Article:
Proctor, G and Hayes, C (2017) Counselling for Depression: a response to counselling education in the twenty-first century. Ethical conflicts for a counselling approach operating within a medicalised bureaucratic health service. British Journal of Guidance & Counselling, 45 (4). pp. 417-426. ISSN 0306-9885

https://doi.org/10.1080/03069885.2016.1274377

Counselling for Depression: a response to counselling education in the 21st century.
Ethical conflicts between a counselling approach operating within a medicalised bureaucratic health service

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Introduction

In this article, we are concerned with the competing discourses of economics and bureaucracy with the importance of relationships, unique people and responding to distress. We consider the increase of the economic and bureaucratic discourses within counselling services and counselling education and the impact of these on the values of counselling, particularly relational counselling. As counselling trainers, we explore the impact of the clashes of cultures and values within counselling education and counselling provision. We use the particular example of training in 'Counselling for depression', provided for counsellors working in the publicly provided health service in the UK.

We will describe Counselling for Depression (CfD), a person-centred and experiential (PCE) approach to counselling (see Sanders and Hill, 2014; National IAPT Programme Team (2011)), accredited by the Improving Access to Psychological Therapies (IAPT) agenda in the National Health Service in the UK. Already trained and experienced counsellors working in primary mental healthcare in the UK are now funded and sometimes mandated to access training in this approach, and we will describe our experiences of providing this training. Our question is whether providing additional training in CfD for counsellors in the NHS within IAPT compromises the values of the CfD approach and whether the PCE approach and the counsellors providing it are able to survive intact.

Providing this training raises many ethical issues which we will explore. We have gained our understanding of these ethical issues as a result of listening to the experiences of over 200 counsellors working within IAPT who have attended the trainings we have provided. We have detected contradictions between the values of the PCE approach on which CfD is based and the medical, bureaucratic and capitalist models that underlie the current operation of the NHS in the UK (see Rizq, 2014, Proctor 2015). Person-centred values are founded on trusting unique clients to move in their own directions, given the facilitative conditions of person-centred therapy where the therapist aims to empathically engage the client with congruent acceptance. These values conflict with the medical model of mental health purveyed by IAPT, which focuses on measuring symptoms and aims to help clients reach recovery, measured by a reduction in symptoms of depression and anxiety. The bureaucratic model and discourse of 'efficiency' which focuses on 'case management'

instead of clinical supervision also leaves little room for the personal reflections on counselling relationships in supervision for the counsellors.

In addition, the political context of the current NHS in the UK has a huge influence on the CfD training. The implications of the privatising agenda of the NHS include massively reduced terms and conditions of service for counsellors which can impact on therapy relationships. Already trained and experienced counsellors are often coerced to attend further training in an IAPT accredited model (such as CfD) with the threat of job loss if training is not completed. As a result, counsellors often arrive at a CfD training course, resistant to learning, angry at having to attend and feeling anxious and unsupported in their work environments.

We will discuss how we will address all these interpersonal and intrapsychic conflicts within the training for CfD. We will also discuss what ongoing ethical conflicts we work with and what supports us to continue to engage in these conflicts. We make a call for further research to document the impact of these competing agendas on clients, counsellors and educators.

Improving Access to psychological therapies (IAPT)

In 2006 a report from the London School of Economics identified that the main cause of claims for sickness benefit was depression (LSE 2006). This research was the evidence that launched the development of Improving Access to psychological therapies (IAPT) in 2008. The idea was to invest in short-term psychological therapies and so at best, prevent or at least, minimise this cost. In this lies the intention of IAPT- by treating depression, the government would save money. Therapy became a tool to reduce costs.

IAPT provision is based on a stepped care mode. Each client is assessed, usually by a Psychological Wellbeing Practitioner who is minimally trained in Cognitive Behaviour Therapy (CBT). The first step offered is often a psycho-educational group, or a behavioural short term intervention (termed low intensity). If this is not enough (and the client has not dropped out), they may then be offered a 'high intensity' approach, which involves short-term individual therapy from a therapist (usually CBT).

The Minimum Data Set

The IAPT model is to require clients to complete questionnaires each time they attend. The sets of questionnaires used are referred to as the Minimum Data Set (MDS)(see http://www.iapt.nhs.uk/data/)

. The MDS measures symptoms of depression, anxiety, phobias and work and social adjustment. The symptom measures were developed by a pharmaceutical company and were chosen to be used in IAPT, despite the availability of much more reliable and valid questionnaires such as CORE (Clinical Outcomes in Routine Evaluation: see www.coreims.co.uk) which have been previously used extensively to demonstrate effectiveness of talking therapies in primary care NHS settings. The diagnostically based, symptom focused measures used underline the medical and diagnostic focus of the IAPT agenda.

The MDS for each client is used to assess their progress with the IAPT service, and each client is deemed to have 'reached recovery' if their scores on these symptom measures have reduced from clinical significance at the start to clinically insignificance at the end of therapy. Outcomes for all clients are collated within services and individual counsellors and services are assessed by these numbers and compared. Funding for IAPT services is contingent on the use of the MDS, with very high completion rates being required.

Each therapy provided and accredited by IAPT required an evidence base for clients with a particular diagnosis and to be presented within a competency framework. Initially, only CBT was accepted as an evidence-based therapy to be provided within IAPT. A case was made to the National institute for clinical evidence (NICE) by The British Association for Counselling and Psychotherapy (BACP) for the inclusion of counselling as a talking therapy for clients diagnosed with depression. The person-centred approach was identified as being the main therapeutic stance identified by the BACP membership. The evidence base was put together and NICE accepted the case in 2011. Counselling for depression (CfD) was born.

Counselling for Depression (CfD)

Counselling for Depression is a person-centred experiential approach. Carl Rogers (1902-1986) developed non-directive counselling in the 1940's in the US. The non-directive stance is key to the approach ensuring the client is at the centre of the therapy. Rogers (1959:213) identified six necessary and sufficient conditions for psychological change:

"For therapy to occur it is necessary that these conditions exist:

1. That two persons are in contact.
2. That the first person, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. That the second person, whom we shall term the therapist, is congruent in the relationship.

4. That the therapist is experiencing unconditional positive regard toward the client.
5. That the therapist experiencing an empathic understanding of the client's internal frame of reference.
6. That the client perceives, at least to a minimal degree, conditions 4 and 5, the unconditional positive regard of the therapist for him and the empathic understanding of the therapist."

The evidence from RCTs (randomised controlled trials) for the approach was drawn from person-centred therapy (PCT) and from emotion focused therapy (EFT). EFT is a development of PCT which focuses on emotion, which is considered key to the experience of depression (see Sanders and Hill 2014). The CfD therapist is not engaged with tools or techniques. The focus of the therapist is on the attitudes they embody.

The Person-Centred Experiential Psychotherapy scale (PCEPS)

Friere, Elliot and Westwell (2011, 2012, 2014) developed a scale that could assess PCE therapists' attitudinal stance. The original fifteen point scale was reviewed and reduced to ten points (see Sanders and Hill 2014). Measuring the attitudes is the way of ensuring the CfD approach is being offered, enabling CfD to be described as a 'manualised' therapy as adherence to the approach can be assessed. The scale can also be used to enable the therapist, CfD trainer and the supervisor to reflect on the therapist attitudes to the client and explore areas for development.

To qualify as a CfD therapist, therapists submit up to six encrypted client recordings. These recordings are rated by the CfD trainers and feedback is sent to the therapist with a score. Four recordings need to reach adherence and therapists need to have logged 80 hours of CfD practice. These logs are signed by their CfD supervisors and sent to the University to be checked. The license is then issued if all these criteria are met. Since 2013, we have received 473 submitted recordings at the University of Nottingham, 403 (85%) of those reached adherence and 70 (15%) failed to reach adherence.

Our approach to the training

Delegates are accepted for CfD training if they have a counselling diploma that includes a person-centred or humanistic model as its core approach, or integrated with other modalities. Integrative possibilities are quite diverse. Humanistic (which is a broad term) and psychodynamic approaches is a common combination. Many applicants additionally have certificates or diplomas in CBT. Delegates must also have experience of working in an NHS funded service. As part of the application, counsellors are asked to present a written case study based on working with a client

with a diagnosis of depression. From this, we assess the applicant's knowledge and use of person- centred theory in practice. We ask all delegates to read pre-course material, which covers the functioning of IAPT and the competencies (see National IAPT Programme Team (2011)) developed by Skills for Health and NICE.

We choose to focus during the contact time we have on what we consider to be the essential aspect of CfD which is the person-centred therapeutic stance or attitudes of the therapist. Regardless of initial qualification, most therapists attending the training have been influenced heavily by a solution focused, outcome driven, toolbox based approach to therapy. The decision to focus on the attitudinal stance was made quite early on in our experience of delivering the training. We discovered that most therapists had lost the non-directive stance and also had great difficulty in articulating empathy, or demonstrating empathic understanding. The training introduces the PCEPS scale to therapists and encourages therapists to be reflective on their attitudes and the intention they hold when listening to clients.

The course is an intensive 30 hours with video recording as a key part of the course. The delegates have a great opportunity to observe themselves 'in action' with each other and receive feedback from their peers. The number of delegates who report having never been filmed before is high. The use of video is an aspect of the course which often causes much anxiety at the start but is most positively evaluated at the end.

After the end of the course, the process of submitting recordings, receiving feedback and attending CfD supervision continues for a further four to eighteen months depending on progress and subsequent audio recordings of therapy are submitted to be assessed for adherence to the model through the PCEPS scale.

CfD training is intended to be personally meaningful and useful for therapists and frequently the feedback we receive after the course indicates this to be the case:

'*Good to re-establish the value of person-centred principles in my work. Excellent and beyond expectations'*

'I found the course enabled me to get back to being person-centred. I will aim to try and connect with the core values when I return to my practice'

However, is the learning from the course transferable to the IAPT context and can the CfD therapists maintain the therapeutic stance in the IAPT

setting? What happens when therapists return to their place of work is crucial and the next section of this article focuses on this.

IAPT work context for counsellors

IAPT arrived at the time that the privatisation of the NHS was well underway, with services bidding for short-term tenders and competition focused on the measurement of outcomes and justifying which service could offer something to the highest numbers of clients. Inevitably, better value for money is achieved at the expense of terms and conditions for the staff. Thus, IAPT services are currently provided within traditional NHS Trusts, or by voluntary sector, social enterprise or even private sector providers, resulting in highly variable contexts for counsellors.

Some IAPT services offer zero hours contracts to counsellors, which often include the counsellor not being paid if clients do not attend. Many services use payment by results (PBR) where counsellors get paid different amounts depending on whether clients demonstrate recovery on the symptom measures of the MDS.

Recovery rates are the key priority for IAPT services, with regular league tables being published comparing services. Within services, clinicians are set up in competition with each other, with individual recovery rates and targets for number of clients seen being circulated among staff. Caseload management is the backbone of this system, with managers regularly meeting with counsellors who are asked to justify why clients are not reaching recovery or why counsellors offer more appointments to clients who do not seem to be demonstrating a good outcome or indeed justify why a client who already has a good outcome would need more appointments. Whereas counsellors traditionally use clinical supervision to reflect on our work and consider decisions about clients, in IAPT, all decisions about the client's progress and how to offer a service are made in caseload management meetings with managers who may not have any training or experience as counsellors.

The focus on measurement and instability of working conditions are key characteristics of such a system under New Public Management, described by Rizq (2014). Cotton (2016) similarly describes these common factors shaping healthcare today and in recognition of the costs for people working in such a context, has put together a survival guide for workers.

Value conflicts in the NHS

The existence of conflicting values and cultures within the NHS has long been documented. Fulford et al (2002:1) argue that traditional approaches to ethical codes and practice in healthcare (which they call

'quasi-legal ethics') are based on legalism and a scientific model of healthcare. In contrast they argue for value-based ethics, founded on the idea of partnership and a diversity of values. They start from the recognition of the diversity of human values in healthcare among patients and professionals alike. Proctor (2014) argues that this parallels the shift from principle based ethics to relational ethics within counselling. This recognition of the inevitable diversity of values necessarily leads to individual variety in what constitutes an ethical conflict or dilemma.

The psychiatric model in mental healthcare is a medical model, purveying hopes of 'cure' from disease, through medication. Whilst critiques of the shortcomings of a medical model of mental health are plentiful, the cultural implications of this model as a foundation for services remain. Thomas (2014) documents how and suggests why psychiatry is in crisis, with the failure to find any sense of pharmacological cure leaving psychiatrists with few useful technical tools, but with this technical focus obscuring the significance of human relationships, meanings and values. Bracken et al (2012:432) call for a necessary shift in the heart of mental health practice, away from technical interventions and towards "highlighting the importance of examining values, relationships, politics and the ethical basis of care and caring."

Those that work within this psychiatric system despite holding different values document the personal effects of this and suggest strategies for survival. Johnstone (2000) demonstrates the importance of taking a different perspective and challenging the dominance of the medical model. Freeth (2007) documents her personal response of despair when faced with a patient asking if his condition could be cured. She eloquently conveys the ethical quagmire that she attempts to negotiate with person-centred beliefs in a human capacity to change which can be facilitated in a certain relational environment, yet working as a psychiatrist in a mental health care system which diagnoses and perpetuates the belief in a disease model for social problems. She explicitly notes (p. 164) "a major source of stress...when I experience a conflict of expectations and values, particularly when my values clash with those of the organisation and policy makers." Sommerbeck (2003) argues for the importance of seeing each individual worker as a unique person with personal values, rather than merely a representative of their profession or role. She thus advocates for mutual respect across a diversity of values and perspectives.

Despite individual differences however, the culture of IAPT represents the values of the New Public Management system of efficiency and universality, providing a "one size fits all" solution (see Rizq 2014 and Proctor 2015). Counsellors trained in a relational and person-centred model work with foundational values of unique individuals and unique

personal relationships, irreducible to numbers or prescriptive remedies. Culture and ethical clashes are inevitable.

These culture clashes and value conflicts between relational or person-centred approaches and traditional medical, scientific or rational approaches are exemplified by the position of counsellors within IAPT and were commonly presented by counsellors who participated in our CfD training.

'*I was resistant to do the course but after the first day and the honesty and reasons why the course was available I'm really pleased I've been on it…'*

'I really liked the real and honest delivery of the training and the way it was/has been delicately moved into the IAPT way of working, being as sensitive and respectful as much as possible to the approach. Very useful and thoroughly enjoyed it.'

Value conflicts for CfD counsellors in IAPT

As should be clear already from the above descriptions, there are many potential value conflicts for counsellors working from a relational model of counselling in CfD with the IAPT system. CfD prioritises relationships with clients, whereas the IAPT system focuses on outcomes. Given the evidence for the effectiveness of CfD, these need not be incompatible. However, the salience of how outcome is measured can result in value conflicts. In CfD, the client is their own expert and only the client can say whether and how therapy is helpful. In IAPT, progress is determined by standardised measures and the client's perspective on the relevance of these measures to their priorities is considered irrelevant.

In CfD, the client determines their own need. Brief therapy is familiar to person-centred practitioners (Tudor 2008) However, in IAPT a maximum number of appointments is usually enforced (this can be 3, 6 or occasionally 12 appointments) with neither client nor counsellor having any autonomy about this. In CfD, reflection is valued and indeed necessary for the counsellor to be self-aware about their gaps in being able to offer the attitudes necessary. In IAPT services, there is little time for reflection, which is seen as a luxury. Numbers of clients seen is the name of the only game and often meetings among counsellors for peer support, supervision or development are actively discouraged or severely minimised. Many counsellors in IAPT can only maintain ethical practice through reflection by this taking place in unpaid time.

CfD requires the counsellor to be fully engaged emotionally with a distressed client. This requires attention to the counsellor's own mental health and well-being. Feeling valued, respected and trusted are crucial ingredients to promote the well-being of counsellors, and are often sadly lacking in IAPT services. Instead, depression, anxiety and very low work satisfaction are the norm for workers within IAPT (Cotton 2016). The recent BPS survey of IAPT workers concluded that "The overall picture is one of burnout, low morale and worrying levels of stress" (BPS 2016)

In CfD, the client is considered unique with only the client being able to define and express their own experience. In contrast, IAPT services are based on diagnoses of depression and anxiety (or other diagnoses which then usually exclude clients from receiving a service). Clustering - diagnosis with another name (see Proctor 2015), is now associated with the increasingly common process of Payment By Results (PBR), and CfD counsellors may be expected to cluster their clients in an IAPT service.

Ethical conflicts

These conflicts in values can lead to many possible ethical conflicts for CfD counsellors, trying to preserve the principles of the CfD approach with their clients and yet manage the demands of the IAPT service. How do they manage to stay focused on the expertness of the client's perspective, whilst being expected to cluster or diagnose or predict progress in case management meetings? Clustering involves rating severity of distress and level of need according to criteria that may not refer at all to how the client describes their experience so staying with the client's experience may not be possible. Clustering also forms part of the medical record, thus demonstrating a certain level of distress which could have implications for clients in the future, for instance in disclosures for occupational health.

How can CfD counsellors stand by the principle of non-directivity with clients when they are paid by results, and case managed with this focus? It takes some solid stance on behalf of the CfD counsellor to stand by this principle rather than attempt to focus on something to try and influence the direction of the client towards recovery as measured by the MDS.

How can CfD counsellors consistently convey the attitude of unconditional positive regard towards a client who misses an appointment and the counsellor is consequently not paid for this time? Similarly, if the client does not complete the MDS to demonstrate recovery, yet the counsellor is aware that the client has found CfD helpful, is it possible to remain free of judgment or resentment of the client or not be involved in persuasion or influence of the client to complete the MDS in a different way?

When the CfD counsellor is under constant stress to see high numbers of clients with few breaks or time for reflection, is it possible to remain empathic and accepting of clients who remain highly distressed or emotionally demanding? With little capacity to deal with anything outside the allotted session time, it can be very hard for counsellors to remain supportive of clients who present risks to themselves or who do not flow smoothly towards recovery in a proscribed fashion.

These are some of the common ethical conflicts faced by a CfD counsellor, working in an IAPT context that we know from our own experiences and have heard consistently from counsellors attending our CfD training, so it is crucial that we address these conflicts of values and of ethics within the training.

Addressing ethical conflicts in training

Many counsellors arrive on a CfD course resentful and angry about having to be there. All counsellors are already trained therapists (unlike most practitioners sent on CBT courses for IAPT), often with many years of experience of working as counsellors in primary care in the NHS and may have been given little choice by managers about attending the CfD training. After years of being made to feel second best to the dominance of CBT, counsellors are often demoralised and have given up trying to challenge the dominant medical and CBT models and survive by doing their own thing in an isolated fashion.

Some CfD delegates' feedback illustrate this experience:

'I had given up hope of my NHS work providing training and development that had relevance.'

'*It has helped me see the political importance and also helped me become grounded again in an approach that in retrospect had been modified to fit the needs of NHS IAPT NICE etc desires'*

We respond to this situation in a way that is consistent with the PCE approach to therapy and education. The first thing we do as trainers is to acknowledge this situation, respond empathically and take time for counsellors to discuss as a group the various work pressures they are under in IAPT. As trainers, we have both worked as therapists in IAPT services and understand these pressures from personal experience, whilst being aware that every service is slightly different. We do not see our role as to support IAPT, but to support counsellors who want to offer a service within IAPT. So we are open about the value differences between IAPT and CfD and consequent ethical dilemmas and costs for counsellors.

Feedback from counsellors attending the training indicates that the focus on offering CfD in the IAPT context is a crucially valued part of the training.

' I have much more understanding of the trends and politics that have led to the recent/ current situation. This is empowering'

We encourage counsellors to consider their own values and beliefs about therapy as part of the training and be aware of their own responses to the values underlying CfD and IAPT. We have no agenda for them to complete the CfD training but instead want to facilitate those for whom the approach suits and fits to be able to obtain their license and to survive within IAPT if possible.

The CfD training is founded on experiential learning – both through our attitudes towards the participant counsellors, valuing them as people and counsellors. We aim to facilitate a climate of peer support and feedback, believing that allies are crucial to survive in such a system. Much of the training time is spent in practice, with counsellors working with each other as clients, so they each have the opportunity to experience the power of the CfD approach personally. One purpose and usual consequence of this is to breakdown the general climate of us and them (staff and clients) within IAPT services. Coming from a work context where there is no space to reflect, on the CfD training, counsellors are offered space to reflect, to think about themselves, to experience emotions and to receive peer and tutor support. The result of this is that often the training is an intense, personal, emotional and at times transformative experience. Most counsellors finish the training feeling inspired, encouraged and supported in their validity as counsellors who value relationships with unique clients and supported to ethically practice within IAPT.

'I have found this CfD course inspirational and affirming. I believe in who and how I am and how this way of being translates into working with clients, there is now an additional aspect of potential global recognition now CfD exists.'

'*I felt contained, educated and cared for throughout the five days .The delivery of the course has been exceptional from start to finish. The trainers have facilitated a learning environment that I have treasured'*.

We also stress the evidence base for the approach and the necessity to remain within the ethical framework of the CfD approach with the client, trusting that good outcomes will follow. Counsellors are often encouraged to be validated in their desires to follow the direction and expertise of

their clients rather than the outcome measures dictating the direction of counselling.

Support is not easy to maintain once CfD trained counsellors return to their workplaces and then need to produce recorded sessions of therapy which reaches adherence to a CfD model. However, some feedback post training shows that learning can be successfully transferred and built upon:

'*I did not find any difficulty in taping clients. Reviewing the work and reflecting on it in supervision was very helpful. I found reviewing my work in this way gave me new insight and I believe helped me improve as a therapist. I will continue to use recording in my supervision process'.*
We encourage training groups to find ways to support or offer supervision to each other and we offer refresher days to trainees who have completed the initial CfD training. In September 2016 the first 'gathering' of CfD practitioners was held at the University of Nottingham. Over fifty delegates from all over the country attended (https://www.nottingham.ac.uk/education/study/counselling-depression/index.aspx) We acknowledge that the differences in the two value bases are such that the dominance of the medicalised CBT-based IAPT system is difficult to counteract with so few opportunities for alliances with others with CfD value bases. Some practitioners are the sole CfD therapist within a region:

'a supervisee has realised how much her own agenda has become an issue with her client. She acknowledges that despite the fact that she is no longer in this setting, that IAPT has 'tainted' her ability to work at the client's pace, struggling with both tracking and respecting the client's process as a result. She names her frustration and recognises that it is as a result of her time within an IAPT setting and the tension that creates - respect for the client's process versus the pressure to deliver quickly with a sufficiently reduced PHQ9 and GAD7 score'.

Where CfD practitioners had a team and were not isolated the sense of conflict with IAPT seemed to disappear. People reported feeling supported and respected. They could determine the number of sessions with their clients.

'I feel we are supported within our service to work as CFD Therapists and any issues arise we are able to take these to our managers'.

Conclusion

Counselling is sought by clients, many waiting months for their treatment of choice. IAPT is aware of the popularity of counselling as experts by

experience regularly ask for alternatives to CBT at IAPT conferences. Many clients, and staff also, have experienced counselling in the past and wish to access counselling rather than having to attend groups or CBT before reaching counselling.

Officially, the discourse of 'choice' is propagated for clients within IAPT. However, currently this choice is extremely limited: 42% of IAPT practitioners offer CBT, 28% are Psychological wellbeing practitioners and 19% of staff are not qualified in any IAPT approved approach. Only 4% of IAPT services offer CfD (Dance 2015)

However, if the option of counselling or CFD is to be offered in a sustainable way to clients within IAPT, the voices of CfD practitioners need to be heard. CfD needs to be recognised and validated as a non-medical alternative if it is to survive the IAPT project. CfD counsellors need to be supported to work in a way that is consistent with the attitudes required towards the client with CfD supervision to support clinical decisions, rather than caseload management. Counsellors need to work together, prioritising peer support, to form allies as a marginalised minority group within the dominant medical discourse. CfD requires counsellors to engage fully and emotionally with distressed clients, and this needs to be supported by IAPT services creating structures and systems of work that promote, rather than ignore the mental health of its practitioners. Reports have demonstrated the devastating impacts on the well-being of IAPT workers of its bureaucratic and depersonalising practices (see Cotton 2016 and BPS 2016). Further research to document how CfD practitioners negotiate these value conflicts in practice is necessary to discover if ways have been found without too costly consequences on the counsellors. If CfD is to offer the public what is can as a non-medical approach to human distress it needs to be given a chance rather than being compromised and squashed into a medicalised symptom based service.

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