clients discuss their expectations of the therapy and help them to identify outcomes which are achievable

An ability to clarify the responsibilities of the counsellor and those of the client in the therapeutic relationship

Indicative content

Values and principles

- Taking a holistic approach
- The actualising tendency
- The importance of subjectivity

Person-centred theories of human growth and development and the origins of psychological distress

- Conditions of worth
- Introjection
- Organismic valuing process
- Internal/external locus of evaluation
- Incongruence
- The denial and distortion of experiencing

The person-centred conditions for, and goals of, therapeutic change

- Psychological contact
- Empathy
- Unconditional positive regard
- Congruence and transparency

Communicating the rationale for therapy to clients

- Summarising theoretical concepts clearly and succinctly
- Role-play practice in explaining the CfD therapeutic approach to clients

Suggested reading

Barrett-Lennard GT (1998) Carl Rogers' Helping System: Journey and Substance. London: Sage

Cooper M, O'Hara M, Schmid PF, Wyatt G (2007) The Handbook of Person-Centred Psychotherapy and Counselling. Houndmills: Palgrave Macmillan

Embleton Tudor L, Keemar K, Tudor K, Valentine J, Worrall M (2004) The Person-Centred Approach: A Contemporary Introduction. Houndmills: Palgrave Macmillan

Module 5: Working with depression

Aims of the module

Conceptualising depression from a person-centred/experiential (PCE) perspective allows counsellors to develop formulations for depressive presentations and thus work more focally with the emotional processes which maintain depressive mood. It provides a link between PCE theory and practice and clients' subjective experience of their problems. Rogers (1951) originally hypothesised incongruence within the self-concept as a source of psychological distress. More recently incongruence has been operationalised as self-discrepancy and links established between this concept and depression. Self-discrepancy results in and is maintained by a variety of emotional processes, such as self-conflict, excessive self-criticism and the distortion or interruption of emotional experiencing. The identification of such processes provides opportunities for focused work with clients, aimed at reducing the intensity of such processes and, in turn, the degree of self discrepancy. The net result of this is a reduction in emotional distress and depressed mood.

Competences covered in this module

Knowledge of the PCE conceptualisation of depression

An ability to draw on knowledge that PCE counselling conceptualises depression as resulting from particular types of emotional experience, emotional processes and ways of construing the self

An ability to draw on knowledge that PCE counselling views difficulty in the regulation of emotions as a process associated with depression:

- where emotions are over-regulated and hence difficult to contact, leading to a sense of numbness
- where emotions are under-regulated, experienced as overwhelming and impair the client's ability to function

An ability to draw on knowledge that emotional regulation is shaped by early attachment experiences

An ability to draw on knowledge that depression can result from the client's inability to experience primary adaptive emotions that:

- are fundamental reactions to a situation
- are irreducible to any other feeling
- promote a useful orientation to the world and to problem-solving

An ability to draw on knowledge that depression can result from secondary emotional reactions:

- feelings which serve to obscure primary emotions and are a learned response to these feelings (for example, as a means of replacing a feeling that is experienced as unacceptable)

An ability to draw on knowledge that depression can result from the experiencing of maladaptive emotion:

- long-established, core feelings (such as feeling abandoned or worthless) that (because they do not map to the current situation) do not help the person to grow and develop

An ability to draw on knowledge that depression may result when the relationship between different aspects of the self is hostile (for example, where a person experiences a punitive "inner critic") or oppressive (for example, where an aspect of the self is suppressed or silenced) and these conflicts between aspects of the self leads to:

- a lack of ready access to feelings
- significant emotional pain
- the blocking of primary emotional responses
- the client feeling stuck and unable to take adaptive action
- a sense of hopelessness
- intense feelings of worthlessness

An ability to draw on knowledge that depression is associated with discrepancies between different aspects of the self, particularly:

- where there is discrepancy between a person's sense of who they are and their sense of who they would like to be

- where there is discrepancy between a person's sense of who they are and their sense of who others think they should be

An ability to draw on knowledge that a reduction in the discrepancies between these aspects of the self is associated with reductions in depressive symptoms

Indicative content

Rogers' theories of self-concept and incongruence
- The organismic self
- The introjected self
- The denial and distortion of experiencing

Research into self-discrepancy
- Different types of self-discrepancy
- Measuring self-discrepancy
- The relationship between self-discrepancy and depressive symptoms Emotion theory
- Primary adaptive emotion
- Secondary emotion
- Maladaptive emotion

Emotional processes associated with depression
- "The inner critic" where the relationship between different aspects of the client's personality is hostile or oppressive
- "Unfinished business" where the client is feeling lingering, unresolved hurt or resentment toward a significant other

Suggested reading

Elliott, R., Watson. J.C., Goldman, R.N., & Greenberg, L.S. (2004) Learning emotion-focused therapy: The process-experiential approach to change. Washington DC: APA

Greenberg, L.S. and Watson, J.C. (2006) Emotion-Focused Therapy for Depression. Washington DC: APA

Rogers, C.R. (1951) Client Centred Therapy. Boston: Houghton Mifflin

Watson, N and Bryan, B.C. (2010) Relations of Self-Discrepancies to Anxiety and Depression in the Change Process in Psychotherapy. Paper presented at the meeting of the Society for Psychotherapy Research, Pacific Grove
http://www.wm.edu/research/watson/

Module 6: Working briefly

Aims of the module

As 6 to 10 sessions of CfD are normally recommended for subthreshold to moderate cases of depression (up to 20 sessions for more serious cases) counsellors need to be equipped to work briefly and focally with clients. This module describes the relationship between number of sessions and therapeutic gains. It also presents information on clients' preferences for number of sessions. The fact that the greatest improvements are experienced in the early stages of therapy and that the majority of clients prefer to terminate therapy within approximately 12 sessions establishes a clear rationale for working briefly. This module also focuses on the need to locate a therapeutic aim or focus in the early stages of counselling and, at the end of the contract, to conclude therapy in a thoughtful and collaborative manner.

Competences covered in this module

Ability to work with the client to establish a therapeutic aim

An ability to understand the ways in which the client views their main presenting difficulties:

- an ability for the counsellor to track those areas that are emotionally significant for the client
- an ability to understand the significance of events and experiences as perceived by the client and how these might be contributing to current difficulties

An ability to explore and locate a therapeutic focus with the client in the early stages of therapy and to adapt this focus as necessary during the course of therapy

An ability to collaborate with the client to clarify their primary therapeutic goals

An ability to renegotiate goals as therapy progresses

An ability to balance the identification of therapeutic goals with the maintenance of a strong therapeutic relationship

Ability to conclude the therapeutic relationship

An ability to work collaboratively with clients to identify when they may be ready to end therapy, for example:

- where clients begin to look back over their time in therapy
- where clients begin to acknowledge their achievements in therapy
- where clients begin to plan for the future

An ability to initiate the conclusion of the therapeutic relationship when appropriate

An ability to negotiate with the client how therapy will end

An ability to develop with the client strategies for change and plans for action

An ability to review with the client their progress over the course of therapy

An ability to help clients make effective use of the ending phase of therapy:

- an ability to help clients review their prospects for the future, taking into account their current social context and relationships

- an ability to assist the client in expressing thoughts and feelings not previously addressed in therapy

- an ability to help the client express feelings connected to endings, such as sadness and loss or concerns about dependency

Where the client does not have informed choice about the timing of the ending, an ability to discuss this with them in a way which supports their progress

An ability to explore with the client options for future therapeutic interventions should the need arise

Indicative content

- Contracting with the client to work briefly
- Establishing a therapeutic aim or focus
- Facilitating autonomy and client agency
- Encouraging the client to reflect and work on their problems outside of therapy sessions
- Reviewing therapeutic progress with the client
- Concluding the relationship

Suggested reading

Bor R, Gill S, Miller R, Parrott C (2004) Doing Therapy Briefly. Houndmills: Palgrave Macmillan

Tudor K (2008) Brief Person-Centred Therapies. London: Sage

Module 7: The CfD Relational Stance

Aims of the module

This module aims to describe the CfD relational stance and its role as facilitator of therapeutic change. The stance is characterised by an empathic attunement, an

accepting and non-judgmental attitude and an authentic and transparent presence. The communication of this stance and its receipt by the client provides the basis for a deepening of awareness of self and a reduction in self-discrepancy arising from increased contact with experience which had previously been denied or distorted. Trainees are encouraged to offer and experience the stance in practical exercises.

Competences covered in this module

Ability to experience and communicate empathy

An ability to maintain a consistent empathic attitude

- to be responsive to the client's verbal and non-verbal communication
- to sense the emotions and perceptions of the client as if they were the counsellor's own (while maintaining an awareness of the counsellor's own experience)

An ability to sense and understand those feelings and perceptions of which the client is aware, as well as those that have not yet entered the client's awareness

An ability to understand the potential significance of body language (i.e. facial expression, bodily posture) as indices of the client's inner experience

An ability to understand the potential significance of paralanguage (i.e. tone of voice, intonation, diction, cadence) as indices of the client's inner experience

An ability to identify inconsistencies between the client's verbal and nonverbal behaviour

An ability to empathise equally with all aspects of the client's experience, even where these aspects are contradictory

An ability to communicate empathically with the client in a way that conveys an accurate understanding of their emotions and perceptions, for example:

- making empathic responses that the client can use constructively
- accurately summarising and paraphrasing the client's discourse
- accurately reflecting the client's feelings back to them
- using metaphor where appropriate

An ability for the counsellor to check that their perceptions of the client's inner world are consistent with the client's own experience, and to revise them in light of the client's feedback

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

An ability to value clients regardless of their behaviour, attitudes and beliefs

An ability to hold an attitude of consistent acceptance towards the client and to demonstrate this through a welcoming and non-judgmental attitude

An ability to communicate genuine warmth and acceptance to the client both verbally and non-verbally

An ability to respond to failures of unconditional positive regard (for example, if the counsellor experiences rejecting and judgmental feelings towards the client) through self-reflection and the use of supervision

An ability for the counsellor to reflect on their own values and the ways in which these might influence their work with clients

Ability to maintain authenticity in the therapeutic relationship

An ability for the counsellor to be aware of own experience in an accepting and non-evaluative manner throughout the process of building a relationship with the client

An ability to maintain consistency between what is experienced by the counsellor and the way in which this is portrayed in the therapeutic relationship

An ability to be fully engaged in the therapeutic relationship

An ability to relate to the client in a non-defensive and open manner

A capacity to tolerate and work with strong emotions

An ability to relate to the client in a spontaneous way, where appropriate

An ability to relate to the client without adopting a professional façade

An ability to demonstrate consistency between verbal and non-verbal communication

An ability to match outward responses to the client with the counsellor's inner experiencing of the client

An ability to be aware of emotional, bodily and cognitive reactions to the client and to use these therapeutically

An ability to self-disclose and communicate experience of the client to the client, especially where this is:

- relevant to the client's concerns
- persistent or striking
- likely to facilitate, rather than impede, the client's therapeutic process

Indicative content

Empathy

- Sensitisation to paralanguage and non-verbal communication
- Understanding the client's frame of reference
- Checking the therapists' perceptions against those of the client
- The role of empathy in increasing the client's contact with their experience
- Working with feelings and perceptions of which the client is not yet aware
- The importance of empathising equally with all aspects of the client's experience, even where these aspects are contradictory

Non-judgmental acceptance

- Experiencing the effects of non-judgmental acceptance
- Communicating warmth while at the same time avoiding collusion with the client
- The effects on the client of the counsellor's accepting and nonjudgmental attitude

Authenticity

- Definitions of authenticity, for example, congruence, genuineness
- Counsellor self-awareness
- Counsellor transparency
- The relationship between authenticity and other therapeutic conditions

Suggested reading

Mearns, D and Thorne, B (2007) Person-centred counselling in action (3rd ed). London: Sage

Rogers, C.R (1957) The Necessary and Sufficient Conditions of Therapeutic Personality Change. Journal of Consulting Psychology, Vol. 21, No. 2: 95-103

Module 8: Working with emotional processes

Aims of the module

Being able to contact and process emotional experience is viewed as an indicator of healthy psychological functioning. Hence clients need to access, express, articulate and reflect on the meaning of their emotional experience. Counsellors need to be able to identify where there is a disruption to this process and work focally with the client to reduce the disruption and support optimal emotional processing. The work not only involves helping clients get in touch with their emotions but also to develop new meaning and new forms of action.

Competences covered in this module

Ability to help clients access and express emotions

An ability to identify the ways in which clients manage and process their emotions, including the ability to recognise when clients are finding it difficult to access these

An ability to help clients experience feelings which may be out of current awareness, for example:

- by helping clients focus their attention inwards in order to become more aware of their feelings
- by helping clients find ways of describing emotions which seem difficult to access
- by listening empathically for feelings that are implicit and not yet fully in awareness
- by focusing the client's attention on bodily sensations by making empathic conjectures about feelings that have not yet been expressed

An ability to judge when it is appropriate to help clients reduce the extent to which they avoid experiencing underlying feelings

An ability to use methods that help clients increase contact with avoided emotion for example:

- by helping clients explore what might be making it difficult for them to acknowledge and/or experience feelings

- by identifying moments when clients seem to be having difficulty acknowledging and/or experiencing underlying feelings and drawing their attention to this

- by helping clients explore the ways in which they avoid acknowledging and/or experiencing underlying feelings, and possible factors that may influence this for example:

o previous negative experiences of expressing emotions to others o cultural and family attitudes to the expression of emotion

An ability to help clients achieve a level of emotional arousal that is optimal for exploring their feelings, for example:

- helping clients who are overwhelmed by feelings for example, by offering a calming and containing presence, containing imagery, or help to self-soothe

- enabling clients who are out of touch with their feelings to increase emotional contact, for example by:

o helping them review current concerns and focus on the most significant

o helping them bring to mind and discuss previous episodes when they experienced heightened emotion

o the counsellor using vivid imagery or language aimed at promoting feelings in the client

o suggesting active methods that promote emotional expression (for example, encouraging clients to repeat a phrase more forcefully)

An ability to help the client differentiate between feelings that are appropriate to (and hence useful for) dealing with a current situation and those that are less helpful to them, for example:

- because they are emotional responses relating to previous experiences rather than the present context

- because they are reactions to other, more fundamental, emotions

Ability to help clients articulate emotions

An ability to help the client clarify and find appropriate words to describe their emotions

An ability to help the client verbalise the key concerns, meanings and memories which emerge out of emotional arousal

An ability to help the client identify and verbalise the wishes, needs, behaviours and goals associated with feelings and emotions (i.e. the 'action tendency' inherent in emotions)

An ability to suggest imagery and metaphor to help the client become more aware of, and to articulate the meaning of, their experiences

An ability to work with images or metaphors in a way that is helpful to clients: by communicating in a manner that helps clients focus on their experiencing:

- by checking the 'fit' of images or metaphors with the client's experience • by working with the client to elaborate the image or metaphor

Ability to help clients reflect on and develop emotional meanings

An ability to help clients explore their implicit central assumptions about self, others and the world

An ability to help clients adapt central assumptions in the light of experience An ability to help the client explore alternative ways of understanding their emotional difficulties and the ways in which they experience themselves and others

An ability to help clients explore and evaluate new perspectives on their experiences in order for them to:

- develop alternative ways of understanding their experiences
- revise their views of themselves
- develop new narratives relating to themselves and their world

An ability to help the client develop metaphors for themselves that fit with their newly-emerging experience

An ability to help the client reflect on any new meanings that emerge:

- to check the accuracy of meanings against experience
- to assess the implications of the new meanings
- to re-examine behaviour and where appropriate consider alternative forms of action

An ability to help clients evaluate new perspectives in terms of their social context, personal values and goals in life

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

An ability to recognise and to help clients reflect on reactions that they experience as problematic and/or incongruent (for example, when they over or under react to an situation, or react in ways which they describe as being out of character)

An ability to help the client describe both their emotional reactions and the external situation, in ways that encourage the client:

- to identify how they were feeling before they encountered the situation
- to re-imagine the situation
- to identify the moment when the reaction was triggered
- to explore their reaction to the situation
- to make links between their reactions and the way they construed the situation
- to develop new ways of understanding the situation and their responses to it

Indicative content

Working with emotions

- The adaptive nature of emotion in human functioning
- Types of emotion: primary/secondary, adaptive/maladaptive, instrumental
- Containing the client who is emotionally overwhelmed
- Helping the client access feelings which are remote

Working with emotional processes

- Working with difficult emotional processes, for example: conflict between different aspects of the self; learned, maladaptive emotional responses (for example, feeling angry instead of hurt or vice-versa)
- Working with unresolved emotional processes
- Strategies to help the client make sense of their feelings and reactions

Suggested reading

Elliott, R., Watson. J.C., Goldman, R.N., & Greenberg, L.S. (2004) Learning emotion-focused therapy: The process-experiential approach to change. Washington DC: APA

Greenberg, L.S. and Watson, J.C. (2006) Emotion-Focused Therapy for Depression. Washington DC: APA

Module 9: Assessment of trainee competence

Aims of the module

It is in this module that the assessment of trainees' competence will take place. Each trainee will be video-recorded in the role of counsellor, with another trainee in the role of client. The recorded sessions will be assessed using the CfD adherence scale. Hence the assessment will focus on the key competences listed on the adherence scale (see below). These represent skills and abilities central to maintaining the CfD therapeutic stance and those necessary to facilitate work with more specific emotional processes.

Competences covered in this module

Ability to experience and communicate empathy

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

Ability to maintain authenticity in the therapeutic relationship

Ability to work with the client to establish a therapeutic aim

Ability to help clients to access and express emotions

Ability to help clients articulate emotions

Ability to help clients reflect on and develop emotional meanings

Indicative content/Teaching and learning methods

Trainees will work together in groups of five or six adopting the roles of counsellor and client in order to undertake 20 minute "counselling" sessions which will be video-recorded and assessed by trainers using the therapy adherence scale. Group members will make use of the therapy adherence scale in order to reflect on each others' work, thus introducing an element of peer-assessment.

Suggested reading

Rennie, D (1998) Person-centred counselling: An experiential approach. London: Sage

Module 10: Supervision and clinical practice

Aims of the module

This final module aims to consolidate learning, to provide information about the period of supervised clinical practice and to review and evaluate the fiveday training programme. The requirements for successful completion of the supervised practice element will be presented for discussion and trainees asked to consider how they will meet these criteria in the context of their own work settings. The module will address the role of supervision in supporting trainees' learning of the CfD competences and the importance of monitoring therapy adherence in the context of supervision. In order to review and evaluate the five-day programme trainees will be invited to discuss their experience of the programme and feedback to tutors, followed by the completion of a course evaluation form.

Competences covered in this module

Ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context

Indicative content

Requirements for supervised practice

- 80 hours of practice with a range of clients
- All cases taken to supervision
- A minimum of one hour of supervision per fortnight
- Supervisors to provide a report on each trainee at the end of 80 hours evidencing attendance and participation in supervision
- Submission of four recorded counselling sessions with different clients (at least two recordings with clients from the late phase of counselling contracts: i.e. from the last two or three sessions before the therapy ended)
- Assessment of recordings using therapy adherence scale
- Two opportunities to resubmit in cases where recordings fail to meet criteria for adherence

Review and Evaluation

- Evaluation of the training programme by group discussion and questionnaire
- Group discussion to review and consolidate learning

Endings and farewells

Suggested reading

Tudor K and Worrall M (2004) Freedom to Practise: Person-Centred Approaches to Supervision. Ross-on-Wye: PCCS Books

1. Appendix A Counselling for Depression Adherence Scale

Client ID_____ **Session**_____

Rater_____ **Segment**_____

COUNSELLING ADHERENCE SCALE

Use the scale below to rate the items according to the quality and frequency of each activity during the therapy segment to which you've just listened.

Shows no evidence of	Shows some evidence of	Shows moderate evidence of	Shows good evidence of	Shows very good evidence of
0	1	2	3	4

NOTE: Reversed item **1.6 only** testing ability to be non-judgmental should be scored as follows:

Shows no evidence of	Shows some evidence of	Shows moderate evidence of	Shows good evidence of	Shows very good evidence of
4	3	2	1	0

An overall minimum score of 36 is required for a therapist to be judged as adhering to the Practitioner Manual. If a therapist has low scores (0 or 1) on individual items, these should be discussed in supervision with a view to developing practice in those areas.

PART ONE

The first part of the scale addresses the following competences from the Counselling Practitioner Manual:

B3.1 Ability to experience and communicate empathy
B3.2 Ability to experience and to communicate a fundamentally accepting attitude to clients
B3.3 Ability to maintain authenticity in the therapeutic relationship

0 1 2 3 4	**1.1 CLIENT FRAME OF REFEREN** **Do the therapist's responses convey an understanding of the client's experiences as the client themselves understands or perceives them?**	**CE:** Do the therapist's responses convey an understanding of the client's inner experience or point of view, as immediately expressed by the client? Or conversely, do therapist's responses show a failure to appreciate aspects of the client's experience or point of view?
0 1 2 3 4	**1.2 CLIENT TRACK*:*** **Is the therapist following the client's track?**	Are the therapist's responses attuned to the client's flow of experience? Is the therapist "staying with" the client, responding in the "here and now"? Conversely, are the therapist's responses a diversion from the client's own train of thoughts/feelings?

0 1 2 3 4	**1.3 CORE MEANING:** **Do the therapist's responses reflect the core, or essence, of what the client is communicating or experiencing in the moment?**	Responses are not just a reflection of surface content but show an understanding of the client's central/core experience and its personal meaning for the client. Therapist responses are attuned to both implicit and explicit communication from the client and do not detract from the core meaning of client's communication.
0 1 2 3 4	**1.4 WARMTH:** **Does the therapist's attitude convey warmth?**	Does the therapist's tone of voice convey gentleness and caring? Is their attitude welcoming and receptive?

0 1 2 3 4	**1.5 ACCEPTING PRESENCE*:*** **Does the therapist's attitude convey an unconditional acceptance of whatever the client brings?** Do the therapist's responses convey a calm, receptive and accepting presence?
0 1 2 3 4	**1.6 JUDGMENT:**
	Do the therapist's responses convey judgments of the client's experiences / behaviour? (Reversed item) Do the therapist's responses convey an evaluative attitude towards the client, either positive or negative? For example, do the therapist's responses convey criticism or praise which indicates bias, collusion or manipulation?

0 1 2 3 4	**1.7 AUTHENTICITY: Does the therapist's attitude demonstrate congruence between what is experienced and what is communicated?**	Do the therapist's responses indicate defensiveness or the presence of a façade? Is there evidence of therapist self-incongruence or inner struggle which is not communicated to the client? Is the therapist freely her/himself in the relationship; open to experiences and feelings of all types? Does the therapist recognise and accept contradictory feelings? Do therapist verbalisations match inner experience? Is there congruence between the therapist's linguistic and paralinguistic communication?

PART TWO

The second part of the scale addresses the following competences from the Counselling Practitioner Manual:

B2.2 Ability to work with the client to establish a therapeutic aim
S1.1 Ability to help clients to access and express emotions
S1.2 Ability to help clients articulate emotions
S1.3 Ability to help clients reflect on and develop emotional meanings

0 1 2 3 4	**2.1 COLLABORATION:** **Does the therapist adopt a collaborative approach with the client to clarify and work towards their therapeutic goals?**	Does the therapist help the client locate and maintain a focus for the therapy, while adapting this focus as necessary? This may include: explaining the rationale for therapeutic work; clarifying what the client hopes to get from therapy; helping the client work towards the resolution of difficulties and the achievement of goals.
0 1 2 3 4	**2.2 EMOTION FOCUS:** **Does the therapist focus on client emotional experiences, both explicit and implicit?**	Does the therapist help the client contact their feelings by: helping the client focus their attention on bodily sensations; focusing on emotionally poignant experiences; helping the client contact the intensity of how they feel; helping the client find ways of describing emotions; making empathic conjectures about feelings that have not yet been expressed? Does the therapist help the client to differentiate between different aspects of emotional experience?

0 1 2 3 4	**2.3 ARTICULATION OF EMOT** **Does the therapist actively try to help the client verbalise their emotions along with associated meanings and concerns?**	**ONS:** Does the therapist help the client to find appropriate words to describe their feelings? Does the therapist help the client to verbalise the memories, wishes and needs associated with particular emotions? Where appropriate, does the therapist suggest imagery and metaphor to help articulate the meaning of the client's experiences?
0 1 2 3 4	**2.4 DEVELOPING EMOTIONA** **Does the therapist help the client explore their explicit or implicit central experiences of self, others and the world?**	**. MEANING:** By offering empathic exploration of core experiences, does the therapist support the emergence of new understanding, new emotional experience, new sense of inner strength and new ways of experiencing self, the world and others?

0 1 2 3 4	**2.5 EMOTIONAL REGULATION:** **Does the therapist help the client achieve and maintain an optimal level of emotional arousal for exploring their feelings?**	(a) If the client is overwhelmed by feelings, does the therapist help the client to manage these emotions by offering a calming and containing presence; offering containing imagery; helping the client self-soothe? (b) If the client is distant from or out of touch with their feelings, does the therapist help the client to increase emotional contact by helping them review current concerns and focus on the most important or poignant; helping them remember and explore memories of emotional experiences; using vivid imagery or language? (c) If the client is at an optimal level of emotional arousal for therapeutic work, does the therapist help them continue working at this level?

2. Appendix B Exemplar Programme for the Five-Day Training

Day 1

10.00 – 12.30 Module 1: Introduction to the NHS Talking Therapies programme and understanding of depression

13.30 – 16.00	Module 2: Introduction to the NHS Talking Therapies programme and understanding of depression (cont.)

Day 2

10.00 – 12.30	Module 3: Orientation to the CfD competence framework
13.30 – 16.00	Module 4: Theoretical principles and values

Day 3

10.00 – 12.30	Module 5: Working with depression
13.30 – 16.00	Module 6: Working briefly

Day 4

10.00 – 12.30	Module 7: The CfD Relational Stance
13.30 – 16.00	Module 8: Working with emotional processes

Day 5

10.00 – 12.30	Module 9: Assessment of trainee competence
13.30 – 16.00	Module 10: Supervision and clinical practice/Review and evaluation

3. Appendix C Exemplar Course Evaluation Questionnaire

Counselling for Depression (CfD) training programme

Developed by the
British Association for Counselling and Psychotherapy

Course Evaluation

Please help us by completing this form, which should take no more than 5-10 minutes

Please score each module in terms of content and delivery using the following ratings:

1-2 not at all satisfied 3-4 somewhat satisfied 5-6 moderately satisfied 7-8 mostly satisfied 9-10 extremely satisfied

Module 1: Introduction to the NHS Talking Therapies programme and understanding of depression

Content: Delivery:

Module 2: Introduction to the NHS Talking Therapies programme and understanding of depression (continued)

Content:

Delivery:

Module 3: Orientation to the CfD competence framework

Content:

Delivery:

Module 4: Theoretical principles and values

Counselling for Depression (Curriculum) February 2011 – BACP	Content:	Delivery:

1-2 not at all satisfied	3-4 somewhat satisfied	5-6 moderately satisfied
7-8 mostly satisfied	9-10 extremely satisfied	

Module 5: Working with depression

Content:	Delivery:

Module 6: Working briefly

Content:	Delivery:

Module 7: The CfD Relational Stance

Content:	Delivery:

Module 8: Working with emotional processes

Content:	Delivery:

Module 9: Assessment of trainee competence

Content:	Delivery:

Module 10: Supervision and clinical practice/Review and evaluation

Content:	Delivery:

Please give EACH of the following three questions an overall score

1-2 not at all satisfied 3-4 somewhat satisfied 5-6 moderately satisfied
7-8 mostly satisfied 9-10 extremely satisfied

The Trainers:	Overall score:
Course materials:	Overall score:
Course venue:	Overall score:

Did the course fulfil your expectations:	Yes	No
Would you recommend this course to colleagues?	Yes	No

Any comments:

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Thank you for taking the time to complete this questionnaire *The information provided will assist in evaluating and improving the CfD training course*

4. Appendix D Exemplar Teaching Materials

1. Symptoms of Depression

- Depressed mood most of the day
- Marked loss of interest or pleasure in daily activities
- Sleep problems
- Loss of appetite and significant loss of weight
- Fatigue/exhaustion
- Difficulties getting to sleep or excessive sleep
- Psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- Feelings of worthlessness or excessive guilt
- Low self-confidence
- Difficulties in thinking/concentrating and/or indecisiveness
- Recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

A diagnosis of depression is based on the presence of a subset of these symptoms

Of these symptoms, depressed mood; loss of interest or pleasure and fatigue are central

Symptoms need to be present consistently over time (for example, DSMIV- TR criteria specify two weeks, ICD-10 criteria specify one month)

2: Assessing clients' suitability for CfD

In order to assess whether counselling is an appropriate way forward for your client there are four Key areas of focus to consider with/in relation to your client:

What are the client's preferences?

Consider…..

- What kind of treatment would the client prefer?
- What do they want from Counselling?
- Are their expectations realistic?
- Is the client committed to engaging in the process?

Is the counsellor able to offer a helpful therapeutic experience to the client?

Consider……

- Is there a sufficient level of psychological contact with the client?
- Is the counsellor able to offer sufficient Empathy, UPR and Congruence?
- Does the counsellor have sufficient resources and levels of competence to work with this client?
- Safety issues
- Boundary issues

Is the client able to receive/benefit from the Core Conditions?

Consider …….

- Is the client receptive to the counsellor's empathy and UPR to at least a minimum degree?

Does the client's level/type of depression fit into the mild to moderate levels as outlined in NICE ?

- Sub-threshold depression symptoms (fewer than five DSM IV symptoms)
- Mild depression (few, if any, in excess of the five required to make the diagnosis and the symptoms result in only minor functional impairment)
- Moderate depression (symptoms or functional impairment are between mild and severe)
- Severe depression (most symptoms, and are symptoms which markedly interfere with functioning).
- Between 5 and 15 on the PHQ-9

Please note: assessment of depression severity is an imprecise science, hence the importance of clinical judgement. 6 to 10 sessions are recommended for sub-threshold/mild/moderate levels of depression.

For more serious presentations, up to 20 sessions are recommended.

3: Assessment of Risk Factors for Self Harm

Factors associated with an elevated risk of self-harm:

- Childhood adversity
- Experience of a number of adverse life-events (including sexual abuse)
- A family history of suicide
- A history of self-harm
- Seriousness of previous episodes of self-harm
- Previous hospitalisation
- Mood disorders
- Substance use disorder
- A diagnosis of personality disorder
- Anxiety disorder (particularly PTSD)
- A psychotic disorder (for example, A diagnosis of schizophrenia or bipolar disorder)
- Presence of chronic physical disorders
- Bereavement or impending loss (where psychological problems preceded the bereavement)
- Relationship problems and relationship breakdown
- Severe lack of social support

- Socio-economic factors for example,
    1. People who are disadvantaged in socio-economic terms
    2. People who are single or divorced
    3. People who are living alone
    4. People who are single parents

Individuals with a history of suicide have a markedly elevated risk of selfharm. Risk factors identify high risk groups rather than individuals. Suicide is a relatively rare event so difficult to predict at the level of the individual. Even when accurate systems of prediction are employed these will incorrectly identify a substantial number of individuals as possible suicides. Most risk factors relate to long term risk. They are less helpful in prediction in short term or immediate clinical situation. Individuals with depression have a significantly elevated lifetime risk of suicide.

- The risk of suicide is highest relatively early in a depressive episode, and less likely during periods of remission

- Hopelessness (negative expectations of the future) may be a more important marker of risk than the severity of depression

- The combination of depression, hopelessness and continuing suicidal intent represents a marker of elevated risk

4: Case Study: Ahmed

Ahmed is a nineteen year old young man who has been referred by his GP. He is reluctant to come to therapy as he wants to be strong and cope alone. He says he will struggle to talk about his problems with anyone as he doesn't want to talk about his family. His father died six months ago after struggling for several years with cancer.

Ahmed was an achiever at school and was away at University at the time of his father's death. As the eldest son he is now the head of the family and takes his responsibilities very seriously. He immediately left his studies and returned home to look after his family. He is currently working with his uncle but is unhappy as he wanted to work in the field of science. He misses his dad and finds himself wanting to cry but stops himself and often cries at night when he is alone.

Ahmed is worried about upsetting his mother as he is sad. He is concerned about his younger brother who has been having problems at school since his father's death. Ahmed is upset because he is arguing with his older sister; she has been going out with friends and not always coming home at night. Ahmed often feels that he is worthless and that he is not living up to his father's expectations.

These feelings are confirmed for him by his uncle, who tells him that he is not fulfilling his role.

Task:

Develop a formulation of Ahmed's issues using the PCE conceptualisation of depression. How might this inform your work with him?

5: Processing Emotion

CLIENT PROCESS	COUNSELLOR INTERVENTIONS
Accessing emotion	
Expressing emotion	
Articulating emotion	
Reflecting on emotional meanings	

6: Briefings for role plays

"Out of touch" client

You've been feeling low and flat for the past six weeks since losing your job. You are not sleeping well and have lost your appetite. Life has lost its pleasure and every day seems the same. Your partner works full-time in a busy job and so is out for most of the day. You spend much of the time ruminating over what has happened to you and the injustice of it all: working for the same company for 15 years and then being made redundant. You also spend time worrying about the future: paying the bills; whether you will find a new job. Most of the people you socialised with were work colleagues, who are still working for the company. Because they are busy at work and you don't want to talk about what has happened to you, you tend to avoid contact with them. You don't really know how you feel about the situation apart from being emotionally flat, gloomy and having lost interest in the things that you used to enjoy.

"Overwhelmed" client

Your father died six months ago, leaving you as the main carer of your mother who is old and quite disabled. You also have a full-time job and school-age children. Your partner also works full-time but in a poorly-paid occupation. You were close to your father and have a strong sense that he would want you to take care of your mother now that he is gone. However you haven't always got on well with your mother, who you find selfish and demanding. You have good relationships with your partner and children, but they tend to resent the fact that since your father's death you spend an increasing amount of time with your mother (who they don't particularly like) and have less time for them. You feel constantly upset and emotional, as if you are trying to please everyone but somehow always fail in this respect. You miss your father and generally feel at the end of your tether.

Puzzling or confusing experience-client briefing

Think of a time when you entered a situation and experienced yourself reacting in an uncharacteristic manner. You may have underreacted/overreacted or behaved in a way which isn't typical. You may have said something which on reflection seemed inappropriate; you may have done something which you wish you hadn't. The situation and people involved may have been familiar or unfamiliar; you may have been feeling stressed or ill at ease. You don't know why you behaved the way you did but feel puzzled, confused or disapproving of it.

Discuss with your counsellor.

Puzzling or confusing experiences-briefing for counsellors Encourage your client to describe the whole event. Encourage your client to go back over the event and "slow down" the description, encouraging a richer and more reflective account.

Encourage them:

- To identify how they were feeling before they encountered the situation
- To re-imagine the situation
- To identify the moment reactions were triggered
- To explore their reaction to the situation
- To make links between their reactions and the way they construed the situation
- To develop new ways of understanding the situation and their responses to it

7: Working with confusing or puzzling experiences

Stages of unfolding	Therapist response
Client describes puzzling personal reaction	Propose working on the issue
Client recalls scene and their reactions	Encourage client to re-enter and reexperience the situation
Tracking the two sides: stimulus situation and client's internal affective reaction	Help client explore stimulus situation, their response and the connection between the two
Meaning bridge: client discovers link between problematic reaction and his or her construal of the stimulus situation	Use empathy and empathic conjecture to identify possible meaning and links between the two sides. Continue to empathise with client's sense of puzzlement
Recognition and re-examination of own mode of functioning and it's wider aspects	Help client explore meaning and wider significance of reactions
Consideration of new options	Explore emerging new understanding and implications for change

5. Appendix E Key Person-centred/experiential (PCE) supervision competences

(adapted from Roth and Pilling *Ability to supervise humanistic psychological therapies*)

- An ability for the supervisor to draw on knowledge of the principles underpinning PCE Counselling for Depression
- An ability to link PCE concepts and principles to therapeutic strategies and methods
- An ability to be reflective and to self-monitor the emotional and interpersonal processes associated with supervisor-supervisee interactions
- An ability to help supervisees review and apply their knowledge of PCE Counselling for Depression
- An ability to adopt an approach to supervision which places the primary focus on the exploration of client issues and the therapist's experience of the client, rather than on developing immediate solutions to problems
- An ability to employ empathic understanding to sense the supervisee's perceptions, experience and responses to their work
- An ability to help the supervisee: ○ to maintaining a primary focus on clients' affective experience ○ to reflect on their experience of the therapeutic relationship (including their affective, cognitive and somatic reactions to the client)
- An ability to help the supervisee become more flexible and spontaneous in their therapeutic role by maintaining an empathic and challenging supervisory relationship which supports their capacity:
  - ○ to be honest and open about their experience of offering therapy and to communicate this in supervision

- An ability to model PCE principles in the context of supervision and the supervisory relationship for example, ○ modelling “core conditions” such as transparency and congruence in responses to the material presented by the supervisee

6. Appendix F Humanistic Supervision Competences

This suite of modality-specific supervision competences has been developed by Roth and Pilling to supplement their supervision competence framework (Roth and Pilling, 2009). Of the various modality-specific suites of supervision competences, the Humanistic is the one which is most closely aligned to the theory and practice of Counselling for Depression. The lists of competences are reproduced here verbatim from the original.

Ability to supervise humanistic psychological therapies

This section describes the knowledge and skills needed for the supervision of counselling. It is not a 'stand-alone' description of competences, and should be read:

1) In conjunction with the supervision competence framework (Roth and Pilling, 2009).
2) With reference to the counselling practitioner manual which describes the generic, basic, specific and meta-competences for the delivery of effective counselling.

1. The supervisor's expertise in humanistic psychological therapies

1.1 An ability for the supervisor to draw on knowledge of the principles underpinning humanistic psychological therapies

1.2 An ability for the supervisor to draw on personal experience of the clinical applications of humanistic psychological therapies.

1.3 An ability to recognise (and to remedy) any limitations in knowledge and/or experience which has implications for the supervisor's capacity to offer effective supervision.

1.4 An ability to ensure that supervision integrates generic therapeutic skills (such as engaging the client) while also focusing on the development and/or maintenance of competences specifically associated with humanistic psychological therapies.

2. Supervisory stance

2.1 An ability to be reflective and to self-monitor the emotional and interpersonal processes associated with supervisor-supervisee interactions.

2.2 An ability to adapt supervision in relation to:

2.2.1 The supervisee's stage of learning and development as a therapist

2.2.2 The supervisee's learning and therapy styles

2.3 An ability to be flexible about the application of theory and technical principles.

2.4 An ability to take a respectful attitude to the supervisee, including an ability to be supportive and non-judgmental, especially in relation to the supervisee's discussion of clinical errors or mistakes.

2.5 An ability to maintain a relationship that is supportive but does not become 'therapy'.

2.6 An ability to maintain a primary focus on the educational goals of supervision.

2.7 An ability to appraise when it is appropriate to help the supervisee attend to personal and/or emotional reactions to their work.

2.8 An ability to maintain an appropriate balance between a collaborative and an authoritative stance.

2.9 An ability to adopt an approach to supervision which places the primary focus on the exploration of client issues and the therapist's experience of the client, rather than on developing immediate solutions to problems.

3. Adapting supervision to the supervisee's training needs and their developmental stage

3.1 An ability to identify the supervisee's knowledge and experience of humanistic psychological therapies.

3.2 An ability to monitor the supervisee's ability to make use of a humanistic perspective to understand the client's presentation and the way in which the therapeutic process develops.

3.3 An ability to help the supervisee reflect on their development as a humanistic practitioner in order to identify specific learning goals.

3.4 An ability to link material covered in supervision sessions to the supervisee's learning needs and personal development.

3.5 An ability to negotiate learning agreements which reflect the supervisee's learning needs and are appropriate to their stage of development.

4. Specific content areas for supervision of humanistic psychological therapies

4.1 An ability to help the supervisee review and apply their knowledge of humanistic psychological therapy.

4.2 An ability to listen actively to the supervisee to help the supervisee reflect on their work.

4.3 An ability to employ empathic understanding to sense the supervisee's perceptions, experience and responses to their work.

4.4 An ability to help the supervisee:

4.4.1 In maintaining a primary focus on the client's affective experience.

4.4.2 To reflect on their experience of the therapeutic relationship (including their affective, cognitive and somatic reactions to the client).

4.5 An ability to help the supervisee become more flexible and spontaneous in their therapeutic role by maintaining an empathic and challenging supervisory relationship which supports their capacity:

4.5.1 To be honest and open about their experience of offering therapy and to communicate this in supervision.

4.5.2 To adopt a position of curiosity towards their experiences in offering therapy, and to be open to exploring the meaning of these experiences.

4.6 An ability to help the supervisee maintain a therapeutic stance appropriate to the humanistic approach they are employing.

4.7 An ability to link humanistic concepts and principles to therapeutic strategies and techniques, with reference to the clinical material presented by the supervisee for example:

4.7.1 Through discussion and exploration of the supervisee's verbal reports.

4.7.2 Through direct observation (for example, through the use of audio or video recordings, or through co-working in humanistic group therapies).

4.7.3 Using process notes (usually made immediately after the therapy session).

4.7.4 Through modelling of humanistic principles in the context of supervision and the supervisory relationship (for example, focusing on the supervisee's growth and development).

4.7.5 Modelling 'core conditions' such as transparency and congruence in responses to the material presented by the supervisee.

4.7.6 Modelling the process through which clinical ideas emerge (i.e.

by 'thinking out loud' to illustrate the development of ideas regarding clients and their issues).

4.7.7 Through observation and discussion of the supervisee's clinical work (i.e. through the use of audio or video recordings, or through direct observation of the supervisee at work).

4.8 An ability to use audio-recorded therapy material in a structured manner:

4.8.1 To plan specific training tasks.

4.8.2 To deepen awareness of relational processes in the therapeutic dyad.

5. Specific supervisory techniques:- 'Parallel process'

5.1 An ability to draw on knowledge of the ways in which similar interpersonal dynamics may be concurrently enacted in both the supervisory and the therapeutic dyad.

5.2 An ability to maintain a focus on the therapy with the client, while recognising the possibility of re-enactment within supervision of significant dynamics between the supervisee and their client.

5.3 An ability to explore with the supervisee interpersonal processes occurring both between supervisor and supervisee and supervisee and client and how these relate to one another.

5.4 An ability to help the supervisee identify when they have been drawn into 'enactments' with the client and to explore their thoughts and feelings when such events occur.

6. Monitoring the supervisee's work

6.1 An ability to make use of recordings/direct observation to monitor the supervisee's ability to use humanistic strategies and techniques appropriate to the humanistic approach being adopted.

7. Sources

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Tudor, K. and Worrall, M. (2004) Freedom to Practice: Person-centred approaches to supervision. Ross-on-Wye: PCCS Books

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