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ORIGINAL ARTICLE

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Person-centred experiential therapy: Perceptions of trainers and developers

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Abstract

Background: Top-up training in person-centred experiential therapy (PCET) was developed in 2011 and is offered, through four university centres, to counsellors working in Improving Access to Psychological Therapies (IAPT) services in England. Research into PCET training has now gained more importance, with the implementation of the IAPT Data Set Version 2.0 in September 2020, which requires IAPT services to report on the qualifications of care personnel. Previous research has explored the experiences of PCET trainees, but there is a need to investigate similarities and differences in the views and experiences of other stakeholders in the PCET initiative.

Method: Ten trainers and developers of the model were interviewed, including the full population of those personnel currently delivering the training. The framework method was used in the analysis of transcripts.

Findings: Tensions were identified between the individualism of the person-centred approach and the standardisation expected by IAPT. Participants recognised that manualisation of the PCET model was controversial, but welcomed the coherence of the model and the ability to articulate theory and practice. Practical differences between centres were identified in the delivery of training, raising the question of whether such differences reflect the individualism of the person-centred approach and the flexibility of the model, or reveal a lack of consistency in the understanding and delivery of PCET nationally.

Conclusions: PCET training is an opportunity to improve the consistency of PCET therapists' theoretical understanding and practice, enhancing their status and opportunities for research. Differences between training centres may compromise this consistency.

KEYWORDS

counselling for depression, IAPT, person-centred experiential therapy, training

1 | INTRODUCTION

The Improving Access to Psychological Therapies (IAPT) programme was rolled out nationally in late 2008 to increase the availability of talking therapies in primary care for common mental health problems, particularly anxiety and depression. The plan was to expand capacity by building on an existing workforce and re-training therapists where necessary to meet specified, evidence-based competencies, and to train a new workforce of low- and high-intensity practitioners (Turpin et al., 2009). While only cognitive behavioural therapy (CBT) was initially offered, from 2011, 5-day 'top-up' training courses in other high-intensity therapies were rolled out for therapists from the pre-IAPT workforce.

For therapists working in the humanistic tradition, which includes person-centred therapy (PCT), the training offered is person-centred experiential therapy (PCET), known at the time as Counselling for Depression (CfD). The model is also known as PCE-CfD, to avoid confusion in IAPT services (Murphy, 2019). PCET is an integration of person-centred therapy with emotion theory and process-guiding components derived from emotion-focused therapy (EFT; Elliott et al., 2004). This approach was informed by evidence for the effectiveness of counselling from randomised controlled trials (RCTs) cited in the NICE Guideline for Depression (National Institute for Health & Clinical Excellence, 2009; Sanders & Hill, 2014). Of the five RCTs cited by NICE, three were trials of EFT, including two showing PCT with the addition of experiential process-guiding interventions to be more effective in reducing depression than PCT alone (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003).

According to participants in the current study, over 1,000 therapists have undertaken PCET training since 2011. Although PCET is the second most frequently delivered form of high-intensity therapy in IAPT after CBT, PCET therapists constituted only 6% of the IAPT high-intensity workforce in 2015, while non-IAPT-trained counsellors constituted 11% (NHS England, 2016). In 2018–2019, CfD, delivered by both PCET-qualified and non-PCET-qualified IAPT counsellors, achieved a recovery rate of 49.3%, compared with 48.0% for CBT (NHS Digital, 2019).

PCET training involves five days of face-to-face teaching and experiential learning. The curriculum is based on the Counselling for Depression Competence Framework developed by the Centre for Outcomes Research and Effectiveness (CORE) at University College London (Hill, 2010, 2011). This is followed by 80 hr of supervised practice within the trainee's usual client work. Up to six session recordings can be submitted to the trainers for assessment, of which four must be assessed as adherent to successfully complete the training. Adherence to the model is assessed according to the Person-Centred Experiential Psychotherapy Scale (Freire et al., 2014).

An evaluation of the first phase of CfD training was conducted by the developers of the model and the curriculum, and those who delivered the first three training courses (Pearce et al., 2013). The evaluation comprised questionnaires, followed by telephone interviews with six trainees, two from each course. Results suggested that trainees viewed the Competence Framework and the adherence scale as helpful, being 'descriptive rather than prescriptive', and they hoped that completing the training would enhance their status and job security within IAPT. Sixty per cent of respondents said that the training had changed their practice, but did not necessarily make them more adherent to the CfD model. The authors noted that anxiety around submitting recordings for assessment was understandable, especially since a number of trainees struggled to meet adherence. Participants felt that the input on EFT was insufficient, and supervisors were not familiar enough with CfD. They also found that IAPT services often did not permit them to offer the maximum of 20 sessions.

A further report investigating the experience of CfD trainees also used a questionnaire and follow-up interviews, with a sample drawn from the British Association for Counselling and Psychotherapy (BACP) CfD Practice Research Network (PRN) (Drewitt et al., 2018). Similar results were obtained: participants were positive about the model and the 5-day training but felt there was a lack of support and understanding from IAPT services during the period of assessed practice. Participants stated that their initial hope that the training would enhance the status of counselling in their IAPT services was not fulfilled. A limitation of this study was that, in being PRN members, the participants had already demonstrated interest in the PCET model.

Nye et al. (2019) addressed this limitation by investigating the experiences of therapists from one IAPT service who were required to undertake PCET training in-house, thereby reducing the level of personal motivation. By asking participants about their previous theoretical orientation, and whether they had completed or dropped out of the training or training was ongoing, the authors were able to investigate whether differences in orientation contribute to success in PCET training. They concluded that theoretical orientation and choice play less of a role in completion than intrapersonal characteristics such as flexibility and resilience.

Taken as a whole, this research utilising practitioners' perspectives found that over the six years covered by these studies very little changed for trainees, especially with regard to the status and understanding of counselling within IAPT services. The PCET training programme continues to offer IAPT-approved training to all humanistic IAPT counsellors, and supports the expansion of the workforce required by the NHS Mental Health Implementation Plan 2019/20–2023/24. There is an increased emphasis on training in the light of the implementation of the IAPT Data Set Version 2.0 in September 2020, which requires IAPT services to report on the qualifications of care personnel. Yet despite the importance of the PCET initiative and training, while the experiences of PCET trainees have been studied, there is to date no research investigating the experiences and views of trainers and developers of the model, or consistency between training courses.

To address this evidence gap, we present data from the perspective of the people who developed the PCET model and the national trainers who have delivered the training since 2011. We ask whether the original aims of the training as set out by Pearce et al. (2012)

are being delivered consistently, in line with the aspiration 'to train counsellors in the CfD competences [and] to ensure the link [is] made between counselling practice and evidence of effectiveness' (p.20). In order to explore the issue of consistency between training centres, which might affect the robustness of the link between evidence of effectiveness and counselling practice, we focused on the context for the training, on potential differences between the participants in their understanding of the PCET model, and between the four training centres in their delivery of training and assessment. We interviewed all national PCET trainers and two stakeholders from the BACP who developed the model, and authors of both editions of the PCET textbook.

2 | METHOD

2.1 | Design and setting

The design comprises a qualitative study, involving all trainers currently delivering PCET training nationally, based in four universities covering the whole of England. Trainers were interviewed face-to-face at their place of work, between May and July 2019, by RH. Participants were interviewed individually, apart from two from one training centre, who were interviewed together. Two stakeholders employed by the BACP to develop and roll out the Competence Framework and PCET training were also interviewed by RH, one by telephone in October 2018 and one by videoconference in March 2020.

2.2 | Ethics

Ethical approval for this study was granted by the University of Sheffield ethics review panel, Application Reference Number 026096.

2.3 | Participants and roles

Of the ten participants, two were employed by BACP in 2010/11, when IAPT called for training to be developed in various non-CBT modalities. One of these had been a member of the Expert Reference Group that developed the Humanistic Competence Framework for Skills for Health (Roth et al., 2009) and subsequently designed the Counselling for Depression Competence Framework (Hill, 2010), as well as being a co-author of the first edition of the PCET textbook (Sanders & Hill, 2014). The other is still involved in the accreditation of PCET courses. Two participants were members of the team who developed the curriculum for the 5-day training, and a programme for assessment and qualification (Hill, 2011; Pearce et al., 2012). They later trained the trainers and are currently trainers themselves. Five other participants are currently trainers, and one participant has been a trainer in the past and is still closely involved in the PCE-CfD project, including writing the second edition of the textbook (Murphy, 2019). All participants consented for quotes from their interviews to be reproduced, and quotes have been anonymised.

2.4 | Materials

A schedule was used to guide interviews, based on the following topics:

1. Context
1.1 Participant's original orientation
1.2 Workload
1.3 IAPT
2. Model
2.1 Integration of person-centred therapy and EFT
3. Training
3.1 Adaptation of the curriculum
3.2 Use of PCEPS
3.3 Barriers to learning

Follow-up probes were suggested to aid in the further exploration of themes (Appendix S1).

2.5 | Procedure

Written consent was obtained from all participants to conduct, record and transcribe interviews. Interviews were between 50 min and one hour and 38 min long. They were transcribed by RH and anonymised, and an encrypted version of their own transcribed interview was emailed to each participant, giving them the opportunity to amend or redact any part. Transcripts were then uploaded to QSR International's NVivo 12 for analysis (Nvivo qualitative data analysis software, 2018).

2.6 | Framework analysis

Data were subjected to framework analysis (Ritchie & Spencer, 2002), which is a pragmatic method for analysing qualitative data in the field of public policy. This method was selected because the systematic charting of themes across cases allows transparency, with each participant's contribution being visible within each theme, and within the context of their contribution as a whole. Issues of generalisability do not arise as the whole target population of trainers is represented.

Framework analysis involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 1994). The identification of a thematic framework began with the a priori themes outlined in the interview schedule. Themes were also identified inductively, beginning at the familiarisation stage, and continuing with a process of reading each transcript and noting where participants' ideas

seemed to group together, revealing similarities and differences (Gale et al., 2013). Potential themes were clarified and defined by combing through all the transcripts multiple times. This resulted in an index of themes, with subject headings and subcategories. The index was then applied systematically to each transcript through the QSR International's NVivo 12 coding facility.

The charting stage was achieved by creating a framework matrix, enabling comparisons to be made between participants' contributions for each of the identified themes, and facilitating a process of defining concepts as described by the participants, mapping the range of participants' views and developing new ideas based on these insights. A link to this matrix in Excel can be found here (Supporting Information).

2.7 | Trustworthiness

In order to ensure the integrity of the analysis, the lead author, who is a practitioner–researcher, wrote her own responses to the interview topics, which are available alongside the responses of the participants (Bolam et al., 2003).

The trustworthiness of the interview transcripts was firstly established by sending each one back to the interviewee via encrypted email, giving participants the opportunity to amend or redact any part, and thus providing a form of member checking for their validity (Brinkmann & Kvale, 2015). A further validation stage was included, called synthesised member checking (SMC; Birt et al., 2016), where the themes that had been developed were submitted to participants to confirm that they had resonance, and to invite additional comments (Appendix S2). The study conforms to the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research, and recommendations for publishing qualitative research (Elliott et al., 1999).

3 | RESULTS

Three themes were identified, with nine subthemes, as shown in Table 1. Every theme is referred to by at least eight of the ten participants. Precise numbers of participants commenting within each theme have not been stated. Such numbers would be misleading, since not all participants expressed views within every theme.

3.1 | Individualism

The responses of participants highlighted several areas where individualism can result in tensions, or a lack of coherence. For example, the valuing of individualism in initial person-centred counselling training can result in diverse, even idiosyncratic understanding of the model. Likewise, the acceptance and apparent valuing of diversity in therapy by the professional body presented tensions for some participants. Participants' moral and philosophical values were sometimes challenged in the course of training and working with IAPT.

TABLE 1 Emergent themes and subthemes

Themes	Subthemes
Individualism	Values
	Training
	Organisational context
Standardisation	Service delivery
	Manualisation
	Adherence
Coherence	Articulating the model
	Flexibility
	Effectiveness

3.1.1 | Values

Some of the participants in this study found that the medical model of IAPT and the NHS clashes with the ontology, values and principles of the person-centred tradition. One of the participants recognised that this caused resistance from some people from the very beginning of the PCET project:

> a lot of Person-Centred people would rather avoid working in the NHS, because they don't agree with the sort of scientific, evidence-based, medical-model type approach.
>
> (P1)

The trainers from one centre particularly struggled with the compromises needed to work in a person-centred way in a health service:

> I'm not even sure that I, you know, I think about Person-Centred therapy as a form of health practice. … Because in our systems, health and mental health really are aligned much more with mental illness, pathology, dysfunction, diagnosis. And that [PCET] as an approach, we're based in a different paradigm, which is about growth, and human development and human potential.
>
> (P7)

Other participants saw PCET as a welcome opportunity to preserve the person-centred values, and to offer a non-medical alternative within the NHS:

> one [trainee] said "You know, when I - I was Person-Centred trained, and then I joined IAPT. And I was kidnapped." They used this term, "I was kidnapped. And doing this training, and just doing this check-in, it's as

> though I've been released to come back to where, and what feels right about why we do the work that we do." And I thought it was such a powerful thing to say, when it was quite small.
>
> (P10)

3.1.2 | Training

Nearly all the participants commented that many trainees who identified themselves as person-centred were disadvantaged by having no 'clear, theoretical underpinning' (P2).

> the kind of understanding of Person-Centred is often quite narrow, and quite shallow.
>
> (P6)

One participant, in the initial interview, and again through the synthesised member checking, described their dismay when listening to practice recordings that trainees claimed to be person-centred:

> I listen to their work, and actually it's quite sort of problem-solving. Quite cognitive and problem-solving. And sometimes avoids emotion.
>
> (P10)

> therapy sessions reflected the relatively superficial, almost conversational, approach.
>
> (P10, from SMC)

Participants attributed this to drift, to being immersed in the CBT-influenced culture of IAPT, or 'the IAPT effect' (P3), and also to trainees' original training courses. Participants believed that some courses were of low-quality:

> they'd be training people in their own personal philosophy, along with a bit of, you know, a bit of philosophy taken from other people. … I'm exaggerating now, but they could be like little cults, where strong personalities would lead the training programme.
>
> (P1)

Integrative trainings were also considered problematic by some trainers:

> they're always called integrative, but really what they're talking about is eclectic, there's no integration.
>
> (P6)

Participants observed that counsellors often had a 'toolbox approach' (P5) to continuing professional development (CPD), which was inconsistent with the person-centred approach. Some trainers indicated that this might reflect counsellors' own doubts about the effectiveness of PCT:

> there's a real feeling amongst a lot of people that you can't work in a person-centred way in a time-limited frame … and therefore you have to incorporate other things in.
>
> (P4)

3.1.3 | Organisational context

The interviews revealed a lack of consistency in the conditions under which participants worked and delivered PCET training in the institutions that employed them. There were also different attitudes among the participants to BACP's accommodation of diverse philosophies and therapeutic models. Responses reflected a common feeling that the person-centred approach was under-valued in many areas, including the NHS and BACP.

At one training centre, a team of supervisors and assessors had been created, and at a different centre, a trainer was employed specifically to deliver PCET training. Another trainer said:

> Now, I work a 60-hr week, [my colleague] works a 60-hr week, we cannot add anything else in. … Short of not having holidays, we do not have time to put [a different] system in place. I know other institutions do do it. They have their workloads completely differently. We cannot do it.
>
> (P3)

Participants' attitudes to BACP varied from appreciation to feelings of being neglected or misunderstood:

> BACP are a broad membership body with therapists of differing orientations … umbrella organisations have to make compromises and hold competing assumptions and practices with equal respect.
>
> (P9 from SMC)

> So I don't think we're in the right home. And I don't know what the home is for PCE-CfD. I don't know where it resides. Because it's certainly not being championed by BACP.
>
> (P5)

3.2 | Standardisation

Against this background and history of individualism and diversity in the person-centred tradition, including person-centred training courses and counselling institutions, the participants observed that the advent of IAPT has brought an expectation of standardisation.

They observed that PCET therapists working within IAPT are expected to meet IAPT rules and targets, and to adhere to the PCET manual when delivering therapy. Participants also reflected on the trainers' adherence to the PCET curriculum.

3.2.1 | Service delivery

Participants identified disadvantages for person-centred therapists working in IAPT, including examples of inequality in pay, sometimes zero-hours contracts or payment by results. Where a service had lone counsellors, or very small numbers, there was no opportunity for mutual support, and often, modality-specific supervision was unavailable.

Participants also observed that there are various ways in which processes in IAPT conflict with person-centred philosophy. Trainers reflected the experience of some trainees that case managers expected clients' scores on outcome measures to improve consistently, which is unlikely to fit with a counselling process:

> it was like, "Well, if the scores are going up and down, that's not a very good sign, is it?" You know, people should be approaching, you know, kind of health, in a consistent way or something. … So there's something about the lack of understanding of the principles that underpin it. And the fact that the system is slightly out of sync, or the system of measuring or gauging how effective something is doesn't fit with those principles.
>
> (P8)

The participants pointed out that the outcome measures comprising the Minimum Data Set themselves represent the medical model, being 'symptom removal forms' (P9).

Some trainers had the experience of counsellors being expected to complete multiple IAPT-approved top-up trainings:

> I can think of a commissioner who wanted to send somebody who hadn't got a humanistic training [background], but "I need her to do this training, because all of the counsellors have got to be able to work in all of the modalities".
>
> (P4)

Disadvantages for person-centred counsellors within IAPT also became barriers for trainees undertaking their 80 supervised practice hours. One problem is that although during training trainees receive specialist PCET supervision, there is often no modality-specific supervision in their services, meaning that therapists may drift from the model:

> how will the fidelity of the model be maintained, if you haven't got a supervisor that understands what you're doing?
>
> (P2)

The other problem recognised by trainers as a barrier to trainees' learning is when services put a limit on the number of sessions they are allowed to offer clients. PCET is designed to be offered in up to 20 sessions, but some trainees were told that, even during training, they could only offer six:

> They're trying to manage a waiting list by arbitrarily putting a number on it.
>
> (P9)

Although IAPT is seen as imposing standardised practices nationally, participants observed that there are still many inconsistencies:

> I think it makes something of a mockery about this idea that IAPT was supposed to provide a level playing field from John O'Groats to Land's End in terms of treatment choice, non-variability of options for care and therapy. It's just not the case.
>
> (P10)

3.2.2 | Manualisation

The Counselling for Depression Competence Framework (Hill, 2010) was originally understood as a manual for PCET, and as being descriptive rather than prescriptive:

> the idea is that you start off with research of effectiveness, and then you try and draw from the research studies' descriptions of practice which you can then train people in.
>
> (P1)

The Person-Centred Experiential Psychotherapy Scale (PCEPS), an adherence measure for PCET therapists, and the two editions of a PCET textbook were also referred to as manuals by some participants. Several participants described the tensions in the person-centred world, and for themselves, around the concept of a manualised model of therapy:

> it's being vilified. It's been described as a manual. … You know, as manualised therapy. And I don't see the PCEPS as a manual.
>
> (P5)

Many of the trainers recognised the value of a manual:

> The antipathy towards the manual is, I think, not well-grounded. To be taken as credible we have to have a model which is generalisable, albeit broadly. This does not mean that the manual is treated slavishly, nor is it an a + b = c either.
>
> (P10, from SMC)

3.2.3 | Adherence

Some of the participants observed that consistent, adherent practice in the PCET model would facilitate future research:

> if we are going to find out what works in therapy, we're never going to be able to do it unless we know that people are doing what we think they're doing.
>
> (P6)

This trainer also spoke about consistency in terms of the theory of common factors for effectiveness in psychotherapy:

> the common factors (inaudible), it seems to suggest that the coherence of practitioners' approaches matters. … To be able to explain what you're doing. … I guess it gives confidence if the practitioner knows what they're doing.
>
> (P6)

The interviews suggest that there are differences between the training centres in their interpretation of some items of the PCEPS, and in their rating schemes, and therefore in the standards they expect of trainees. One trainer acknowledged how rating can be subjective:

> it feels like it's a very subjective process, that is supposed to be objective.
>
> (P4)

A clear difference between centres emerged on the question of whether it is possible to achieve full marks on the PCEPS. Trainers from two centres expressed the view that it is very rare to award full marks to students in any context. A trainer from another centre was clear that they have awarded full marks, whereas at a third centre, the view was:

> We've given people 56/57, but for me, if you, if you are tracking somebody at a 6, and then you use some of the process-guiding elements, you've got to sacrifice some of the tracking. … Because you're not totally within their frame of reference. You're pulling something in from outside, maybe, of their, or, or on the edge of their frame of reference.
>
> (P3)

Such discrepancies were not seen as problematic by one participant, but a reflection of the flexibility of the model:

> Does there need to be some sort of moderation? (Pause). I'm not sure actually. I'm not sure, because I think, I think there's risks in trying to define something too rigidly, and trying to put too tight a set of constraints around what something might be.
>
> (P7)

There was agreement between trainers from several centres that trainees are more likely to drop out during the assessment stage of the training than fail to qualify.

The interviews revealed that adherence is also relevant for the trainers themselves, who deliver PCET training according to a standard curriculum. At one centre, trainers' workloads affected their ability to offer time outside the 5-day training. Another centre incorporated two extra days of training some weeks after the initial five days, to provide 'some theoretical shoring up' (P10). This centre had also introduced a system of providing audio feedback on trainees' recordings, to be more 'experience-near'.

It was acknowledged that some elements of the original curriculum had become 'obsolete' (P2), and therefore:

> we've re-jigged it. And everybody's re-jigged it differently.
>
> (P3)

Trainers delivered the curriculum more or less strictly, according to their own understanding of the model. For example, one trainer said that, in order to be consistent with the person-centred approach, the course was 'facilitated' rather than taught:

> It's not taught modules in our - You know, things come through, things come up.
>
> (P5)

3.3 | Coherence

The experience of the participants expressed in the interviews is that PCET training provides a new coherence for person-centred therapists working in IAPT, fostering greater confidence and consistency in practice, an increased sense of belonging, and creating possibilities for future research. Participants saw the model as flexible and effective. A new, clear articulation of the model was seen as an important element contributing to understanding and confidence for counsellors.

3.3.1 | Articulating the model

Participants observed that trainees' original training courses sometimes did not give them the theoretical foundation to describe their work. They believed that training in the PCET model, and emotion theory, provided language for therapists to understand the theory, and to communicate the model to colleagues from other disciplines:

> I don't think they were adequately able to describe what they were doing and how they were doing it, and how it might work and benefit clients. And this gave them the language to do that.
>
> (P2)

For some participants personally, the way the model enabled them to articulate humanistic principles was very positive:

> it's enabled me to name elements of my practice. So it's been a personal, um, joy, really.
>
> (P3)

Participants from different training centres highlighted different aspects of the model. At one centre, the person-centred ontological foundation of the model, and therefore non-directivity, was emphasised:

> And for me in the ontology of the approach. Just, you know, trusting the client's direction. Not believing that it's worthwhile following my direction, or maintaining my direction. I don't think it's worthwhile, I don't think it's meaningful. It doesn't fit really with what the, with my understanding of the person, from the Person-Centred Experiential perspective. So that will always take precedence.
>
> (P6)

At another centre, the process-guiding element of the model was given more emphasis:

> it's a dance between being directive and non-directive. And if all you do is follow the client, you can be ineffective, but if all you do is lead them you disempower them.
>
> (P4)

These views reflect participants' varying views about whether PCET should be seen as a contemporary, integrative humanistic model, or as no different to person-centred therapy. Three participants used the term 'contemporary' to describe it, for example:

> a sort of contemporary, dialogic sort of Person-Centred frame, which, you know, the sort of focusing experiential arm leads towards.
>
> (P9)

One centre understood the model as humanistic:

> these are Humanistic competencies, or Humanistic philosophies, or Humanistic principles, not just Person-Centred
>
> (P4)

whereas participants from another training centre saw no difference between PCET and classical person-centred practice:

> the attentiveness to the emotion, listening to the emotion, engaging with the feelings. … Which I just still think is the Person-Centred Approach (laughs). I don't see it as any, I don't see it as any different!
>
> (P5)

3.3.2 | Flexibility

Participants observed that the flexibility of the model allows therapists to adapt practice in their own style, as well as adapting to the needs of the client:

> I do feel one of the things we offer on the five days is a space where you, students can go "What makes sense to me?" And we overtly say that. "What makes sense to you? What of this framework do you feel fits? Where might you need to adapt if -?"
>
> (P3)

They described the model as non-directive, client-led, moment-by-moment and creative work, with the theoretical underpinning ensuring coherence:

> what I'm doing is working at the edge of experience of the client. And so, if I'm there, I trust in that process. That's what I really trust in. And so, what comes from that, then sometimes you don't have to direct, sometimes you do.
>
> (P10)

The participants' view was that, although the model was originally named Counselling for Depression, therapy is matched to the client's needs, rather than a diagnosis:

> even though the client is coming with a diagnosis, the counsellor doesn't need to diagnose them. And that the counsellor themselves, they don't need to do anything specific based on the diagnostic label that the client is bringing to them. And our theory demonstrates that that's the case.
>
> (P7)

3.3.3 | Effectiveness

One of the reasons given by several participants for the importance of coherence in theory and practice was the connection with the evidence for effectiveness, acknowledging that the status of humanistic therapy within IAPT depends upon this evidence:

> it's kind of the prestige and the status and the value is still given to specific 'techniques', even

> though they're not the things that are getting the evidence-base.
>
> (P6)

The model was developed on the foundation of empirical evidence:

> the whole idea was to… build a workforce who could be properly trained, training would be approved by IAPT, and who would be delivering, hopefully, evidence-based versions of their therapy, which had been tested in trials.
>
> (P1)

Two participants commented that research into person-centred therapy up to now has been difficult, because:

> with the integration and eclecticism that's out there, we have no idea what people are doing.
>
> (P6)

They believed that having a workforce of therapists consistently delivering this well-defined model could contribute to further evidence of effectiveness:

> it feels quite good that people need to be licenced so that we can actually, you know, be collecting relevant research about its efficacy, and so on, rather than clumping it all together under the title of counselling.
>
> (P8)

Another participant reflected that, although evidence from trials of EFT had contributed significantly to the development of the PCET model, important components of EFT had been left out:

> one of the things that never actually happened in the original manual was that they did bring those things from EFT.… that was a bit of a fudge, really, wasn't it?
>
> (P7)

Some participants commented on their own and trainees' experience of PCET being effective with clients in their own practice:

> I think the thing that really comes through is that if they've really got it, and they work well with the clients, they just are thrilled … to see the impact.
>
> (P8)

4 | DISCUSSION

The interviews conducted for this study capture the experiences of PCET trainers and developers of the model over the nine years of the PCET programme. They confirm the findings of Pearce et al. (2013) and Drewitt et al. (2018) around trainees' difficulties in adjusting to a new model, and a perceived lack of support from employing IAPT services. They also extend previous research by revealing important similarities and differences between training centres in the participants' views about the PCET model and training. The overarching themes of individualism and standardisation reflect various sources of tension around person-centred experiential therapy and the place of PCET therapists within the NHS. The overarching theme of coherence offers the hope that these tensions can be resolved.

One practical source of tension agreed by all the participants was the lack of support for trainees, or even obstacles to success, offered by IAPT services. Examples given were inappropriate supervision, and a limit on the number of client sessions allowed. Another tension emerged around values, in participants' reflections that people who adhere to a classical person-centred approach are resistant to the compromises needed for person-centred therapy to fit with a perceived medical model for delivery in the NHS, and the standardisation implied by a manual. At the same time, they observed that some of the trainees they worked with did not believe that person-centred therapy is evidence-based or effective enough to be offered as a specific modality, and therefore integrated it or supplemented it with other techniques. The interviews also confirmed previous research, which identified gaps in counsellors' original person-centred training (Pearce et al., 2012). While a 2010 survey of BACP members revealed that 72% identified as having trained in person-centred or humanistic therapy (Sanders & Hill, 2014), the experience of the participants in this study suggests that the clinical practice of some counsellors could not be described as adherent to person-centred principles.

Against this background, the participants unanimously welcomed the PCET model and training as an opportunity to strengthen, or even restore, the theoretical coherence of therapists' practice. The Competence Framework and the PCEPS, whether described as a manual or not, were seen as providing a language to clarify the trainees' understanding of the model and to communicate with colleagues from other modalities. The participants witnessed the growth in trainees' confidence in the model and in their practice.

Despite this unanimity, the differences revealed by the interviews suggest that, in some important ways, trainees' experiences may vary between training centres. On a practical level, the working conditions provided by the trainers' host universities, in terms of time and personnel, mean that not all have the capacity to offer extra support to trainees, such as regular follow-up training days.

On a philosophical level, the individualism of participants from different training centres was demonstrated in their diverging views about the definition of PCET, and in their approach to the training. Those who viewed PCET as exactly the same as person-centred therapy (PCT) considered that PCT is already an experiential model and did not seem to see process-guiding as a new skill for trainees. Those who viewed PCET as a contemporary form of PCT, or principally as

a humanistic model, placed more emphasis on process-guiding, and therapists being active in therapy sessions. These differences were reflected in the criteria that trainers applied in assessing recordings, according to their interpretation of the PCEPS, and the importance they gave to active process-guiding.

Such differences raise questions about the consistency of the trainers' approach to the model. While participants stated that flexibility is an important aspect of PCET, it is unclear where the boundary lies between valuable flexibility and unhelpful inconsistency. Lack of consistency between the training centres may have consequences for the original aim of linking evidence of effectiveness with training and ultimately with offering evidence-based therapy to clients (Pearce et al., 2012). While several participants noted that, in the past, trainees were more likely to drop out of the training than to fail, this option will no longer be available with the requirement under IAPT Data Set Version 2.0 for all therapists to hold an IAPT-approved qualification.

There may also be consequences for future research. While practice-based evidence confirms that counselling in IAPT is effective in reducing depression (Pybis et al., 2017), further empirical research is needed to assess which aspects of PCET contribute to its effectiveness. There is already extensive evidence for the effectiveness of the relational elements of therapy (Norcross, 2002), and future research will build on existing evidence for the addition of experiential process-guiding elements (Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). Several participants expressed the hope that PCET training would encourage consistent practice to facilitate such research. This hope may be undermined, however, by the apparent inconsistencies among the training centres in their approach to the model, to the delivery of training and to rating adherence.

4.1 | Limitations of the current study

This study captures participants' impressions of trainees' experiences in IAPT, and the participants' own relationships with IAPT services, that they have accumulated over more than nine years, including in undertaking their own research. While synthesised member checking was carried out, the author also shares many of the experiences and perspectives of the participants, and there remains a risk that participants' reports and the analysis are subject to confirmation bias (Nickerson, 1998).

5 | CONCLUSION

The current study has highlighted similarities and differences between the four centres delivering PCET training to IAPT counsellors in England. All the stakeholders interviewed recognised the significance of their role in strengthening the voice and status of humanistic counsellors in IAPT, as the effectiveness of counselling is increasingly recognised, and the counselling workforce grows. The IAPT Data Set v.2.0, implemented since these interviews were conducted, gives even greater importance to PCET training.

The participants agreed that theoretical coherence is vital in understanding and delivering a model of therapy, for the benefit of clients, and in contributing to further evidence of effectiveness. They agreed that a major aspect of their role is to clarify the PCET model for trainees, to ensure that theory and practice are consistent. The question remains whether the inconsistencies among the centres in their understanding of the PCET model, and especially around interpretation of the assessment tool, the PCEPS, translate into variations in the effectiveness of PCET practitioners. Further research is needed into the specific elements of PCET which contribute to its effectiveness, and how best to incorporate the findings into PCET training.

6 | IMPLICATIONS

6.1 | Practice

- More resources are needed for delivering the training, for example extra days being standard rather than optional, which would improve retention and consistency of trainees' practice.
- All the training centres' host universities need to recognise the workload capacity needed to deliver PCET training, beyond the 5-day face-to-face course, in particular listening to recordings, offering feedback and extra support for trainees.
- More support is needed from trainees' employing IAPT services to complete the training, in particular the availability of modality-specific supervision and ability to offer each client up to 20 counselling sessions.

6.2 | Policy

- Consensus is needed between the training centres on interpretation and application of the PCEPS.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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