The impact of instrumentalism on British counselling and psychotherapy

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A thesis submitted for the degree of PhD

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Submitted on

March 1, 2017

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Abbreviations

AQP Any Qualified Provider

BACP British Association of Counselling and Psychotherapy

CAM Complementary Alternative Medicine

CBT Cognitive Behavioural Therapy

CCBT Computerised CBT

CfD Counselling for Depression

CPD Continuing Professional Development

DoH Department of Health

DSM-IV Diagnostic and Statistical Manual of Mental Disorders, 4th Edition

EAP Employee Assistance Programme

EBM Evidence-Based Medicine

EFT Emotion Focus Therapy

GAD 7 Generalised Anxiety Disorder (7 Items)

GDP Gross Domestic Product

HMSO Her Majesty's' Stationary Office

HPC Health Professions Council

HCPC Health and Care Professions Council, (after August 2012)

IAPT Improving Access to Psychological Therapy

IED Improvised Explosive Device

IPT Interpersonal therapy for depression

NICE National Institute of Clinical Excellence

ONS Office for National Statistics

PCA Person-Centred Approach

PCEPS Person-Centred and Experiential Psychotherapy Scale

PHQ-9 Patient Health Questionnaire (9DSM-IV criteria)

PLG Professional Liaison Group

PWP Psychological Wellbeing Practitioner

PSA Professional Standards Authority

QAA Quality Assurance Agency

RCT Randomised Controlled Trial

SHA Strategic Health Authority

SWB Subjective Well Being

TCK Third Culture Ki

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Timeline of events and the emergence of significant movements and other organisations related to counselling and psychotherapy

1907 British Psychological Society
1910 International Psychoanalytical Association
1913 London Psychoanalytical Society
1919 Institute of Psychoanalysis
Behavioural psychology
1920 Tavistock Clinic
1924 British Psychoanalytic Society
1926 London Clinic of Psychoanalysis
1935 Alcoholics Anonymous
1936 Society of Analytical Psychology
1938 New Marriage Guidance Council (now Relate)
1948 British National Health Service T-groups
First student counselling service (University College Leicester)
1950 International Association for Vocational and Educational Guidance (IAVEG)
Gestalt therapy
1951 Rogers' Person-Centred therapy
1952 Group Analytical Society
Publication of Diagnostic and Statistical Manual (DSM) 1st edition
1953 Samaritans
1958 Behaviour therapy
1959 Cruse
Scottish Pastoral Association
1960 Death of Melanie Klein
1961 Death of Jung
1962 Cognitive therapy
1966 Counselling training at Universities of Reading and Keele
1969 Westminster Pastoral Foundation
1970 First Standing Conference for the Advancement of Counselling
MPA becomes Royal College of Psychiatrists
1971 Foster Report on Scientology

1975 National Association of Young People's Counselling and Advisory Services

1977 British Association for Counselling (BAC)

1978 Sieghart Report on statutory regulation of psychotherapists

1980 Association of Humanistic Psychology Practitioners (AHPP)

1982 Rugby Psychotherapy Conference (set up by BAC)

1983 First BAC accreditation scheme

1987 Death of Carl Rogers

1989 United Kingdom Standing Conference on Psychotherapy (UKSCP)

1990 Cognitive analytic therapy

1991 British Confederation of Psychotherapists

1992 European Association for Counselling

BPS Charter of Counselling Psychologists

First UK appointment of Chair of Counselling (Windy Dryden)

1993 United Kingdom Council for Psychotherapy (UKCP, originally UKSCP): advice, guidance, counselling and psychotherapy lead body

1994 Independent Practitioners' Network

UKCP Register of Psychotherapists

BPS Division of Counselling Psychology

1995 BCP Register

NHS Psychotherapy Services in England Review

1996 United Kingdom Register of Counsellors (UKRC) (individuals)

NHS Psychotherapy Services in England

Department of Health (DoH) Strategic Policy Review

Data Protection Act

CORE psychometric test introduced

World Council for Psychotherapy

1998 Association of Counsellors and Psychotherapists in Primary Care (CPC)

UKRC (organisations)

1999 National Institute for Health and Clinical Excellence (NICE)

2000 BAC renamed British Association for Counselling and Psychotherapy (BACP)

Universities Psychotherapy Associations (UPA) adds 'Counselling' to its title, becoming UPCA

BACP's Ethical Framework for Good Practice in Counselling and Psychotherapy

2001 Lord Alderdice's Psychotherapy bill

Treatment Choice in Psychological Therapies and Evidence-Based Clinical Practice Guidelines (DoH)

2002 Health Professionals Council (HPC) is identified as the regulatory body for all health professions, including counselling and psychotherapy ('talking therapies')

2003 UKCP establishes its Psychotherapeutic Counselling Section

2004 College of Psychoanalysts

British Psychoanalytical Council

Graduate mental health workers in primary care

British Confederation of Psychotherapists (BCP) renamed British Psychoanalytic Council (BPC)

2006 ***Start of period of ethnographic study on which this thesis is based***

Improving Access to Psychological Therapies

2007 Publication of the Core Curriculum

Competent Practitioner Licence scheme begins

Savoy Partnership

2008 BACP represented on HPC's Professional Liaison Group

2009 Maresfield Report

Publication of the Gold Book

2010 Therapy Solutions participant observation

2011 Statutory regulation plans abandoned

2012 Launch of Counselling for Depression

2015 ***End of period of ethnographic study on which this thesis is based***

Acknowledgements

I would have been unable to produce this thesis without the help and goodwill from colleagues and friends from the BACP and the UKCP. Thanks to Frank Spain for letting me spend time with his students and to the many who kindly gave me their time to be interviewed, sometimes more than once. Thanks to my supervisor, Colin Samson, for his invaluable support and clarity of thought. Thanks to Joan Busfield for her wise observations.

Abstract

This thesis explores the impact of instrumentalism on the praxis of counselling and psychotherapy in Britain, and is based on an ethnographic study of responses to state and organisational authority in the form of the social actions of therapists within several therapy-based institutions. Following a brief social history of British psychotherapy, the thesis includes an autoethnographic account of my entry into a psychotherapy habitus and my emerging self-identified role as an involved observer. This is followed by a discussion of material (from the period 2006-2015) arising from an analysis of six case studies and forty-five in-depth interviews. During this time, therapy organisations acted partly to facilitate the expected statutory regulation of counselling and psychotherapy, and partly in anticipation of the Improving Access to Psychological Therapy scheme. These actions included the codification and componentisation of therapy praxis in compliance with NICE guidelines for the empirical evaluation and approval of psychological therapy, using outcome measures and randomised controlled trials. They took place against a backdrop of neoliberal imperatives, designed to reduce welfare payments, (including the use of therapy as workfare), and the recasting of therapy knowledge within an economistic perspective. My informants include: senior therapy managers and training course directors within counselling and psychotherapy organisations who were collectively engaged in the production of monistic representations of therapy, therapy trainers subjected to numericised emotion management, and students on training courses aligned to digitally-Taylorised representations of therapy praxis. The thesis concludes with an interpretation of these actions, using a range of sources, followed by a discussion of the acts of resistance (since the beginning of 2016) by factions of therapists.

Note on terminology

There are some variations in usage where terms such as counselling, therapy and psychotherapy appear; this is addressed in chapter four. Broadly speaking, these terms are often used interchangeably. Competences and competencies also have different shades of meaning (and hence usage), addressed in footnote 13 on p. 66. The usage of 'practice' and 'practise' sometimes overlap in the narration of therapists' actions during training.

Capitalisation and hyphenation also vary; this is where different acceptable versions mean that alternative versions may appear within quotations, or a phrase is being used either adjectivally or as a brand name, depending on context, for example: person-centred, humanistic therapy, High-Intensity, stepped care, core curriculum, well-being. Where terms are problematised they sometimes appear in inverted commas.

Introduction

The possibility that in times of trouble a person might find solace in sharing their distress has been around for a long while in a diversity of cultures. The strapline 'It's good to talk'[1] is used by Britain's largest body representing counsellors and psychotherapists, the British Association of Counselling & Psychotherapy (BACP), which states: 'We will advocate the role and relevance of the practice of the counselling professions in improving psychological wellbeing and mental health, and promoting social justice, in our contemporary and diverse communities.'[2] Although few would argue against these virtuous aims, my research suggests that they are being impacted by a number of political issues.

Some of these issues have been commented on by groups of counsellors and psychotherapists working within Britain's National Health Service (NHS), who are concerned about the claim of: 'State-sponsored therapy to develop a positive attitude to the status quo.'[3] The introduction of the Improving Access to Psychological Therapy scheme (IAPT), has, I will argue, presaged several changes in the provision of counselling and psychotherapy for distressed people. The availability of therapy within local General Practitioner settings has all but disappeared; the choice of therapy through GP referrals has been heavily curtailed in favour of Cognitive Behavioural Therapy (CBT), and long-term therapy is no longer an option for people who need more than a few sessions to address their difficulties within the NHS.

Cuts in the mental health budget[4] and the welfare cap[5] are coexistent with these changes. The introduction of workfare, including mandatory therapy, and the 'co-location' of IAPT therapists in Britain's jobcentres has projected the representation of unemployment as a psychological deficit: 'The government will begin to co-locate IAPT therapists in over 350 Jobcentres from summer 2015, to provide integrated employment and mental health support to claimants with common mental health conditions.'[6] David Harper, a member of Psychologists Against Austerity,

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[1] British Association for Counselling & Psychotherapy (BACP) supported website, available at: http://www.itsgoodtotalk.org.uk/ (accessed 3 June 2016).
[2] BACP, available at www.bacp.co.uk/about_bacp/ (accessed 3 June 2016).
[3] Quoted verbatim from the opening address to the inaugural conference of the 'Free Psychotherapy Network', Friends' Meeting House Manchester, 21st May 2016.
[4] HM Treasury (2015), *Budget 2015,* p. 65.
[5] Ibid., p. 101.
[6] Ibid., p. 72.

has suggested: 'Reviewing someone's benefits for failing to take up therapy in relation to job-seeking seems an entirely disproportionate and probably counter-productive move.'[7]

These changes have been accompanied by an increase in the codification and mechanisation of psychotherapy knowledge, some iterations of which I have been involved with since their inception. My position as an 'involved observer',[8] from where I have been connected to and influenced by my work in the NHS, private practice psychotherapy institutions, college and university settings, as well as state-sponsored psychotherapy forums, has provided me with a unique perspective on a period of change for British psychotherapy from 2006–15, and allowed me access to the ethnographic material on which this thesis is based.

At the core of this thesis is an exploration of the social actions giving rise to changing representations of counselling and psychotherapy occurring during the first decade of the twenty-first century in Britain's NHS. This has raised three key questions:

1) What are the political and economic conditions impacting psychotherapists and therapy praxis at the turn of the twenty-first century?
2) How have therapists responded to these conditions?
3) How has the practice of therapy been shaped during the period 2006–15?

The thesis consists of eleven chapters. Chapter one identifies themes and topics which recur throughout the empirical material. It begins with a historical outline of counselling and psychotherapy in Britain. This is followed by a narration, in response to question 2 above, of social actions (by therapists and therapy organisations) taking place between 2006–15. This was a period when the regulation of counselling and psychotherapy seemed inevitable to psychotherapists' senior representatives, who were acting within the organisational settings of the British Association of Counselling and Psychotherapy (BACP), the United Kingdom Council for Psychotherapy (UKCP), the Health Professions Council (HPC),[9] and Improving Access to

[7] Harper, D. (2015) Is unemployment being rebranded a psychological disorder? *The Psychologist*. 28 (8), p. 616.
[8] See Clark, K. B. (1965) *Dark ghetto: Dilemmas of social power*.
[9] Changed to the Health and Care Professions Council (HCPC) in August 2012 to include the regulation of social workers, following the 2012 Health and Social Care Act (2012).

Psychological Therapy (IAPT). The final section of this chapter outlines the emergence of an 'evidence-based medicine' (EBM) narrative, amid changing representations of therapy praxis.

In chapter two, 'Methods', I outline the sources on which I have drawn for this study and the roles and relationships which have enabled access to the transient settings from which the empirical material is drawn, and some arguments in support of my ethnographic approach—including a brief synopsis of two parallel studies to help situate my research; a description of triangulation achieved through mixed methods; and ethical considerations, including documentation and protection of sources and data. The empirical material includes six case studies based on field notes written during a nine-year period of participant observation of therapists in a range of settings, forty-five in-depth interviews, and documents produced by and for psychotherapists during a period of organisational change.

The empirical narration, addressing the first two questions in more depth, begins in chapter three with an autoethnographic account of my entry into the field of counselling and psychotherapy, to help inform my stance in relation to the data sources, and provide a perspective on the psychotherapy habitus from my self-identified position as an involved observer. Chapter four describes my participant observation as a member of the 'Core Curriculum Consortium' set up by the BACP to write the 'Core Curriculum: Towards Regulation: Benchmarks and Training Requirements for Counselling and Psychotherapy',[10] a text commissioned by the BACP aimed at creating uniformity of standards for therapy training organisations, and leading, five years later, to the creation of the first set of Quality Assurance Agency for Higher Education (QAA) therapy training standards in Britain.[11] Chapter five narrates the design and production of an examination for qualified but unregistered practicing therapists. As a participant observer, I joined a group of psychodynamic, person-centred counsellors and integrative therapists, all with extensive experience as trainers and practitioners, to produce a series of multiple-choice 'proficiency' examinations. These were based on case study 'simulations' of distressed people starting therapy and were intended to test the competence of prospective therapists for possible inclusion on the anticipated statutory register of counsellors and psychotherapists.

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[10] Dunnett, A. C.; Wheeler, S; Balamoutsou; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*.

[11] QAA (2013) *Subject benchmark statement: Counselling and Psychotherapy*.

Chapter six explores the economic case made by Richard Layard and others for the expansion of a 'well-being' agenda and state-funded therapy through the 'Improving Access to Psychological Therapy' (IAPT) scheme, and a narration of my participant observer role in the development of a newly-minted brand of therapy, aligned to IAPT and to the logic of 'measurable outcomes', 'Counselling for Depression' (CfD), for marketing within the NHS. CfD was designed to meet criteria for inclusion as a recommended 'intervention' set by NICE.

Chapter seven provides an account of my participant observation in the setting up and 'delivery' of one of the first CfD 'rollout' trainings in Britain, which took place in a seaside hotel. Chapter eight narrates the impact of monitoring schemes on CfD trainees and trainers using standardised assessment tools and adherence scales. Chapter nine describes a year spent observing a privately-run therapy training institution, Therapy Solutions, where the teaching adhered closely to the 'Gold Book',[12] a BACP training manual based on the 'Core Curriculum'.

Chapter ten, addressing question 2 in the list above, offers some interpretations of the themes emerging from the ethnographic material and examines the impact of changing political imperatives of counselling and psychotherapy praxis in Britain in the light of a range of theoretical perspectives, including instrumentalism and means end rationalities, tacit knowledge,[13] emotional labour,[14] theories of professionalism,[15] digital Taylorism, and the rationalisation of therapy knowledge, through the capturing, codification and routinisation of therapy work and drawing on an 'evidence-base' ideology.[16]

Chapter eleven draws the thesis together with an analysis of the current state of therapy under the influence of instrumentalism in British neoliberal culture. I explore the conjunction of political imperatives and state-sanctioned therapy in the context of workfare, workplace counselling schemes, 'stress management' and the reduction of absenteeism, as well as the relationship

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[12] BACP (2009) *Accreditation of training courses*.
[13] Polyani, M. (1967) *The Tacit Dimension*.
[14] Hochschild, A. R. (2003) *The managed heart: Commercialization of human feeling, with a new afterword*.
[15] Freidson, E. (1988) Theory of professionalism: Method and substance. *International review of sociology,* 9, 117–129.
[16] Brown, P., Lauder, H. & Ashton, D. (2010) *The global auction: The broken promises of education, jobs, and incomes*.

between psychotherapy and the commodification of unhappiness that is framed within a psychologically-sustained, economistic narrative of winners and losers.[17]

[17] Binkley, S. (2014) *Happiness as enterprise: An essay on neoliberal life*.

Chapter 1

A brief political history of counselling and psychotherapy in Britain

This chapter begins with a brief and necessarily partial social history of the development of British psychotherapy over the last two centuries, and outlines the emergence of various factions. The focus then shifts to a narration of actions by therapy managers, academics and representatives of psychotherapy organisations responding to an expectation of the statutory regulation of psychotherapy. The final section introduces an 'evidence-based' conception of health, which surfaces in the ethnographic material in chapters three to nine.

Moral therapy, the application of psychological methods as an alternative to physical restraint (such as prison) to control what we would now call mental disorder, has its origins in the Quaker Retreat in York in the early nineteenth century, with the 'tyranny of social conformity replacing the tyranny of physical interference'.[1] Before the arrival of new asylums, pre-Victorian madhouses were often degrading places. The psychiatric reformer John Connolly described them as follows:

> In the gloomy madhouses in which hands and feet were daily bound with straps or chains...all was consistently bad. The patients were a defenceless flock, at the mercy of men and women who were habitually severe, often cruel and sometimes brutal.[2]

Framed as a 'pro-institutional ideology',[3] moral therapy, through the provision of asylums as a place of safety and retreat from community, was presented as a humane reform to the management of distress. A move away from charitable support for mental disorder during the nineteenth century towards state-funded public asylums helped pave the way for psychiatry to develop as a medical speciality, and for asylums to become more routinised and coercive: 'The small, well-regulated, humane institution was transformed into a large-scale institution encouraging compliance and passivity.'[4] With moral therapy in decline by the end of the nineteenth century, a number of interested factions, comprising psychiatrists, clinical psychologists, psychoanalysts, humanistic psychologists and the state, made jurisdictional and epistemological claims over mental disorder during the twentieth century.

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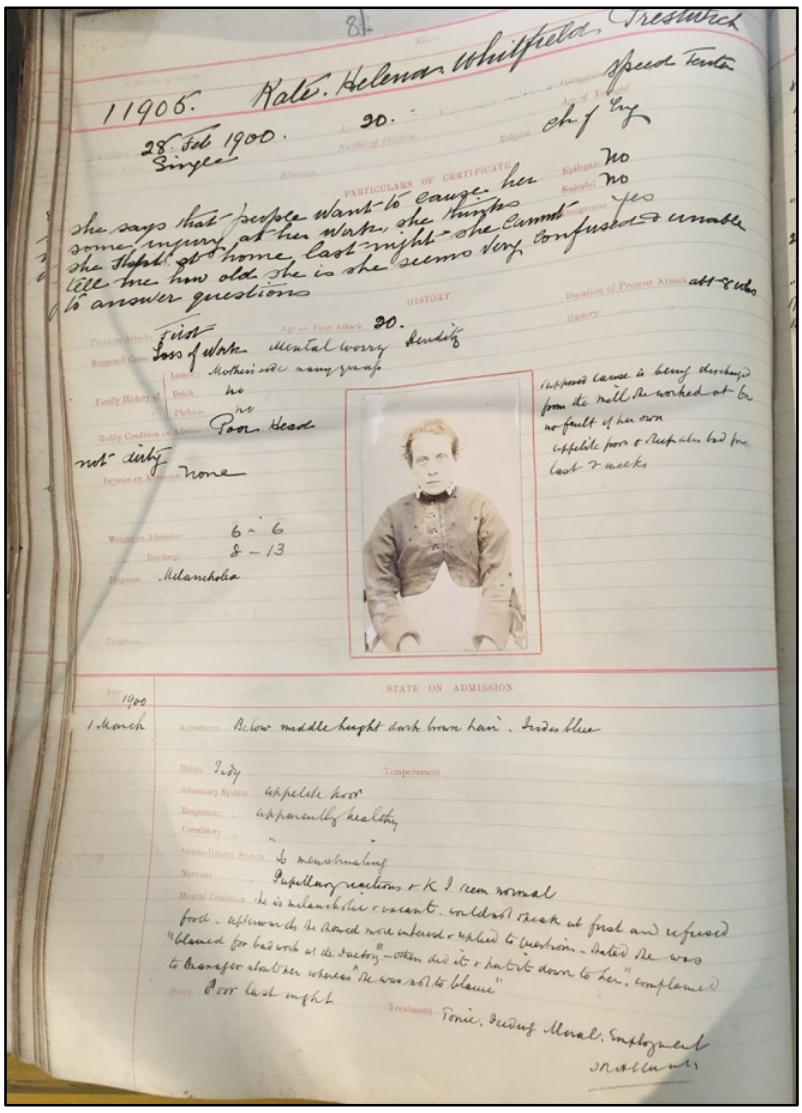
[1] Pilgrim, D., in: Dryden, W. (ed.) (1996) *Handbook of Individual Therapy*, p. 2.
[2] Cited in Taylor, B. (2014) *The Last Asylum,* p. 106.
[3] Busfield, J. (2011) *Mental illness*, p. 166.
[4] Ibid., p. 167.

By securing legal jurisdiction over 'forms of deviance which could be framed as illness'[5] through the Lunacy Act of 1842, and with the expansion of asylums, asylum doctors were able to promote and sustain a dominant biological grasp of 'madness', although a moral perspective did remain. See Figure 1.0, where Kate Prestwick, who was admitted in a frightened and confused state, was recommended to be treated with 'Tonic, feeding, moral (sic) and employment'.

Figure 1.0 Admission record for Kate Prestwick



Source: Manchester Central Library

The First World War shifted psychiatrists' attention to the psychological effects of armed conflict, and helped displace conceptions of distress as rooted in notions of degeneracy. When soldiers and

[5] Pilgrim, D., in: Dryden, W. (ed.) (1996) *Handbook of Individual Therapy*, p. 3.

officers suffered shell shock, the attribution of physical weakness became unsustainable due to their perceived heroism, so psychological explanations gained some ground over biologism. This opened up a space for psychoanalysis as an alternative explanatory framework for the impact of trauma. Sigmund Freud and Melanie Klein settled in Britain during the inter-war years, bringing their approaches to British intellectual life and '...influencing progressive psychiatrists and medical practitioners as well as members of the Bloomsbury Group...'.[6] However, they did not make a significant impact on the dominance of psychiatry, which was ascendant once again after the First World War,[7] until the Second World War, when analytically-informed group therapy[8] began to become established within the new NHS as a cost-effective replacement for individual therapy.

In the peacetime years that followed the Second World War, biological psychiatry, with 'chemical solutions to personal problems',[9] regained much of the ground it had lost to psychotherapy, but it also faced a new challenge. Academic psychology found fertile soil for its expansion in a British cultural climate of empiricism and positivism, giving rise to the emergence, in the 1950s, of the new profession of clinical psychology. Although by this time psychoanalysis had found increased legitimacy by aligning itself with medical epistemology (and many psychoanalysts were also practicing psychiatrists), a new front of attack, founded on testing and assessment, had been opened up by Hans Eysenck. Eysenck was instrumental in helping establish clinical psychology in territory formerly occupied by psychoanalysis: 'It cannot be a coincidence that a preoccupation with the denigration of psychoanalysis, and its clinical derivatives, has gone hand in glove with clinical psychology differentiating itself from medicine and marking out an area of separate epistemological validity.'[10]

Pilgrim suggests that the 'British climate of naïve positivism and empiricism'[11] resisted continental influences such as structuralism, psychoanalysis and phenomenology, which might have challenged a rational, 'common-sense' portrayal of distress grounded in a medicalised conception of natural science. Instead, it helped pave the way for the representation of clinical

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[6] Bateman, A. & Holmes, J. (1995) *Introduction to psychoanalysis: Contemporary theory and practice*, p. 9.
[7] Ibid., p. 4.
[8] Bion, W. R. (2013) *Experiences in groups: And other papers*.
[9] Pilgrim, D., in: Dryden, W. (ed.) (1996) *Handbook of Individual Therapy*, p. 6.
[10] Ibid., p. 7.
[11] Ibid., p. 8.

psychology as an applied science, annexed from its philosophical origins. This led to a treatment-oriented, symptom-focused approach, enabling psychologists to 'follow the epistemological contours and professional directives of medicine',[12] and, at the same time, carve out a degree of structural autonomy for themselves by using techniques such as behaviour therapy. David Smail identifies an epistemological shift from science to 'professional' practice:

> In the days before almost anyone can remember, when the greatest confirmation of professional status was to be permitted to lunch in the 'doctors' dining room' of the old Victorian psychiatric institutions, it was our dream to be able to talk to and try to help patients without first having to get medical consent. That breakthrough was achieved at the cost of espousing and promulgating a clearly inadequate ideology of 'behaviour therapy', and gradually easing our way out of a 'scientific' role, as advocated in the 'Zuckerman Report' (Zuckerman 1968), into a 'professional' one, as advocated in the 'Trethowan Report' (Department of Health 1977).[13]

The 'breakthrough' observed by Smail ensured that psychology would remain anchored to a treatment focus reliant on a 'mechanised/rationalised'[14] methodology which ignores the content of the research on which it purported to be based. The impact of a 'rationalised' research culture (part of an instrumentalist ideology) on psychotherapy, central to clinical psychologists' professionalising strategies, is discussed in the case study in chapter six.

Meanwhile, from within the voluntary sector, a phenomenologically-informed humanistic approach to therapy, antagonistic to psychiatrists' and psychologists' 'mechanised' accounts of the aetiology and relief of distress, was taking shape outside the domain of clinical psychology's enlarging role within statutory mental health services. Organisations within the voluntary sector, echoing the original compassionate aims of moral therapy, included the Samaritans, student and youth counselling, the National Marriage Guidance Council (now Relate), and organisations such as Al-Anon, dedicated to helping people adversely affected by alcohol. Although the importation of a humanistic therapy culture from continental Europe and the USA initially found resistance in a climate of British empiricism, the libertarian ethos of the 1960s eventually opened a cultural space to admit the 'third force' as an alternative psychotherapy paradigm to psychoanalysis or behaviourism. Within a post-war context of consensus politics, the coexistence, on the one hand,

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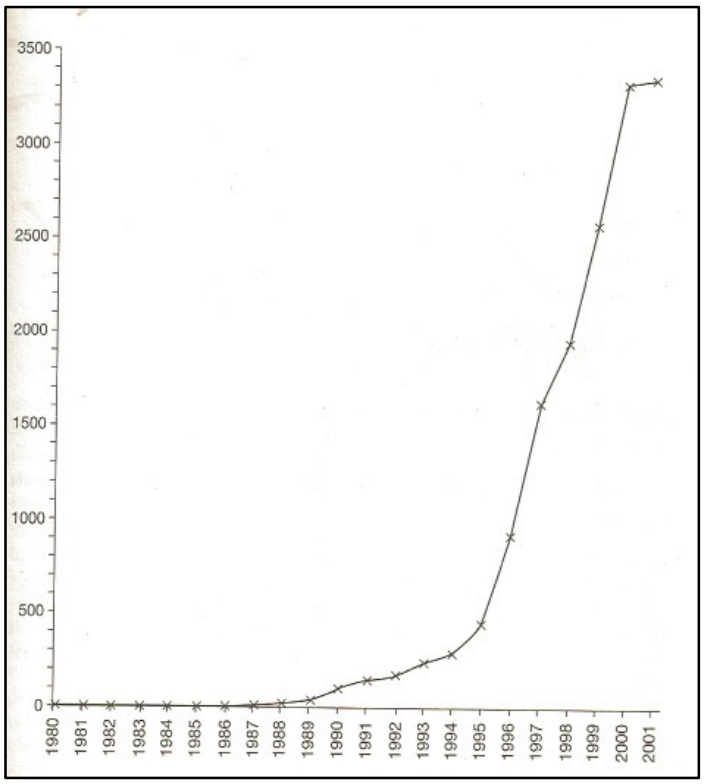
[12] Ibid., p. 9.
[13] Smail, D. (2006) Is Clinical Psychology Selling its Soul (Again)? *Clinical Psychology Forum*, 17–20. p. 17.
[14] Ibid., p. 21.

of psychoanalytical and humanistic phenomenology, and Eysenck's empiricism, on the other, prefigured a phase of psychotherapeutic pluralism founded on new streams of welfare capital. The arrival of Thatcherism, and its views that publicly-funded welfare bureaucracies were a drain on the state, further encouraged the commodification of therapy: 'Welfare structures themselves are encouraged to fall victim to market forces and thus are relocated in the private profit-making area of the economy.'[15] The marketisation of therapy within the NHS (the Tavistock Clinic and the Maudsley Hospital, for example), and the private sector, helped inflame therapeutic modality 'turf wars' fought on epistemological grounds for professionalising gains, helping to undermine therapeutic pluralism. Disputes, drawing on notions of 'efficacy' and framed within the enlarging 'evidence-based medicine' imperative (see later in this chapter), emerged between factions representing counsellors, psychotherapists, psychologists and psychoanalysts. These disputes inform some of the ethnographic material in chapters three to nine.

The rise of psychodynamic therapy within social work, accompanied in the 1960s by a mood that was antithetical to psychiatry,[16] helped establish counselling and psychotherapy within British culture. Frank Furedi suggests that a 'culture of emotionalism', supporting a 'shift of focus from the social to the internal life of the individual',[17] facilitated a cultural acceptance of therapy with 'a growing tendency to redefine public issues as the private problem of the individual. This mood is vividly captured through the individualised idiom of therapy'[18]—an example of which is the escalating prevalence of terms such as 'self-esteem' (see Figure 1.1).

[15] Pilgrim in: Dryden, W. (ed.) (1996) *Handbook of Individual Therapy*, p.11.
[16] Cooper, D. (2013) *Psychiatry and anti-psychiatry*.
[17] Furedi, F. (2004) *Therapy culture: Cultivating vulnerability in an uncertain age*, p. 25.
[18] Ibid., p25.

Figure 1.1: Citations for the term 'self-esteem' in British newspapers 1980–2000



Source: Furedi, F, Therapy culture: Cultivating vulnerability in an uncertain age, p. 3

Furedi argues that the rise in the usage of psychotherapeutic idioms suggests that: 'This turn towards emotionalism represents one of the most significant developments in contemporary western culture.'[19]

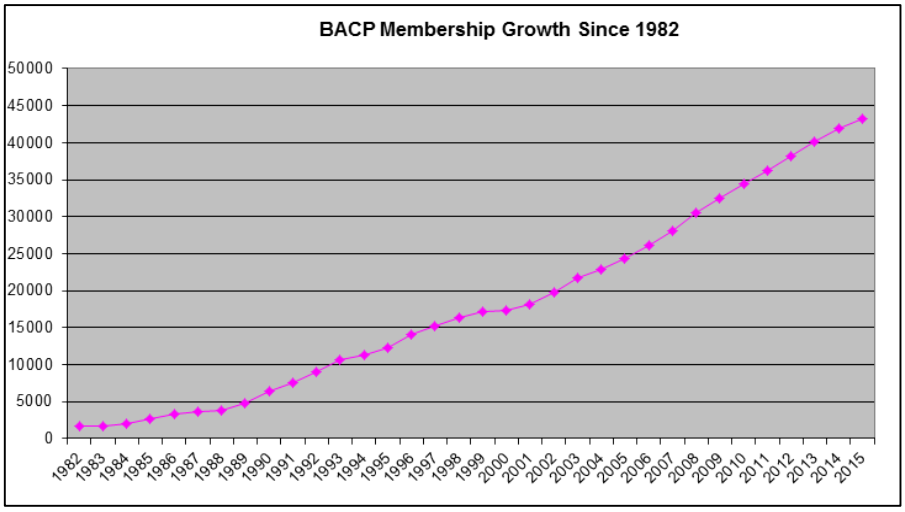
An increase in Employee Assistance Programmes (EAPs), where therapy is offered as a resource in the workplace to help employees to continue working while coping with bullying, harassment and anxiety, has added to the demand for counsellors and psychotherapists. Counselling in employment-related settings is having an increasing role in 'workfare', and efforts to reduce absenteeism. The impact of neoliberal policies on the working poor, discussed in chapter twelve, has contributed to the villainisation of vulnerable groups,[20] and an essentialist representation of people claiming welfare benefits. Adam Perkins[21] has suggested that welfare recipients, a group significantly targeted by IAPT for CBT treatment (see chapter six, 'Happiness Economics') have

[19] Furedi, F. (2004) *Therapy culture: Cultivating vulnerability in an uncertain age*, p. 4.
[20] Standing, G. (2011) *The Precariat: The new dangerous class*.
[21] Perkins, A. (2015) *The Welfare Trait: How State Benefits Affect Personality*.

bequeathed 'employment-resistant' personalities to their children: '…habitual welfare claimants with employment-resistant personalities are likely to have offspring with similar personalities'.[22] The rise of neoliberal identities in this narrative of degeneracy is discussed in chapter eleven.

The number of counselling and psychotherapy practitioners within the BACP membership has increased approximately tenfold during 1982-2015, as Figure 1.2 shows:

Figure 1.2: BACP membership growth



Source: Karen Duffin, PA to BACP Director of Marketing, Communication and Membership[23]

A climate of therapeutic eclecticism in Britain, accompanying an increase in the number of psychological therapists, had, towards the end of the twentieth century, fostered a wide range of therapeutic approaches, each underpinned by concepts, values and performances informing a domain of therapy praxis—a habitus identified by therapists as 'orientations', or 'perspectives', and representing configurations of knowledge and practical interests. An eclectic representation of therapy may have helped counsellors and psychotherapists claim a degree of authority, enabled by their exercise of expertise through the choice of approach to the treatment of unhappiness and mental ill-health. Challenges to eclecticism have been proposed as a factor in the declining of clinical authority, in the context of a fracturing of medical dominance within British psychiatry.[24]

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[22] From a review of Perkins' book on the Adam Smith Institute website, available at www.adamsmith.org/blog/miscellaneous/a-review-of-adam-perkins-the-welfare-trait/ (accessed 2 February 2016).
[23] Personal communication, 21 March 2015.
[24] Samson, C. (1995) 'The fracturing of medical dominance in British psychiatry?' *Sociology of Health & Illness* 17.2, 245–268.

A concern with rank and status amongst therapists, psychiatrists and psychologists within the NHS suggests that 'the status of psychotherapy within the NHS is a prime consideration and thus shapes and energises professionalisation registration, statutory or otherwise'.[25]

Of the approximately five hundred 'brand-name' theories of counselling and psychotherapy, about twenty are fairly well-known, and of these, three psychological therapy approaches predominate in Britain's NHS: psychoanalysis, cognitive behavioural therapy and humanistic person-centred therapy.[26] The narrowing of psychotherapy's eclecticism, partly through the reframing of 'approaches' as 'therapeutic modalities', and giving the appearance of self-sufficiency, singularity and standardisation, was accompanied by a proliferation of 'branded' organisational interest groups, some of which are shown in Figure 1.3, signatories to the 'New Savoy Declaration 2012'. The nature and aims of the New Savoy Partnership are summarised by the CBT psychologist Jeremy Clarke in his 'welcome note' on their website:

> The New Savoy Partnership is a unique coalition of organizations that came together in 2007 to persuade government to recognise the value of psychological therapies provided free on the NHS. Its core mission – choice of evidence-based psychological therapies to improve national wellbeing, has been taken up by successive governments.[27]

The Savoy Partnership's mission of choice is limited to 'evidence-based therapies'; other therapies are, by default, excluded. Clarke's advocacy for 'evidence-based psychological therapies', and his role in helping establish Improving Access to Psychological Therapies (IAPT) in Britain's NHS, is narrated in chapter six. The signatories are shown in Figure 1.3.

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[25] Postle, D. (2007) *Regulating the psychological therapies*, p. 101.
[26] Feltham, C. (2013) *Counselling and Counselling Psychology: A critical examination*, p. 46.
[27] New Savoy Partnership, available at www.newsavoypartnership.org (accessed 20 January 2016).

Figure 1.3: Signatories to the New Savoy Declaration

Source: www.newsavoypartnership.org (accessed 20 January 2016)

The establishment of IAPT as the British state's key strategy to make psychological therapy widely available, funded through savings in welfare payments,[28] had implications for the future employment of therapists working in general practitioner settings, voluntary agencies and private practices taking funded referrals from local GP surgeries. Many of these therapists were members of, and represented by, the British Association for Counselling and Psychotherapy (BACP), which had its origins in the 1970 Standing Conference for the Advancement of Counselling, since when it has engaged with external pressures from government and the public and has grown into Britain's largest counselling and psychotherapy organisation. As a body funded by its members, the BACP has described itself as acting in their 'professional interests', responding to changing governmental and economic conditions. In a press release on 19th October 2004, titled 'Huge step taken towards the statutory regulation of the talking therapies', the BACP made its own position clear:

> It shocks many to be told that there is no formal regulation of talking therapy in Britain. In fact, anyone can call themselves a counsellor, psychotherapist, psychologist or psychoanalyst and open a practice the same day. The public finds this a risky and undesirable state of affairs. The position is one that the British Association for Counselling and Psychotherapy (BACP), a leading self-regulator, has long deplored. Now

[28] See chapter 6: 'Happiness Economics'.

> through the facilitation of the BACP, new groundwork has been laid to clear a path to statutory regulation.[29]

Claims of a public perception of risk were made without reference to any supporting evidence. For example, James Antrican, the chair of Britain's second-largest organisation representing counsellors and psychotherapists, the United Kingdom Council for Psychotherapy (UKCP), took a similar position to the BACP in response to the question of regulation, claiming: 'Psychotherapy and counselling are powerful and risky. Therapy activities take place behind closed doors around intimate material. The risks need to be managed.' [30]

These positions, promoting state regulation and framed within a narrative of risk, were adopted by senior managers in the BACP and the UKCP without canvassing their members. The possibility of regulation had been hovering over therapists for many years, beginning in 1971 with the Foster Report,[31] which criticised scientology as a 'pseudo-science' and advised that psychotherapy be subject to legislation as soon as practicable. Seven years later, the Sieghart Report[32] recommended the statutory regulation of counselling and psychotherapy in Britain. Both reports, commissioned by the state, created a climate of uncertainty for therapy workers, reaching an apogee following the publication in 2007 of the Department of Health (DoH) White Paper: 'Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century',[33] which proposed statutory regulation through the Health Professions Council, set up in 2003 for the regulation of a range of health professions:

> Psychologists, psychotherapists and counsellors *will* be regulated by the Health Professions Council, following that Council's rigorous process of assessing their regulatory needs and ensuring that its system is capable of accommodating them. This will be the first priority for future regulation.[34] [My emphasis.]

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[29] Press statement provided by BACP media centre (personal correspondence, 19 October 2004).
[30] James Antrican in *The Guardian*, 1 July 2009, available at www.theguardian.com/society/joepublic/2009/jul/01/state-regulation-psychotherapy-counselling (accessed 3 February 2016).
[31] Foster, S. J. G. (1971) *Enquiry into the Practice and Effects of Scientology*.
[32] Sieghart, P. (1978) *Statutory Registration of Psychotherapists: The Report of a Professions' Joint Working Party*.
[33] Department of Health, *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century.*
[34] Ibid., p. 85.

The 2007 White Paper emphasised safety and expressed an intent of protecting the public from abuse after a number of instances of professional malpractice, and worse. The Shipman Enquiry, for example, following a guilty verdict against Dr. Harold Shipman for the murder of fifteen of his patients, led to the recommendation: 'With effect from 2009–10 all healthcare providers, NHS and private sector, will need to be 'registered' with the regulator and assessed against national standards of quality and safety.'[35]

Anticipating the statutory regulation of psychotherapy, the Department of Health funded the UKCP and the BACP to collaborate in an exercise aimed at 'mapping the professions of counselling and psychotherapy'.[36] Disagreement between the two 'umbrella' organisations over the titles 'counselling' and 'psychotherapy' intersected with the 'mapping' task, with the BACP taking an inclusive approach to the terms, representing them as equivalent,[37] and suggesting there is 'no reliable evidence that indicates any significant difference',[38] while the UKCP sought to make a distinction between the titles:

> …the BAC changed its name (somewhat provocatively) to the British Association for Counselling and Psychotherapy (BACP), yet has persistently refused to distinguish the difference between its members practicing these two quite different professional practices. […] These splits have significantly delayed the process of statutory registration as the UK government consistently wishes for, and insists upon, the whole profession to be regulated satisfactorily, rather than just some bits of it. [39]

Looking at the occupational titles from a historical perspective, the BACP had earlier downplayed any difference between counselling and psychotherapy, arguing in a different report:

> Professions form and flourish when they claim jurisdiction over delivery of a discrete service to a particular client group. With regulation of the psychological therapies looming, it is inevitable that interested parties will jostle to claim jurisdiction over particular aspects of psychotherapeutic work. Had this happened thirty

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[35] Home Secretary and Secretary of State for Health, (2007) *Learning from tragedy, keeping patients safe,* p. 16.
[36] Wake, L. (2006) Towards the Statutory Regulation of Psychotherapy in the UK. *International Journal of Psychotherapy,* 10, 72–80, p. 78.
[37] See chapter 5 for further discussion on differences between counselling and psychotherapy in the context of an ethnography of the production of a 'competence exam' for therapists.
[38] Dunnett, A. C.; Wheeler, S; Balamoutsou M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 6.
[39] Wake, L. (2006) Towards the Statutory Regulation of Psychotherapy in the UK. p. 77.

> years ago it would probably have been possible to draw a clear distinction between counselling, as it was understood then, and psychotherapy. Today, no such distinction is possible.[40]

The 'mapping' exercise began when, in December 2007, the UKCP and the BACP joined the HPC in a 'Professional Liaison Group' (the PLG). The group had three aims: to produce a retrospective 'map of existing therapy training and qualifications', in order to explicate standards on which these qualifications were based; to produce a new 'ethical framework' aligned with the Health Professions Council's code of conduct; and, finally, to produce a 'toolkit comprising competencies and processes' which would facilitate the development of a new template on which to base training, monitoring, fitness to practice investigations, and requirements for continual professional development.[41]

In an executive summary by the Health Professions Council to the Professional Liaison Group in 2010, the question of differentiating, and giving statutory protection to, the titles 'counsellor' and 'psychotherapist' was proposed. The document outlined a proposal that the protected titles 'counsellor' and 'psychotherapist' be aligned to levels five (foundation degree) and seven (Master's degree), respectively.[42] I attended a meeting at which this proposal was discussed in the light of detailed descriptions, provided by the UKCP and the BACP, of the work carried out by counsellors and psychotherapists. Since the discussion led to the conclusion that the work appeared to be of similar complexity, a further proposal was made that if the prefix 'therapeutic' were added to the title 'counsellor' then level seven could apply to counsellors and psychotherapists. The proposed standards of proficiency for both titles were set out in an HPC document under the heading 'Profession-specific standards of proficiency for counsellors and psychotherapists', in which one sentence apportions an autonomous role to 'psychotherapists': the 'ability to independently identify and work appropriately beyond the limitations of the standards of proficiency as needed for the client'.[43] This clause represented counsellors, implicitly, as rule-

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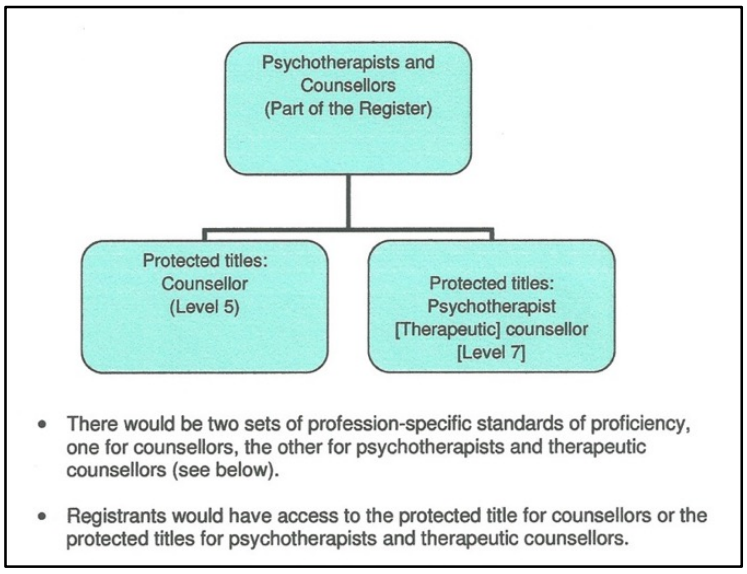
[40] Dunnett, A. C.,; Wheeler, S; Balamoutsou M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 10.
[41] Ibid., p. 6.
[42] Health Professions Council, *Executive Summary and Recommendations,* available at: www.hpc-uk.org/assets/documents/1000065Dcouncil_meeting_20041006_enclosure03.pdf (accessed 3 February 2016).
[43] Ibid., p. 7.

constrained semi-professionals,[44] and psychotherapists as able to exercise 'professional' judgement autonomously (a defining feature of medical professionalism)[45] by acting outside the same 'Profession-specific standards of proficiency' on which their work was putatively based. These ideas are summarised in Figure 1.4.

Figure 1.4: Protected titles



Source: Health Professions Council Executive summary and recommendations[46]

Expressing concern at the prospect of statutory regulation, a professor in the Department of Management at King's College, London, published a statement expressing views in favour of self-regulation, subject to an increased emphasis on 'evidence for effectiveness' in October 2009:

> In order to be able to own a system of mandatory regulation, we suggest that psychotherapy and counselling would need to become less insular as professions. Psychotherapy and counselling needs to focus more attention on developing evidence for the effectiveness of its practices. Professional bodies have to ensure

[44] Etzioni, A. (1969) *The semi-professions and their organization: Teachers, nurses, social workers*.
[45] Friedson, E. (1999) *Profession of medicine: A study of the sociology of applied knowledge*.
[46] Health Professions Council, (2010) *Executive Summary and Recommendations,* available at www.hpc-uk.org/assets/documents/1000065Dcouncil_meeting_20041006_enclosure03.pdf (accessed 3 February 2016).

> that they are not seen as self-serving or out of touch with the public, so that they retain the confidence of other key stakeholder groups.[47]

In the same month as McGivern's report was published, a coalition of ten psychoanalytically-oriented psychotherapy organisations produced the Maresfield Report on the Regulation of Psychotherapy in the UK. This report questioned many assumptions implicit within the state's proposal of the HPC as the regulator of therapy, suggesting that the 'consultation process has been narrow and biased',[48] and pointed out that 'Many forms of therapy do not consider themselves health professions and are based on highly disparate philosophies and approaches'.[49] The report cites 'scare stories circulated to the media by HPC' aimed at justifying protection from unregulated practitioners. Psychotherapists Richard Reeves and Phil Mollon provided one example of HPC's marketing strategy: 'In a recent media campaign on London Underground, an HPC poster portrayed alarming creatures represented by unregulated, that is to say non-HPC regulated practitioners, where the strap-line read: "There is no need to fear any longer such monsters and charlatans." '[50]

Regulated therapists were to be provided with car stickers: 'Even car stickers are available: "You're in safe hands, I'm regulated by the HPC." It was as though the HPC needed to foster a fantasy of the rapacious, unprincipled and inept therapist preying on the vulnerable general public'.[51] This was despite the fact that, according to Reeves and Mollon, the Department of Health had not provided any statistical evidence for the existence of therapist abuse: 'It is ironic that this most unsatisfactory situation is compounded when one considers that part of the HPC/DoH ethos for psychoanalytic psychotherapy is to be a so-called evidence-based approach.'[52] One observation they made was that: 'It is clear that HPC intends to regulate psychotherapy through an authoritarian top-down jurisdiction.'[53] An example of promotional material provided by the HPC to the public on their website is shown in Figure 1.5.

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[47] McGivern, G. (2009) *Statutory Regulation and the Future of Professional Practice in Psychotherapy & Counselling. Department of Management*, p. 9.
[48] Arbours Association, (2009) *The Maresfield Report on the Regulation of Psychotherapy in the UK*, p. 4.
[49] Ibid., p. 4.
[50] Reeves, R. Mollon., P. (2009) *The State regulation of psychotherapy: from self-regulation to self-mutilation,* p. 18.
[51] Ibid., p. 18.
[52] Ibid., p. 17.
[53] Ibid., p. 5.

Figure 1.5: Health and Care Professions Council promotional material

Source: Health and Care Professions Council [54]

The Maresfield Report claimed that the HPC aimed to regulate professions in ways inimical to the unexpected and unpredictable nature of the therapeutic encounter:

> HPC regulates professions within a framework which explicitly aims to remove these variables, and so it cannot accommodate those therapies which give a valued and central place to risk, shock and disappointment, seen as tools of growth and development.'[55] The report made a distinction between techniques of social engineering, reminiscent of the mental hygiene movement, and psychotherapy which had: '…for the last 100 years offered the patient a system of values freed from the moral judgments of social authorities.'[56]

The report concluded that if HPC regulation of psychotherapy were to be mandated by the state, then therapists would, under the sanction of being 'struck off', have to 'adhere to a moralistic and normative framework.[57]

In 2011, the Coalition Government, in a change of direction, rejected the idea of statutory regulation of psychotherapists and legislated for the voluntary regulation of counselling and

[54] Health Professions Council, *Executive Summary and Recommendations,* available at: www.hpc-uk.org/assets/documents/1000065Dcouncil_meeting_20041006_enclosure03.pdf (accessed 3 February 2016).
[55] Ibid., p. 12.
[56] Ibid., p. 12.
[57] Ibid., p. 12.

psychotherapy as documented in the Command Paper: 'Enabling excellence: autonomy and accountability for healthcare workers, social workers and social care workers.'[58] The HPC's argument based on risks to 'service users' for statutory regulation did not find its way into the Command Paper:

> For the overwhelming majority of occupational and professional groups which are not currently subject to statutory regulation and which are generally not considered to present a high level of risk to the public, but where recommendations that regulation should be introduced have been made (including those groups recommended by the HPC for statutory regulation in the past, but not yet registered) the assumption will be that assured voluntary registration would be the preferred option.[59]

The government gave the Professional Standards Authority,[60] which oversees the UK's nine health and care professional regulatory bodies, the task of implementing the newly-legislated requirement for 'assured voluntary registration' of counsellors and psychotherapists. The registration of counsellors and psychotherapists was given to the BACP through the Accredited Registers scheme, and in 2012 the BACP Register of Counsellors and Psychotherapists was created, which claimed: 'The main purpose of the Register is to protect the public. It provides reassurance to clients, employers and the general public that a registered therapist adheres to high standards of proficiency and good practice.'[61]

Acting on the fact that only a minority of BACP's membership were eligible for inclusion on the new register, a 'proficiency' test was devised by BACP's management to provide an entry route. In creating the test, the BACP faced two challenges: firstly, the range and disparity of therapeutic orientations and practice (therapeutic eclecticism) to be subsumed within one exam; and secondly, how to align the exam to the evidence-based approach, demonstrating 'clinical effectiveness', that had been successfully deployed by psychologists in their advocacy of CBT. Figure 1.6 shows that between 2008-12 the amount of money spent by government on training therapists in CBT was approximately twenty-five times greater than the amount spent on training therapists in other

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[58] Department of Health Command Paper, (2011) *Enabling excellence: autonomy and accountability for healthcare workers, social workers and social care workers*, Stationery Office.
[59] Ibid., p. 18.
[60] Professional Standards Authority, available at www.professionalstandards.org.uk/regulators, (accessed 23 March 2016).
[61] BACP Register of Counsellors and Psychotherapists, available at www.bacpregister.org.uk (accessed 23 March 2016).

approaches. The spending on CBT and Brief Dynamic Interpersonal Therapy training was reduced after 2010 when targets for the number of trained therapists were approached.[62]

Figure 1.6: Monies spent training therapists within IAPT 2008–12

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Therapy	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Step 2 Cognitive Behaviour Therapy (CBT)	2,190,000	4,430,000	2,620,000	2,680,000
Step 3 CBT	4,870,000	10,040,000	6,230,000	2,910,000
Counselling for Depression	-	-	192,000	204,000
Couple Therapy for Depression	-	-	44,000	(1)207,000
Brief Dynamic Interpersonal Therapy	-	-	189,000	81,000
Interpersonal Psychotherapy	-	-	258,000	246,000

(1) Includes training fees for the National Institute for Health and Clinical Excellence approved Behavioural Couples Therapy

Source: BACP internal memorandum[63]

An adaption of health care provision to the concept of effectiveness, requiring quantification of treatment and care, can be traced to the beginning of the evidence-based medical approach attributed to a series of lectures given by Archie Cochrane in 1972 and published as *'Effectiveness and efficiency, random reflections on health services'*.[64] Cochrane argued that the prevailing form of evidence offered in support of clinical practice was opinion, '… the simplest (and worst) type of observational evidence'.[65] He was particularly critical of psychiatry, which, he suggested, '…must be criticised as using a large number of therapies whose effectiveness has not been proven. It is basically ineffective'.[66] Cochrane had tried a number of experiments to challenge the received wisdom of medical authority, including one on a remedy for jaundice, while he was a prisoner of war in Greece. He suggested to his German captors that they could be prosecuted for war crimes if they did not follow his 'incontrovertible' proof that yeast would cure the prisoners, which it did, but for reasons outside his initial hypothesis.[67] In 1960, Cochrane was invited to set up a new

[62] BACP research department (personal correspondence 11 March 2015).
[63] Personal correspondence 2 February 2015.
[64] Cochrane, A. L. & Fellowship, R. C. (1972) *Effectiveness and efficiency: random reflections on health services*.
[65] Ibid., p. 20.
[66] Ibid., p.60.
[67] Robbins, R. A., Profiles in Medical Courage, (2012) Evidence-Based Medicine and Archie Cochrane, *Southwest Journal of Pulmonary and Critical Care.,* 5, pp. 65–73.

epidemiology unit in Cardiff, from which he established an international reputation for the quality of his research and his advocacy of randomised controlled trials.[68]

After his death in 1988, the Cochrane Collaboration was established in the early 1990s, to encourage systematic reviews of healthcare, since when the focus of evidence-based medicine has shifted towards three issues: an increase in emphasis on cost-effectiveness, greater attention given to outcome measures, and meta-analyses of existing research.[69] These, and their impact on a philosophy of counselling and psychotherapy, are discussed in an interpretation of the empirical material, in the light of a contemporary political and economic landscape, in chapter ten.

Counsellors and psychotherapists have, with the introduction of the register and the challenges created by IAPT,[70] had their work scrutinised within a lexicon of 'effectiveness', 'outcomes', 'evidence-base', 'criteria', 'equivalence' and 'performance'. The manner in which therapists' accounts of their work have been colonised by this language, and the means by which this has happened through involvement with organisations such as the BACP and IAPT, is described in the ethnographic material in chapters three to nine. Amid these changing representations of what therapy is and what it is for, therapists have responded to demands to demonstrate that therapy is 'effective' with reference to the claimed soundness and pedigree of their epistemological foundations, and the long and arduous training carried out by therapists, who are usually required to undertake several years of therapy themselves.[71] Pilgrim suggests that the 'unfounded professional zeal and arrogance'[72] of therapists is unsupported, due to the fact that lay people can be as 'effective' as trained therapists. Claims of effectiveness based on 'modality' differences are brought into question in a study of the 'equivalence paradox',[73] which suggests that CBT, person-centred and psychodynamic therapies have similar effects. 'Results for these three treatment approaches as practiced routinely across a range of NHS settings were generally consistent with previous findings that theoretically different approaches tend to have equivalent outcomes.'[74]

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[68] Ibid., p.70.
[69] Ashcroft, R. E., (2004) Current epistemological problems in evidence-based medicine. *Journal of Medical Ethics,* 30, pp. 131–135.
[70] See chapter 6: 'Happiness Economics'.
[71] Pilgrim, D. (1967) *Psychotherapy and society*.
[72] Ibid., p. 151.
[73] Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark, J. & Cooper, M. (2006) Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practiced in UK National Health Service settings. *Psychological medicine,* 36, pp. 555–566.
[74] Ibid., p. 555.

Paul Moloney and Paul Kelly are critical of claims made by CBT practitioners in particular, and psychotherapists in general.[75] Discussing a large body of 'clinical outcome' research, they conclude: 'This has convincingly shown that for a wide range of clinical problems psychotherapy effectiveness bears little relation to the therapist's clinical orientation or even to their qualification and alleged expertise.'[76] Katherine Mair argues[77] that although psychotherapy can be a valuable way of helping people, its 'efficacy' is consequent on the *myth* of knowledge and the expectation of improvement, a placebo effect, not on the models and methods used. Therapist charisma has been identified by Michael Hyland as the most significant contextual factor, and the primary cause of any improvement following counselling and psychotherapy, according to an empirical study using meta-analysis of complementary and alternative medicine.[78]

In the final section of this chapter, I discuss some epistemological perspectives on the three dominant strands of British counselling and psychotherapy prevailing at the end of the twentieth century: psychoanalysis, humanism and behaviourism—and how they have been impacted by the social actions narrated in chapters three to nine.

In a discussion of Freudian ideas, Richard Webster suggested that half a century after Charles Darwin had published *The Origin of the Species,* there was no systematic attempt to explain our species' violent nature, the depth and power of emotions, and the complexity of non-reproductive sex.[79] He argued that the success of science in other, secular, areas of enquiry was constrained by religion when applied to introspection. A secular self, he suggested, is fractured and divided between rational thought, unconscious desires and the emotional dynamics of loss without a religious context, or explanatory framework. On the value of psychoanalytic theories, Anthony Elliott argued that they:

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[75] Moloney, P., and Kelly, P. (2008) *Beck never lived in Birmingham: Why cognitive behaviour therapy may be a less helpful treatment for psychological distress than is often supposed,* in House, R. & Loewenthal, D. (ed.), *Against and for CBT: Towards a constructive dialogue*.
[76] Ibid., p. 282.
[77] Mair, K., in Dryden, W. & Feltham, C. (1992) *Psychotherapy and its discontents*, pp. 135–160.
[78] Hyland, M. E., A tale of two therapies: psychotherapy and complementary and alternative medicine (CAM) and the human effect. *Clinical Medicine,* 5, pp. 361–367.
[79] Webster, R. (1996) *Why Freud was wrong: Sin, science and psychoanalysis*.

> '...are rich and challenging not only because they dethrone common-sense understandings of individual intentions and reasoning; what is valuable in psychoanalytic concepts of the self is the stress on emotional dynamics of loss, longing and mourning.'[80]

Elliott describes the emergence of a secular self no longer divinely created and sustained. Instead, it is constructed from within its own embodiment and made comprehensible through Freud's medicalised topology of the psyche,[81] which proposed the unconscious, and the repression of powerful and sometimes disturbing emotions, as central features of psychoanalysis: 'The *theory* of repression is the corner-stone on which the whole structure of psychoanalysis rests.'[82] Freud positions the concept of repression in a Darwinian narrative: 'A necessary condition of its happening must clearly be that the instinct's attainment should produce unpleasure instead of pleasure.'[83] Philip Reiff has argued that the Freudian analytic attitude overturns the prevailing religious moral order in a new ethic of tolerance by 'psychological man': 'The power of the analytic attitude rests on the assumption that its proper exercise can cut off revitalisation movements of the classic moral demand system.'[84]

Freud privileges introspection over 'external perception' in the pursuit of knowledge: 'We shall be glad to learn, however, that the correction of internal perception will turn out not to offer such great difficulties as the correction of external perception—that internal objects are less unknowable than the external world.'[85] The German *unbewusst* has the grammatical form of a passive participle, and translates to 'not consciously known', suggesting that Freud proposed the concept of an unconscious as a working hypothesis, rather than a reified entity, to help explain the presence of dreams, slips of the tongue (parapraxes), and humour—rather than an a-priori (reified) entity. Citing Habermas, the French psychoanalyst Francois Roustang discredits the tautology of Freudian theory: 'Psychoanalytic theory, and particularly that of the unconscious, does nothing but repeat in a different guise the facts it is supposed to explain.'[86] Thus, the theory is perceived as a restatement of the empirical facts. By way of analogy with ancient pantheons, invented to alleviate anxiety and help provide a framework within which to grasp the human condition,

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[80] Elliott, A. (2013) *Concepts of the Self*, p. 10.
[81] Freud, S., Strachey, J. & Richards, A. (1984) *On metapsychology: The theory of psychoanalysis*.
[82] Ibid., p. 141.
[83] Ibid., p. 145.
[84] Rieff, P. (1987) *The triumph of the therapeutic: Uses of faith after Freud,* p 54.
[85] Ibid., p. 173.
[86] Roustang, F. (1984) On the epistemology of psychoanalysis. *MLN*, 928–940, p. 931.

Roustang suggests that knowledge of the unconscious is '...a methodological absurdity, an epistemological blunder', and goes on to suggest that psychoanalysis has no claim to science and is indistinguishable from myth. Freud's adherents, Roustang argues, attach a scientific legitimacy to his doctrines and have managed '...to pass off its myths as truths'.[87]

Karl Popper described the irrefutability of psychoanalysis (where confirming evidence is easily found in 'clinical observations') as a vice, rendering it pre-scientific as it fails to live up to his criterion that *'...*the scientific status of a theory is its falsifiability, or refutability or testability'.[88] He contrasts a dogmatic attitude, and strong beliefs based on first impressions, with a critical attitude which 'is ready to modify its tenets',[89] suggesting that a scientific tradition carries this attitude forward, in Hellenic style, 'with the aim of discovering their weak spots so that they may be improved upon'.[90] Popper implies that dogmatic thinking underpins a pseudo-scientific attitude towards psychoanalysis, with its tendency towards verificationism thus undermining any mythic value it may have by misappropriating it within a scientific discourse. Popper does find some hermeneutic purchase in psychoanalysis when he frames dogmatism as a form of neurosis, a 'partly arrested development of a critical attitude'.[91]

In contrast to the pessimism of psychoanalysis, Carl Rogers, the founder of 'Person-Centred' therapy, took a prosocial view of the human condition:

> One of the most revolutionary concepts to grow out of our clinical experience is the growing recognition that the innermost core of man's nature, the deepest layer of his personality, the base of his 'animal nature,' is positive in nature - is basically socialized, forward-moving, rational and realistic.[92]

Rogers confronted the Puritan traditions that emphasised humanity's basic sinfulness, and took issue with Freud's deterministic conception of humans being propelled by fearful and angry unconscious impulses. Rogers' own empirical findings suggested to him that the 'untamed forces' are not the inner core of the organism; rather, the human is 'essentially both self-preserving and

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[87] Ibid., p 938.
[88] Popper, K. (2002) [1963]. *Conjectures and refutations: The growth of scientific knowledge*, p. 48.
[89] Ibid., p. 65.
[90] Ibid., p. 67.
[91] Ibid., p. 65.
[92] Rogers, C. R. (1961) *On becoming a person,* p. 91.

social'. Rogers' model is one describing a person as inhabiting a private world of perceptions, each having the effect of a hypothesis formulated in the service of holistic goal-directed behaviour:

> The outstanding fact which must be taken into theoretical account is that the organism is at all times a total organised system, in which alteration of any part may produce changes in any other part.[93]

From this perspective, the mind is not divided into discrete and conflicting components. Rogers' theory is '.....basically phenomenological in character, and relies heavily on the self as an explanatory construct'.[94] The aim and end-point of his therapy is a congruence between the phenomenal field of experience and self-concept; a state of harmony, free from strain or anxiety, contrasting with the Freudian aphorism that humans could escape neurotic misery only by attaining ordinary human unhappiness. Rogers emphasised a 'certain type of relationship' as the key factor promoting personal growth leading to 'self-actualisation':

> If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur. [95]

Rogers proposed that this relationship has three core conditions: firstly, empathy; secondly the avoidance of façade, or 'congruence'; and thirdly, a state of warm regard, or an 'unconditional' acceptance. When these conditions are met, within the context of a helping relationship, Rogers believed that '...change and constructive personal development will *invariably* occur – and I include the word 'invariably' only after long and careful consideration'.[96] His directive to therapists is that they meet the client's inauthenticity or 'incongruence' with their own 'congruence' and self-acceptance: 'No one fully achieves this condition, yet the more the therapist is able to listen acceptantly to what is going in within himself, and the more he is able to be the complexity of his feelings, without fear, the higher the degree of his congruence.'[97] The pursuit of 'self-actualisation', finding a 'true self', as the touchstone of authenticity, raises some epistemological difficulties. Leonard Geller suggests that self-actualisation theory is based on an 'erroneous assumption' that the 'true self' is '…an unchanging thing-like substance that can be an

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[93] Rogers, C. R. 1989 [1951]. *Client-centered therapy,* p. 487.
[94] Ibid., p. 532.
[95] Rogers, C. R. 1961. *On becoming a person,* p. 33.
[96] Ibid., p. 35.
[97] Ibid., p. 61.

object of exploration and discovery but not a subject or agent'. [98] This atomistic representation of Rogers' theory of 'self-actualisation' points, paradoxically, to an *a priori* self, independent from social interaction.

Cognitive Behaviour Therapy (CBT) is an amalgam of two main influences: the behaviour therapy developed by Joseph Wolpe and others in the 1950s and 1960s, followed by the 'cognitive revolution' of the 1970s.[99] In a reaction against speculations of unconscious process, behaviour therapy took observable phenomena such as *stimuli* and *responses* as the basis for experimental observation and the formulation of theory. The approach informed an increasing interest in learning theory as a major paradigm in the context of socialisation, motivation and mental ill-health. During the 1970s, however, it became clear that the exclusion of thoughts and beliefs (which are an obvious part of psychological life) weakened a purely behavioural perspective, leading to the inclusion of cognitive phenomena in psychological therapy.

Beck argued that conscious awareness contains elements directly responsible for blurred thinking and emotional upset[100] and he suggested that people have the key to understanding their psychological disturbances from within the scope of their awareness. Therapeutic change is achieved by unravelling negative distortions of reality-perception to bring about a more positive view, with a consequent reduction in negative emotions. 'In the broadest sense, cognitive therapy consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals.'[101]

Paul Moloney and Paul Kelly consider the 'Cartesian Theatre of the mind, in which thoughts might be viewed and then manipulated...',[102] problematic. Such a view ignores the way people actually frame and shape their distress within social networks. They cite a number of reasons to doubt the

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[98] Geller, L. (1982) The Failure of Self-Actualization Theory. A Critique of Carl Rogers and Abraham Maslow. *Journal of Humanistic Psychology,* 22, 56–73, p. 59.
[99] Westbrook, D., Kennerley, H. & Kirk, J. (2011) *An introduction to cognitive behaviour therapy: Skills and applications*.
[100] Beck, A. T. 1991. *Cognitive therapy and the emotional disorders*.
[101] Ibid., p. 214.
[102] Moloney, P., & Kelly, P. (2008). Beck never lived in Birmingham: Why cognitive behavioural therapy may be a less helpful treatment for psychological distress than is often supposed. In House, R. & Loewenthal, D. (Ed.), *Against and for CBT: Towards a constructive dialogue?* p. 281.

claims to effectiveness made by CBT advocates: the selective reporting of studies that only show positive results; poor sample sizes and inadequate follow-up; the selection of privileged research populations such as university students; and the questionable reliability of using abstract numerical measurements. The creed of self-affirmation implicit in CBT is, in their view, unlikely to make any significant changes to those with the least financial, social and material assets:

> When it comes to the practice of psychological therapy, we would suggest, any attempt to modify 'negative' thoughts is unlikely to have much impact upon the sufferer's long-term psychological state – beyond their ability to alter the landscape of social and material influences in which they are embedded.[103]

Michael Guilfoyle discusses CBT's integration into contemporary power arrangements. He suggests that its status as a therapeutic hegemony diminishes the 'once rich landscape of therapeutic possibilities'.[104] Describing the difficulties in challenging this dominance, he argues that it is not hard to question the scientific basis upon which CBT makes its claims, but that these challenges have little effect. Guilfoyle concludes that a challenge on scientific, ethical or political grounds will be fruitless, because CBT serves to sustain existing power arrangements:

> ...the political reality is that therapies that perform such a reproductive function are useful institutional partners, and thereby more likely than others to become successful, popular, and recognised, and even to become part of the common-sense discourse (which itself then enhances the likelihood of effectiveness).[105]

Some detailed samples of the social actions sustaining an evidence-based ideology and impacting 'the once rich landscape of therapeutic possibilities' that Guilfoyle alludes to are narrated in the empirical material in chapters three to nine.

Instrumentalism

This section provides a brief historical overview of the emergence and massification of instrumentalism as it becomes aligned to political imperatives bearing on psychotherapy and the training of therapists.

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[103] Ibid., p. 284.
[104] Guilfoyle, M., (2008). CBT's integration into societal networks of power. In House, R. & Loewenthal, D. (ed.), *Against and for CBT: Towards a constructive dialogue?*, p. 233.
[105] Ibid., p. 239.

Early accounts of instrumental rationality can be seen in the pragmatic turn, initiated by Charles Sanders Peirce, away from idealism and towards concreteness, facts and action, establishing a philosophical backdrop attuned to a modern world of practicality tempered by reason. John Dewey, (preferring the term instrumentalism over pragmatism), rejects an accommodation of the real and the spiritual, a problem he suggests most philosophers have been preoccupied with.[106] His approach calls for a prioritising of action over thought, rendering thought 'operative' and the under-labourer of action. Thought is that: '...which frames and defines ideas in terms of what may be done, and which uses the conclusions of science as instrumentalities.'[107]

The role of 'truth' as a defining feature of pragmatism is developed in the 'pragmatic theory of truth', attributed to William James, who argued that experience cannot be set aside for an entirely objective analysis. In an interview published in the New York Times at the end of the long nineteenth century, in 1907, he argued: 'Reality as such is not truth, and the mind as such is not a mere mirror. Mind *engenders* truth *upon* reality.....the pragmatist writers have shown that what we call theoretic truth is itself full of human contradictions.'[108] Ideas are here relegated to the role of tools or instruments to solve problems, resonating with a Darwinian teleology from which James drew some inspiration. In a letter to William Erasmus Darwin, (Charles Darwin's eldest son), written on 12th January 1883, he suggests:

> Into the question of the comparative rightness of the 'ways' or that of the comparative perfection of the several types as measured by an absolute standard, a question which any professional moralist would then immediately take up, your father does not enter. Of course, he would have said here too that the notion of an absolutely perfect type, considered out of connexion with 'conditions of existence' was a meaningless idea to him.[109]

As the pace of change in the world during late modernity increased and humanity struggled in the face of uncertainty, the position of the professional moralist became weakened by James and some of his contemporaries.

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[106] Thayer, H. S. (1982) Pragmatism the classic writings.
[107] Ibid., p. 314
[108] Ibid., p133
[109] Skrupskelis, I. (2007) Evolution and Pragmatism: An Unpublished Letter of William James.

The negating effect of instrumentalism on moral certainty, eroding the power of speech, is articulated by Arendt a hundred years later in reference to the political judgement of scientists.[110]

> The reason why it may be wise to distrust the political judgement of scientists *qua* scientists is not primarily their lack of 'character' – that they did not refuse to develop atomic weapons-or their naïveté-that they did not understand that once these weapons were developed they would be the last to be consulted about their use- but precisely the fact that they move in a world where speech has lost its power.[111]

Arendt takes the view that the mastery and exploitation of the natural world through science lent impetus and justification to the expansion of an instrumentally-informed approach to knowledge and action. The resulting manipulation of complex materiality is generalised into a dominant mode of thought. An example is found in the displacement of virtue, a dimension of individual conscience, by bureaucratic instrumentality. In *Eichmann in Jerusalem- A Report on the Banality of Evil,*[112] Arendt describes functionaries such as Eichmann, as cogs in an administrative machinery rendering bureaucracy the rule by 'Nobody.' 'When Hitler said that a day would come in Germany when it would be considered a 'disgrace' to be a jurist, he was speaking with utter consistency of his dream of the perfect bureaucracy.'[113] Bureaucracy and the means-end rationalities it deploys have been described by Weber as a potential revolutionary force, but with consequences: 'But it revolutionises with technical means […] It first changes the material and social orders, and through them the people.'[114]

The effect of bureaucracy on the personality, a cognitive restructuring, leaves the bureaucrat's personality incapacitated through the maximisation of efficiency and calculability.[115] Resultant traits may include timidity, conservatism and technicism. This, in Weber's own words results in: 'Specialists without spirit, sensualists without heart; this nullity imagines that it has attained a level of civilisation never before achieved.'[116]

According to Blaine Fowers, the impact of instrumentalism on the specialists of counselling and psychotherapy practice is evident in the difficulty of separating fact from value in psychology.

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[110] Arendt, H. (1989) *The Human Condition.*
[111] Ibid., p4.
[112] Arendt, H. (1994) Eichmann in Jerusalem: a report on the banality of evil.
[113] Ibid., p. 290.
[114] Allen, K. (2005) Explorations in Classical Sociological Theory, p. 174.
[115] Merton, R. (1957) Bureaucratic Structure and Personality.
[116] Weber, M. (2012) The Protestant Ethic and the Spirit of Capitalism, p. 116.

This then becomes a major obstacle to the pursuit of virtue ethics. He sees irony in the effort to avoid moral concerns on the path to objectivity, an effort which has occluded the very human purpose with which psychology is putatively engaged. Citing Fromm, Fowers and his colleagues wonder if psychology might make things worse: 'Fromm worried that modern psychology might actually compound many of the dilemmas of a modern existence focused on liberation without providing any compelling purposes that might make a liberated way of life worth living.'[117]

A study of the history of psychology, Fowers argues, reveals that the pursuit of value neutrality has foregrounded instrumentalism and individualism with the consequence of driving the ethical dimension of psychology 'underground.'[118] Fowers explores and critiques the predominance of instrumental rationality in psychology, and proposes an alternative viewpoint based on constitutive goals, activities which are ends in themselves. This perspective, which enables a critical stance, requires a clear separation between means and constituent-end practices. He points out that social enquiry itself is a form of constituent-end practice that is shaped by and in turn shapes the aims and practices of the human community.

Weber draws attention to the moral dimension of vocational activity: 'Vocational activity has itself nothing of the instrumental; it is an end of itself (thus in some sense moral) but without reference to any grounding or act other than the freely chosen commitment of individuals to their own particular fates.'[119] A tension between instrumentally-acquired knowledge and an acceptance of the unknown is an integral part of counselling and psychotherapy, echoing Weber's observation that intellectualisation and rationalisation do not imply an increase in understanding of the way we live; rather it is: '...the knowledge or conviction that if *only we wished* to understand them we *could* do at any time.'[120] His point here is that the civilised person accepts not-knowing; citing Tolstoy he suggests that death has no meaning to a person who accepts the provisional and contingent nature of mature knowledge. The possibility that '[…] we can in principle *control everything by means of calculation.'*,[121] provides the conditions for disenchantment. The possibility for re-enchantment through myth and fairy tale in a therapeutic context, (where incomplete answers to life may possibly be found), include the stimulation of curiosity and

[117] Richardson, F.C., Fowers, B. J., & Guignon, C. B., (1999) Re-envisioning psychology: Moral dimensions of theory and practice, p. 3.
[118] Ibid., p. 6.
[119] Weber, M. (2004) *The vocation lectures*, p. xiii.
[120] Ibid., p. 12.
[121] Ibid.,

imagination whereby moral behaviour emerges not from externally imposed abstract ethical concepts, but through the development of an inherent capacity for engagement with the otherness of imaginary beings.[122]

Constituent-end activity was elaborated by Aristotle in *The Nicomachean Ethics*, where he comments on activities likely to be conducive to happiness: 'Now these activities are desirable in themselves from which nothing is sought beyond the activity.'[123] Fowers extends the contrast between constitutive and instrumental goals to a distinction between intrinsic and extrinsic goals.[124] In an analysis of motivation, he draws parallels between extrinsic goals and instrumental rewards of money and power. A reward system contradicts intrinsic goals co-existent with the putative purpose of therapy, for example personal growth and the development of intimacy. Fowers argues that when observed performatively, from an exterior viewpoint, constitutive practices may appear similar to means-end practices. This has a bearing on the training of counsellors and psychotherapists during role-play, narrated in the empirical chapters.

The widespread proliferation of means, in an age of individual satisfaction and a culture of consumer choice, is consequent on ends as given and beyond question. In psychology and psychotherapy this leads to researchers' creation of outcome measures which have little relevance to those who are being measured. 'If psychology limits itself to instrumental rationality, then it will likewise be unable to describe and understand a complete human life.'[125]

The most dangerous factor here, according to Fowers, is the ideological capacity of instrumentalism. The hegemonic positioning of instrumentalism in psychology is based neither on empirical evidence nor on any compelling argument. It is assumed as normative, from which he concludes that it is therefore ideological and can have negative consequences across a spectrum of human action, including areas of scholarship, friendship and parenthood where psychology has influence; thus, the ways in which psychology adherents benefit disproportionately are concealed.

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[122] Bettelheim, B., (2010) The uses of enchantment: The meaning and importance of fairy tales.
[123] Aristotle, (2009) *The Nichomachean ethics,* p. 192.
[124] Fowers, B., J. (2005) Virtue and psychology : pursuing excellence in ordinary practices, p.118.
[125] Ibid., p. 110.

Psychology is seen to undergird this ideology by providing a conceptual framework of human action that privileges and sustains instrumentalism.

A rise of instrumentalism correlates with an effort to move beyond GDP measures to capture the nation's wellbeing. The ONS household survey, and its findings, leading to the inception of IAPT, narrated in chapter six, follows the positivistic epistemological contours of clinical psychology by using numerical rating scales to discover the nation's well-being. An economistic utilitarian imperative to apply numericism in the form of efficiency savings through measurable outcomes and target settings has contributed to the massification of instrumentalism to the point that it has become ubiquitous in matters of public health and education. This thesis focuses on the education of counsellors and psychotherapists working within the remit of political initiatives such as IAPT and the possibility of statutory regulation – although the effects of (for example) the research excellence framework on therapy training and the QAA 'benchmark' standards suggests adds further instrumental pressures to bear on the training of counsellors and psychotherapists in HE settings. Illustrations of some of these pressures emerge at several points during the narration of the ethnographic material.

In Conjectures and Refutations Karl Popper makes a distinction between prediction, which instrumentalism achieves within its frame of reference, and discovery, which he claims does not because of instrumentalism's: '[…] denial of the descriptive function of abstract words, and of disposition-words. This doctrine by the way, exhibits an essentialist strain within instrumentalism – the belief that events or occurrences or 'incidents' (which are directly observable) must be in a sense more real than dispositions […]'[126] This, and other limitations of instrumentalism, (such as naïve empiricism and incommensurability), in the field of psychotherapy and education are identified at a number points in the empirical chapters.

This chapter started with a description of the emergence of talking therapies in the form of moral therapy, a humane alternative to the othering of mental distress by banishment to asylums. The changing contours of factionalism between groups of professionals engaged with helping distressed people has been reviewed briefly in the light of a rise in positivism, and more recently naïve empiricism in the politicised space of mental distress framed by utilitarian neoliberal

[126] Popper, K. (2002) [1963]. Conjectures and refutations: The growth of scientific knowledge, p. 158.

imperatives. More recently the emergence of the industrialisation of therapy, and therapy training, within an instrumentalist representation of human distress and its amelioration marks the end of this short history of counselling and psychotherapy in Britain and the beginning of this research.

Chapter 2

Methods and methodology

Introduction

An account of my entry into the field of counselling and psychotherapy is part of an autoethnographic narrative in chapter three, and leads up to a description of the point at which I began the fieldwork which forms the basis of this research. In 1992, employed as a psychotherapist and therapy trainer, I wrote to the BACP about what appeared to be unfair practice in their membership categorisation; this led to an invitation to work for them on a professional standards committee as 'a critical friend'. From this point onwards I became increasingly interested in and involved with decisions about the changing representations of counselling and psychotherapy offered to members of the BACP and their clients. What appeared to be an emerging tendency to decontextualise therapy knowledge from its historical and hermeneutic roots suggested that a qualitative approach to understanding the social actions giving rise to these changing representations would be justifiable.

By 2001 it appeared that I was uniquely placed in the roles I had taken up to observe and document a sample of the social actions taken by therapy organisation managers, academics, therapy trainers, counsellors, psychotherapists and trainee therapists during a period when psychological therapy was of increasing interest to the state. My immersion as an active member in the field of counselling and psychotherapy in policy-making groups, as well as my involvement in writing and 'delivering' training, together with my membership of the 'core curriculum consortium',[1] provided me, through my participation in and familiarity with the webs of social relationships connected to my roles, with a unique opportunity to record and try to comprehend a sample of a set of observations within what appeared to be a period of significant import for the future of British psychotherapy.

[1] Narrated in chapter four.

The research processes

My sociological perspectives on counselling and psychotherapy, beginning during my psychotherapy training, when I began to question the ideological character of therapy praxis, is the basis of my ethnographic and ambivalent relationship with therapy and its adherents. This is discussed in more detail in the next chapter, along with a commentary on the effect of my formative years on the genesis of my outsider perspective.

The specific focus on the impact of instrumentalism began with my working relationship with the BACP and other therapy organisations. Incredulous at what seemed from my naïve standpoint to be the zombification of therapy praxis, I became curious about what was going on and planned to investigate the social phenomena surrounding changes in therapy praxis more deeply by becoming a participant observer in a range of policy-writing and training events as part of a PhD thesis. These events form the basis of the six case studies presented in this thesis. The case-studies follow a timeline of significant change for counselling and psychotherapy in Britain, beginning with the creation of a 'core' curriculum, narrated in chapter four. Through my involvement in the training of counsellors and psychotherapists I already knew several individuals who were gatekeepers to organisations and institutions relevant to my enquiry. This afforded me access leading to a direct observational perspective on a sample of social actions linked to my research into the changing epistemological contours of psychotherapy. The case-studies are presented in chronological order – the social actions from each setting flow forward in time, from one case-study to the next, with an accumulating body of data evidencing the consolidation and inevitability of the instrumentalisation of therapy knowledge.

My participant observation sometimes placed me in contradictory positions. For example, at the beginning of the participant observer period, when co-writing the 'core curriculum' with a group of senior academics in the domain of counselling and psychotherapy training in HE, I was unable to resist suggesting that the education of psychotherapists should at least include some philosophy and sociology with which students could critically engage with the tracts of knowledge from foundational writers such as Freud, Rogers, Klein and Jung etc. I pointed out my surprise that I appeared to be the only core curriculum member suggesting this. (It appeared to me that my colleagues in this context had not taken much interest in a metatheoretical approach, appearing to prefer the relative familiarity and security of their chosen modalities – avoiding cognitive dissonance.) My suggestion seemed to me to be not only ethical but part of my implicit contract

as an involved observer – to participate as myself, and help balance my feelings of being an imposter. My small success in this regard was the inclusion of an (admittedly vague and generalising) section of the core curriculum requiring students to engage critically with some epistemological aspects of therapy theory:

> '*9.1. D. The social professional and organisational context for therapy*
>
> 2. Show a critical awareness of the history of ideas, the cultural context and social and political theories that inform and influence the practice of counselling and psychotherapy.
> 3. Identify and critique the philosophical assumptions underpinning the practice of counselling and psychotherapy.
> 4. Understand the inter-relatedness of truth claims, belief and ideology and their influence on professional practice.' [2]

My participant observation of the writing of the core curriculum is narrated in chapter four, the implementation of the core curriculum in the form of the 'Gold Book' is narrated in chapter nine, and discussed in the conclusion.

At the other end of the spectrum, towards the end of the research period, my participant observation of the implementation of the 'Gold Book' at a privately-run therapy training organisation, Therapy Solutions, led me to want to empower students, some of whom appeared crushed by the non-negotiable and contradictory edicts of instrumentalised therapy praxis. The narration, in chapter nine, includes an account of me, in participant observer role, helping some students manage some of these contradictions. As already suggested this seemed to me to be an implicit part of my involved observer contract.

These actions, taken while using the participant observer role to obtain a detailed thick description of the social actions of therapists in positions of power on one hand and relative vulnerability on the other, helped me tolerate the tensions arising from an involvement with the production and consumption of instrumentalised therapy praxis. The possibility and hope that my research might lead to a broader understanding of these social actions was another factor which sustained me in the face of the contradictions inherent in my role as an involved observer.

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[2] Dunnett, A. C.; Wheeler, S; Balamoutsou; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy,* p. 20.

From 2001, I kept a journal during my participation as a panel member or 'consultant' in several these activities, where far-reaching decisions about the future of counselling and psychotherapy in Britain were being made. This journal took the form of a diary in which I wrote my observations and on which I base the case-studies. I was careful to keep my own personal reflections in a separate column, bracketing off the narrative of an involved observer from my efforts to be as detached as I could in an effort to capture as rich a description as I could. Samples from this journal are narrated in the form of some multi-sited case studies in the empirical chapters. My colleagues, most of whom were academically-inclined psychotherapists, were supportive about my sociologically-based research, and many of them agreed to be interviewed. Access to interviewees was enabled further by my work as a therapy trainer and as 'consultant' to the BACP and Skills for Health, as well as by a short period as part of a group advising the Quality Assurance Agency for Higher Education on benchmark standards for counselling and psychotherapy.

The case-studies enabled me to meet interviewees who were at the production as well as the consumption level of codified therapy praxis. The forty-five in-depth interviews I conducted between 2010 and 2016 include some with therapy trainees at the beginning of their career, some with mid-career therapists and some with therapy trainers actively engaged in changing the face of therapy. I also conducted interviews with a sample of therapists reaching the end of their working lives. Five participants were interviewed a second time to follow up on events and actions anticipated during the first interview. Other interviews were with therapy service managers and therapists within the NHS, who were acting through the institutional settings of the Improving Access to Psychological Therapy (IAPT) scheme.

A sample of my interviewees were working during this period in senior advisory, regulatory, research and management positions within the BACP, the UKCP, the HPC and the IAPT scheme; others were drawn from a cohort of counselling students following training based on the 'Gold Book'. The focus of the interviews followed the contours of the unfolding drama of therapy praxis during a period of existential threat. My questions were predicated on the specific challenges my interviewees faced. All, in some way or another, seemed to be responding to an enhanced presence of organisational and state authority. The more senior ones appeared to identify with authorities' demands for the codification of therapy praxis, appearing to accept the legitimacy of positivism to promote the continued existence of therapy as a social practice. Interviewees at the lower end of

the hierarchy, trainers, supervisors and students took a more defiant and resistant approach to the substitution of hermeneutic conceptions of therapy with 'criteria', 'outcomes' and 'competencies'. My engagement with the former seemed collusive, and the latter collaborative – although at all times I did my best to use the therapist skills of hovering attention and non-judgementality combined with emotional engagement to elicit the social realities I was pursuing. An understanding of the phenomenon of countertransference, in the sense that it underpins all social interactions, has helped me steer my interviewees towards candour: 'This approach takes its cue from Freud's remark that everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious of other people.'[3] Although trained to see the other's perspective without prejudice I found the justifications given by many senior actors for the instrumentalisation of therapy praxis to be self-serving and contradictory by the standards of 'objectivity' they claimed as a rationale for their actions. By contrast I found I was in sympathy with students and lecturers who had an innate grasp of the contradictions they were being shoehorned into and, during the interviews described their criticisms with clarity and a lack of defensiveness. My role as a fieldworker in this context led to my own emotion work, where for example my reactions to comment or offer support were tempered by the necessity to avoid the contamination of data with my personal opinions. In Fieldworker feelings as data: 'emotion work' and 'feeling rules' in first person accounts of sociological fieldwork, Young and Lee describe this work as: 'the attempt to create a desired feeling, or by suppression, the attempt to diminish an undesired feeling.'[4]

The open-ended interviews, lasting between one and two hours and usually took place at the interviewees' place of work or study under conditions of anonymity. My strategy for interviewing consisted of providing open-ended invitations for example: 'Please tell me about your work, and the effects of any recent changes you have noticed.' My interviews were recorded digitally with any identifying features of the narrative deleted. I transcribed each of the interviews in full and printed them out. Once printed I analysed the text to identify emerging themes and highlighted sections which appeared to add depth to the emerging stories unveiled in the case studies. The themes – preoccupations, fears, hopes and acts of resistance are recorded in chapters four to nine.

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[3] Laplanche, J., and Pontalis, J.B. (1988) *The Language of Psychoanalysis,* p. 93

[4] Young, E. H., and Lee, R.M., Fieldworker feelings as data: 'emotion work' and 'feeling rules' in first person accounts of sociological fieldwork. In James, V., and Gabe, J., (ed.), (1996) *Health and the Sociology of Emotions,* p. 97.

Apart from the specific case-study settings narrated in chapters four to nine, other field notes have been obtained from participant observation within policy-making groups, for example Skills for Health (SFH), which took on the task of creating measurable therapist credentials, using manualised observable therapy behaviours configured to align with evidence-based methodologies. Evidence obtained from these sources have helped inform my questioning, exploring therapists' responses to institutional authority emanating from a range of settings. The focus of my research followed the case-study events as they unfolded in response to changing political and organisational imperatives; moving from the production of codified knowledge as an inevitability in the face of professional extinction, through a phase of justification through an 'evidence-base' narrative towards a situation where instrumentalised therapy knowledge became a given, (evidenced by accounts from participant observation in the Gold Book and IAPT regimes). In these latter situations are therapists who have only known instrumentalised therapy, while earlier interviews preceding the case studies, (see chapter three), gather perspectives who have only known traditional, modality-based, therapy. The dissonance between these different therapy habitus becomes sharper as the impact of instrumentalised therapy deepens – this is mirrored in the evolving focus of the interviews. The focus of the research therefore moved, through a concentrated phase of rapid change in the history of counselling and psychotherapy, from social actions underpinned by enthusiasm, the legitimation of authority and professionalising interests towards subservient resignation, passivity, and resistance. A summary of therapists' responses to the events recorded in this thesis is discussed in the conclusion in a section *'Therapists' responses to instrumental reason'*.

Triangulation

A strategy for triangulation includes the use of combined methods: data triangulation through case studies, interviews, official and unofficial documents[5] and ethnographic vignettes, in a diversity of settings and contexts. Hence, each of the case studies in chapters three to nine unveils different facets of therapy praxis within a flux of changing political and cultural conditions. Chapter three, 'Outsider', describes the emic perspective of an 'involved observer',[6] who 'could never be fully

[5] Including inter-departmental memos, emails, meeting minutes, PowerPoint presentations, educational literature and handouts, assessment forms, promotional literature, training manuals, supervision reports, clinical assessment forms, counselling adherence scales and some anonymised extracts from students' personal journals.
[6] Clark, K. B. (1965) *Dark ghetto: Dilemmas of social power,* p. xv.

detached as a scholar or participant',[7] where my ambiguity, curiosity and equivocation are inextricable from this research. Chapter four, 'The Core Curriculum', narrates my participant observation of a group engaged with the reframing, standardisation and codification of therapy knowledge as a standardised basis for British psychotherapy training. Chapter five describes the implementation of therapy codification in the creation of an examination for therapists, giving rise to a standardised computer-based assessment of routinised therapy praxis as a sample of digitally-Taylorised knowledge. Chapter six outlines the effects of political authority (intersecting therapists' professionalising strategies) on therapy praxis, leading to the IAPT scheme. The role of institutional authority (in the form of the National Institute for Health Clinical Excellence) is narrated in chapter seven, where social actions of reductionism and instrumentalisation of therapy knowledge are a precursor to the emergence of the manualised form of therapy practice, 'Counselling for Depression'. Chapter eight narrates some samples of the experiences of therapists subjected to an audit culture of target-setting, 'clinical' supervision and monitoring using repurposed measures, where 'Measure collapses into target'.[8] The final case study is narrated in chapter nine, 'The Gold Book', in which codified and routinised therapy knowledge is the basis for an education in counselling and psychotherapy at a private institution, where students are immersed in a manualised therapy training regime.

The case studies provide opportunities for between-method and within-method[9] triangulation by using documents, interviews and observation within and across them which are part of a wider cultural landscape and '...also a single example of a broader class of things'.[10] These are separated by purpose, social location, authorship and institutional context, but share generalisable characteristics, where inferences are drawn from significant features, which are then compared with instances of similar features identified in different contexts outside the research parameters, aimed at strengthening authenticity, typicality and transferability.

Theoretical triangulation of the interpretation of empirical material is sought through a mix of sociological and philosophical approaches, using resources from writers on, for example, the topics of tacit knowledge, emotion management, digital Taylorism, professional strategies and neoliberalism.

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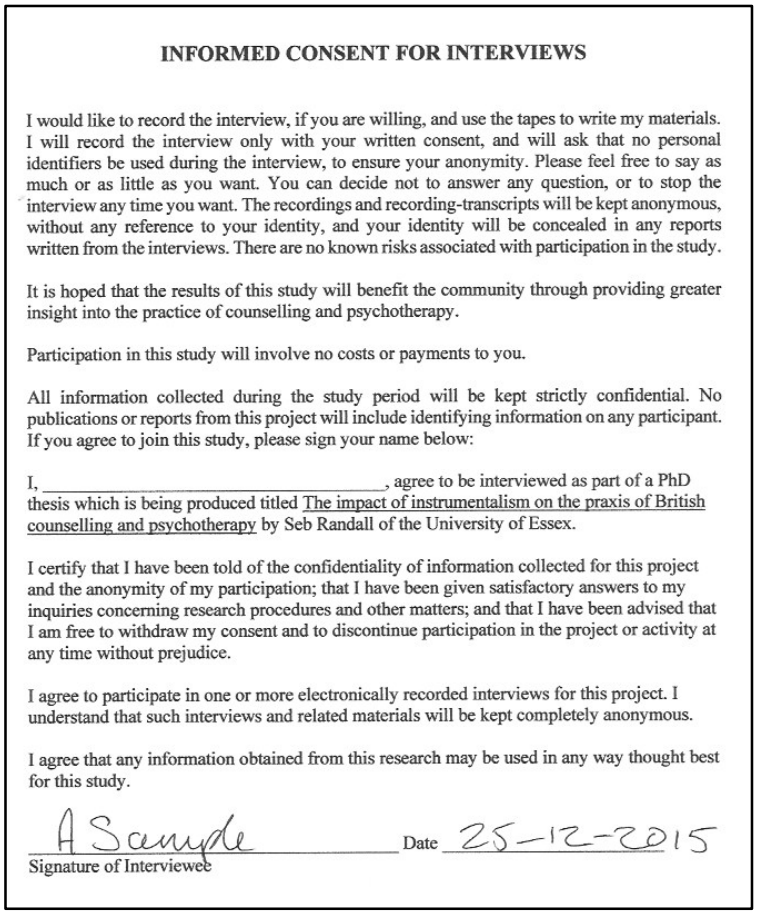
[7] Ibid.
[8] Riles, A. (2006) *Documents: artefacts of modern knowledge*, p. 198.
[9] Denzin, N. K. (1973) *The research act: A theoretical introduction to sociological methods*.
[10] Denscombe, M. (2011) *The Good Research Guide*, p. 60.

Ethics

Ethical approval was granted for this research by the Sociology Department at Essex University on September 5th 2012. Interviews were conducted under conditions of anonymity, except in the case of Counselling for Depression where its author, Andy Hill, who was also head of BACP research, stated at the beginning of his interview that he was willing to be identified. (See figure 2.1 providing information about and consent for the interviews, and an agreement that recordings and related materials remain anonymous.)

Figure 2.1 Informed consent form



INFORMED CONSENT FOR INTERVIEWS

I would like to record the interview, if you are willing, and use the tapes to write my materials. I will record the interview only with your written consent, and will ask that no personal identifiers be used during the interview, to ensure your anonymity. Please feel free to say as much or as little as you want. You can decide not to answer any question, or to stop the interview any time you want. The recordings and recording-transcripts will be kept anonymous, without any reference to your identity, and your identity will be concealed in any reports written from the interviews. There are no known risks associated with participation in the study.

It is hoped that the results of this study will benefit the community through providing greater insight into the practice of counselling and psychotherapy.

Participation in this study will involve no costs or payments to you.

All information collected during the study period will be kept strictly confidential. No publications or reports from this project will include identifying information on any participant. If you agree to join this study, please sign your name below:

I, _____, agree to be interviewed as part of a PhD thesis which is being produced titled The impact of instrumentalism on the praxis of British counselling and psychotherapy by Seb Randall of the University of Essex.

I certify that I have been told of the confidentiality of information collected for this project and the anonymity of my participation; that I have been given satisfactory answers to my inquiries concerning research procedures and other matters; and that I have been advised that I am free to withdraw my consent and to discontinue participation in the project or activity at any time without prejudice.

I agree to participate in one or more electronically recorded interviews for this project. I understand that such interviews and related materials will be kept completely anonymous.

I agree that any information obtained from this research may be used in any way thought best for this study.

A Sample Date 25-12-2015

Signature of Interviewee

No person is identifiable from my participant observation, the narration of which disguises any features which may compromise anonymity. In each of the settings within which I took on the role of participant observer, having gained consent from managers and others who provided access, I declared my research interests during the opening round of introductions, explaining that I would not identify any person/s involved and that all notes would be anonymised. I did not receive any

objections to my participation; several participants were encouraging of my research, and many offers for interviews were made. A research culture within the field of counselling and psychotherapy is written into the BACP ethical framework: 'The Association is committed to fostering research that will inform and develop practice. All practitioners are encouraged to support research undertaken on behalf of the profession and to participate actively in research work.'[11] The qualitative approach taken for this research may help to balance a preponderance of quantitative outcome-oriented psychotherapy research in counselling and psychotherapy literature.

Critical ethnography

There is an extensive amount of research grounded in therapy practice on psychopathology, therapeutic process, supervision and monitoring, professionalism, LGBT issues (in a therapy context), reflexivity, outcome measurement, shame, dreams, and the workplace, to name a few. Many of these studies are coexistent within the therapeutic project and are focussed on an individualistic conception of the human condition, paying little attention to the social context of psychotherapy in general or to imperatives towards the codification and routinisation of therapy knowledge which inform the social actions narrated in this thesis. Although my, (thus far), unsuccessful search for sociologically-informed qualitative perspectives on social actions comparable to those narrated in chapters three to nine cannot have been exhaustive, it has been difficult to find any studies which could reasonably be seen as parallel. I have identified three studies, each offering different degrees of relevance to my study.

In Mirrors of Madness,[12] Bruce Luske takes a social-constructionist approach to the interaction between staff and residents in an ethnographic account of psychiatric work; there are some parallels with my own studies. in terms of the subject matter, such as Luske's degree of institutional involvement and his advocacy of a critical ethnography. Luske declines 'claims to privileged explanatory status',[13] making the point that 'Institutional circumstances are built up from countless practical face-to-face situations',[14] leaving us trying, but ultimately failing, to grasp our rational interests. The institutional circumstances narrated in my thesis are from the perspective

[11] BACP (2002) *Ethical framework for good practice in counselling and psychotherapy*, p. 8.
[12] Luske, B. (1990) *Mirrors of madness: Patrolling the psychic border*.
[13] Ibid., p. 116.
[14] Ibid., p. 117.

of an involved observer, already immersed in a paradoxical relationship with several institutions related to counselling and psychotherapy for over two decades.

Much of my participant observation and many of the interviews took place in a policy-making environment sustained by an evidence-based narrative. In Alex Stevens's Telling policy stories: an ethnographic study of the use of evidence in policy-making in the UK,[15] the use of evidence in policy formulation is the basis for a participant observation-based study of civil servants. In a similar vein to some of the psychotherapy policy-making narrated in this study, Stevens observed '...a high level of commitment to the use of evidence'[16] in a climate where uncertainty was perceived as a barrier to action, prompting the production of 'totemically tough'[17] policies. He concluded that '... this selective, narrative use of evidence is ideological in that it supports systematically asymmetrical relations of power'.[18] The positioning of a scientifically justified, evidence-based narrative within a culture of uncertainty is a theme emerging from some of the empirical material discussed in the conclusion.

Kenneth Clark's Dark Ghetto, written in 1965, explores a distinction between social truths and social facts: 'Fact is empirical while truth is interpretative.'[19] Clark seeks to move '... beyond a narrow view of fact, beyond the facts that are quantifiable and are computable, and that distort the actual lives of individual human beings into rigid statistics'.[20] A fuller, if incomplete, understanding of the social actions accompanying the current quantification and measurement of psychotherapy narrated in my study may be achieved by an interpretivist approach: 'Since truth is not easy to grasp or recognise – it remains more of a quest than an attainment – one is obliged to seek it through a continuous process of observation, speculation, refinement of hypothesis, and testing of those hypotheses which are at present testable.'[21] In the next chapter, 'Outsider', I describe the emergence of my relationship with counselling and psychotherapy with which I have been ambivalently involved, as opposed to be being immersed or embedded in it. Finding a voice has been predicated on distance: 'Distance – not being completely there – can provide perspective

[15] Stevens, A. (2011) Telling policy stories: an ethnographic study of the use of evidence in policy-making in the UK, *Journal of Social Policy*.
[16] Ibid., p. 237.
[17] Ibid.
[18] Ibid.
[19] Clark, K. B. (1965) *Dark ghetto: Dilemmas of social power,* p. xxiv.
[20] Ibid., p. xxiii.
[21] Ibid., p. xxiv.

and freedom to speak';[22] and this may help mitigate some of blind spots consequent on insider knowledge.

[22] Westbrook, D. A. (2009). *Navigators of the contemporary: Why ethnography matters*, p. 49.

Chapter 3

Outsider

> 'After a while you could get used to anything.'
> *Albert Camus.' L'Étranger,* 1942.

This chapter starts with a short narration of autoethnographic vignettes and photographs, as 'a form of self-narrative that places the self within a social context'.[1] As I write this, I feel cautious about its inclusion in my thesis, but hope that perspectives on the cultural landscape I have traversed help to make the ethnographic material, and the arguments that emerge, more meaningful in the chapters that follow. I have not been able to fully separate my identity from the effects of the colonial social context I grew up in. These effects, I propose, have informed my perspective on the ethnographic material. In 'Third Culture Kids', Pollock and Van Reken describe the 'hidden immigrant' those who '... view life through a lens that is different from the dominant culture as any obvious foreigner. People around them, however, presume they are the same as themselves inside since they appear the same outside.'[2] The recollections and observations I recount look outwards on the world, and seem to have been anchored by buildings and places, after which the sections have been named. An introspective narration of my 'psychotherapeutic journey', framed within a language of developmental psychology, psychoanalysis, existentialism or humanism, would have felt misplaced from the sociologically-informed, therapy-critical perspective of this thesis by reifying some of the constructs I am problematising. My brief account narrates some recollections and voices that seem intense, or epiphanic. Apart from memory notes, my sources, providing descriptions of early years, include my godmother-aunt Clare, now a retired paediatrician living in Toronto, and some photographs that accompany the text. Later in the chapter, I narrate my entry into the field of psychotherapy, with accounts of my experiences as a therapist, 'trainer' of therapy and 'consultant' to the BACP, the (problematic) standpoints from which this thesis emerges.

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[1] Reed-Danahay, D. (1997) *Auto/ethnography*, p. 9.
[2] Pollock, D. & Van Reken, R. (2010) *Third culture kids: Growing up among worlds*, p. 54.

Lebanon and Mexico

Compared to my colleagues and friends, I felt that I had an unusual childhood. I had very little formal primary education; what I did have was fragmented and inconsistent, although memories of family outings to places like the ruins of Baalbek in Lebanon (see Figure 3.1) contributed to my informal education. I spent most of my childhood in Mexico and the Middle East, with short spells of time in England every few years, and had tentative, transient friendships. For most of my early life I remember looking onto a social world I could not fit into; in company, I felt like a visitor and found freedom in solitude. I felt like an outsider, watchful and curious.

Figure 3.1 With my parents and sister at the Roman ruins in Baalbeck, Lebanon

Source: Family photo album

I first separated from my parents at the age of four, when I was taken by my paternal grandmother and my Aunt Clare from a flat on Chelsea Embankment to Harwich, and, so I'm told, a rough crossing of the North Sea. Clare was my godmother; she looked after me for some of my early childhood while she worked part-time in Great Ormond Street Hospital. We headed for Copenhagen where my grandfather was the British Ambassador, and I stayed at the British Embassy for a few months while my parents were having difficulties with their marriage following my mother's reaction to the birth of my sister Jane. Although I remember only a few fragments of my first spell abroad, I have been told by Clare that I was distraught much of the time. I imagine that my existence was secondary to the pomp and ceremony of embassy life, which included a visit by the British Prime Minister, during which, according to Clare, I was kept out of sight.

Figure 3.2 Clare and my grandparents at the British Embassy in Copenhagen, during a visit by Churchill and his wife, October 1953

Source: Carl Ramusssen, Social-Demokraten press

My parents, Clare suggested, should never have had children, because they were too preoccupied with themselves. A few years later, we moved to Beirut, where we lived in an apartment overlooking the sea, and they employed a woman named Yvette to look after me. Yvette was born and raised in Beirut and spoke English; she had experience of childcare as the eldest in a large family. I remember her as warm and loving; my 'real' mother. She stayed close to me for six years, including a three-year period in a large house serviced by five servants and a small team of gardeners in Avenida de los Insurgentes, Mexico City.

Figure 3.2 Avenida de los Insurgentes

Source: Family photo album

When not with Yvette I spent some of my time with my younger sister Jane, wandering around the grounds and helping the gardeners who would sometimes share their hot chilli lunch with us.

I was often unsure where my mother was, apart from one vivid memory of a night when there was an earthquake (which made the little clay toys on my bedside table wobble and fall off). She ran into my bedroom to carry me outside, from where we saw the building next door collapse. We sat on the grass in the warm, cicada-filled night before sirens started wailing; we then went back into our undamaged house and my father played the piano for a while. The next day I heard from Yvette rumours that Mexican Independence had been reversed as the statue of El Ángel atop the nearby Monumento a la Independencia had fallen to the ground. After a brief walk, my father, sister and I stood in the crowd looking at the shattered angel on the ground and I felt sad.

Figure 3.3 Yvette with my father

Source: Family photo album

Figure 3.4 Me with my sister Jane in the bright colours and heat

Source: Family photo album

Between these tropical periods abroad, we lived in an isolated and dilapidated house in a bluebell wood on the South Downs in Surrey. Years later my father told me that the owner was one of the Cambridge spies he had encountered at a Communist Party meeting during his time studying history at Magdalen College, Oxford, where my father was recruited by MI6. The house was vacant as the owner had defected to Moscow, remaining there until he died.

Figure 3.5 House in the bluebell wood

Source: Family photo album

My father's work was a mystery for much of my childhood. There were late night knocks on the door or on windows, men carrying machine guns creeping around the garden (sometimes on the roof), candles placed in windows as signals, frequent noisy cocktail parties, and bomb searches. I carried out some of the latter myself, after some training from one of my father's Royal Marine bodyguards. The Marine let me play with his unloaded guns, and they seemed heavy; I felt drawn to their cool touch and to the implicit violence of their oily-smooth, mechanical ways. I remember a long argument when I overheard my parents shouting at each other about an assassination task. My father usually smelt of whiskey and often became ferociously drunk, sometimes reciting long passages from Shakespeare's 'Hamlet', once naked and in the garden, scaring me and my unhappy mother. I recall her as being nervy and distant, and for as long as I remember I felt I had to look after her. I did not expect to be cared for by her, so I learned to be self-reliant. She once told me that as a child she had danced ballet and was a platform diver, and in her late teens she drove troop carriers for the army during WW2. I felt sad for what she had become: the bored, neglected, gin-

addicted wife of a British spy. She habitually wore sunglasses and a headscarf, hiding from the world, a lonely and anxious expatriate.

Figure 3.6 A family day out in Bahrain

Source: Family photo album

Figure 3.7 With my mother and sister at Isla La Rocqueta, Acapulco

Source: Family photo album

My childhood was punctuated by frequent separations; life was unpredictable and insecure.

Woolverstone Hall

When I reached eleven years of age, my parents sent me to a Suffolk boarding school, Woolverstone Hall, set in ornamental grounds with an Adam-style main building surrounded by prefabricated, flat-roofed dormitories. The teaching took place in WW2 Nissen huts, warmed by coke-fuelled pillar stoves. Some people from the local villages referred to it as the 'borstal', as the children, most of whom came from poorer parts of London, were troubled and 'in trouble' much of the time. The school was an experiment run by the London County Council to provide a public school experience for disadvantaged children. Although from very different backgrounds, I found solidarity with my new friends, who had been displaced from the familiarity of life within their home communities and were now living within a rigidly authoritarian culture over which they had little sense of belonging or control.

I struggled to get through each day; the contrast with my expatriate existence was painfully sharp. My parents were thousands of miles away and I looked out for their letters every morning, but would receive only two or three each term. My social life abroad had been limited to contact with the children of a few isolated expatriates whom I met at birthday parties; we were ferried around in chauffeur-driven cars. There had been no English-speaking friends near my various homes abroad to hang out with, so in that was I was unlike my new school friends, who had been immersed in their communities since birth.

For the Easter vacations, I stayed in London on friends' sofas, or on the street, as only two home flights per year were allowed by the Foreign Office for diplomats' children.[3] Once, aged thirteen, I was kidnapped and attacked while wandering about the West End in the early hours of the morning. It seemed that my naïve trust in strangers, not out of place in an Arabic culture at that time, was misplaced in a western city. This unforgettably terrifying experience deepened my understanding of some of the stories I would hear much later as a therapist.

During holidays in my early teens, after my parents moved to Jordan, I attended the occasional boisterous Jordanian police poolside barbecue party to which my father's allies in the Jordanian Intelligence Directorate invited us. When I was old enough for my parents to let me wander alone

[3] According to my father, MI6 provided diplomatic cover for most of its spies; this arrangement helped with secure communications, bodyguards and weaponry, the latter sometimes brought in by my father in the 'diplomatic bag', handcuffed to him and secure from customs scrutiny.

in the alleys of Amman, my European appearance made me feel self-conscious and strange. Salma, a friend at the time, told me a story about how, while sitting in a car beside her brother Mahdi, looking over the evening glow from Jabal Amman (a hill overlooking the old city), a man, whom she did not know, started to chat to her through the open window. Her brother got out, walked around the car and shot the man dead. He then drove off. No action was taken as it was reported as an honour killing, and her brother had friends in the police force. I kept my distance from her after that.

After what seemed like an eternity, my grim secondary schooling ended and I visited my parents for the last time in Bahrain. I was seventeen when my father gave me a parting gift of twenty pounds and two hundred Rothmans King Size cigarettes while I waited for the London-bound flight after a final summer with my family. As the VC10 climbed, banking steeply, I could see the dark-green palm trees, white sand and azure sea; I was uncertain of what lay ahead, and already ached for the imperfect life I was leaving. I recognised then how irretrievable this point was even as I traversed it, the VC10 delivering me to a different phase of my life.

Both of my parents had been alcoholics. They died from alcohol-related illness within three months of each other, after I had lost contact with them, in their early fifties. I responded to their demise with mute equanimity, having somehow anticipated an early departure. Their funerals brought few mourners. They had had short lives amongst transient friends, thus shaping my own expectations. The experience of their children in the cultural climate of elite, upper-class, white, colonial expatriates was both different and similar to other forms of marginalisation. My brother had a severe breakdown after my parents died, but found solace in religion. My younger sister became a heroin user, and although no longer addicted, lives a life dominated by anxiety and is not able to work. My other sister suffered severe panic attacks and lived in poverty and isolation until her premature death. For me, anxious watchfulness was my parents' bequest, leaving me curious and, paradoxically inured to uncertainty.

The cross-cultural world I had occupied as a child left me with an uncertain identity. On the one hand, I had lived, as a child and an adolescent, in an expatriate world within the implicit violence and rituals of a colonial legacy; on the other, I felt I was an immigrant, eager for more of the warm embrace of Arabic hospitality, underscored by my Lebanese 'mother' Yvette. I was from neither my parents' culture, nor the culture of my various host countries, leaving me in an intersectional limbo imbued with secrets, disruption, separation and loss. It seems to me now that my enforced

exposure to otherness may have given rise to an outsider perspective on the world, and a sense of exclusion.

Ethelburga Towers

The twenty pounds my father had given me soon ran out, and I sold my Rothmans one-by-one at Piccadilly Circus so I could buy food. I lived on the streets of London, sleeping, in the winter of 1967–68, under Ethelburga Towers in Battersea and in shop doorways. I knocked on doors, doing odd cleaning and gardening jobs, getting by. I had the occasional respite of school friends' sofas to sleep on, and public bathhouses in which to enjoy long hot baths. Some nights were too cold to sleep, so I walked until daybreak.

Figure 3.8 Ethelburga Towers, Battersea, London

Source: Personal archive

I was adrift but felt joyfully unbounded. After a while, I found a bedsit in Belsize Park for two pounds a week, and employment as a hospital porter in the nearby Royal Free Hospital, but the atmosphere of sickness and death, as well as the rigidly authoritarian porters' hierarchy, became unbearable. When the head porter put his arm round me and suggested that, in time, and if I 'played my cards right', I could take his place, I knew my time there was limited. I left soon after the announcement of my possible promotion, and worked from my bedsit, making bags from scrap leather, gluing together brightly-coloured offcuts (given to me by workers from a local leather clothing factory) which I cut and plaited. I sold them door to door, and to shops on a sale or return basis. I was surprised by their popularity, but worried about how well the glue would hold out. I woke one night after having a dream about my bags falling apart, strewing possessions over the pavement—possibly a comment-to-self on my precarious existence. I often walked over nearby

Hampstead Heath, and would sometimes look up at a passing jet and fleetingly miss the warm ease of my earlier life. After a couple of years of increasing stability, I became involved in community art projects and volunteered for Task Force, helping disabled and older people with their shopping, redecorating their homes or escorting them on long train journeys to visit friends and relatives. Then, for two evenings a week, I began to attend an Introduction to Sociology course at Holloway College; our tutor, Harry, arrived wearing a donkey jacket with NCB[4] stencilled on the back, and habitually started his lectures with a raised fist.

Camden Square

Figure 3.9 Me on the left with other dinosaur makers, Camden Festival 1972

Source: Personal archive

For three years, in the early 1970s, I worked for Camden Council as a play-leader in a community project, Camden Square. This was a piece of unused land with ropes, swings and a large metal freight container providing shelter from the rain and a space to store equipment and make drinks. Children and teenagers who had been hanging around the street, avoiding school, sometimes fighting and robbing, came in to chat with the play-leaders whom they could rely upon not to contact the educational welfare officer (who would try to get them back to school). I helped set up

[4] National Coal Board.

a free-school, where young people could turn up any time and do what they liked. More than a few arrived at seven in the morning, after their parents had chucked them out, clamouring to get in. When they did, we would just talk, sometimes making jewellery by heating nails in a coke brazier and hammering them into bangles, necklaces and rings. The kids made candles that we sold on a stall outside Hampstead Town Hall in Haverstock Hill in Belsize Park. We used the money raised to go on trips into the countryside, which many of the children and teenagers had never seen before. Frank and Nita were at the Square most days; they entertained us with tales of their adventures out of school.

Figure 3.10 Nita

Source: Personal archive

Figure 3.11 Frank

Source: Personal archive

Figure 3.12 Camden Square, 1972

Source: Personal archive

Essex

Following my employment with Camden Council, I found work labouring on building sites and, over a few years, learned how to lay bricks, plaster walls, fix roofs and hang doors. I moved out of London and worked as a joiner in a small shipyard in Essex, fitting out military ships for export to the Middle East. The siren sounded at 7.30 every morning as I clocked in. We were not allowed to sit down during morning and afternoon breaks as they were unofficial and meant we could clock off at four. The walls were plastered with soft pornography; I did not think I would last there. After about a year, during which I learned about joinery, institutional sexism, racism and workplace bullying, I placed an advert in the local paper offering general building services and found enough work to live on. I began to study psychology with the Open University and began doing voluntary work with the Samaritans, listening to suicidal callers. Although not suicidal myself, the callers' difficulties resonated with my own sense of insecurity and fearfulness. Jenny, a warm and friendly fellow Samaritan, suggested I contact Alesha, a therapist who had helped her through a difficult time. Jenny wrote Alesha's name and number down for me, and I called her to arrange my first psychotherapy session.

Alesha opened a creaky, wrought iron gate at the side of her house in a quiet street and led me down an alley into her small garden. (In hindsight, that gate seems to have been a portal into the psychotherapy habitus I have occupied for the last thirty years.) A mossy, soapstone Buddha looked impassively down on me from his perch on a tree as Alesha let me into a shingle-clad shed.

As I stepped into the dimly lit room, a warm pall of incense enclosed me. A dreamcatcher turned slowly in the window as the rising smoke, cut with sunlight, curled towards the sky-blue vaulted ceiling. Alesha sat in a large cushioned chair that was covered with a brightly coloured patchwork quilt and waved towards a crimson chaise longue. Mandalas hung on the dusty-looking yellow walls; one end of the room, furthest from the door, was covered in books. I sat down and looked around. She waited until my gaze found her and then she said, 'What brings you here?'

Over a couple of years, for two fifty-minute sessions a week, I told Alesha whatever I could remember, or whatever bothered me at the time. She listened, and when she did speak it seemed to me that she had been doing more than just listening to what I had said. It took me a while, but eventually I discovered that I could say anything I liked to her and nothing changed her quiet interest in me. I gave up pretending to be okay when I was not; I was sure that she would eventually tell me the arrangement was over, but despite my best efforts to push her away, she did not abandon me, disabusing me of my expectation of being rejected by her.

Summerville College of Humanistic Therapy

As I discovered later, many people who have psychotherapy train to be psychotherapists themselves, and I turned out to be one of them. I applied for training at Summerville College of Humanistic Therapy and was taken on to the final year of a Diploma in Humanistic Counselling, since by that time I had had several years' experience as a volunteer for the Samaritans.

I was enthusiastic about the training at first; the tutors, Anne and John, seemed accepting and open-minded. However, it was not long before I felt doubtful of the course's exclusive reliance on the teachings of Carl Rogers, the charismatic founder of the Person-Centred Approach, (PCA). Although, from his writings and films of him working as a therapist, Rogers seemed to be both compassionate and perceptive, I mistrusted the zealous fervour of his followers—both the staff and some of the students. The person-centred narrative, asserting a person's essential goodness, seemed to me to be at odds with what I had seen of the harshness of the human condition, which could not be dispelled by fiat. I was unwilling to put faith in Rogers' teachings, or the teachings of any one person, as the sole basis for working as a therapist. I became incredulous at Anne and John's expectation that students 'perform' Rogers' core conditions[5] of authenticity and spontaneity

[5] Introduced in chapter two.

in rote fashion, in role-play for filming and subsequent analysis. Barry, one of my co-students, said to me once: 'The harder I try to be genuine, the more insecure and doubtful I feel.'

Working together in a group did provide help for those of us who had experienced distress in childhood and current relationships, and the goodwill of my peers included compassion, support and understanding. I noticed that those who had had the most distressing experiences were the least judgmental. The few essays demanded of us required evidence of allegiance to Carl Rogers' approach and related examples of the application of counselling skills, and criticisms of the Rogerian approach were discouraged by Anne and John as 'unhelpful'. John was very wary of other approaches; of psychoanalysis he said, without elaboration, 'It is dangerous and should be avoided'. When performing therapist/client role-plays, we were prevented from saying anything not predicated in the 'client's' narrative. We were directed to select parts of their story and 'reflect' or repeat it back without adding any commentary or alternative perspective (the latter was critiqued by Anne and John as the 'therapist's agenda'). I felt that my training was turning into a dogmatic indoctrination, denying me a voice. The emphasis on autonomy, personal choice, and a disregard of social context contradicted the political values that I had gleaned from my earlier sociological studies with the Open University, and which I had hoped to encounter in a therapy training. I was expecting open-minded debate, tolerance, pluralism and diversity.

With the training complete, I felt like an imposter and ill-equipped to help people with enduring and intractable anguish. Worst of all, I felt that the dogmatism of the training worked against, rather than with, the grain of my innate, naïve, grasp of human distress, which I trusted. I felt that the Rogerian approach had over-represented goodness and neglected humanity's gloomier side, espousing a bourgeois optimism and imposing the burden of self-improvement on marginalised and distressed people. In hindsight, my training seems to have embraced a humanistic universalism grounded in the Enlightenment project, giving life to a 'theory of action that puts the individual agent at the centre of the universe'.[6] I felt uneasy about the reification of the self, so central to the Rogerian approach, through a narrative of 'self-actualisation', promoting self-absorption and sustaining individualistic ideologies of autonomy and action. During my training, I had challenged John by suggesting that Rogerian therapy was well-suited to YAVIS[7] types who had sufficient emotional and economic capital to draw on. The bourgeois link between self-absorption and

[6] Plummer, K. (2001) *Documents of life 2: An invitation to a critical humanism*, p. 257.
[7] Youthful, Attractive, Verbal, Intelligent and Successful. Coined by Schofield, W. (1986) *Psychotherapy: The purchase of friendship*.

neoliberal culture has been commented on by David Harvey: 'The narcissistic exploration of self, sexuality and identity became the leitmotif of bourgeois urban culture.'[8]

I began work as a therapist at the end of the Thatcher era in the late 1980s. It was easy to find work; it appeared that the prospect of therapy was touching a widening, psychologically-minded public, reflexivity having an increasing stake in popular culture. Most of the changes narrated in the chapters that follow—the codification, instrumentalisation and commodification of therapy facilitated by an increasingly economistic and scientistic culture—had not yet made a significant impact on therapy praxis. My work started in a private therapy group practice, where most of my new colleagues had trained in psychoanalysis and had sessions with clients once, twice or three times a week, sometimes for years. I was drawn to psychoanalytical developmental narratives, calling the taken-for-granted into question and opening up the view that unconscious influences may be informing identity. Psychoanalysis seemed to offer a critical perspective I had not found in Rogerian therapy's representations of humanism. Optimistically, I decided to train as a psychoanalytic psychotherapist and found a part-time course in London running two evenings a week, with a duration of about five years, subject to retaining a 'training patient' in therapy for a minimum of three years.

The Institute of Psychoanalytic Psychotherapy

In the late 1980s, psychoanalytic psychotherapy trainings typically took place in city-based private institutions, and would demand a background in social work, medicine, counselling or psychology. Following my application to train, I was invited to a meeting in North London by the Institute of Psychoanalytic Psychotherapists, where the convener, who happened to be the chairperson of the United Kingdom Council of Psychotherapy, told us that entry was highly selective and included two one-hour interviews, as well as participation in 'observed group activities', heightening my unease. I arrived, on time, for my first interview in Agar Grove, Camden Town. I had to wait on the pavement for fifteen minutes before my knocks were answered. A large man with long greasy hair opened the door, saying 'I'm Dennis', and led me up dark stairs to an untidy first-floor room. I picked my way over dirty plates, piles of books and papers to a chair and sat down. Dennis fired off a series of questions. He criticised my answers as 'defensive' and asked me, 'Why are you smiling?' He avoided my attempts at engaging in a conversation and interrupted me whenever I

[8] Harvey, D. (2005) *A Brief History of Neoliberalism*, p 47.

spoke. He attacked my self-descriptions, my motives and expectations. This was successful to the extent that I felt subdued and downcast, a shift he seemed to relish, blue pebble eyes glinting over his wild beard. An hour later I left with the feeling that neither of us would want anything more to do with each other; the 'interview' had felt intrusively abusive. My next interview, two weeks later, was with a cheerful brightly-dressed woman, who reminded me of a well-known comedian. She started with the announcement: 'Lie on the couch. We have an hour. I won't be saying anything.' After an uncomfortable pause, I started to blurt out what I hoped would be a description of my aptitude to practice as a psychoanalytic psychotherapist.

In spite of these bewildering experiences, the training committee offered me a place on the course, which I accepted with gratitude. I joined a group of six women and three men in twice-weekly seminars based on the writings of Freud, Klein and Jung. It seemed to me that some of the seminar leaders had little teaching experience; Jock asked us to take turns reading aloud, in liturgical style, sections of the text we had already studied during the previous week. The training did not provide any scientific, historical, philosophical or sociological perspectives within which to contextualise the ideas we studied, shielding psychoanalytic discourse from analysis and critique. It soon dawned on me that psychoanalytic texts, in the setting of therapist training, had an ideological character. A few years later, I read a passage where Terry Eagleton put it far better than I could have done:

> It is possible, then, to think of ideological discourse as a complex network of empirical and normative elements, within which the nature and organisation of the former is ultimately determined by the latter.[9]

Tutors narrated 'patient' case studies from their own 'clinical' practice as 'empirical evidence', foundations for the 'truth' of psychoanalysis. Samuel, who was already qualified as a psychoanalytic psychotherapist, told me he was retraining as a psychoanalyst, which would take a further six years, seeking 'a deeper understanding of the unconscious'. He said: 'My new analyst is only three analyses away from Freud himself.' He seemed to have found faith in psychoanalysis. Some of the normative strands within psychoanalytic discourse appeared to me to have religious connotations. I found a little book in the shop selling memorabilia (including mugs, badges of

[9] Eagleton, T. (1991) *Ideology: an introduction*, p. 23.

Freud and pens) at the Freud Museum in North London, a short walk from the 'Tavvy'.[10] Writing on 'The meeting of psychoanalysis and religion', Joel Kovel reminds readers:

> We should remember, too, that psychoanalysis – and the psychotherapeutic movements in general – owe their existence to the decline of religion and spirituality in recent history. In some measure psychoanalysis occupies cultural space abandoned by traditional religion.[11]

Within a genealogical perspective, Suzanne Kirschner frames psychoanalytic discourse as an extension of Calvinism, the 'redeployment of a pre-existing cultural template to a new context, the recently delineated domain of the psychological'.[12]

David Pilgrim[13] suggests that psychotherapy trainings are intended to produce adherents to a set of ideas, leading to an elitist psychoanalytic habitus. My own experiences at the time suggested to me that 'candidate' selection was based on, and training a reinforcement of, a combination of bourgeois and Protestant values, including a capacity for autonomy, impulse control and the privileging of a reflective inner life. Some of the training was guided by Jock's selected readings of fairy tales and myth,[14] containing metaphors of journeys from ill-health to well-being, framing narratives of redemption through suffering and guided introspection. I was discouraged from questioning key underpinning concepts, such as the unconscious, proposed by tutors as self-evident. As Jock said, 'Just take it from me, all will become clear to you during your analysis'. I felt patronised and disappointed—again. After I had completed the training, I interviewed a psychoanalyst, Paul (who had retired from the clergy). Paul put it this way:

> Psychoanalysis is so similar to religious belief, it's like a sort of [pause] it is a steady brainwashing that happens to you over a long period of time and soaks right into the system and is like a dye that you can never wash out. I really don't know the answer, except that I certainly feel there are dangers to it. There are sort of aspects of it that I feel very uncomfortable about, about the whole way psychoanalytic and psychotherapeutic organisations operate, which seem to me, having come out of the church, seem to be sometimes so fundamentalist that they expect a going along with something. I remember when I first started in this business

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[10] Shorthand for what is now the Tavistock Clinic Foundation, an NHS foundation trust specialising in mental health.
[11] Ward, I. (1993) *Is psychoanalysis another religion?: Contemporary essays on spirit, faith and morality in psychoanalysis*, p. 20.
[12] Kirschner, S. R. (1996) *The religious and romantic origins of psychoanalysis: Individuation and integration in post-Freudian theory*, p. 7.
[13] Pilgrim, D. (1997) *Psychotherapy and Society*.
[14] Bettelheim, B. (1977) *The Uses of Enchantment*.

> somebody said to me; 'Oh, you haven't had a psychoanalysis yet so you can't criticise what's going on; you have got to have psychoanalysis', and when I went into psychoanalysis I was told you have just got to suspend belief and have faith and you will then 'discover the reality of the unconscious' etc. Those were almost exactly the same words that were said to me when I became a Christian many years ago; that makes me very suspicious.[15]

Jock referred to people receiving psychoanalysis as 'patients', and psychiatrists were represented by tutors as 'colleagues providing valuable sources of referrals'. In contrast to the humanistic approach, a bio-medical model of mental illness was framed, in a psychoanalytic community, as complementary rather than antagonistic to psychotherapy. Although I was reluctant to embrace psychoanalysis as a faith, as several of my peers and most of the tutors seemed to have done, I did have first-hand experience of the explanatory power it had, creating a meta-narrative for clients' stories, and helping to explicate a social context in which to understand feelings such as rage, jealousy and envy. My therapy work became informed by, but not limited to, psychoanalysis; I was open to all the help I could get to comprehend what I could of human distress in its many forms.

Beckford College

After my psychoanalytic training, in the summer of 1988 I was invited, at short notice, to help Nicky (a talkative and enthusiastic sex therapist and former co-student on my Rogerian therapy training), who was teaching on a residential counsellor-training course for Beckford College at the Rectory Residential Training Centre near Cambridge. The setting was a gothic-style rectory in well-tended gardens, on the lawn of which Nicky briefed me about an emerging 'difficult situation'. Students were hanging out in small groups on the lawn and the granite steps in the late afternoon sun and talking animatedly, some smoking, and drinking tea, coffee, wine and juice. A young woman was crying and in the arms of another. They appeared to be aged from early twenties to late sixties, were casually dressed, in jeans and tee shirts, and were mostly women.

[15] Interview 4.

Figure 3.13 The Rectory residential training centre

Source: Personal archive

Nicky told me that Andy, one of the students, was distressing his peers during 'awareness' group meetings by saying whatever came into his head to other group members. He had argued that the ethos of the course, and the empowering effect of the group, entitled him to be honest with his feelings even if some people 'found it difficult to hear the truth'. Andy was the only man on a residential therapy course where four of the staff and twenty-two of the students were female. This situation led to him being accommodated in a single room with *en suite* facilities, while the staff and students were all in dormitories. In the evening, I joined the meeting, led by 'group facilitator' Melinda, where students talked openly about their experiences on the course, directing their commentary to me, the new member, who, Melinda said, 'needed to be brought up to speed'. Most of the group agreed that, having not been away from home on their own before, they found the communal facilities a struggle; some said they felt so anxious they could not sleep. Towards the end of the meeting one of the students told Andy, to murmurings of approval, that he was an 'arrogant prat', after which he remained silent.

Within a week of taking part in the residential course, the College Principal, Tony, who was nearing retirement at Beckford College, invited me to join the staff and teach on the Diploma in Counselling course. Within a year, the programme director Nicky moved to the USA to teach and Tony offered me the post of director of the counselling course. The 'integrative' training provided by Beckford was, unlike the two narrowly-constrained courses in humanism and psychoanalysis I had experienced as a student, not aligned to a singular therapeutic approach; instead my colleagues and I were free to shape the course as we pleased. It was already popular in the local community and with volunteer groups, and attracted a wide range of ages, cultural backgrounds and levels of

education, with females outnumbering males by an average of eight or nine to one. The admissions procedure devised by the course tutors was simple, but unusual for therapy trainings in general. We invited potential applicants to an information evening, and did what we could to put them off applying. We suggested, on the basis of our own experience and observations, that they would almost certainly not find full-time employment in counselling, and that they would be lucky to find employment at all in a field rapidly becoming saturated with therapists. We pointed out that many people had personal as well as relationship breakdowns during the therapist training. This approach usually discouraged enough people to allow self-selection onto the course for the rest of the applicants. There were not many adult students at the college; most of those who had come straight from school were on a range of vocational courses and the staff worked hard to stop them leaving so they could complete their studies, thereby meeting targets for retention and achievement. By contrast the adult therapist trainees were actively engaged participants with high attendance levels, and very few dropped out. Beckford College benefited financially, and by reputation, so we were left to ourselves with minimal interference from management.

Nicky had organised the training into three stages over four years. Each stage could be seen as an end in itself, depending on whether students wanted to work as volunteers or in some form of paid employment. Some took time off to recover from personal difficulties, to go into personal therapy or secure further financial resources to study and work with clients during their counselling placements. In the foundation year, students were introduced to basic listening skills and an eclectic mix of psychoanalytic, psychological and humanistic ideas. Classes were argumentative, noisy, tearful and sometimes tragic. Client-based case studies and students' accounts of their own distressing experiences provided an abundant source of stories in which students could identify and help narrate their own childhoods and current relationships. The second year piled more emotional work on the students. Many were in therapy themselves by this stage and had become self-reflexive and articulate in the use of metaphor, analogy and psychological constructs. An openness to vulnerability and destructive feelings became part of a learning environment where established emotional norms and values were discussed and challenged. Students shared stories about changing or emerging sexualities as well as tales of violence, abuse, self-harm and oppression. My own estimates suggest that around half the students in most cohorts would disclose victim experiences of sexual abuse or violence at some point during training.

Most of the students completing the introductory part of the course would stay for the final two years of training, after a discussion with tutors. A common reason they gave for wanting to

complete this last section was the sense of purpose and meaning the training had given them, that their future life's work would be to listen to the stories of people in some sort of mental distress. Others planned to continue their studies in related areas, the course having given them an entry into higher education, some proceeding straight to post-graduate study. By the final year, many of the students had experienced significant changes to their lives and outlook; these changes contributed to, and reinforced, a sense of freedom expressed in feelings of renewal, hope and purpose. Relationship breakdowns were common, often framed in a narrative of self-discovery and empowerment.

The Beckford Diploma in Counselling and Psychotherapy remained intact and largely unchanged for the eighteen years I worked there until 2006. External appraisals from the BACP were supportive; the college management admired our course (Tony, the College Principal, suggesting it was the 'jewel in our crown'), and there was no shortage of enthusiastic applicants. Following the publication of the Core Curriculum,[16] in anticipation of statutory regulation, courses across Britain, such as Beckford's, fell under scrutiny from the BACP who were acting in response to the government's stated intent to regulate counselling and psychotherapy. There was also pressure from college management for staff to provide evidence that academic knowledge on each subject was within the new 'programme specification' and met criteria for 'consistency' with other non-vocational subjects. The College's management required us to conform to a new modular structure, which could only be achieved by rewriting the course. After much deliberation, the tutors, all practicing therapists, felt unable to support the proposed modifications to the course in good faith. The Beckford College Diploma in Counselling would have to change beyond recognition, so we decided to close the course once all the enrolled students had completed their studies, thus ending nearly two decades of one of Beckford College's most popular courses.

City College

I found a job at City College, near Chelmsford, as head of a department providing counsellor/psychotherapy training within a BA (Hons) programme.[17] My dark-suited new manager, Bill, had a background in 'human resources' and felt he was particularly well-placed to

[16] The writing of the Core Curriculum is the basis of a case study in chapter four.
[17] At the beginning of my teaching career, almost all BAC accredited trainings were provided at FE institutions to NQF levels 4 and 5. By 2010, very few BACP-accredited trainings were not at level 5 or above.

be ‘marketing a therapy training ready for regulation’. Although Bill had no experience of counselling or psychotherapy, he told me in my ‘induction’ meeting that the government's workfare programme, which included mandatory counselling to qualify for unemployment benefits, was a ‘significant income-stream opportunity for the college’. Two of the first tasks he set me were to ‘identify the course’s USP[18] for my new marketing strategy’, and to prepare for my personal development review at the end of my probationary three months. He gave me a ‘self-assessment’ form (see Figure 3.14), which emphasised an economistic, corporately-framed representation of my teaching position, and demanded from me a numerical assessment of such nebulous concepts as ‘A buzz created by modern dynamic approaches’, and ‘Develop and take forward initiatives to create further income streams’.

Figure 3.14 City College Personal Development Review form

PDR SELF ASSESSMENT FORM FOR TEACHING STAFF (ACADEMIC AND BUSINESS SUPPORT)

Next steps: please provide your line manager with a copy of your completed self-assessment form **at least three working days before your PDR.** You and your line manager will discuss your self-assessment and your performance during your PDR meeting.

Using the rating scale 1-4 above, please self-assess your performance against each of the following expectations:

Expectations	**1**	**2**	**3**	**4**
Strive to achieve excellent levels of achievement and performance in teaching and learning				
Contribute to ensuring College data is accurate and used to achieve College targets.				
A vibrant community which enthuses all				
Act responsibily to ensure that budgets are met or bettered				
Actively seek out and apply new ways for saving money				
Develop and take forward initiatives to create alternative income streams				
High levels of demand and a first class reputation				
Involve customers and action their feedback so that our services meet their needs				

[18] Unique Selling Proposition.

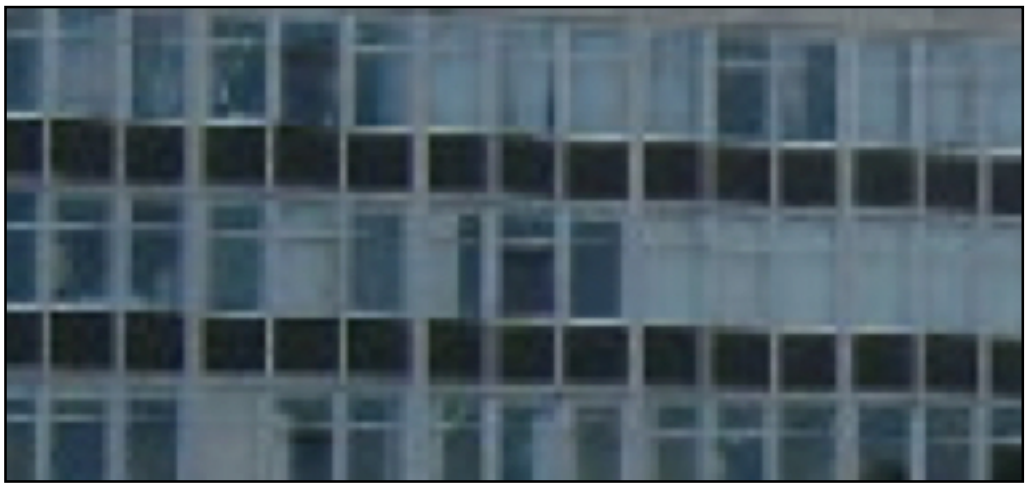
Achieve excellence in all aspects of the student's experience whilst at College				
Actively communicate and celebrate what we do well				
A buzz created by modern dynamic approaches				
Provide students with positive employability skills and attitudes through both your own behaviour and your teaching and learning				
Create a welcoming environment for employers and industry				

Source: City College, Human Resources department

My desk was one of thirty in a noisy and untidy open office in J block, dubbed the 'call centre' by those who worked there. The content of the course was solely within a Rogerian paradigm, and the existing staff, most of whom had been at City College for many years, were antagonistic to other therapeutic perspectives. I was soon disappointed to find that there would be no time or appetite for changes, which one of the tutors, Orla, said might compromise 'the purity' of a Rogerian approach underpinning the 'course rationale'. Outnumbered by therapist trainers who had no training or experience outside the Rogerian paradigm, it appeared that the status quo would prevail, and it also seemed certain that any attempts on my part to add a critique of humanistic universalism[19] to the course would be interpreted as intrusive.

[19] Plummer, K. (2001) *Documents of life 2: An invitation to a critical humanism*, p. 257.

Figure 3.14 The 'call centre' in J block



Source: Personal archive

My workload became overwhelming and difficult to complete; the working day started at eight in the morning and ended in the evening after meetings, only possible once staff had finished their lectures, group facilitation and role-play observation. There seemed to be no time for thinking. My 'line manager' Bill framed the therapy training as 'delivering a programme'; it seemed to me like a ready-meal, lacking thoughtful care, functional and instrumental, and packaged for profit. A significant part of my job was the time spent managing a counselling centre providing in-house therapy placements for trainees, a service to the local community. Most people using the free service were in crisis and had either failed to get access to NHS therapy through IAPT[20] or had found it to be unhelpful. The tragic stories relayed to me by students in supervision sessions added to the administrative burdens that were beginning to wear me down, so after a couple of years I handed in my notice before the damaging effects of the job would become irreversible. As I became more acquainted with the 'call centre' staff, it emerged, on a rough count, that over half of the lecturing staff were taking anti-depressant medication and were thinking about leaving. Four of the counselling tutors had suffered breakdowns, and my predecessor had said he was handing me a 'poisoned chalice'. Although I had thought he was joking, it did seem that I had imbibed enough of a toxic cocktail of human misery, managerial bullying and the misrepresentation of compassion as a formulaic set of competencies, to be measured, assessed and monitored. It seemed

[20] See chapter seven and eight for some ethnographic material narrating strategies deployed by the NHS to ration therapy.

ironic that the therapy trainers were, it appeared, in greater distress than lecturers in other areas of study.

Back in 1996, I had started work on a thesis exploring the beliefs and values held by counsellors and psychotherapists. The end of my marriage and consequent bankruptcy, followed by the death of my supervisor at the time, Ian Craib, led me to take a break from thesis-writing and to make an effort to refocus. I continued to take field notes in a growing number of training and consultancy roles that were offered to me by the BACP and some universities. I wanted to participate in, observe and understand the transformations counselling and psychotherapy were going through during a period of rapid and significant change in the face of external pressures from the state following the 2007 White Paper[21] on the future of health regulation—including the prospect of statutory regulation, the arrival of happiness economics in the form of Improving Access to Psychological Therapy, and the rewriting of therapy discourse as 'competencies', fuelling an expansion of therapist training in higher education. I narrate some of these observations over the next six chapters. These changes have been informed and substantively sustained by a reductionistic, psychological form of instrumental rationality.

[21] Home Secretary and Secretary of State for Health, (2007) *Learning from tragedy, keeping patients safe.*

Chapter 4

The Core Curriculum

> One dark and rainy Autumnal night a woman, walking home from work, noticed a man on his hands and knees searching frantically among fallen leaves under a streetlight. She stopped and asked if he needed help. He replied 'I've lost my keys', and looked up at the woman. She said 'I'll help you look, did you drop them somewhere around here, under the lamp?' The man said 'Oh no, I lost them some way back.' The woman frowned and asked 'So why are you looking here?' The man paused and said 'Because this is where the light is.' (Anon.)

In the winter of 2007, I was asked by Professor Sue Wheeler from the Institute of Lifelong Learning at Leicester University to join a writing group named the Core Curriculum Consortium consisting of therapy trainers working in higher and further education. Initially I declined the offer, but changed my mind when I recognised the research opportunity the invitation represented and said I would be willing to join the group as an involved participant observer. The writing of the core curriculum was commissioned by the BACP: '...with the specific task of developing standards for training and subsequent awards in counselling and psychotherapy [...] it makes recommendations for future standards of training to prepare the profession for negotiations leading up to the statutory regulation of counselling and psychotherapy.'

This chapter outlines BACP's rationale underpinning the publication of the core curriculum, and includes some narration of the writing process and content of the final document, 'Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy'.[1] The chapter also describes social actions leading to the codification and componentising of psychotherapy knowledge, and its reductive impact on counselling and psychotherapy's knowledge base. Sources for this chapter include my own journals and field notes taken during participant observation of group meetings of the consortium, and the core curriculum document itself.

The background to a concern with training standards can be found in a rise in the practice of talking therapy during the 1980s and 1990s, which led to public interest, echoed by journalists critical of

[1] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C.; Hill, A.; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*.

counselling and psychotherapy, about the lack of regulation in the field. Minimal standards set for membership of the British Association for Counselling, as it was then named, were laid bare by the BBC in an exposé, following complaints from viewers. TV presenter Anne Robinson and colleagues on the 'Watchdog' programme set up a scenario which threatened to undermine the legitimacy of the largest organisation representing therapists in Britain, a body whose proclaimed mission was to promote public protection from 'unprofessional' therapists:

> Bernard Manning is unlikely to be the first person to turn to if you have sensitive problems. He was criticised by the Prime Minister last year after he was secretly filmed telling racist jokes at a police charity dinner. He also had to promise to tone down his act after there was an attempt to stop the renewal of the entertainments licence at his Embassy Club in Manchester. To highlight the lack of regulation for counsellors, the BBC programme Watchdog asked Mr Manning to attempt to join the organisation. He listed his occupation as performer and performance counsellor and for specialities he put down sexual matters and racial awareness. He also claimed to hold an imaginary diploma in counselling and sent off the joining fee. A few days later he was welcomed into the organisation, became entitled to vote at general meetings and could be listed in its directories. Central regulation of counsellors has been urged for some time. The BAC is hoping to launch a United Kingdom register later this year.[2]

Following this revelation, two senior BAC staff were interviewed and criticised on a subsequent 'Watchdog' broadcast for their poor judgement, and accused of 'failing to protect the public from unscrupulous therapists'. Their response was apologetic; they said they would look into the matter. A few months later, the BAC, concerned about its reputation, had overhauled its entry standards:

> Tim Bond, the BAC's chairman, said since Mr Manning's application it had 'accelerated the process of change. From now on members' training and qualifications will be subjected to a thorough check. We do not claim that membership of BAC is a qualification. We have a system of accreditation by which some members choose to gain extra status but ordinary members of BAC are forbidden from using membership as a qualification to practice...[3]

In September 2000, the association recognised that it no longer represented just counselling, but also psychotherapy. It changed its name from the British Association for Counselling (BAC) to the British Association for Counselling and Psychotherapy (BACP). By this time, the BACP had

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[2] Cooper, G., (1996) *Manning signs up as race and sex counsellor,* available at http://www.independent.co.uk/news/manning-signs-up-as-race-and-sex-counsellor-1321152.html (accessed 20 January 2017).
[3] Ibid.

refined its entry procedures for new member admissions and had set down a minimum training standard, described in their manual as: '...a two-year part-time training including twenty hours in a supervised placement'.[4] Therapy trainings remained diverse and of variable quality:

> The quality's variable. Some...it depends very much on the tutors. Some are very good, some courses are excellent, and some teaching the same thing are not. And in the private sector, many trainings have gone for university franchises or validations. I'm not sure they'll survive because if they are not paying their way the universities will drop them.[5]

Concerns about legitimacy in the enlarging field of counselling and psychotherapy, and a rising culture of credentialism, put pressure on therapy training courses to be offered at degree level.[6] Towards the end of the 1990s, most counselling and psychotherapy trainings were situated in private or further education settings offering diplomas and certificates in national qualifications such as BTEC.[7] An increasing number of training establishments, both public and private, were validated by universities which were able to charge substantial[8] 'top slice' fees to provide academic credentials for candidates on counselling and psychotherapy training, shifting some of the workload of these universities from teaching into the profitable role of an awarding body. This meant that training courses based in further education (FE) colleges attracted students who could, in England, be charged national undergraduate tuition fees, thus providing additional college funding. Many validating universities therefore gained an income stream from the fees charged to colleges for credentials, keeping vocational therapy trainings at arm's length without having to get involved in the onerous practicalities of vocational work-placements in GP practices, voluntary agencies and college-based counselling services.

The opportunity for students to develop their capacity to help people in various forms of mental distress, through counselling and psychotherapy placements, was a core component of training, mandated by the BACP and a valued asset for FE college managers eager to demonstrate their

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[4] The BACP training manual called the 'Red Book' was replaced, following the Core Curriculum, by the 'Gold Book'. The use of the latter training manual forms part of a case study in chapter nine.
[5] Interview 30.
[6] The source of material in this section was taken from field notes written while working as a counselling and psychotherapy trainer in FE and HE.
[7] Business and Technology Education Council, a vocational qualification offered by the Pearson Group.
[8] 22% of the £12,400 per annum fees charged to students at Therapy Associates (see chapter eight for a case study) was the 'top slice' taken by the validating university.

involvement in the local community as part of a strategic plan to meet 'quality investors-in-people' targets. It fell to the teaching staff to manage the complex, and highly confidential, client documentation to sustain this part of the training, a burden often voiced at BACP's national and regional trainer meetings, where I was a regular delegate.

A further challenge to therapy teaching staff in FE settings was an increase in the administration required to meet the compliance regimes set by both the validating university and the BACP; the former preoccupied with academic standards, and the latter with public protection through compliance with the BACP Ethical Framework. Missed student placement therapy sessions, due to the difficulties clients were experiencing in their lives, and delays finding and documenting new referrals, often resulted in students having insufficient placement hours to complete their course to the satisfaction of the academic boards, resulting in increasing layers of documentation to narrate extenuating circumstances, while, at the same time, protecting the confidentiality of the therapy relationship. FE colleges often had little administrative support for courses beyond what was required for their marketing strategies. The long-awaited prospect of statutory regulation, first proposed in the Foster report,[9] had for some time provided an incentive for tutors to locate therapist training in an academic rather than vocational context, aligned with national qualification frameworks.[10] Although this gave rise to ambivalence amongst some counselling and psychotherapy teaching staff who preferred to keep counselling and psychotherapy training within a vocational remit, to others it seemed a rational and more certain way forward, where they would gain status and secure their future employment. Some of the events which followed in the 2000s, described next, facilitated this shift.

BACP's entry standards, revised after the Bernard Manning episode, had been placed under scrutiny once again following calls for the regulation of counselling and psychotherapy from the Department of Health around the turn of the century, in the shape of Lord Alderdice's Psychotherapy Bill.[11] By 2007 the Labour government set out their intentions to regulate counselling and psychotherapy by means of the Health Professions Council (HPC) in the White Paper 'Trust, Assurance and Safety' introduced in chapter one:

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[9] Following the Foster report: Foster, S. J. G. (1971) *Enquiry Into the Practice and Effects of Scientology:Report*.
[10] QAA (2014) *The Frameworks for Higher Education Qualifications of UK Degree-Awarding Bodies*, available at www.qaa.ac.uk/en/Publications/Documents/qualifications-frameworks.pdf (accessed 20 January 2017).
[11] Department of Health (2001) *Treatment choice in psychological therapies and counselling.*

> 7.2 The Government is planning to introduce statutory regulation for applied psychologists, psychotherapists and counsellors and other psychological therapists [...] because their practice is well established and widespread in the delivery of services, and what they do carries significant risk to patients and the public if poorly done.
>
> 7.16 Psychologists, psychotherapists and counsellors will be regulated by the Health Professions Council following that Council's rigorous process of assessing their regulatory needs and ensuring that its system is capable of accommodating them. This will be the first priority for future regulation.[12]

The White Paper did not elaborate on what it meant by psychological therapy's 'significant risk to patients if poorly done', nor offer any evidence in support of the claim. The basis for regulation by the HPC is through the linkage of 'competencies to roles',[13] which should: '...be a discrete and homogeneous area of activity, encompass a defined area of knowledge, have defined routes of entry into the profession, and carry out evidence-based practice'.[14] The BACP and the United Kingdom Council of Psychotherapists (UKCP) represented the majority of talking therapists outside Clinical Psychology in Britain.[15]

> The move towards regulation has compelled BACP to make decisions about the future *standards for practice* that can be put forward in negotiations with the Health Professions Council and inevitably for training in counselling and psychotherapy. The Health Professions Council will regulate the profession using a discrete title for registered practitioners. Only registered practitioners will be legally entitled to use that title.[16] [My emphasis.]

The larger of the two organisations, the BACP, had taken the initiative and set out academic and occupational standards for training: 'In late 2006, a report on the Core Competencies for

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[12] Department of Health (2007) *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century.*

[13] The term *competency* (plural *competencies*) is attributed to David McClelland, indicating personal characteristics utilisable in the workplace. See Mcclelland, D. C. (1973), Testing for competence rather than for 'intelligence', *American psychologist,* 28, 1. The terms *competence* and *competency* are sometimes used interchangeably by therapy trainers (see chapter nine), in counselling and psychotherapy literature, as though they are synonyms,.

[14] Department of Health, Department of Health (2007) *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century.* 7.11.

[15] BACP has 42,390 members, UKCP has 7,800 and falling at the time of writing. Source: BACP research department (personal correspondence March 2015).

[16] Dunnett, A. C.; Wheeler, S; Balamoutsou, M.; Wilson, C.; Hill, A; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 6.

Counselling and Psychotherapy had already been commissioned by the BACP, recommending that the standard for training of counselling and psychotherapy should be at a minimum of an Honours Degree.'[18] The prospect of statutory regulation accelerated the shift of the BACP's resources and attention towards the establishment of a more refined conception of therapeutic praxis. A process of epistemological narrowing, under the sway of academic and professionalising influences, had already begun, laying down the groundwork for the introduction of the concept of a 'core curriculum'.

With the HPC's requirements set out, the Core Curriculum Consortium had their first meeting in April 2007 with the task of creating a document bringing existing 'Core Competencies' together within prevailing academic and occupational frameworks to reach '...the best possible consensus from a wide range of different perspectives and opinions so as to resource the professional association in its future negotiations'.[19] The group of four women and five men, including myself, who comprised the Core Curriculum Consortium, met in a teaching room at the University of Leicester. Most of the group had senior lecturer positions in counselling and psychotherapy trainings; some were well known amongst the counselling and psychotherapy community through the course textbooks they had written or contributed to. With only a few months before the proposed publication date of the core curriculum, our task was limited to the writing of a rationale, and adapting the 'generic core competencies' into a document designed to strengthen the BACP's position, and their representation of counselling and psychotherapy, in negotiations over statutory regulation with the HPC. Engaging with the writing task suggested tacit acceptance by the group that a curriculum could be described unproblematically as 'core' to the praxis of counselling and psychotherapy. Accepting the term 'core' privileges a singular conception of counselling over more discursive and pluralistic representations through a diversity of approaches. One of the first difficulties the group encountered was the extent of compromise each subject specialist had to submit to in order to find common ground in 'generic competencies', a concept some members of the group called into question. During a coffee break a humanistically-oriented psychotherapist commented on therapy 'tribalisms':

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[18] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C; Hill, A.; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 5.
[19] Ibid., p. 4.

> I know we've got to get past our tribalisms in this brave new world, but we're throwing the baby out with the bathwater. What happens in a therapy session is hard enough to say in our own jargon. This generic language seems very corporate to me, and I don't think it's got much chance of doing justice to what happens in therapy. Perhaps tribalism is the lesser evil.[20]

This therapist seemed to suggest that multi-causal effects taking place in the therapeutic relationship, alluded to in modality-specific language, are reduced, by the use of a singular 'generic' level of analysis, to an 'outcome' or a 'specified level of proficiency'. This reductive approach could have the effect of eliminating co-determinants from a representation of therapy, such as paralinguistic features of speech, which may have an important impact on the therapy relationship. The codification of therapy knowledge has an impact on these features as well as other co-determinants, such as the toleration, and normalisation, of uncertainty. The reification of concepts such as 'level of proficiency' is the theme of a case study on a specific therapy technique, Counselling for Depression, in chapter seven.

Before the prospect of statutory regulation came more sharply into view, the BACP, in their guidance to trainers,[21] had represented therapist training as the development of a set of practical skills, using role-play, and assessed by course tutors from recordings of therapy sessions in approved placements. Tutors assessing this work had recognised that trainee therapists' efforts to engage with their clients was experimental and formative, so feedback was generally constructive and open-ended. Tacit human capacities such as not-knowing,[23] tolerating uncertainty, tentativeness and genuineness[24] are frequently referred to in counselling and psychotherapy literature as essential constituents of an ability to help facilitate a safe space for feeling, thinking and self-expression. These capacities are recognisable by trainers inferentially in students' work through supervision and case discussion.

Therapy course leaders, in conjunction with the validating universities, found that the introduction of academic levels demanded a different assessment 'strategy', emphasising the summative, formal and final, and establishing a more positivistic approach to assessment. This emphasis, in turn, suggested that therapy should be measurable in terms of 'outcomes', with the effect that

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[20] From notes taken during participant observation of the writing of the Core Curriculum.
[21] The 'Red Book', superseded by the 'Gold Book': BACP (2009) *Accreditation of training courses*.
[23] Bollas, C. (1987) *The shadow of the object: Psychoanalysis of unknown thought*.
[24] Rogers, C. (1961) *On becoming a person: A therapist's view of psychotherapy*.

tutors recognising students' future potential to develop therapeutic capacities (emerging in the light of more experience of working with clients) could no longer submit this inference as an observation, or as evidence of a nascent ability to work with distressed people in a helpful way. Summative assessment led to a more literal and concrete interpretation of trainee 'progress' through predefined criteria, with little room for discretion. Mindful of the requirements of the Health Professions Council, the writers of the Core Curriculum framed the concept of 'proficiency' with an emphasis on 'evidence of effectiveness':

> The Health Professions Council has specific requirements that regulated professions must fulfil. It sets standards for inclusion which include standards of proficiency for safe and *effective* practice, standards of conduct, performance and ethics, standards of 'good health' for the health professional, standards of education and training and standards for continuing professional development. Criteria for regulation include a professional group that covers a *discrete* area of activity applying a defined body of knowledge. Practice should be based on evidence of efficacy and effectiveness. There should be *defined routes* of entry to the profession, independently assessed entry qualifications and standards in relation to conduct, performance and ethics.[25] [My emphasis.]

The prescriptive language of 'discrete' and 'defined' suggests an emphasis on specificity, counteracting plurality and diversity. The importance of 'defined routes of entry'[26] contributes to the consolidation of the HPC's authority as occupational gatekeeper; 'independently assessed' qualifications and training helped secure their governmental, regulatory, role. A demand for 'effective' practice militates against those tacit dimensions of therapy praxis lying beyond the scope of the measurement of effectiveness.[27] The maintenance of uniformity and compliance through emotion measurement to provide consistency in training schemes is the basis for a case study narrated in chapter eight, 'Monitoring Adherence'.

Members of the group collaborated by phone and email, as well as meeting several times over a four-month period, and, with a deadline looming, worked within four 'key domains of knowledge':

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[25] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C.; Hill, A.; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 5.
[26] A 'defined route of entry' is discussed in chapter five, 'The Competent Practitioner'.
[27] See chapter nine, 'The Gold Book'.

> The key domains of knowledge, skill and application for counselling and psychotherapy practice identified in the generic core competencies document (Wheeler *et al*, 2006) are used to determine the core curriculum. These domains are:
>
> *A* *The professional role and responsibility of the therapist*
>
> *B* *Understanding the client*
>
> *C* *The therapeutic process*
>
> *D* *The social, professional and organisational context for therapy*
>
> The core curriculum is described here in terms of learning outcomes, incorporating knowledge and performance criteria that are summary statements for the elements identified in the generic core competencies. They are organised using the four domains listed above.[28]

This presents a four-sided conception of therapy praxis where interdependent and contextual constructs, such as process, understanding and responsibility, are codified into components of knowledge with the simplifying elegance of 'domains' A, B, C and D.

The task, to generate learning outcomes which could fall within the HPC's definition of a 'discrete area of activity applying a defined body of knowledge' and 'be based on evidence of efficacy and effectiveness', drawing on an extensive range of empirical material supporting the 'competency model',[29] was accepted without question by members of the group, who did not express any doubts they might have about the validity of the project.

The group framed 'learning outcomes' gathered together under the four domains A–D into a modality-free language, avoiding reference to psychoanalytic, CBT or humanistic jargon. For example, 'learning outcomes' under 'domain A' require that the practitioner:

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[28] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C; Hill, A.; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 13.

[29] Castonguay, L. G. & Beutler, L. E. (2006) *Principles of therapeutic change that work*; Roth, A. & Pilling, S. (2007) *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders.*

> Show a commitment to personal and professional development including self-awareness and an awareness of fitness to practice in relation to clients.
>
> Reflect on personal development including ways in which life experiences affect self and relationships with peers, clients and other professionals.[30]

The task of the writers, as specified by the BACP, did not include detail on how the 'learning outcomes' would be assessed; this would be left to individual course leaders. BACP's prime objective was the creation of a document to use in negotiations with the HPC about the future of counselling and psychotherapy under statutory regulation. The document was published in October 2007. Having taken a leading role in negotiating proposed regulatory frameworks through the HPC's Professional Liaison Group, the BACP separated from the latter and established a voluntary register for members who had either completed an approved training, or, for those who had already been trained, could pass an online proficiency test. The development of a national counselling and psychotherapy online exam is the basis of a case study narrated in the next chapter.

In 2013, the BACP Register of Counsellors and Psychotherapists became the first psychological therapists' register to be accredited under a scheme set up by the Department of Health and administered by an independent body[31] accountable to Parliament. The creation of the core curriculum appeared to signal a paradigmatic departure from traditional therapeutic pluralism, woven from the diverse threads of historic therapy traditions, towards a common, 'generic' language. Criticisms voiced during the writing of the core curriculum were grounded in a modality allegiance, with advocates of discrete approaches struggling to keep hold of their familiar language, and the habitus it signified. A psychodynamic counsellor who wanted to include the concept of transference in the core curriculum asked:

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[30] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C.; Hill, A.; Randall, S.; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 14.

[31] The Professional Standards Authority, promoting 'Right-touch' regulation with a problem-oriented focus on risk and outcome: http://www.professionalstandards.org.uk/ (accessed September 2015).

> Isn't the concept of transference part of popular culture now? It was featured in 'The Sopranos'. If we collapse the whole of therapy into this tortured language we'll lose the treasure it holds, the passion, the misrecognitions, the bewilderment.[32]

Critical voices were eventually subdued by the scale of the task, an agenda which was non-negotiable, and a rapidly approaching deadline.

The standardised knowledge on which the core curriculum is based has had a significant impact on the training of counsellors, implemented through the means of the BACP's revised training manual, 'The Gold Book'.[33] In 2013 the BACP, in collaboration with the Quality Assurance Agency (QAA), produced 'Benchmark Standards for Counselling and Psychotherapy',[34] largely based on the core curriculum, for use in higher education settings.

In an effort to capture as much of the therapy encounter as could be reduced to a set of objectives, the core curriculum consortium eventually produced sixty-eight 'learning outcomes'. These outcomes were framed within normative psychological jargon, emphasising a reductive conception of human distress, described, for example, as 'signs and symptoms associated with mental distress', or 'the application of a comprehensive, in-depth and research-informed body of knowledge in their practice'.[35] The language of the core curriculum reinforced a narrative of individualism, reducing the social to the individual, emphasising 'therapeutic goals' and 'client autonomy'—for example: 'Take account of the client's capacity for self-determination and ability to reflect on his/her psychological functioning';[36] attributing clients' fate to their own responsibility; and promoting an obligation to engage with scientistic concepts, such as 'psychological functioning'. The apparent inevitability and scale of the task before the writing group seemed to have diminished space for criticism. The hoped-for precision and validity in which 'learning outcomes' were intended to be framed ended up as vague and generalising, catch-all statements without meaning, contradictory in their own terms.

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[32] From notes taken during participant observation of the writing of the Core Curriculum.
[33] BACP (2009) *Accreditation of training courses,* a case study on the use of the 'Gold Book' is narrated in chapter nine.
[34] QAA (2013) *Subject benchmark statement: Counselling and Psychotherapy*.
[35] Dunnett, A. C.; Wheeler, S.; Balamoutsou, M.; Wilson, C; Hill, A.; Randall, S.; Pugh, V.; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*, p. 17.
[36] Ibid., p. 31.

Before the regulation of counselling and psychotherapy became a probability, therapy training had largely been represented as constituent-oriented, a good thing in and of itself, intended to facilitate and refine human qualities which can help a therapist be with another person in distress in a meaningful and compassionate way, led by the client, with no particular outcome in mind beyond the solace of self-expression. Writing for The Guardian in a critique of the commodification of counselling and psychotherapy, Darian Leader argues:

> In today's outcome-obsessed society, people must become countable, quantifiable, transparent. And this leads to a grotesque new misunderstanding of psychotherapy. Therapy is now conceived as a set of techniques that can be applied to a human being. This makes sense if we see it as a business transaction with a buyer, a seller and a product. But it totally ignores the most basic fact: that therapy is not like a plaster that can be applied to a wound, but is a property of a human relationship. Therapy is about the encounter of two people, and the real work is done not by the therapist but by the patient. As the psychoanalyst Donald Winnicott observed, the therapist provides a space in which the patient can construct and create something.[37]

The representation and commodification of therapy praxis as a series of 'outcome' and 'competency' statements imply that a recombination of these statements would bring to life the complexities of the original therapeutic relationship. Such reductions '...involve misattributions of causality and misinterpretations of the meaning of discourses'.[38] The creation of a 'core curriculum' appears as a key moment in a period of significant change in the field of counselling and psychotherapy in Britain, transforming therapy institutions and the people within them. I asked Matt, a therapist from Bolton, how recent changes had affected him. He put it this way:

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[37] Leader, D., (2008) *A quick fix for the soul*, available at www.theguardian.com/science/2008/sep/09/psychology.humanbehaviour (accessed 20 January 2017).

[38] Lee, R. E. & Wallerstein, I. (2010) *Questioning Nineteenth-Century Assumptions about Knowledge, II,* p. 6.

> I have had to become much more kind of orthodox. I used to say more or less whatever I thought would help, even if it was difficult for my client to hear. Now I feel I'm editing myself as I speak, thinking is this okay to say; is it too wild, might I be accused of something; could I get into trouble? Clients have access to therapy performance criteria; sometimes they construct a basis for complaint outside the therapy relationship, just look at the professional conduct pages in the BACP magazine; the complaints are aired before guilt is established. One complaint and your job is over; I know two people who lost their job in an IAPT service because of unfounded complaints. One of the complainers said that she wasn't happy after therapy: she thought her therapy was supposed to cure her of unhappiness. Everyone seems so scared these days. You've got to CYB, cover your back. Taking risks used to be seen as the cutting edge of therapy, where you could mention the unmentionable. Now we have to play safe; keep to a script. So, what does that make me now, some kind of clone, an enforcer of the status quo?[39]

Matt seemed to have lost some of his former sense of identity as a therapist, taking a defensive approach to his work with distressed people, and fearful of a 'Professional Conduct Hearing' and the consequent loss of his job.

[39] Interview 43.

Chapter 5

The Competent Practitioner

> 'The train is leaving the station and you need to decide whether or not you want to be left behind.'
>
> *Anthony Bateman,[1] chairing a meeting for Skills for Health developing National Occupational Standards for Psychological Therapies, London, April 2007.*

In the early summer of 2007, Gary Leatherman, who worked for Optimum, an awarding body specialising in health education, asked me to join him working on a new project related to the expected statutory regulation of counsellors and psychotherapists. Gary was aware of my research interests concerning changes taking place in the field of counselling and psychotherapy; we had met several times over a period while I was working on a panel, as a subject specialist, developing National Occupational Standards for counselling and psychotherapy. He had just completed his PhD on counselling in the workplace, was supportive of the idea of me as a participant observer and said he would appreciate any contributions I could make to the project. Gary had a background in social work and 'human resources' management, and although he had completed some basic counsellor training he was not an experienced therapist but a manager in whom the Optimum board of directors, Gary told me, had placed their hopes for the success of this large contract.

I arrived at the Hotel Royale in York, a worn-looking sandstone building, checked in, and found several people I knew from various counselling and psychotherapy meetings and conferences. The group assembled for a drinks reception near the hotel bar. Half-an-hour later, Gary tapped his glass, waited for the chatter to fade, and thanked everyone for arriving. He said that the reasons for our invitation would be revealed the next morning, and that, for tonight, we should just enjoy ourselves. A long and lavish dinner with some speculative conversations followed.

After breakfast the following day, the group of two men and six women (a proportionate representative of BACP members' gender ratios)[2] gathered in a poorly-lit, Victorian-themed conference room with a musty beer smell. The walls were covered with flock dark crimson and

[1] Anthony Bateman, consultant psychiatrist and psychotherapist at University College London.
[2] 16.06% male, 83.94% female; figures from 2015 provided by BACP membership department (personal correspondence, November 2015).

black patterned wallpaper. Gary asked us to introduce ourselves, making sure we included our therapy orientation and place of work. All of the group had worked as therapists for at least fifteen years and had experience teaching counselling and psychotherapy in universities or colleges. Two grey-haired women from north London, sitting close together and who identified themselves as 'psychoanalytic psychotherapists', were also members of the United Kingdom Council for Psychotherapy;[3] Rachel described herself as 'Kleinian', and said she liked working with 'borderline patients'. Amélie said she was 'mostly Jungian, but Kleinian when needed'. Rosa, an 'integrative' therapist from Edinburgh, who started her therapy career while working as a model in Ventura California in the early 1970s, had entertained the group the night before with tales of hedonistic encounter groups, primal therapy,[4] and her eventual split from the Human Potential Movement[5] following the breakdown of a relationship with one of the group's leaders. The only other male apart from myself was Freddy, a long-haired Gestalt therapist from Northern Ireland who had worked as a documentary filmmaker before a sequence of alcoholism, recovery and retraining had ignited a career change. A couple, Joan and Jean, described themselves as 'pure person-centred' and had travelled by train from Peckham in London. Joan and Jean wore similar bright clothing, bright heavy makeup and gold jewellery. They shared a career trajectory which had begun in the Probation Service, moving on to youth work before training as therapists. During the introduction, Joan announced that she and Jean were 'co-counselling and co-supervising' each other on an ongoing basis. The group appeared to be close to the average age, around fifty years,[6] of British therapists.

Gary told us that we had been chosen to help take the 'profession of counselling and psychotherapy through a critical stage'. He said: 'As a group of therapists you represent the geographical length and breadth of the UK, and a wide, representative, range of therapy orientations.' The reason for our gathering, Gary continued, lay in the inevitability of statutory regulation, and the fact that most UK therapists would not be eligible for inclusion on a future register of therapists, as the BACP and UKCP membership entry standards did not meet 'the Health Profession Council's minimum

[3] The UKCP is the second largest organisation, after the BACP, representing psychotherapists with 7,800 members: UKCP website, retrieved from: http://www.psychotherapy.org.uk/about-us (accessed 11 November 2015).
[4] A trauma-based therapy, attributed to Arthur Janov following the publication of his *The primal scream: Primal therapy: The cure for neurosis* (1970).
[5] This was a countercultural movement that began in the 1960s and was substantively based on Maslow's concept of 'self-actualisation', and is key to Rogers' Person-Centred approach.
[6] BACP Membership Department (personal correspondence November 2015).

entry standard of an honours degree'. Gary outlined an exception, agreed between the HPC and the BACP, during Professional Liaison Group[7] meetings where 'accredited' BACP members,[8] many of whom had trained before therapist qualification was aligned with academic qualifications, could bypass HPC's proposed graduate entry criterion and be 'co-opted by the BACP onto the expected national register'. 'Accredited' status was not linked to academic level, and was promoted by the BACP as:

> [...] a quality standard for the mature, experienced practitioner who wishes to demonstrate their knowledge, experience and understanding of what they do and why, and there is no better way than to become BACP-accredited. BACP is the largest professional body representing counselling and psychotherapy in the UK, and its accreditation standard is arguably the most widely recognised.[9]

'Unfortunately', Gary pointed out, 'the accredited category of membership has limited appeal to the majority of members who are voluntary or part-time and don't meet the minimum accreditation eligibility criterion of 450 hours' supervised practice.' Freddy agreed, saying that many of his trainee students were put off the accreditation scheme by the 'difficulties of narrating their therapy practice within a lengthy paper-based application process, requiring case studies and criterion-based justifications for interventions to be framed within a narrowly-defined therapeutic approach'.

The BACP application form for accreditation asks candidates to: 'Describe a rationale for your client work with reference to the theory/theories that inform all your practice.'[10] The standardising methodology of the accreditation scheme, and scarcity of subject-specialist assessors in marginal therapy orientations, has diminished therapy pluralism by privileging codified iterations of 'mainstream' approaches,[11] such as Psychodynamic Psychotherapy, Rogerian Person-Centred Counselling or CBT. Therapeutic practice grounded in less conservative therapeutic approaches—

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[7] The Professional Liaison Group comprised a 'working group of stakeholders' with an interest in proposed statutory regulation including representatives from the BACP and the UKCP.
[8] Of 42,390 members, 10,802 are 'Accredited'. Figures from 2015, (personal correspondence from BACP research department).
[9] BACP Accreditation - Individual Counsellor/Psychotherapist Accreditation, available at http://www.bacp.co.uk/accreditation/Counsellor%20&%20%20Psychotherapist%20Accreditation%20Scheme/ (accessed November 2015).
[10] BACP Accreditation application form, available at http://www.bacp.co.uk/accreditation/Counsellor%20&%20%20Psychotherapist%20Accreditation%20Scheme/ (accessed November 2015).
[11] Clarkson, P. & Pokorny, M. (2013) *The Handbook of Psychotherapy*.

for example, critical psychotherapy[12] or Lacanianism— would be unlikely, with an inclination towards hermeneutics or post-structuralism, to find much representation within the outcome-oriented 'accreditation criteria'. Furthermore, since these therapeutic perspectives comprise a critique of some of the underpinning assumptions perpetuated by prevailing therapeutic modalities practiced in Britain, they were regarded as 'subversive' by at least one assessor,[13] since they problematise modality-specific concepts such as 'self-esteem', 'self-actualisation', 'personal autonomy' or 'projection'. One impact of the 'Accreditation Scheme' was therefore to marginalise critical voices within the counselling and psychotherapy community, and help normalise codified extant representations of humanism, psychoanalysis and behaviourism within a narrative of 'competencies'.

Gary continued by explaining that although a minority of therapists accredited by the BACP or UKCP would be included in the proposed statutory register of counsellors and psychotherapists, the majority did not have the minimum entry requirements specified by the Health Professions Council. These therapists could be made jobless as a 'direct consequence of upcoming regulation'. Aiming to protect workers' rights, and 'avoid possible litigation under Human Rights legislation', Optimum proposed a scheme, endorsed by the HPC, allowing therapists to demonstrate 'competence' and gain entry to the proposed National Register of Counsellors and Psychotherapists on a 'grandparenting' route via a 'Competent Practitioner Licence' (CPL) for a limited period. The 'grandparenting' scheme is described by the HPC as:

> A 'transitional' period of registration is necessary when introducing statutory regulation. This might be introducing regulation of a profession for the first time or alternatively moving from a voluntary model to a model of compulsory registration. During the transitional period, individuals not eligible to be members of the voluntary or state register can apply for registration. The period is temporary and time limited. After this period only those who hold a qualification approved by the regulator can be registered.[14]

'One final point before we have a break', Gary continued, 'is the fact that the Health Professions Council have advised the Professional Liaison Group (PLG) that there is only one place around

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[12] Loewenthal, D. (2015) *Critical psychotherapy, psychoanalysis and counselling: Implications for practice*.
[13] Field notes, taken from a conversation with a 'BACP Accreditation Assessor'.
[14] Health Professions Council (2003) *A Review of the grandparenting process,* p. 8, available at www.hpc uk.org/assets/documents/10001d39grandparenting_report_cfw.pdf (accessed 2 January 2015).

the table for counsellors and psychotherapists.' Although the BACP had endorsed the generic term 'counsellor/psychotherapist' to be used without giving prominence to one or other of the two historic titles, UKCP delegates on the liaison group were unwilling to share a professional identity with counsellors. Gary said that one of the UKCP representatives suggested, in a phone call after a PLG meeting in October 2010, that it was 'unthinkable that we should be lumped together with counsellors, we have done far more training, we work with severe mental illness, and we have had long periods of our own therapy'. The minutes of the next PLG meeting suggested that title differentiation was, for a limited period, promoted as a possibility:

> 1.6 Registrants would have access to the protected title(s) for psychotherapists, or the title(s) for counsellors, or both if they were registered more than once.
>
> The threshold educational level has to be set at the level necessary to achieve the standards of proficiency. As there would be two separate sets of standards of proficiency, this would mean that the level could potentially be set at different levels for psychotherapists and for counsellors.[15]

BACP's position on distinctions between the practice of counselling and psychotherapy is summarised in the 'core curriculum':

> Despite numerous attempts by organisations and individuals to clearly distinguish between the knowledge base, skills, responsibilities and activities associated with counselling and psychotherapy, there is no reliable evidence that indicates any significant difference. It is clear that the descriptive title given to professional psychological therapists depends largely on the core theoretical model they adhere to, the setting in which they practice and to some extent on the training they have received. [...] It has not been possible to find any statement that makes a clear evidence-based distinction between counselling and psychotherapy.[16]

The distinction has been recognised in a 2010 study of Public perceptions of professional titles used within psychological services: 'Although the titles "counsellor" and "psychotherapist" are readily distinguishable lexically, the functional distinctions provided by professionals practicing under each title are a matter of ongoing debate in the field.'[17] The position of counsellors' and

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[15] Professional Liaison Group minutes, 19th October 2010, p. 2, (personal correspondence January 2015).

[16] Dunnett, A. C., M; Wheeler, S; Balamoutsou; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy,* pp. 6-9.

[17] Kanellakis, P. & D'Aubyn, J. (2010) Public perception of the professional titles used within psychological services. *Counselling and Psychotherapy Research,* 10 (4), p. 258.

psychotherapists' professional titles seemed uncertain at this point. This debate has continued during negotiations over regulation in the context of professionalising strategies,[18] aligning symptom severity to professional expertise.

Gary told us that he would spend the remainder of the day describing the creation of the 'Competent Practitioner Licence' (CPL), and the group's proposed role in developing it. He explained that the exam was based on a 'task-oriented job analysis of what therapists actually do'. He described his recent trip to Virginia in the US to study the 'job analysis process' at the Centre for Corporate Education in Richmond and 'adapt it for therapy and bring it to the UK'. Gary summarised the process in a handout:

> The job analysis process initially involved convening a group of practitioners, representing a range of theoretical perspectives, to share ideas on the knowledge, skills and abilities involved in their therapeutic work. These group ideas were then collated and used to form the basis of a questionnaire which was to be available to a large sample of therapists.[19]

The exam, Gary explained, was a departure from traditional therapist training 'assessment strategies', such as the observation of role-plays, essays and case studies. These had been aimed at immersing trainees within the epistemological framework of a discrete therapeutic modality. The CPL was designed to ensure candidates were working in a 'competent and ethical manner', which would make the testing of modality-specific competence 'obsolete'. Therapists volunteering to take part in the original job analysis were 'required' by Optimum to narrate their therapy practice within the 'job analysis specification' and asked to 'profile' their clients, 'identifying presenting problems and underlying issues'. Gary said that some therapists participating in the job analysis process, who were unable to frame their responses within the categories provided, were 'deselected'. Freddy told the group that he had taken part in the job analysis process, saying that he had objected to having to 'reframe my therapy practice within this objectifying language', and said that the idea of 'profiling' the people in distress he worked with 'seemed to be in conflict with my humanistic values'. Gary reiterated his claim that the use of a 'common psychological language' was essential to the 'workability' of the scheme, which needed to 'be agnostic to specific therapeutic modalities'. The job analysis process elicited a long list of responses to a wide range

[18] For example, theoretically-based discretionary specialisation; see Freidson, E. (1999) Theory of professionalism: Method and substance. *International review of sociology,* 9, 117–129, p. 119.
[19] Optimum (2007) *An introduction to case-study based examination.* p. 1.

of clients' 'presenting issues' in a language that did not rely on specialised knowledge of any discrete theoretical orientation. These responses were entered onto a database by Gary's colleagues using software coded by the Centre for Corporate Education. The 'output', as Gary put it, was a list of core behaviours and responses, or 'therapist interventions', on which to base an examination. Gary seemed convinced that the totality of a conversation aimed at understanding and helping a distressed person could be reformulated as a checklist of 'interventions', rendering a therapist's idiosyncratic knowledge redundant.

The process of job analysis was intended, Gary said, to capture and summarise a representative range of therapists' behaviours, which are then used to create a database of 'generic competencies'. With reifying circularity, these 'competencies' are aligned to the job descriptions they emerged from as a 'rationale'. This is claimed to provide 'credibility in the profession':

> The case study exam is based on the findings of the job analysis process and is written by practitioners from the field of counselling/psychotherapy and should therefore have credibility within the profession.[20]

The nouns 'competencies' and 'metacompetencies' are modified in the CPL exam-writing guidance notes by adjectives such as 'adequate' or 'appropriate', without further elaboration and leaving the reader free to apply their own subjective judgement to vague and sometimes arbitrary descriptions of 'knowledge and understanding', thus undermining Gary's claims to credibility:

> Demonstration of an *adequate* level of knowledge and understanding of mental health problems. As evidenced by: a knowledge of the *appropriateness* of referrals to health professionals; an understanding of the different types of prescribed medications and their likely impact; an ability to recognise signs of common mental health problems.[21] [My emphasis.]

Rachel said: 'This makes assessment of a candidate's exam responses subjective to the point of an opinion, which is what the exam's so-called objectivity is supposed to eliminate.' Gary responded, explaining that the exam-writing group would seek a consensus over what responses were adequate or appropriate while writing the exam. This consensus, he said, 'would ensure candidates were meeting professional standards that experienced practitioners like yourselves all agree on—that is what makes them valid'. Gary's flattery did not dislodge the misgivings of Rosa, who

[20] 'An introduction to case study-based examination.' Optimum handout provided by Gary.
[21] Competent Practitioner Licence, guide notes for exam-writers.

interjected loudly with: 'Well actually it takes more than a small consensus to demonstrate validity, the exam could be reliably invalid.' After the laughter subsided, Gary began to explain the task ahead.

He said he hoped we would agree to write case studies, 'initially in groups on working weekends in Bath or London and eventually on our own'. The case studies would then be used to create 'mock-ups' of competent therapy practice. Gary continued: 'As it's likely most members will have to take the exam to keep working, a lot of case studies will be needed so the content doesn't get around and put the validity of the exam in question.' Our task, he said, was to create 'realistic' case study narratives, a journey beginning with an imaginary person in distress meeting an imaginary therapist and usually ending in a 'resolution of the case', where the clients' 'presenting issues are resolved'. By following the story and placing themselves in the role of the imaginary therapist, candidates could make 'decisions' which were either 'competent or not competent', reducing the complexity of a therapy encounter to a binary level.

Gary described the structure of each 'mock-up'. The first page would include an introductory paragraph, with a short 'biography of the client' and their 'presenting issue'. Following this would be an outline of the role and context of the therapist in whose shoes the examinee would metaphorically be standing; for example: 'within a GP practice', 'at an HIV support centre' or 'in a Rape Crisis refuge'. The introductory 'Stem' section would provide details of the number of sessions available as well as other 'contract setting' information the therapist might need, emphasising a corporate representation of the therapy encounter. Interrupting Gary, Joan asked: 'Why is the therapeutic orientation of the therapist not included in the stem?' She then reminded the group how vital 'adherence to an approach' was to the BACP accreditation scheme[22] in particular and the 'beliefs and values of therapists' in general.

Joan seemed to have identified a contradiction between BACP's highest credential, 'Accreditation', which is rooted in a singular modality, and the 'generic standards of proficiency' base underpinning the new exam. This seemed to signal a shift in the theoretical core of counselling or psychotherapy, as represented by the BACP and the UKCP, away from a modality-based epistemology towards a more generic, standardised conception of therapist expertise and

[22] The BACP Accreditation scheme requires a candidate to demonstrate specialist knowledge of a clearly defined 'mainstream' therapeutic approach.

rule-bound practice framed as 'competent'. Gary responded to Joan by explaining that although 'core theoretical models remained important to many therapists', a 'strategic shift' in policy meant that the 'leading psychotherapists' were now promoting 'a core generic curriculum applicable across all therapeutic modalities'. The new strategy is revealed in the core curriculum:

> This strategy concurs with much of counselling and psychotherapy outcome research which consistently suggests that change in therapy tends to be related to generic factors (such as the therapeutic relationship and clients' levels of motivation) rather than orientation-specific interventions, and that when different therapies are tested against each other with specific populations, outcomes are not significantly different. National Occupational Standards (NOS) for counselling describe generic competencies, and hence it seems prudent for BACP to proceed towards regulation holding together the common features of practice that all members can aspire to.[23]

Gary elaborated on this development—which was, in effect, a reductive change bringing therapeutic pluralism within the narrower confines of 'occupational standards' and 'generic competencies'— telling the group that 'it was the only way forward'. Gary said that the significance of theoretical orientation would 'become increasingly irrelevant in a therapy culture dominated by evidence-based treatment'. He argued that the best way to avoid the possibility of psychotherapy becoming obsolete was to embrace these 'progressive reforms'. Freddy suggested that we seemed to have embarked on 'a damage limitation exercise'. Gary made no comment on this; he continued by presenting a PowerPoint slide of the Optimum handbook:

> Generic competences are behaviours that are common to all psychological therapies, for example the creation of a trusting, collaborative relationship, an ability to deal with the emotional content of sessions, or an ability to end sessions. Generic competences can be observed and rated through audio or video recordings of sessions with clients. Metacompetences are more abstract and hard to observe directly, for example the capacity to use clinical judgement when implementing treatment models, or *the capacity to use and respond to humour*.[24] [My emphasis.]

Gary said that 'generic competences are not modality-specific', and reiterated his earlier point that the aim of the case study exam was to test 'evidence-based generic competences and metacompetences'. He said that language used in the exam should make no reference to modality-

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[23] Dunnett, A. C; Wheeler, S; Balamoutsou M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy,* p. 11.
[24] Optimum, (2007) *An introduction to case study based examination,* p. 2.

specific language, 'such as defences, congruence, negative thoughts, projection, transference, etc.'. Gary continued by remarking on the relative success of psychologists in promoting their 'leading brand, CBT', attributable to a prevailing culture 'in the NHS of evidenced-based practice, supported by randomised controlled trials'. The suggestion, that all therapy research should be conducted within this paradigm, has been described by one critic as unwarranted and '...a form of scientific hegemony, and an epistemologically naïve and unsustainable position'.[25] The handout page[26] Gary had just spoken to, describing the capture of 'the capacity to use and respond to humour', within a 'metacompetence', seems naïve and unsustainable, suggesting that the complexity of humour and the difficulties of making a judgement within the context of a person's distress can be reduced to a 'metacompetence statement'.

Gary continued, explaining that each case study would be divided into a series of sections to a maximum of ten. There are three types of section: the first section required the therapist to obtain some background to the client's 'presenting problem', which involved asking direct questions, a practice inimical to a literal interpretation of Rogerian therapy. Jean's face reddened as she raised her voice: 'You can't ask questions if you are person-centred; that's the therapist's agenda.' Gary suggested a break during which, in an aside to me, he said: 'We're going to have trouble with those two.'[27]

The following day, Gary moved on to describe some of the practicalities of the CPL. The proposed exam, he said, would be presented online in locations across Britain. It would be divided into up to ten sections of multiple choice questions. In each section the candidate has a list of options down the left-hand side of the page from which they have to make their choice as to how they would respond to an imaginary 'client'. An 'appropriate' response will reveal some aspect of the client's situation which will help a candidate to make steps towards resolution of their 'presenting issue'. An 'inappropriate' answer will elicit the response: 'Not relevant'. A third column, not visible to the candidate, provided the 'competence code number' to demonstrate that each 'intervention' was supported by the 'evidence-base'. This, Gary said, was 'really important as the

[25] House, R., and Bohart, A. C. (2008) Empirically Supported/Validated Treatments as Modernist Ideology. In: House, R. & Loewenthal, D. *Against and for CBT: Towards a constructive dialogue*, p. 213.
[26] Optimum, (2007) *An introduction to case study based examination,* p. 3.
[27] Gary's words were prophetic; Joan and Jean remained implacably opposed to any perceived departure from a literal interpretation of 'Person-Centred Theory' – they left the exam-writing group within a few weeks.

exam will be closely scrutinised by some individuals who have already suggested that the CPL is 'dumbing therapy down'.

Each exam had a section with one right response, one wrong response and two responses which might give pause for thought, but a 'competent therapist' would not choose. In response to Freddy's suggestion that a candidate could 'select everything', Gary pointed out that each section is made up of a combination of 'appropriate and inappropriate options' and 'if a candidate were to select all options they would come away with a zero score'. The basis of the exam, it appeared, relied on a notion that therapy could be reduced to an 'assessment of the relative merits of a range of decisions'.

> The decision-making sections are designed to reflect decisions which a candidate may need to make in their therapeutic work. There are single decision-making sections and in these there is *only one appropriate answer* (out of a choice of four possibilities). In addition, there are multiple decision making sections and in these the candidate is instructed to choose as many as they think appropriate. The multiple decision making sections also have an equal number of appropriate and inappropriate options. [28] [My emphasis.]

The therapy encounter is here reduced to a set of explicit and observable decisions. Capacities such as intuition, or hunches, described as 'not always knowing what one is doing',[29] become invisible. Contextual factors, non-linguistic elements of interaction—for example, prosodic and paralinguistic features of speech, pitch, volume, gesture, eye contact and tone—are displaced by the prominence of the 'decision'. These excluded contextual factors may be key to the establishment of a beneficial relationship:

> Meta-analyses show that psychotherapy and complementary and alternative medicine (CAM) are *effective primarily or entirely due to contextual factors* rather than the specific disease-treating factors suggested by the therapy. Therapists are the most important contextual factor. [...] Therapist effects are unrelated to experience or type of therapy.[30] [My emphasis.]

Contextual factors in psychotherapy have been cited in support of the 'Dodo bird verdict', the claim that: 'Useful outcomes of a psychological therapy are primarily the result of a helpful

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[28] Optimum, (2007) *An introduction to case study based examination,* p. 1.
[29] Atkinson, T. & Claxton, G. (2000) *The intuitive practitioner: On the value of not always knowing what one is doing*.
[30] Hyland, M. E. (2005) A tale of two therapies: psychotherapy and complementary and alternative medicine (CAM) and the human effect. *Clinical Medicine,* 5, pp. 361–367.

relationship rather than the result of any identifiable therapeutic technique.' This verdict emerged after competing therapeutic orientations failed to find convincing evidence of superiority.[31] The 'job analysis process' outlined by Gary was designed to circumvent modality-specific technique and expertise to identify 'competent practice'; it sought to identify 'generic factors' common to all therapy practice. Although the process succeeded in eliminating modality-specific language, it had the effect of removing any reference to contextual factors which were beyond the reach of a positivistic epistemology of therapy praxis. This exclusion of important contextual elements of the therapeutic relationship appears to be part of the price paid for 'effective, evidence-based assessment instruments'.[32]

Moving on to measurement, Gary continued by explaining that each of the ten options within a section would have a 'score associated with it'. He placed a new slide on the screen: 'A score of 10 for essentials of good practice; a score of 5 for good things to do; -5 for a poor or badly timed option; -10 score for options that may be harmful to the client or be of detriment to the therapeutic process.' The 'essentials of good practice' are represented here as unproblematic, although there is little detailed agreement between therapists as to what constitutes essential or good practice, beyond the broad outcome-oriented generalities described by 'competencies'. Gary told us that the narrative of the case study on which the exam is based would be informed by the 'client profiles' identified in the original job analysis, as well as physical settings ranging from open-ended therapy in private practice, usually a residential property, to six sessions in a GP surgery. Gary fielded questions at length and with patience, but the CPL did not find universal acceptance in the group. Rachel did not remain in the exam-writing group after the initial weekend at the Hotel Royale. In an interview, months later, she commented on the case study-based exam:

> You can't reduce therapy to these statements; it doesn't reflect the reality of what we do. We may appear to do some of these things some of the time, but the case studies won't capture what really goes on in a session, like body language, silences, atmosphere. It's not just what we do that makes a difference; it's what we are, the way we make ourselves available to the people we work with. The exam is a test of what can be observed to someone watching from outside, things like making a contract, decisions, problem-solving, [...] limits of confidentiality and risk management.[33]

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[31] Middleton, H. (2015) The Medical Model: What Is It, Where Did It Come From and How Long Has It Got? In: Loewenthal, D. *Critical psychotherapy, psychoanalysis and counselling: Implications for practice*, p. 29.
[32] Optimum, (2007) *An introduction to case study based examination*, p. 2.
[33] Interview 29.

Freddy suggested that the exam was not a good representation of therapy practice, but decided to stay, saying: 'I think I can do more good by working with the exam than against it; it won't go away. It's going to happen whether we like it or not.'

Following an invitation from Gary, the reduced group of five met a few weeks later in a London West End hotel to start writing case studies which would become the basis of future CPL exams. Gary took us all out to a restaurant the evening before, and the friendly chat and banter seemed to create a sense of solidarity and common purpose (despite our very different conceptions of human distress). By way of an update, Gary told us that the exams would be taken in health and safety training centres across Britain. Rosa said that she thought that was rather 'tacky', but following a series of jokes everyone agreed they could not come up with a better idea, since, as Gary put it: 'Health and safety centres have all the necessary security and invigilation resources in place.' After breakfast the next morning, we assembled in a 'corporate facility room' around a conference table facing a large wall-mounted screen where a blank grid was displayed. The cells on the grid were ready to be filled with the codified elements of a representation of a distressed person experiencing psychotherapy. Gary told us that after about four meetings working as a group, we would be ready to start writing exams on our own. The exams would then go through a verification and evaluation stage across Britain and Northern Ireland, using pilot groups of therapists and non-therapists to determine the extent to which the exam identifies 'professional practice'. The whole process, Gary hoped, would take about three years,[34] at the end of which a suite of exams would be ready for therapists who did not meet the new 'minimum standards for inclusion on a future statutory register of counsellors and psychotherapists'.

Each exam, Gary reminded us, should be designed to test a selection of 'Job Analysis Criteria'[35] and be aligned to 'competency statements', so that by the time an examinee had worked through four or five exams, responding to imaginary clients, they would have been 'tested against a broad selection of competencies'. The starting point for each case study was a fictional client who, as Gary put it, 'presents with issues', framing the complexity of a person's distress as a problem to be solved, subject to them 'presenting' it in a way that accommodates the therapist's conception of 'good practice'. This required the group to work backwards from 'competent' therapist

[34] Six years passed before the first exam was taken; 12,000 had taken the exam by late 2014 (personal correspondence, January 2015).
[35] The 'Job Analysis Criteria' were drawn from the therapists canvassed during the job analysis process described earlier in this chapter.

'interventions' in order to produce a storyline into which the 'competence' criteria could be neatly accommodated.

The group named their first 'client' Sadie, a recently separated mother of three facing violent abuse, financial hardship, distress and loss. With a basic storyline agreed, the summary was placed at the beginning of Section A of the exam:

'You are a counsellor / psychotherapist working in GP practice funded by the NHS, offering six fifty-minute sessions. Sadie is 38. She was referred to you by her GP, following the loss of her husband's job after which he started to drink heavily and repeatedly punched and slapped her. She would sleep on the sofa in her clothes with her car keys in her hand to make a quick exit through the back door when her husband returned from the pub, to avoid being raped. She moved away from the marital home after he put a railway sleeper under the car so she could not get away from him by car. Sadie has three children and is finding it difficult to get through the day. She is living with her mother. She has difficulty sleeping and is anxious and tearful most of the time. She has been prescribed anti-depressant medication but would like to talk to someone.'[36]

Gary described our next task, which was to 'identify job analysis criteria to test' by offering a range of choices where an examinee could select the 'right' choices and therefore 'demonstrate competence'. The 'job analysis' generated several hundred items, some of which may be relevant all the time, others some of the time, and many which may only be relevant in an 'unusual situation' or when a specific risk emerges, such as thoughts of suicide. Gary displayed the first tranche of 'job analysis' items[37] to 'be evidenced' in the first section of the 'Sadie mock-up' on the screen:

Carry out a risk assessment on your personal safety
Assess the psychological functioning of a client
Gauge the level of self-esteem of a client
Listen to the client
Focus attention on the client
Recognise when you are receiving an onslaught from a client

[36] 'Sadie', a mock-up case for the CPL.
[37] Optimum job analysis specification.

Act with integrity
Be aware of yourself as a therapist

Freddy pointed out that the idea of a risk assessment on the therapist's safety seemed 'perverse, making the therapist appear more vulnerable than the client'. Gary insisted that all the job analysis items had been generated by a 'wide range of therapists with several years of experience', and could therefore be relied on as representative of 'appropriate therapist behaviours'. Amélie said that she had no idea what 'psychological functioning' meant, and that she 'certainly couldn't assess it'.

'Self-esteem' as an imperative to feel good about oneself and be affirmed by others, is presented unproblematically in the job analysis as measurable with a requirement to 'gauge the level'. Listening to and focussing attention on the client seems too obvious to mention. The job analysis description does not elaborate on what an 'onslaught' might comprise. The imperative to 'act with integrity' assumes a normative transcultural moral perspective.

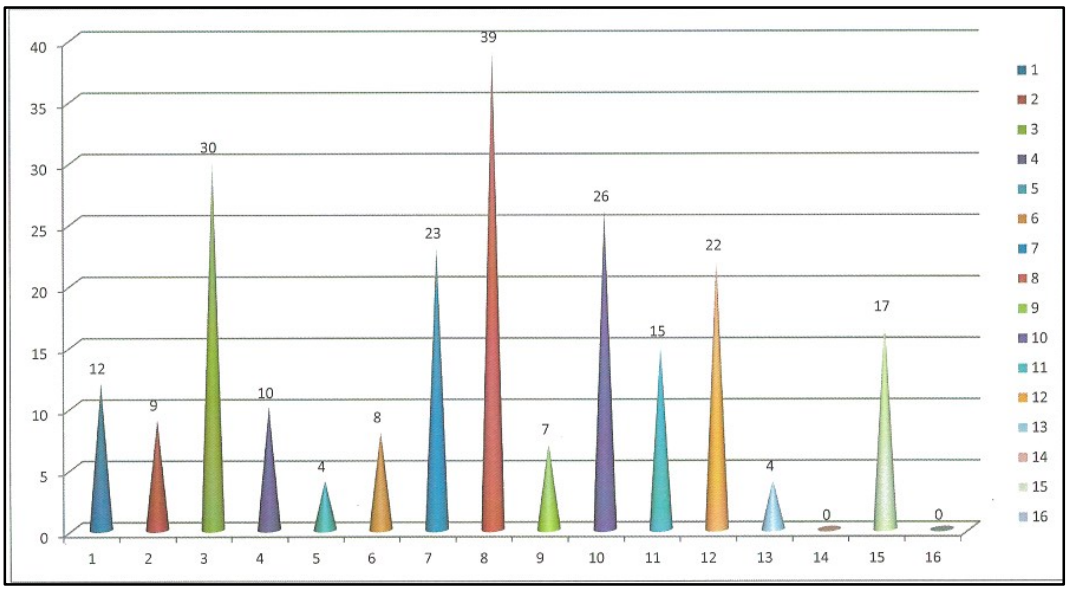
Amélie objected: 'This seems back-to-front to me; we're making the client fit the job analysis... all of this is so obvious.' Gary responded: 'This is where we are, this is the way the exam goes, we can't change it now.' Freddy said: 'Why don't we just get on with it?' Gary assured us the task would make sense and become easier once we got going, and then asked the group how 'Sadie' might present her story in a way that complements the 'job analysis items'. Each segment of her story was then given a response, which the group could agree was 'appropriate' or 'inappropriate'. The group soon became engaged with the task and appeared to work together with enthusiasm, with the occasional sarcastic comment from Amélie, who, after a while, seemed to forget her opposition to the project, having become immersed in it and seeming to enjoy the banter. Gary displayed a 'stem' question on the screen:

'During your first session, what aspects of Sadie's story might it be important for you to understand or pay attention to?'

After some discussion, the group agreed that 'appropriate' answers, with maximum scores of 10, could be: 'Sadie's feelings about herself', and 'What she wants from the sessions'. Gary was pleased with this as it seemed to cover at least four 'metacompetencies'. Over the course of the following year, case studies produced by the writing group were analysed by Gary and his team to

create a ‘metacompetence distribution graphic’ (see Figure 6.2), aimed at ‘identifying weaknesses in the CPL’.

Figure 6.2, Competence distribution graphic



Source: Optimum

The graphic in Figure 6.2 represents the abstraction and quantification of a helping relationship into a row of cones, creating an image for the adjustment of the ‘key instrument’, the CPL, underscoring the distance between it and the lived experience of a distressed person seeking compassionate understanding. Following Gary’s creation of this and other graphics, all exams had to be written so that each section covered only one ‘competence’, to ‘avoid confusion as to what competence is being tested’ and creating a tidy ‘assessment instrument’, devoid of uncertain, multi-causal, complexity.

The group agreed on two wrong, ‘inappropriate’, answers scoring for this section: ‘Relationships with family and friends’ and ‘Housing needs’. Ranking as ‘appropriate’, therapist responses were framed within the ‘generic competencies’, with a focus on individualism and the client's capacity for ‘psychological-mindedness’, an ability to objectify themselves through normative psychological constructs such as ‘insight’, ‘resilience’ and ‘appropriate boundary-keeping’. Attention to the social realities of Sadie’s situation, ‘Housing needs’ (with a zero score) is ‘detrimental to the therapeutic process’. This positions the origin of disturbance within the individual, promoting the problematic ideology that a person could and should take responsibility for their distress. Social context is marginalised in favour of a psychologistic, individualised

account of the causes of suffering, in which poverty, ill-health and poor housing are displaced from view.

Promoting the 'Competent Practitioner Licence', the Optimum literature proposes: 'Those successful in the assessment will be evidencing the knowledge, skills and abilities involved in being a professional counsellor/psychotherapist.'[38] The exam therefore purports to offer a valid methodology through which a therapist can be described as competent enough to help people in troubled circumstances and be eligible for inclusion on a statutory register, without which they would be unable to continue work. The creation of the exam did not engage with the problem of what a 'proficient therapist' would have to do or be, beyond the circularity of 'job analysis', where existing practice is routinised and codified into competencies and metacompetencies in order to create an assessment instrument, the CPL computer-based exam. Some members of the writing group, especially Amélie, expressed a view that the exam was blind to the nuanced detail of a therapy encounter, excluding 'ingredients' crucial to psychotherapy, such as intuition, which 'could not be described as a competence'.

Freddy suggested that without the exam 'psychologists would become *de facto* gatekeepers for all counselling and psychotherapy'. After some initial reluctance, the group seemed to forget about their differences and reservations; they concentrated on doing the best they could in what had become an absorbing and challenging task. The social and political contexts of therapy seemed to have become buried by the painstaking detail of exam production within the context of professionalising strategies by therapy organisations.

The CPL exam was enthusiastically taken up by unregistered therapists hoping to continue finding employment in an era of increasing credentialisation and regulation. Moral and value-based therapy practice that had previously remained outside the professionalising and ideological[39] discourse of clinical psychology became increasingly instrumental in an uncertain climate of regulatory control. Psychologists, separating fact from value, had for some time established instrumentality as a means to legitimacy through the factual quantification of human suffering:

[38] Optimum, (2007) *An introduction to case study based examination.*
[39] Hook, D. (2007) *Foucault, psychology and the analytics of power*.

> The management of uncertainty encompasses 'management strategies and heuristics dealing with life's uncertainties'. According to this portrayal, wisdom involves a kind of detachment from value commitments with a strong emphasis on pragmatics, strategies and heuristics designed to help the individual manage contexts, uncertainties and 'life matters'. This detached, managerial posture is the very picture of instrumentalism, particularly in the absence of any explicit consideration of the wise person or the overall good that wisdom is to serve. [...] This separation of technical prowess and ethical consideration is a hallmark of contemporary instrumentalism.[40]

Counsellors and psychotherapists, formerly more preoccupied by value-based understanding to grasp belief, irrationality and mortal fears, have, in the creation of the CPL, aligned themselves to a paradigm of psychological instrumentalism. In this deployment of means-ends rationality, the *ends,* a 'demonstration' of 'adequate' knowledge and the framing of human distress as a 'mental health problem', are presented in the CPL exam as unproblematic and self-evident. The task of the exam-writing group was directed to the *means* by which these ends are achieved: How can 'adequate knowledge' be 'evidenced'? The truth claims within 'competencies' are non-negotiable, since, tautologically, they are rooted in what therapists 'actually do', following the 'job analysis'. Any critique of this new order could undermine the legitimacy of counselling and psychotherapy, by exposing the influence of neo-liberal ideologies of economism,[41] austerity, individualism and positivism on prevailing 'clinical' practice.

[40] Fowers, B. J. (2005) *Virtue and psychology: pursuing excellence in ordinary practices,* p. 113.
[41] See chapter six for a case study exploring the theme of 'Happiness Economics'.

Chapter 6

Happiness Economics

> 'Economics are the method, but the object is to change the soul'.[1]
> *Margaret Thatcher*

This is the first of three chapters narrating my observer-participation in roles associated with the implementation of a 'happiness agenda', and its impact on the character of counselling and psychotherapy in the NHS in Britain over a period of ten years up to 2015. These roles are related to the production and 'delivery' of a new 'evidence-based treatment', Counselling for Depression, (CfD), by the BACP in collaboration with the NHS. The ethnographic material illustrates some of the processes accompanying this production, such as reductionism, reification and codification. These processes, and their relation to the instrumentalisation of therapy in Britain, will be discussed in chapters ten and eleven. CfD has been developed against a background of four influences (the first of which was introduced in chapter one):

i) A long period of planning for statutory regulation by therapists since the publication of the Foster Report,[2] which has been resolved by the 2010 coalition government's creation of a voluntary register.[3]
ii) The growth of therapy training in Higher Education.
iii) A shift in public policy to measure subjective well-being directly, rather than as an implied effect of a rise in GDP.
iv) The impact of the Core Curriculum, and a consequent reduction of therapeutic eclecticism on therapy praxis.

In terms of the first of these influences, the expectation of statutory regulation contributed to heightened concerns within the field of counselling and psychotherapy about legitimacy and transparency. These concerns resulted in sustained efforts by 'umbrella' organisations representing

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[1] Cited by: Harvey, D. (2005) *A brief history of neoliberalism*, p. 23.
[2] Foster, S. J. G. (1971) *Enquiry Into the Practice and Effects of Scientology: Report*.
[3] Department of Health (2011) *Enabling excellence: autonomy and accountability for healthcare workers, social workers and social care workers*.

therapists in Britain to describe what therapy is and what it is good for. Some of these efforts led to a standardisation of therapy in the form of a 'Core Curriculum',[4] narrated in chapter four, and the creation of 'Benchmark Standards',[5] which provided impetus to the second of these influences, where counselling and psychotherapy training moved away from vocational settings such as community-based colleges to universities.

An example of the third influence, an enlargement of existing outcome-oriented mental health policies, can be found in a publication by economists Paul Dolan, Richard Metcalf and Richard Layard,[6] who propose the measurement of 'subjective well-being' as a part of public policy in the Office for National Statistics and the Government Statistical Service. The document is part of a response to the Stiglitz Commission,[7] set up by the French president Sarkozy in 2008 to address the inadequacy of GDP figures alone in identifying progress in social well-being. In another ONS publication, Sam Waldron proposed: 'There may be a role for ONS and the Government Statistical Service to support the delivery of subjective wellbeing data on a national scale.'[8] The publication suggests three criteria on which the data are based. The first is a claim to theoretical rigour by grounding the measures in 'accepted philosophical theory', which refers here to Jeremy Bentham's philosophy of Utilitarianism.[9] The second criterion is policy relevance; the measures must be 'politically and socially acceptable, and well understood in policy circles'[10]. The third criterion requires the use of 'reliable and valid quantitative methodologies'; these are applied to two aspects of a subject's well-being: 'function' and 'symptoms'. The first is an index of 'function' across a range of dimensions, such as the capacity to 'sustain' relationships, work 'motivation' and 'sociability'; the second measures 'symptoms' such as 'depression' or 'anxiety', as 'defined' in the diagnostic and statistical manual of mental health disorders.[11]

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[4] Dunnett, A. C., M; Wheeler, S; Balamoutsou; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy.*

[5] Quality Assurance Agency (2013) *Subject benchmark statement: Counselling and Psychotherapy.*

[6] Dolan, P., Layard, R. & Metcalfe, R. (2011) *Measuring subjective well-being for public policy.*

[7] Stiglitz, J. E., Sen, A. & Fitoussi, J.-P. (2009) *Report by the commission on the measurement of economic performance and social progress.*

[8] Waldron, S. (2010) *Measuring subjective wellbeing in the UK,* p. 3.

[9] Jeremy Bentham (1748–1832) is widely regarded as the founder of Utilitarianism, a moral philosophy, embraced by Layard, based on the notion that conduct should be guided by the principle of the greatest happiness to the greatest number.

[10] Waldron, S. (2010) *Measuring subjective well-being in the UK,* p. 4.

[11] American Psychiatric Associaiton (2013) *Diagnostic and Stastistical Manual 5*.

These reified psychological entities can be seen in the light of Habermas's critique of scientism, where epistemological positivism (the doctrine that science is the only legitimate form of knowledge)[12] is expropriated from clinical psychology into the discourses of counselling and psychotherapy.

Following Dolan's concluding recommendation that, 'The time has certainly come for regular measurement of SWB (Subjective Well-Being) in the largest standard government surveys',[13] the economist Richard Layard proposed that increases in GDP should no longer be a priority, as they would 'bring little extra happiness', arguing that the *perception* of inequality has a greater negative impact on 'average levels of happiness' than inequality itself. [15] He is silent on the conditions from which this perception arises, and avoids the contradictions pointed out by William Davies[16] about the expectations imposed on people arising from a neoliberal culture, in relation to enthusiasm, hope and energy, while, at the same time, having those expectations undermined through job insecurity, powerlessness and the unattainability of the contrived ideals of advertising, whereby: 'Unhappiness has become the critical negative externality of contemporary capitalism.'[17] Critical of the positivism inherent in Layard's proposals, Davies argues that, on the one hand, a neuro-psycho-economic view leads to an instrumentalisation of Enlightenment concerns, but also says that, on the other hand, '...the contradictions and injuries of neo-liberal capitalism start to show up within the very positivist bodies of knowledge that are intended to regulate and sustain it.'[18] Layard's appeal for a movement aimed at happiness for all is undermined by the inevitability that capitalism is sustained by want and insatiability:

> [...] when positivists seek to grasp and quantify the immeasurable problem of unhappiness, they encounter causes of that unhappiness that are far larger than economic or medical policy can calculate or alleviate. Is it too much to hope that, if critique can be rendered psychological, then the reverse may also be true: that mental ill-being may be rendered critical?[19]

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[12] See Keat, R. (1981) The Politics of Social Theory Habermas, Freud and the Critique of Positivism.
[13] Dolan, P., Layard, R. & Metcalfe, R. (2011) *Measuring subjective well-being for public policy,* p. 12.
[15] Layard, R. (2011) *Happiness: lessons from a new science,* p. 272.
[16] Davies, W. (2011) The Political Economy of Unhappiness, *New Left Review*, pp. 65–80.
[17] Ibid., p. 68.
[18] Ibid., p. 70.
[19] Ibid., p. 80.

The rise of therapeutic systems of meaning supports a culture of emotionalism, causing social problems to be recast as emotional ones[20] and leading to a rise in technologies of emotion management such as Counselling for Depression, a case study on which is narrated in chapter seven. In earlier times, state intervention was limited to the cultivation of acceptable conduct and beliefs. Accompanying the mobilisation of therapeutic values, priorities have shifted to the management of subjectivity: 'This approach extends the business of government from the public to the private, and more disturbingly to the internal life of the individual.'[21] The introduction of workfare programmes—such as mandatory labour and training for people on benefits, for example—underpinned by a culture of 'psychological deficit' is seen as coercive by Freidli and Stearn:

> ...the coercive uses of psychology in UK government workfare programmes; as an explanation for unemployment (people are unemployed because they have the wrong attitude or outlook) and as a means to achieve employability or 'job readiness' (possessing work-appropriate attitudes and beliefs).[22]

In an article written for Therapy Today,[23] Catherine Jackson quotes a past chair of 'BACP Workplace', Kevin Friery, who seems to be embracing a workfare agenda:

> The prime contractor doesn't want you to have a nice chat and help the person cope with being unemployed; they want you to increase their employability so they can get work, and help keep them in work. It's a business relationship: *you have to be able to market what you are offering*.[24] [My emphasis.]

The article also quotes Sean Williams, Managing Director of the G4S Welfare to Work programme: 'The real challenge is that counselling and psychotherapy is not an end in itself: the end is that the person has to find and keep a job.' [25] Richard Layard played a significant role in the context of workfare by implementing a response to 'subjective well-being data' through the 'Improving Access to Psychological Therapy' (IAPT) scheme.

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[20] Furedi, F. (2004) *Therapy culture: Cultivating vulnerability in an uncertain age*.
[21] Ibid., p. 197.
[22] Friedli, L. & Stearn, R. (2015) Positive affect as coercive strategy: conditionality, activation and the role of psychology in UK government workfare programmes. *Medical humanities,* 41, pp. 40–47.
[23] Jackson, C. (2012) Counselling the jobless back to work. *Therapy Today,* 23, pp. 4–7.
[24] Ibid., p. 6.
[25] Ibid., p. 7.

Richard Layard

With a background in the quantitative study of happiness (Happiness Economics), the New Labour economist Richard Layard and his colleagues laid the ground for the 'Improving Access to Psychological Therapy' scheme in the 2006 Depression Report[26] where he presents an economic case for the implementation of NICE guidelines:

> For someone on Incapacity Benefit costs us £750 a month in extra benefits and lost taxes. If the person works just a month more as a result of the treatment, the treatment pays for itself. So we have a massive problem – the biggest problem they have for one in three of our families. But we also have a solution that can improve the lives of millions of families, and cost the taxpayer nothing. We should implement the NICE guidelines; and most people with mental illness should be offered the choice of psychological therapy. Everyone who wants something done should write to their MP calling for action.[27]

Layard argued that 'happiness scientists' can now 'accurately measure' individual and societal happiness by using some of positive psychology's methods. The approach is a reaction against traditional psychology's preoccupation with disorder and 'illness', promoting the mapping of 'character strengths and traits' amenable to 'empirical measurements'.[29] These measurements, Layard proposed,[30] provide meaningful and adequate information to guide policy for government, conjuring a Benthamite dream.

The IAPT scheme was masterminded by CBT psychologist David Clark in collaboration with Layard. The pair met in 2003 when they became fellows of the British Academy:

> They met during the tea break, and Layard said he was writing a book on happiness and was interested in mental health. Clark told him a bit about CBT, and the rest, as they say, is history.[31]

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[26] The Centre for Economic Performance's Mental Health Policy Group (2006) *The depression report: A new deal for depression and anxiety disorders* (No. 15). Centre for Economic Performance, LSE.
[27] Layard, R. (2011) *Happiness: lessons from a new science*, p.1.
[29] Peterson, C. & Seligman, M. E. (2004) *Character strengths and virtues: A handbook and classification*.
[30] Layard, R. (2011) *Happiness: lessons from a new science*.
[31] Jules Evans in: 'Five years of IAPT', available at: http://philosophyforlife.org/five-years-of-iapt-improving-access-for-psychological-therapies/#sthash.ak9qkEAO.dpuf (accessed January 2014).

Layard has expressed his support for therapies amenable to 'measurable outcomes': 'The beauty of these treatments is that their success can be measured. It's possible to measure the behaviour of a person before, during and after receiving treatment.'[32] He cites a case to provide evidence for his support of CBT:

> The most striking experience I've had in the last few years was when the chief executive of a mental health trust ... said his life had been saved by CBT ... He said he is a fully fledged bipolar case but he has not had a day off work for the last 15 years. He has a little book, which he carries around, and whenever he has funny thoughts coming into his mind, he turns to the relevant page, according to what kind of thought it is or if he has a mood attack, and he does exactly what it says on the page. Now, you could say that's mechanical. I say that it's brilliant and not so different, you know, from what Jesus or any other great healer did for people.[33]

The Department of Health put the scheme into practice in 2007 on demonstration sites[34] 'to substantiate a business case for a national roll-out of the IAPT service model.'[35] The programme was aligned to the Coalition government's NHS reforms where Health and Well-Being Boards[36] can commission 'any qualified provider'[37] to tender for mental health services within IAPT.

The 'service model' advanced within IAPT has three aims: The provision of NICE-approved treatments within a 'stepped-care framework' (see Figure 6.1), providing 'risk stratification'; a 'range of interventions aligning symptom severity with approved treatments'; and a system of data collection aimed at increasing access to 'evidence-based treatment'. The stepped care model shares

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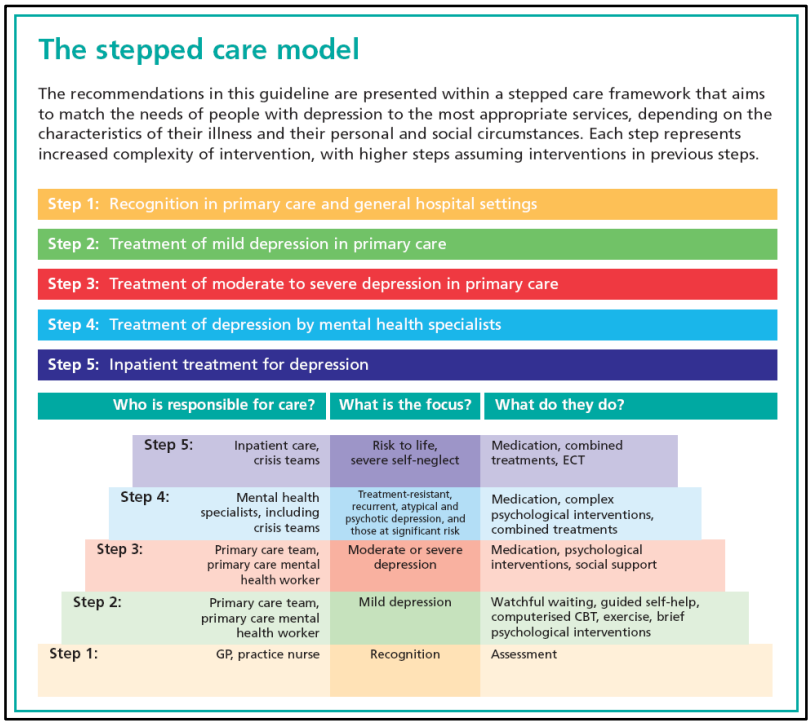
[32] Blackhurst, C., (2014) *Money is not the only thing affecting people's happiness,* available at http://www.independent.co.uk/news/people/profiles/richard-layard-money-is-not-the-only-thing-affecting-people-s-happiness-9603424.html (accessed 20 January 2017).
[33] Leader, D., (2008) *A quick fix for the soul*, available at www.theguardian.com/science/2008/sep/09/psychology.humanbehaviour (accessed 20 January 2017).
[34] The more cautious term 'pilot site' was abandoned by the NHS in favour of 'demonstration sites', see: House, R. & Loewenthal, D. (2008) *Against and for CBT: Towards a constructive dialogue*, p. 295.
[35] Department of Health: IAPT Information Sheet (personal correspondence March 2016, BACP Research Dept.).
[36] Implemented under the Health and Social Care Act 2012 as a forum to reduce health inequalities, available at www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf (accessed 20 January 2017).
[37] Any qualified provider (AQP) - where patients are referred, usually by their GP, for a particular service; the patient should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations (personal correspondence March 2016, BACP Research Dept.).

some features of the long-established Goldburg and Huxley[38] pathway to psychiatric care used in primary care settings to 'filter' people with 'severe forms of mental distress' to hospital from those who remain in community care.

Figure 6.1: The stepped-care model



Source: Hill, A. (2011) *Curriculum for Counselling for Depression*

The diagram in Figure 6.1 uses colour-coded bands to separate 'increased complexity of intervention'. 'Steps' 1 and 2, yellow and green, require 'Low-Intensity' treatments such as telephone support, eight sessions of computerised CBT, 'Bibliotherapy' (the recommendation of self-help books), and 'education or guided cognitive-behavioural self-help'. 'High-Intensity'[39] therapy is indicated in Steps 3 and 4, the red and light blue zone on the chart; this is the point at which 'people with depression' meet a therapist 'face-to-face' for the first time, for an average of seven sessions of CBT. Distressed people qualifying for therapy in the setting of a personal encounter with a 'High-Intensity' therapist providing NICE-approved 'interventions' may also be

[38] Goldberg, D. & Huxley, P. (1980) *Mental illness in the community.*
[39] The term 'High Intensity', as applied to therapy, had not been used by counsellors and psychotherapists prior to IAPT. Since IAPT an increasing number of therapists have promoted themselves as offering 'High Intensity Interventions' (steps 3 and 4), in contrast to 'Psychological Well-being Practitioners', who offer 'Low Intensity Interventions' (field notes).

prescribed anti-depressant medication by their GP.[40] The focus of step five is on 'crisis management', in relation to incidents of self-harm or suicidal ideation, requiring hospitalisation and combined treatments including Electroconvulsive Therapy.[41]

The 'stepped-care model', at the core of IAPT from its inception,[42] informs decisions about the increasing 'intensity of treatment' to match 'severity of symptoms':

> This model provides a framework for organising the provision of services, and helps patients, carers and practitioners to identify and access the most effective interventions. The least intrusive, most effective intervention is provided first. If a person does not benefit from that intervention, or declines an intervention, they should be offered an appropriate intervention from the next step.[43]

Until 2009 CBT was the only NICE-approved psychological treatment available through IAPT, resulting in an expansion of the CBT workforce aligned to an evidence-base ideology, including non-medical 'well-being practitioners' and nurse practitioners, who are paid less than clinical psychologists. Between 2008–2009 the Department of Health spent over £21m[44] training CBT therapists to offer 'High Intensity Interventions' to distressed people meeting criteria for inclusion in step 3, having progressed through steps 1 and 2. The effect of this enlargement was felt by non-CBT trained therapists. BACP's head of research put it this way:

> CBT is recommended by NICE as the evidence-based treatment of choice. As a first-line treatment for anxiety and depression under the IAPT Programme, CBT therapy services have expanded enormously, sometimes at the expense of counselling services. Counselling has been cut in some areas, and jobs have been lost. The impact for counselling professionals is clear, as is the impact for clients: less counselling services and less work for counsellors – and less choice and limited access to counselling for clients.[45]

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[40] In most cases a course in Selective Serotonin Reuptake Inhibitors (SSRIs), such as Prozac or Citalopram (field notes).
[41] Recommended under NICE guidelines in potentially life-threatening conditions for people with 'severe depressive illness', available at: http://www.bmj.com/rapid-response/2011/10/29/nice-guidance-ect (accessed 8 February 2016).
[42] IAPT Outline Service Specification, *Care Services Improvement Partnership/National Institute for Mental Health in England,* 2008.
[43] NICE (2013) *Clinical guidelines for Depression*, available at nice.org.uk/guidance/cg90/chapter/1-Guidance#stepped-care (accessed 15 March 2016).
[44] See Figure 1.6.
[45] Interview 17.

The evidence on which manualised[46] therapy techniques are justified to NICE are based on Randomised Controlled Trials—which are questioned by some counsellors and psychotherapists, because they appear to be based on 'an epistemologically naïve and unsustainable position'.[47] This raises the possibility that depression, and other diagnostic categories, 'has a non-problematic facticity that separates it clearly from ordinary misery'.[48] A further question remains over the reductionistic effect of using outcome measures with limited and limiting options. It is in this landscape that 'evidence in support of the effectiveness of counselling interventions' remained 'uncertain'. BACP's director of research policy felt that counselling is marginalised in the NHS:

> NICE guidelines for depression (NICE CG90, 2009) state that if people with depression decline an antidepressant, CBT, IPT, behavioural activation and behavioural couples therapy, consider counselling, but that when recommending counselling 'for people with persistent sub-threshold depressive symptoms or mild to moderate depression […] discuss with the person the uncertainty of the effectiveness of counselling […] in treating depression'. *Is it any wonder that counselling in the NHS is under threat?*[49] [My emphasis.]

The bias against therapies that have not been exposed to the RCTs is evident, leaving the BACP in a dilemma as to how their members' needs for continued legitimacy and employment can be adequately represented. IAPT had been collecting 'routine outcome data' from contracted services, suggesting that counselling and psychotherapy appear to be as effective as CBT in treating depression.[50] Because these findings were not made within the context of a randomised controlled trial, and are therefore not admissible within NICE guidelines, they did not help counsellors gain a foothold in IAPT. Following representations from the BACP and other psychotherapy organisations between 2009–2012, the Department of Health allocated funds totalling nearly £1.5m to train therapists in evidence-based, non-CBT talking therapy for use within IAPT. Of this total, a sum of £396,000[51] was allocated to a new BACP-endorsed therapy brand, 'Counselling for Depression' (CfD), the emergence of which is narrated in the remainder of this chapter.

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[46] Manualised therapy has exact steps to minimise therapist personality variables.
[47] Bohart, A and House, R in: House, R. & Loewenthal, D. (2008) *Against and for CBT: Towards a constructive dialogue*, p. 213.
[48] Pilgrim, D in: House, R. & Loewenthal, D. (2008) *Against and for CBT: Towards a constructive dialogue*, p. 262.
[49] Nancy Rowland, BACP Director of Research Policy and Practice in a press release: 'BACP Research Foundation advertises funds for an RCT of counselling' (personal correspondence April 2012, BACP Research Dept.).
[50] Glover, G., Webb, M. & Evison, F. (2010) *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll-out year*.
[51] See Figure 1.6, *Monies spent training therapists within IAPT.*

Joy

In the Spring of 2012 I was given an opportunity to participate in and observe an early phase of the 'roll-out' of CfD by one of my contacts in the BACP Research Department, Joy, who was seeking therapists with teaching experience to help 'deliver' the new course. Joy had worked for the BACP for over twenty years, helping to raise the profile of the organisation in the eyes of a public whom she described as 'wary of therapists'. She appeared to me as a friendly, brisk and ebullient person who described herself as having had a background in management. Joy was aware of my research interests, and she suggested, during our long phone call, that my involvement might be mutually beneficial. She explained the structure of the course: an intensive week's study to be followed by the continuous assessment and 'clinical' supervision of 80 hours' therapy with 'depressed' patients who had been referred to an IAPT provider by their GP. The five-day course provided informational content and experiential sessions in the new 'evidence-based' therapy process, CfD, followed by an extended period of 'clinical' supervision:

> 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.[52]

Towards the end of the conversation Joy told me that CfD was still in its early developmental stages and some details of the programme, such as recruitment, training and supervision, were not finalised. This turned out to be an understatement.

Later that day, Joy sent me a copy of the eighty-nine-page Curriculum for Counselling for Depression[53] to study in preparation for a proposed meeting with the author, Andy Hill, who was head of BACP research.

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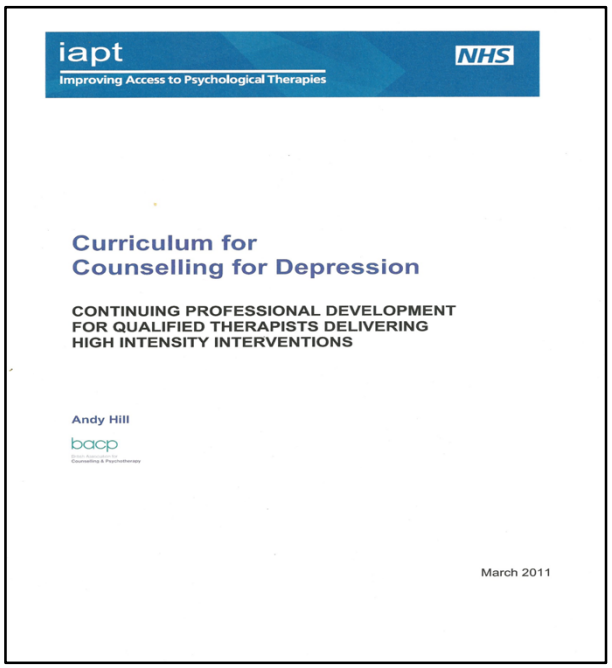
[52] Hill, A. (2011) *Curriculum for Counselling for Depression*.
[53] Ibid.

Figure 7.2: Curriculum for Counselling for Depression



Source: Hill, A. (2011) *Curriculum for Counselling for Depression*

The front cover of the CfD curriculum provides a visual linkage between IAPT, the NHS and the BACP. The blue banner design and logo uses a format commonly found on NHS publications. The brief course description—aimed at Strategic Health Authority commissioners as well as IAPT therapy 'providers'—foregrounds professionalism, qualifications and 'delivering high intensity interventions' (where a distressed person meets a therapist as opposed to receiving telephone or online 'support').

The acknowledgements section of the manual indicates collaboration between IAPT, the BACP and academics in the fields of psychology, counselling and psychotherapy:

> This curriculum was commissioned by The Improving Access to Psychological Therapies (IAPT) Programme and was developed by the British Association for Counselling and Psychotherapy (BACP). We would like to thank Professor Robert Elliott and Dr. Beth Freire, from the University of Strathclyde, for their work in designing the Counselling Adherence Scale. We would also like to thank members of the IAPT *'four modalities'* team for their generous sharing of ideas and material, in particular, Professor Alessandra Lemma

> (Tavistock and Portman NHS Foundation Trust), Dr David Hewison (Tavistock Centre for Couple Relationships) and Dr. Roslyn Law (IPT National Lead).[54]

The CfD curriculum sets out a comprehensive guide to a 'manualised' type of therapy, with exact steps to minimise therapists' 'personality variables', and where their responses to clients are framed within specific behaviours that have 'empirical support for efficacy'.[55] The specified therapist behaviours are based on Carl Rogers' core conditions of unconditional positive regard, empathic mirroring, and genuineness, also known as 'congruence'. CfD differs from Rogerian therapy insofar as it prescribes a radically proactive engagement with the client's feelings by importing the 'treatment strategy' of Emotion Focus Therapy (EFT). The curriculum refers to the Psychometrics of Self-Discrepancy Instruments,[56] a study conforming to NICE's positivistic criteria for inclusion in IAPT. This study compares self-reports on a subject's beliefs concerning the attributes they actually possess with attributes they feel are expected of them by significant others. The subjects for this study were 137 female and 141 male students between the ages of 18–41. Ethnicity was 78.1% white American; 4.0% were on medication for depression and 3.2% were on medication for anxiety. Watson's study is included in the CfD curriculum as evidence in support of EFT, an integral component of CfD. The statistically significant ($p<0.05$) findings suggest a higher magnitude of difference between 'real-ideal' (RI) and 'real-ought' (RO) 'self-beliefs' correlated with increasing levels of dejection, dissatisfaction, disappointment and depression.[57] The therapist's non-judgemental focus on expressed emotion, such as weeping or anger, was intended to deflect the client from a preoccupation with 'oughts' and 'shoulds', helping them to find self-acceptance. The absence of an external, judgemental locus of evaluation, the study proposes, starves the client of expectations to strive for, giving greater space for the development of an 'internal locus of evaluation and control', with a resultant improvement in 'self-worth'. A focus on individuals and interiority is echoed by Layard in an article written for *Prospect* magazine in 2005:

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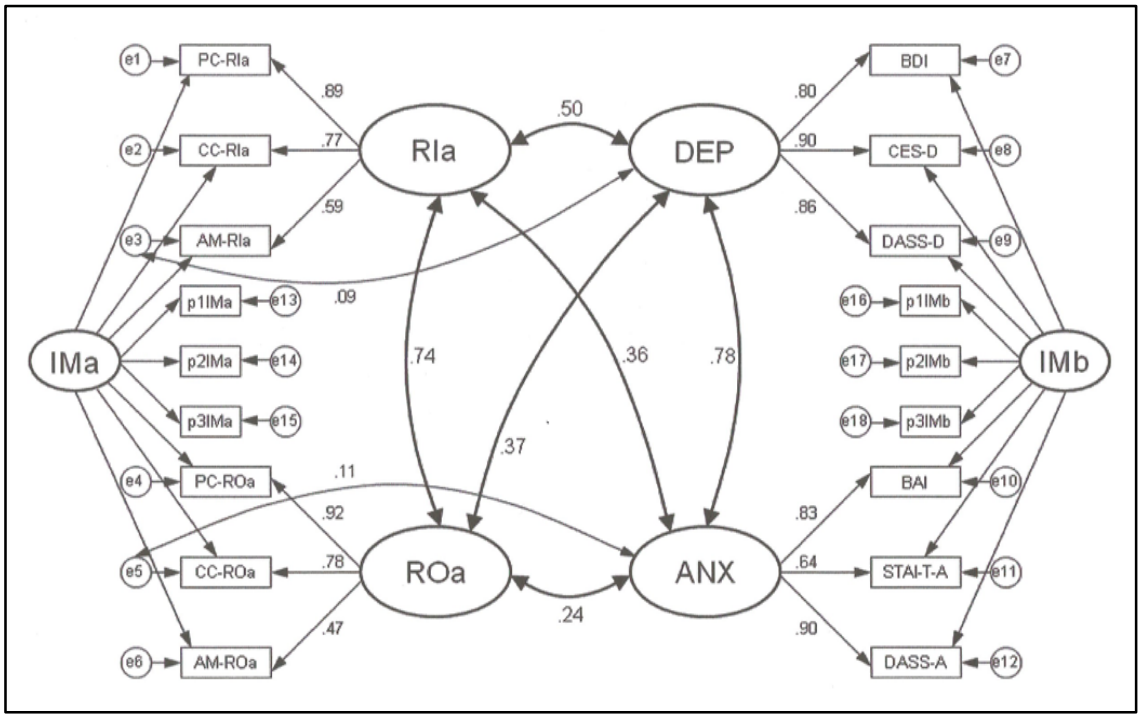
[54] Hill, A. (2011) *Curriculum for Counselling for Depression*, p. 3.
[55] Watson, N., Bryan, B. C. & Thrash, T. M. (2010) Self-discrepancy: comparisons of the psychometric properties of three instruments. *Psychological assessment,* 22, 878.
[56] Ibid.
[57] The methods used in this study include DASS (Depression Anxiety Stress Scales), and CFA (Confirmatory Factor Analysis).

> Only 15 per cent of people with clinical depression see a specialist (a psychiatrist or psychologist). For the rest, it is ten minutes with a GP and some pills. Most depressed people want psychotherapy to understand what is going on inside them. [59]

The 'Self-Discrepancy' study is positioned within the CfD curriculum to promote an empirical rationale for 'evidence-based interventions', aimed at promoting the legitimacy of CfD. Peter, one of the trainers described later in this chapter, said: 'It looks impressive but I'm not sure it means anything useful to therapists.' Andy told me it was unlikely that most counsellors or psychotherapists would understand it, as quantitative methodologies 'are not part of the core curriculum for counselling and psychotherapy'. The study was not included in a version of the manual used for training. It seemed that its purpose, acceptance by NICE gatekeepers, had been served once CfD had been 'identified' as an 'approved treatment' through its representation as 'evidence-based'.

Figure 6.3: 'Real Ought' and 'Real Ideal' personal constructs and their relation to depression and anxiety, from the Psychometrics of Self-Discrepancy Instruments



Source: Watson, N., Bryan, B. C. & Thrash, T. M. (2010) Self-Discrepancy: comparisons of the psychometric properties of three instruments. *Psychological assessment,* 22, 878.

[59] Layard, R. (2005) *Prospect.*

Figure 6.4 Index of abbreviations accompanying figure 6.3

Note. AIC = average inter-item correlation; PC = Personal Constructs; CC = Conventional Constructs; AM = Abstract Measure; RI = Real-Ideal Discrepancy; RO = Real-Ought Discrepancy; BDI-II = Beck Depression Inventory-II; CES-D = Center for Epidemiologic Studies-Depression Scale; DASS-D = Depression Anxiety Stress Scales-Depression scale; BAI = Beck Anxiety Inventory; STAI-T-A = State-Trait Anxiety Inventory-Trait-anxiety factor; DASS-A = Depression Anxiety Stress Scales-Anxiety scale; IM = Impression Management; T1 = Time 1; T2 = Time 2.

Source: Watson, N., Bryan, B. C. & Thrash, T. M. (2010) Self-discrepancy: comparisons of the psychometric properties of three instruments. *Psychological assessment,* 22, 878.

Figures 6.3 and 6.4 represent isolated and reified constructs of human misery, fostering an impression of precision, certainty and confidence. The concept of 'self-discrepancy' and the associated study outlined briefly above is offered as an adequate and comprehensible explanatory framework for the existence and 'treatment' of 'depression' in an individualising narrative:

> 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.[61] [My emphasis.]

In this narrative, distress is represented as a process to be focussed on, inspiring the newly-coined 'focal processes' and leading unproblematically to a reduction of 'self-discrepancy'. It is difficult to see how this language corresponds with lived human experience in any meaningful way, raising challenging questions of validity for this study. The framing of feelings within an abstracted positivistic discourse perpetuates the marginalisation of feelings which may be represented through the medium of narrative or artistic expression. Paul Feyerabend critiques the misuse of scientific theorising: 'Abstraction drives a wedge between our thoughts and our experience, resulting in the degeneration of both.'[62]

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[61] Hill, A. (2011) *Curriculum for Counselling for Depression,* p. 7.
[62] Feyerabend, P. (2011) *Tyranny of science*.

The range and depth of evidence offered in support of CfD seems weak even by the scientific standards the authors claim to be aligned with. This single US-based study, underpinning CfD's inclusion as 'NICE-endorsed research', parallels the reification of a discrete set of diagnostic terms and categories in common with Beck's 'a-theoretical psychiatric pragmatism'. In a critique of Layard's uncritical embrace of CBT, Pilgrim comments:

> Having no theoretical allegiance to behaviourism *per se,* but a desire to extend the applicability of behaviour therapy to inner events, Beck's a-theoretical pragmatism prevailed. Hence there was the eventual dominance of the current orthodoxy of cognitive-behavioural therapy and its emphasis on treating diagnostic categories. Psychiatric knowledge and medical dominance were thereby left intact, neither scrutinised nor criticised. Layard, in his book, simply accepts this inheritance and its epistemological assumptions.[63]

An importation of a positivistic orthodoxy into the creation of CfD perpetuates an uncritical acceptance of CBT's scientistic epistemological assumptions in a newly repurposed brand of therapy.

Andy

After I had accepted her invitation to participate in the 'early phase' of the 'CfD rollout', Joy outlined my 'trainer package': a study of the curriculum, an 'induction delivered by its author Andy Hill', including my 'shadowing' of an existing CfD training in Reading and followed by my participation in a newly-proposed training based in the east of England. I travelled by train, re-reading the CfD curriculum, to BACP House in Lutterworth, close to the geographical centre of England, to meet Andy. I had met Andy several times previously during BACP meetings. A warm and engaging person with an enthusiasm for humanistic therapy, he greeted me in the reception area where I was being issued with the ID card that I was to wear. Andy agreed to the recording of our meeting and to be quoted in my research. He suggested that once he had given me an overview of CfD and clarified any questions I had about the curriculum, he would be happy for our discussion to evolve into an interview. Andy has a background in training as a lecturer in counselling at the University of Salford, and has been working for the BACP as 'Head of Research'. He described his role:

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[63] Pilgrim, D. (2008) Reading 'happiness': CBT and the Layard thesis. *European Journal of Psychotherapy and Counselling,* 10, p. 265.

> My role? Well I work for BACP, the professional Association for Counsellors and Psychotherapists and my role on a practical operational level is to head up the research department which, you know is a fairly small unit. There's only five people in it including me, so we're a fairly small operation within BACP. Our function within the organisation and across the membership is firstly to develop a strategy for research so that the association has a sense of how it wishes to develop research and what kind of research it may wish to support and promote. And obviously to implement that strategy we aim to support research that impacts on policy. For example, there are key areas of policy that we are helping to provide research evidence for. For example, at the moment there's a lot of work for counselling in schools, with various projects which we are supporting in that field. We commission projects. So, for example, we've commissioned systematic reviews, in different areas. But also, we help to develop capacity so we put on training workshops in research methods. We have the research conference which hopefully gets people interested and motivated to get involved in research and disseminate what's going on in the field.[64]

On the top floor, we had the spacious modern boardroom to ourselves, and in the recycled air-conditioned environment (windows could not be opened for security reasons) Andy described the rationale and proposed national 'roll-out' of CfD. Counselling for Depression is described by the BACP in a short summary within the CfD practitioner manual:

> This document describes the competencies required to deliver high-quality, NICE-approved Counselling for Depression (CfD). The sets of competencies were derived from the competence framework for humanistic psychological therapies (Roth, Hill & Pilling, 2009). The process of identifying and structuring the competences into a coherent model for the practice of Counselling for Depression is described briefly, along with a discussion of how the model should be applied by practitioners.[65]

Andy explained that competencies, described in chapter four, are observable practical skills, demonstrating knowledge, which are evident when enacted in role-play or discussed 'appropriately' during monitoring sessions with approved supervisors. He stressed the point that the training is a CPD (Continuing Professional Development) opportunity for therapists, and competence is demonstrated performatively through role-play and recordings of sessions with NHS 'clients'[66]– an intellectual grasp alone of the competencies was insufficient to merit validation as a 'CfD High Intensity-Therapist'.

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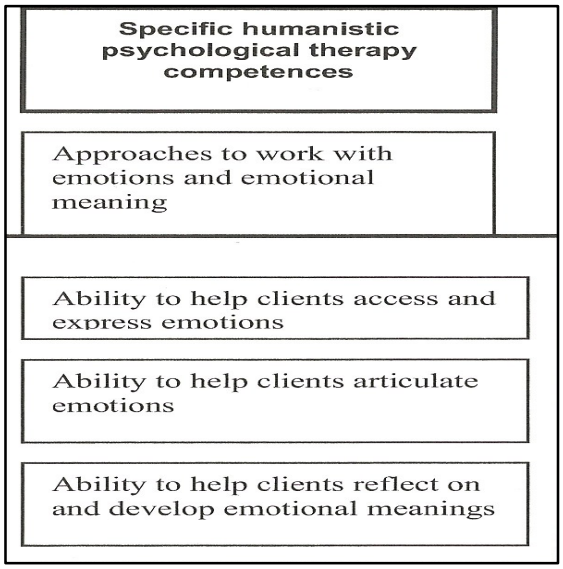
[64] Transcript from CfD induction meeting.
[65] Hill, A. (2011) *Curriculum for Counselling for Depression,* p. 1.
[66] The homogenising effect of the term 'client', used to describe a diverse range of distressed people, raises problems, discussed in the concluding chapter, over the valid application of a standard instrument for 'outcome measurement', and techniques for 'treatment'.

Figure 6.5: A section of a 'competence framework' setting out 'specific humanistic psychological therapy competences'



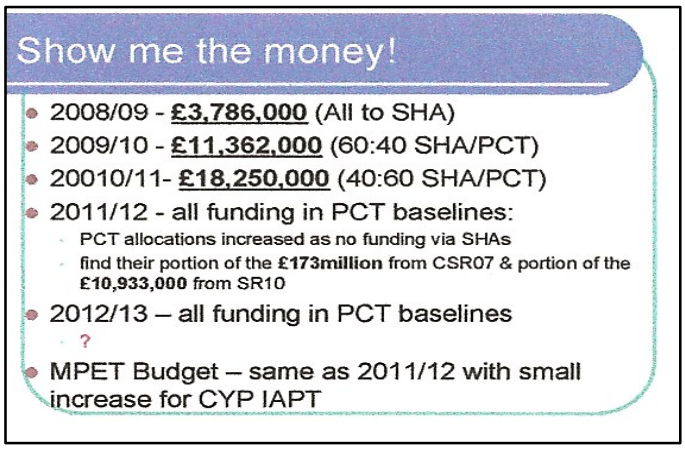
Source: CfD course handbook

The CfD curriculum places an emphasis within the 'competence framework' on emotions and 'emotional meaning' (see Figure 6.5). I asked Andy what he thought was meant by 'emotional meaning' and he said he thought it was 'what the emotion was about'. This 'competency' seems to promote a circularity whereby the therapist confirms something the client already knows. Andy told me that the training is underpinned by a reformulation of Person-Centred therapy, shaped into a 'measurable set of therapist behaviours demonstrating effective treatment for depression'. The training is intended to '...both build upon existing knowledge and, more particularly, to align counsellors' practice with a competency framework which has strong links to research evidence'.[67]

Having outlined some key points of the CfD training, Andy said he had some PowerPoint slides to show me which would help to provide the broader context behind CfD, using data provided by the BACP research department. During Slide 1, (see Figure 6.6), he described an increase in funding available to IAPT. He was enthusiastic about the opportunities this funding would create to help raise the profile of counselling in general and Humanistic/Person-Centred counselling in particular. He outlined the range of funding bodies and ratios of funding from each, with Primary Care Trusts obtaining an increasing control of IAPT funding over the period 2008–2009.

[67] Hill, A. (2011) *Curriculum for Counselling for Depression*, p. 5.

Figure 6.6: Slide 1

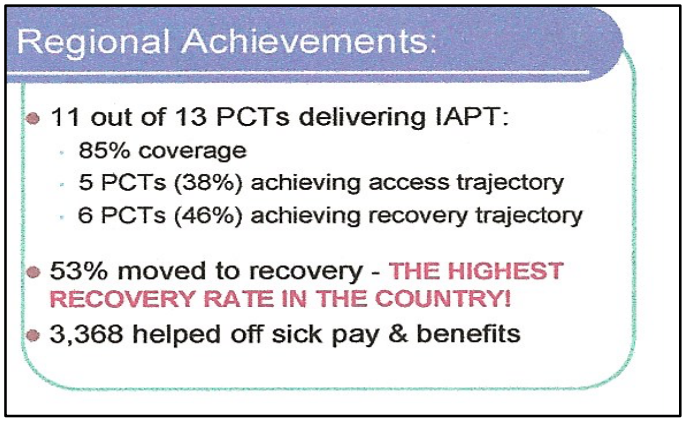


Source: CfD course materials

SHA: Strategic Health Authority; PCT: Primary Care Trust; MPET: Multi-Professional Education and Training; CYP IAPT: Children and Young People's IAPT; SR10: Spending Review period 10; CSR 07: Comprehensive Spending Review 2007.

Slide 2 (see Figure 6.7) highlighted the high 'recovery' rates in the east of England and the 'economic significance' of the fact that over 3,000 people who had received IAPT therapy were 'no longer on state benefits'; a reference to Layard's economistic rationale for IAPT.

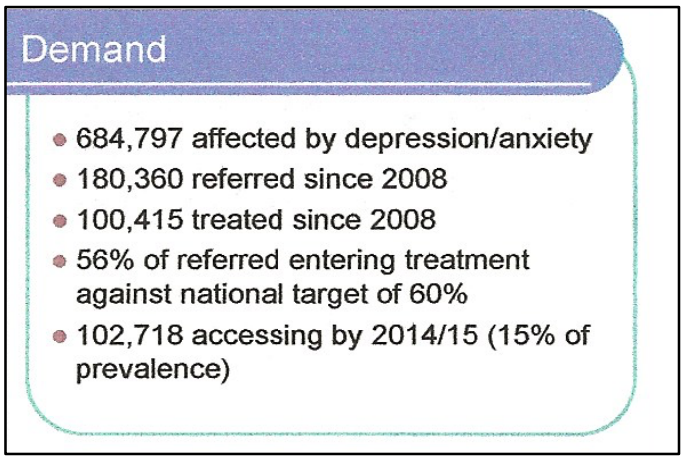
Figure 6.7: Slide 2



Source: CfD course materials

While narrating the content of Slide 3 (see Figure 6.8), Andy described the number of people identified with 'depression/anxiety' as the local 'demand'. The slide indicates that 100,415 people in distress had received treatment within IAPT between 2008 and 2012.

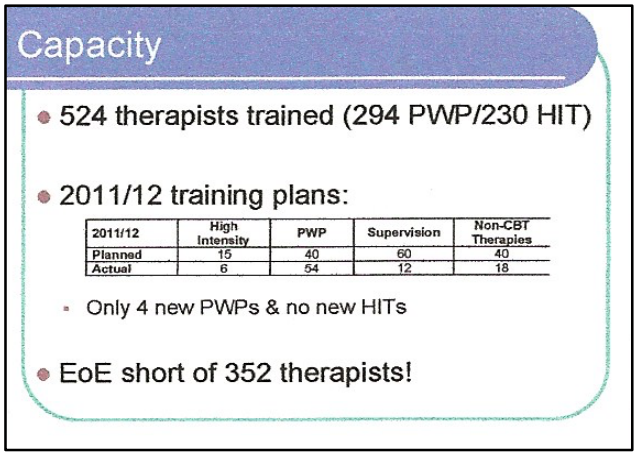
Figure 6.8: Slide 3



Source: CfD course materials.

The fourth and final slide (see Figure 6.9) that Andy presented made a case for increased training capacity, concluding with: 'East of England short of 352 therapists!'

Figure 6.9: Slide 4



Source: CfD course materials
PWP: Psychological Wellbeing Practitioner; HIT: High Intensity Therapist.

The PowerPoint presentation had the characteristics of a marketing promotion, with its emphasis on money and the commodification of distress, clients and therapists as units of consumption and production, and a culture of competition between regions as well as factions of therapists.

Andy talked next about the 'legitimacy' of CfD and its evidence base. He told me, citing the curriculum, that CfD 'competences' are 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 IAPT Programme.'[68]

Andy illustrated the process by which the scheme would be 'cascaded throughout Britain' by trainers[69] learning through participation in the first 'roll-out of CfD training'. He emphasised the key aim of the programme: 'To enable Person-Centred therapists working in the NHS to bid for referrals against CBT who took the vast majority of referrals for High Intensity Therapy.' He made the point that the majority of BACP members have had a humanistic/person-centred training, and that many of those who worked within the NHS were being marginalised, and finding it difficult on zero-hour contracts to obtain therapy referrals, by the positioning of CBT as the 'NICE recommended treatment for depression'. I asked Andy to enlarge on this point and he put it this way:

> The fact is, even though CBT is, you know, is the main beneficiary, the fact is that we have had a huge shift in this country from prescribing anti-depressants towards psychological therapy. You know the fact psychological therapy is a frontline treatment and not drugs are actually something really significant and it's something and that hasn't happened in North America, for example, where drug treatment tends to dominate. So, I think that, you know, okay, CBT is an issue but, I mean, the general trend is toward psychological therapy which, you know, can only be good professionally.[70]

He continued by commenting on a Sheffield University randomised controlled trial (RCT)[71] commissioned by the BACP to provide an 'evidence-base' for counselling and psychotherapy:

> In terms of playing the evidence-based game, you know, it has to be done. I think if BACP doesn't, nobody else is going to do it really. BACP needs to provide the resources for that. I know some people would like to wait until it [CBT] dies a death but we could be waiting too long. We might die the death first so that the evidence-based paradigm really requires our profession to do several things really. It's sometimes controversial within our membership to actually recognise strengths, or dominance of the evidence-based paradigms, that it's not something that can just be dodged. Unless counselling is actually in the NICE guidelines, the danger is that it'll just be ignored and marginalised. It [the trial] is going to be quite a

[68] Hill, A. (2011) *Curriculum for Counselling for Depression*, p. 6.
[69] Trainers were drawn from the staff of existing BACP Accredited Courses.
[70] Interview 17.
[71] A BACP Research Committee funded RCT with 550 respondents using: 'PRaCTICED methodology; Pragmatic Randomised Controlled Trial assessing the non-Inferiority of Counselling and its Effectiveness for Depression', (personal correspondence, April 2012, BACP research dept.).

> significant piece of work really and it's BACP-funded and it is directly aimed at influencing NICE guidelines and national policy on therapies delivered in the NHS so it's, in a sense, it's positioned politically to, to have that sort of impact.[72]

Andy saw a life and death struggle of humanistic therapy pitted against CBT in the frame of a 'game', his weapons of choice being 'evidence-based paradigms' currently dominating the legitimation of NHS-funded therapy. In a published interview, the author of the Sheffield University trial, Michael Barkham, argued in support of 'evidence for effectiveness':

> For the world of counselling, I think this trial is hugely important. We – whether we are researchers, practitioners, managers, commissioners or, most importantly, clients – need robust evidence for the effectiveness (or otherwise) of *bona fide* interventions. We live in a climate where there is increasing scrutiny of our interventions and NICE has a huge influence on decisions about which psychological interventions are recommended and which are not. Researchers need to deliver evidence that is acceptable to the stringent criteria employed by NICE. The evidence also has to fit the needs of stepped care that is driving much of service development.[73]

Barkham appears to advocate the importation of psychology's positivistic 'stringent' methodology into an evidence-base culture of 'increasing scrutiny'. Perhaps unsurprisingly, for a trial predicated on the 'non-inferiority of Counselling and its Effectiveness for Depression', he has embraced CBT's positivistic epistemology.

The justification for CfD through a putative alignment with 'robust evidence' and 'bona fide interventions' is enacted, in the production of a new brand of therapy with its underpinning rationalisations, as a performance. In this view, naïve empiricism and factualism serve as performative props to sustain an appearance of scientific rigour. The concept of 'bona fide interventions' is presented without elaboration, (since there is no agreement on what a bona fide intervention might consist of) and is therefore not a constative statement: 'While the words of a performance do in some sense "fit" the world, conforming to the conventions that govern their success, they also constitute it, so that by their very utterance the world is also made to fit the words.'[74] The 'game' alluded to by CfD's author was played to reposition a subordinated group in the context of a dispute between factions within the field of talking therapy – not to uncover new

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[72] Interview 17.
[73] Barkham, M. (2013) Counselling for Depression vs.CBT. *Therapy Today,* 24.
[74] Hall, K., (2000) *Journal of Linguistic Anthropology* 9(1-2), Washington DC: American Anthropological Association, p.185.

knowledge. The role of performativity is a recurring trope in the following chapters where an emphasis on performance during role-plays for the assessment of competence are a regular feature of counsellor training.

We reached the end of our meeting. I had no further questions. Andy felt that he had covered enough material to enable me to participate as an observer in a course for qualified Humanistic Therapists to train in CfD in the east of England. As my next step was to 'shadow' a course due to start in a few weeks in Reading, he gave me a copy of the Course Handbook, an edited version of the CfD curriculum I had studied earlier. The front cover of this version (see Figure 6.11), does not make mention of the NHS or IAPT. The Modernist image, *Composition with Yellow, Blue and Red* by Piet Mondrian,[75] is placed prominently on the cover. A brief description runs:

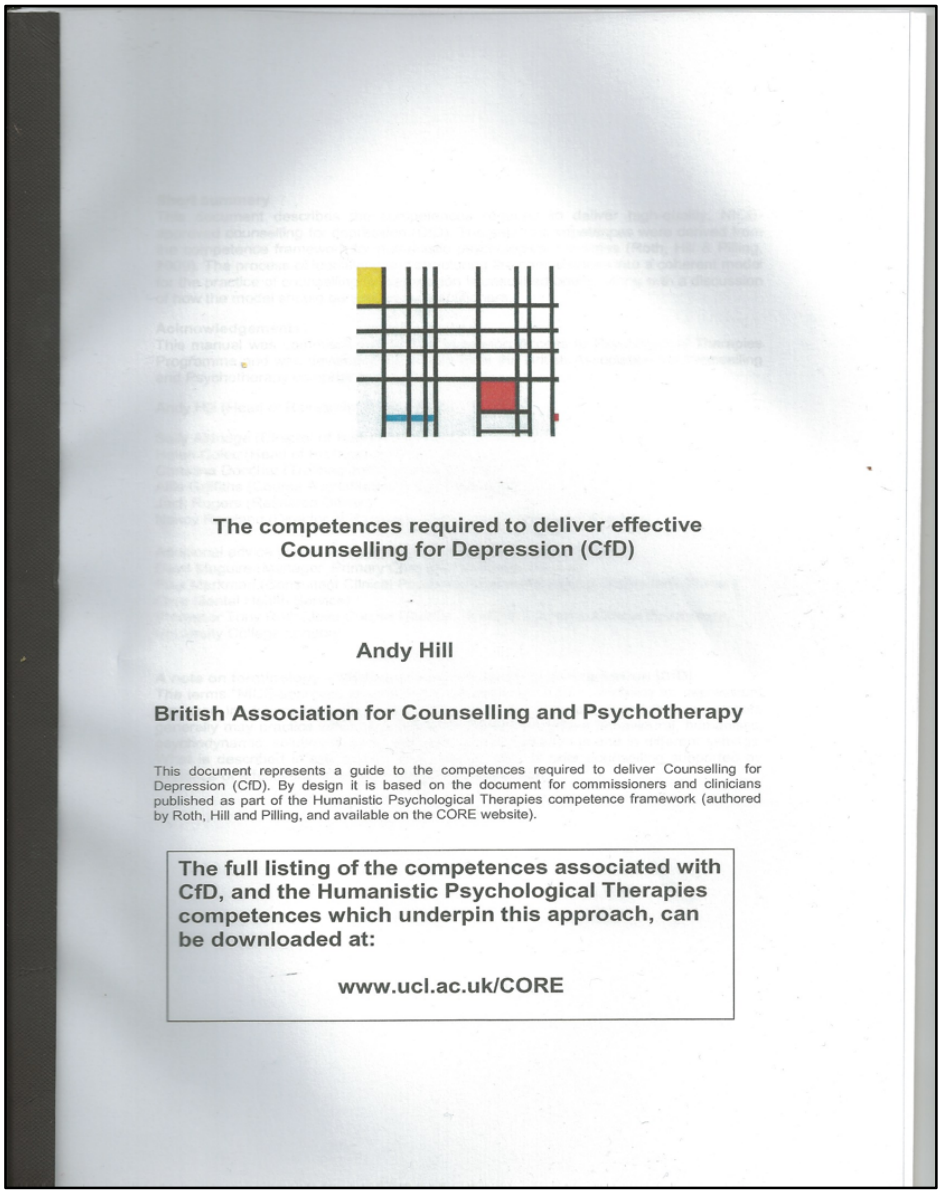
> This document represents a guide to the competences required to deliver Counselling for Depression (CfD). By design it is based on the document for commissioners and clinicians published as part of the Humanistic Psychological Therapies competence framework (authored by Roth, Hill and Pilling, and available on the CORE[76] website).

The CfD project, represented within a criterion-based curriculum and endorsed by NICE, was presented to me by the head of research for the leading body representing counsellors and psychotherapists as both necessary and sufficient in an economistic rhetoric of brands, markets and consumers, where a new 'market' of distressed people had been opened using the constructs of DSM-5[77] to identify suitable 'depressed clients'. A workforce of psychological therapists would be needed to meet this 'demand', and clinical psychologists, nurses and wellbeing practitioners had already made considerable progress in establishing themselves using the market-leading therapy product, CBT. In the light of this, and feeling marginalised, humanistic and psychoanalytic counsellors and psychotherapists, traditionally opposed to the medicalising of distress, responded with a codified and digitally-Taylorised representation of therapy, using a lexicon of competences, components and processes to promote Person-Centred counselling as an alternative to CBT in the

[75] The same design is used for other 'competences', for example: Lemma, A., Roth, A. & Pilling, S. (2008) *The competences required to deliver effective psychoanalytic/psychodynamic therapy.*
[76] Centre for Outcomes Research and Effectiveness; UCL division of psychology and language sciences.
[77] American Psychiatric Association (2013).

NHS. This narrative, medicalising ordinary human unhappiness within a culture of epistemological positivism, has made a significant impact on the character and praxis of counselling and psychotherapy in Britain's NHS.

Figure 6.1: CfD Course Handbook



The competences required to deliver effective Counselling for Depression (CfD)

Andy Hill

British Association for Counselling and Psychotherapy

This document represents a guide to the competences required to deliver Counselling for Depression (CfD). By design it is based on the document for commissioners and clinicians published as part of the Humanistic Psychological Therapies competence framework (authored by Roth, Hill and Pilling, and available on the CORE website).

The full listing of the competences associated with CfD, and the Humanistic Psychological Therapies competences which underpin this approach, can be downloaded at:

www.ucl.ac.uk/CORE

Source: British Association for Counselling and Psychotherapy

Chapter 7

Counselling for Depression

This chapter narrates my shadowing of one of the first CfD trainings in Britain, which was led by one of the creators of the scheme (who had worked with Andy Hill in devising 'strategies to translate the CfD curriculum into a five day training') and a further week spent as one of a team 'delivering' the training in the east of England as a participant observer.

A few weeks after my day at BACP House, narrated in the previous chapter, Andy proposed that I apply to join a CfD training that was planned to take place in the psychology department at the Charlie Waller Institute at the University of Reading, in an observational role. This second iteration of the programme, which was still in its developing stages, was led by Robin, the director of Person-Centred counselling from the Rogers Institute.[1] I had met Robin a year earlier during a Quality Assurance Agency (QAA)[2] for Higher Education 'benchmark' standards meeting, and, over a buffet lunch, had asked him if he thought that the new standards might facilitate pluralism in the training of counselling and psychotherapy following a proposal to include some philosophical and historical context in therapy trainings.[3] Members of the QAA group were attempting to produce a 'modality-free' set of 'benchmarks' for the teaching of counselling and psychotherapy in higher education. The proposed standards would not promote the epistemology of any one counselling or psychotherapy approach, but, in a process of reduction, would identify and explicate common factors such as 'therapeutic alliance' or 'risk assessment'. Robin told me of his lack of confidence in therapeutic 'modalities' outside the Person-Centred Approach—in direct contradiction to his role on the QAA group. He was openly hostile to psychoanalysis, suggesting that psychoanalytic theory '...gave something for analysts to think about while they were being bored by their patients'.

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[1] The Rogers Institute, a humanistically-oriented psychotherapy training organisation, had collaborated with the BACP in devising the CfD Programme and documentation.

[2] The Quality Assurance Agency for Higher Education (2013) *Subject benchmark statement: Counselling and Psychotherapy.*

[3] E.g. 'Identify some of the philosophical assumptions underpinning the practice of counselling and psychotherapy', or 'Appraise the interrelatedness of truth claims, belief and ideology, and their influence on professional practice.' Ibid., p. 11.

In an email reminding me of our discussion, Robin said he thought I might want to question the underpinning assumptions[4] of Person-Centred therapy during the training, and may therefore have a distracting and disruptive impact. However, after assurances from me that I would take a neutral position in my role as participant observer, I was warmly welcomed onto the course. Robin had been wary of a policy of therapeutic pluralism, fearing that his deeply-held beliefs in Rogers' concepts of 'self-actualisation' and 'the true self' might be problematised, undermining his faith in the singularity of the Person-Centred Approach.

Hence, I spent a humid Sunday night in a dilapidated Reading hotel used by the local council to provide temporary accommodation to homeless people. The next day, a short morning walk in the sun took me to the psychology department of the University of Reading and the start of the five-day course. The Charlie Waller Institute is a collaborative initiative between the university, The Charlie Waller[5] Memorial Trust, and Berkshire Healthcare Trust. The objectives of the institute are to: evaluate psychologist training effectiveness; undertake research to add to the evidence-base for psychological treatments; and train clinicians in evidence-based psychological treatments, in particular those recommended by NICE.

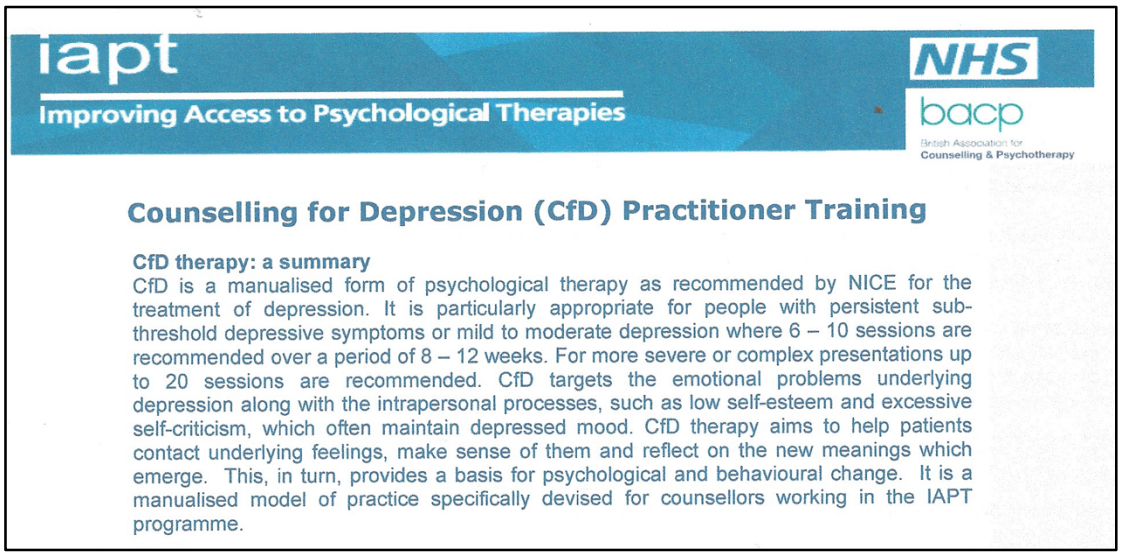
Once the registration process was complete, the group, (consisting of sixteen women and three men) assembled, chatting earnestly over cake and coffee in a large modern teaching room. The group was drawn from counsellors and psychotherapists employed in NHS settings in the southeast of England who shared a therapeutic identity derived from their person-centred training and subsequent practice. Each group member introduced the person next to them in an 'ice breaker' and it soon became evident that many participants were anxious about the lack of referrals coming their way. As one of them put it: 'CBT has taken over; we're at the back of the queue for referrals.' The nineteen candidates were, it appeared, seasoned therapists who spent most of their working life providing an empathic and thoughtful ear to people in various states of distress, but whose working conditions were becoming increasingly precarious.

In his opening address, Robin outlined the structure and aims of the five-day training course and narrated documents he circulated as the morning progressed—for example, 'CfD therapy: a summary'. This document (see Figure 7.1), in the NHS 'house' style, brings together the

[4] An examination of therapy's underpinning assumptions formed part of the Core Curriculum and was imported into the QAA specification for counselling and psychotherapy.
[5] Charlie Waller was a 28-year-old man with depression who took his own life.

'corporate' fonts of the NHS, IAPT and the BACP. The text uses language that is not a part of counsellors' or psychotherapists' usual lexicon, such as 'treatment', 'persistent sub-threshold depressive symptoms' and 'severe or complex presentations'.

Figure 7.1: A summary of CfD in a document co-produced by the BACP and the NHS in a course handout


iapt
Improving Access to Psychological Therapies
NHS
bacp
British Association for Counselling & Psychotherapy

Counselling for Depression (CfD) Practitioner Training

CfD therapy: a summary

CfD is a manualised form of psychological therapy as recommended by NICE for the treatment of depression. It is particularly appropriate for people with persistent sub-threshold depressive symptoms or mild to moderate depression where 6 – 10 sessions are recommended over a period of 8 – 12 weeks. For more severe or complex presentations up to 20 sessions are recommended. CfD targets the emotional problems underlying depression along with the intrapersonal processes, such as low self-esteem and excessive self-criticism, which often maintain depressed mood. CfD therapy aims to help patients contact underlying feelings, make sense of them and reflect on the new meanings which emerge. This, in turn, provides a basis for psychological and behavioural change. It is a manualised model of practice specifically devised for counsellors working in the IAPT programme.

Source: CfD programme outline

The modular structure of the training would, Robin told us, provide a balance between didactic input and practical work, and be facilitated by his assistant Karina, a cheerful drama therapist who said very little in the first session other than to repeat what Robin said with added gusto. After a buffet lunch, Karina took the lead and invited students to share some of their experiences working within an IAPT setting and the 'stepped-care' model for the treatment of depression.

To be eligible for 'face-to-face counselling'—classified as High Intensity Therapy—clients had to have worked their way through the 'Stepped Care Programme', starting with 'Low Intensity Therapy' such as CCBT (computerised CBT). Several students suggested that clients who were sure they wanted to talk to someone in person felt rejected by the process. Most of the therapists said they objected to the use of paper-based measures; they 'got in the way', or conveyed the impression that the therapist was 'more interested in the paperwork than in the client'.

Lyn, in a broad Yorkshire dialect, spoke of a client who had taken a PHQ9[6] test during the 'Low Intensity' phase of his treatment and felt confounded when he was told he was depressed, as revealed by a high score. She responded to her client by saying: 'You don't seem depressed to me, but you do appear quite worried.' Lyn described the profound effect this observation had on her client, who said he felt 'understood at last'. Lyn had used her own feelings, outside the objectifying narrative of psychological jargon, enabling her to engage with her client in a non-instrumental, meaningful way.

Robin had wanted to find a way to encourage students to engage with IAPT's 'stepped care' model, the 'short-term focus', the use of 'assessment tools' and a focus on 'emotional meaning'. Karina set up role-plays where candidates could experiment with different strategies to encourage clients to complete CORE[7] forms. Lyn said: 'My clients just want to talk.' During the remainder of the course a tension prevailed between what therapists described as various ways of working with their clients and the 'specified high-intensity interventions' of CfD. Bob, a retired GP who had retrained as a therapist, told me: 'This is so mechanical and inhuman, not what I signed up to at all.'

By the end of the course Robin seemed pleased with his students' 'progress'. What he did not know was that most of them had talked privately about him in disparaging, sometimes mocking, terms. His enthusiasm for the Person-Centred approach and 'authenticity' did not ring true to many students, in spite of his smiling and overtly attentive behaviour. One student said that 'Robin's a fake nice person'. Others were less polite.

The 'theoretical' parts of the course appeared to promote the exclusive use of 'evidence-based interventions', designating other, more idiosyncratic and spontaneous interventions as inappropriate, and therefore inadmissible. Practical sections of the training, such as role-play,

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[6] Patient Health Questionnaire, developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc., available at www.ubcmood.ca/sad/PHQ-9.pdf (accessed 21 March 2016).

[7] Clinical Outcomes in Routine Evaluation: a tool for the measurement of progress though therapy and in the evaluation of therapy in RCTs. See: Barkham, M., Mellor-Clark, J., Connell, J., and Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling & Psychotherapy Research*, 6 (1) pp. 3–15.

monitored compliance with codified representations of emotional labour,[8] captured within the reductive constructs of 'therapeutic competency'. This displaces the possibility of tacit knowledge,[9] where therapy training had—prior to the range of the 'mapping', 'scoping', 'benchmarking' and 'job analysis' projects narrated in this thesis—putatively operated as a medium for implicit understanding to emerge from a pluralistic, complex and open-ended view of the human condition. By contrast, the CfD training operated to shut out the possibility that 'we can know more than we can tell',[10] with rote-training procedures displacing discursive and implicit elements of therapy practice.

ThinkAgain

A few days after my return from Reading, Joy, who was managing the 'programme rollout' from BACP headquarters, invited me to participate in the first CfD training in the Essex 'Strategic Health Authority' (SHA) area. This region includes areas of significant deprivation:

> The most deprived neighbourhood in England is to the east of the Jaywick area of Clacton-on-Sea (Tendring 018a), and this was also the most deprived neighbourhood according to the Index of Multiple Deprivation 2010.[11]

Joy suggested I contact Kathy, 'Clinical Lead'[12] at ThinkAgain, one of the Essex SHA IAPT providers. ThinkAgain had secured government funding[13] to train the local counsellors and therapists working for the NHS a group described as being 'marginalised by the dominance of CBT within IAPT' by the CfD curriculum author Andy Hill. I arranged to meet Kathy, who asked me to help her select suitable candidates for CfD training from her team of humanistic therapists.

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[8] Hochschild, A. R. (2003) *The managed heart: Commercialization of human feeling, With a new afterword*.
[9] Polanyi, M. (1966) *The Tacit Dimension*.
[10] Ibid., p. 4.
[11] Department for Communities and Local Government, The English Indices of Deprivation 2015, available at www.gov.uk/government/statistics/english-indices-of-deprivation-2015 (accessed 20 January 2017).
[12] A management role filled by a person with 'clinical' responsibilities, providing treatment to NHS patients (field notes).
[13] Funding for England for CfD 2010–2012 was £396,000 (personal correspondence, March 2015, BACP Research Dept.).

ThinkAgain was located in a refurbished supermarket building in a business park on the edge of a market town in the east of England. A demolished part of the supermarket was enclosed by graffiti-covered hoardings. The space outside was littered and desolate. Once I got through the main door, after an intercom malfunction, the cautiously friendly receptionist logged me in and I was given a name card to wear. My impression was that she thought I might have been coming in for 'treatment', so I explained that I was meeting Kathy as part of my research.

She said she would show me around on the way to Kathy's office. She opened a door near the reception area to reveal a large conference room fitted with two wall-mounted plasma display screens and furnished with an oak-effect table and leatherette chairs. The main part of the building consisted of an open office with about forty-five desks, each equipped with a PC, arranged within the brightly-lit expanse. Some of the desks were divided into clusters by oak-effect separating panels. The receptionist explained that it was from these desks that therapists started their work with new clients. She said the aim was to avoid meeting the clients if at all possible unless they were 'quite unwell', in which case they would, after several weeks, receive CBT. The high windows prevented a view outside, and a few plastic plants sat on adjacent shelves. In the distance, three Senior Managers' offices were screened by floor-to-ceiling one-way mirror glass and grey vertical blinds. On one long side of the remodelled supermarket lay a series of rooms marked 'Clinical Leads'.

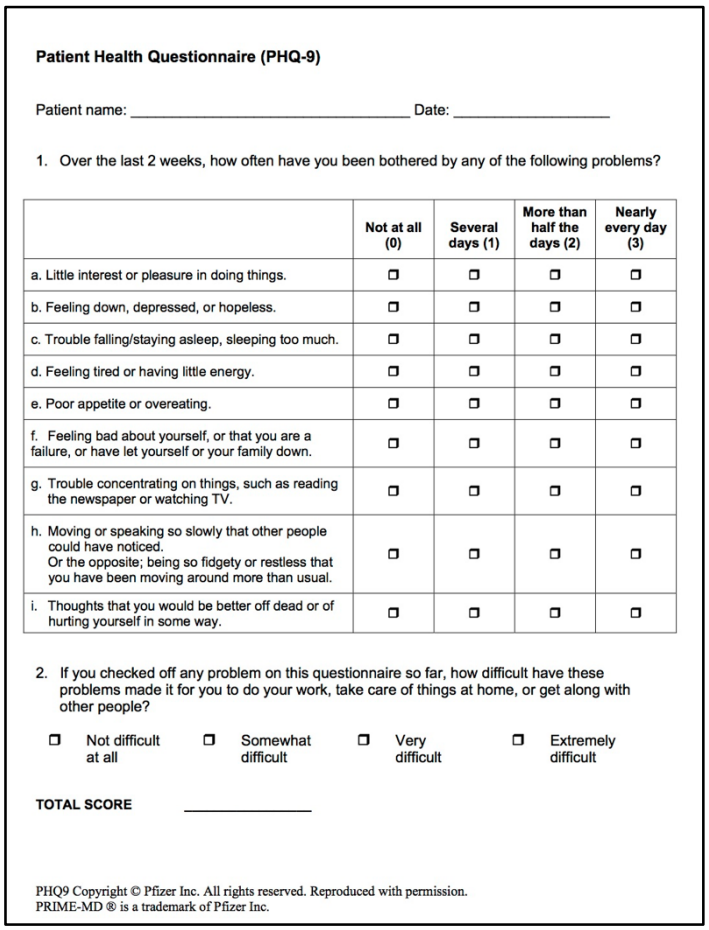
It was in one of these rooms that I met Kathy, dressed in a dark suit and smiling broadly. She told me that she was responsible for 'screening' referrals to her team of 'High Intensity' therapists, where clients would meet therapists for 'face-to-face' counselling. This term has emerged to contrast the (cheaper) telephone and online therapeutic interventions with traditional approaches, where a client would meet a therapist in person. She also had the role of processing applications from counsellors and psychotherapists who were interested in the well-publicised CfD training. Kathy had originally been trained in the Person-Centred Approach but told me she had recently started using CBT and had begun to 'believe in it'. She explained that she still 'likes Rogers', but felt more secure in being able to use approaches 'which are scientific and effective, making them cheaper to deliver'. She said: 'In my heart I agree with a non-directive approach, but we haven't got the time or money to let clients find their own way anymore.' I wondered whether her senior position was contingent on her meeting cost-cutting targets.

As Kathy leafed through the application forms, reading out personal statements, she spoke frankly of her thoughts about the candidates. She expressed irritation towards a few applicants whom, she said, were 'Person-Centred fundamentalists'. Kathy told me how she had tried, but failed, to get these therapists to make their clients fill out the GAD7[14] 'anxiety assessment' or PHQ-9 'diagnostic instrument' forms (see Figure 7.2). She had tried to persuade the counsellors that 'targets for suicide risk management' needed evidence, and the survival of ThinkAgain[15] depended on meeting those targets to maintain NHS funding.

The PHQ-9 (Primary Care Evaluation of Mental Disorders Patient Health Questionnaire) was developed by Dr. Robert L. Spitzer and colleagues using a grant from Pfizer Inc. Pfizer is a major pharmaceutical company responsible for the manufacture of the popularly prescribed SSRI antidepressant Zoloft, originally branded as Lustral in the UK. He was chair of a task force writing the third (1980) edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual'.

[14] Available at www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf. (accessed 21 January 2017).
[15] Disbanded due to expired funding within a year of this meeting.

Figure 7.2: PHQ-9, a measurement for depression used routinely under IAPT



Patient Health Questionnaire (PHQ-9)

Patient name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

TOTAL SCORE _____

PHQ9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission.
PRIME-MD ® is a trademark of Pfizer Inc.

Source: www.ubcmood.ca/sad/PHQ-9.pdf (accessed 21 March 2016)

Kathy explained that it was ThinkAgain policy to ensure clients fill out a PHQ-9 and GAD7 each time they attended a therapy session. The group of 'person-centred fundamentalists' who opposed the use of 'screening tools' told Kathy they wanted 'to preserve client autonomy' by refusing to ask clients to complete the forms. Kathy said she was happy to offer places on the CfD training to therapists who worked well as 'team players', did 'not rock the boat' and had co-operated with ThinkAgain by encouraging clients to complete the 'patient questionnaires'. She wanted the course to succeed; the reputation of ThinkAgain was 'at stake'. The problem, as Kathy put it, was the 'stubbornness of therapists who resist change'. She suggested that a literal interpretation of Carl Rogers, avoiding any kind of assessment, was 'a fiction maintained by purists to preserve an illusion of therapist non-directivity'. Paradoxically, Colin Feltham argues that: '[The therapist] …tries strenuously to avoid interpretation, curiosity, and anything that might influence the client. It has been amply demonstrated however that even Rogers, skilful as he was, tended to reinforce client statements when they coincided with his own beliefs. Halmos among others has emphasised

that non-directivity is a myth.'[16] Kathy told me that without the evidence provided by the assessment tools, ThinkAgain could not satisfy the audit requirements of IAPT and would lose funding.

Kathy said that not all of her counsellors were 'so inflexible'. She said that therapists who described themselves as humanist rather than Rogerian were more eclectic and pragmatic. The original CfD curriculum was aimed at graduates in 'Humanistic *or* Person-Centred Therapy'. Humanistic therapy trainings are inclusive of the Rogerian paradigm, but integrate alternative responses to distress and therefore allow responses from the therapist which are not so closely contingent on the client's narrative.

Put another way, Humanistic therapists may offer their clients some of their own thoughts and ideas based on what they hope might be helpful. Towards the end of our discussion, Kathy said: 'I prefer the creative therapists that can think for themselves and ask questions or make suggestions when they feel it might help the client.' She recalled a story about a therapist who, in a literal interpretation of the Rogerian approach, simply repeated everything the client said. The client complained to Kathy, saying: 'It was like being in an echo chamber.' The significance of this nuanced differentiation between two distinct, but similar, therapeutic modalities is narrated in the next section, and informs a short discussion of professional demarcation strategies in chapter ten.

Rodney

The opportunity CfD provided for non-CBT therapists to bid for work using an 'evidence-based treatment',[17] reinforced an existing factional split between 'Person-Centred purists and more eclectic progressives', as Kathy had put it. Similar situations emerged in other regions of Britain. Some trainers aligned to a more literal interpretation of Rogers' methods wrote to Andy Hill, concerned about 'diluting' the Person-Centred Approach by admitting candidates to CfD training with no primary specialist training in the modality. Andy responded in a group email to CfD trainers in all British regions:

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[16] Feltham, C. (2013) *Counselling and Counselling Psychology - a critical examination*, p. 63.
[17] By this point in the 'rollout' of CfD the validity and status of the 'evidence base' appeared to have become established as an *a-priori* given, and attention was focused exclusively on the means by which specified 'ends', for example a reduction in measures of 'depression', could be achieved.

> A number of discussions recently have pointed out the need for greater access to CfD training for counsellors, particularly those in IAPT services who haven't undergone initial training in either person-centred or humanistic counselling/psychotherapy. Currently these counsellors would not be eligible for CfD training and there are rather a lot of them; they would have difficulties accessing IPT[18] or DIT[19] training for similar reasons. Hence they don't really have access to training in an evidence-based modality, *leaving them vulnerable in the current climate*. We counsellors have spoken in the past about developing a conversion course of some kind for such counsellors as a prerequisite for entering CfD training. It needs to be suitable for experienced psychological therapists working in IAPT/NHS primary care settings and not too onerous, however it needs to provide a basis for integrative therapists to be successful in completing the CfD Programme. *We can't set people up to fail*. [20] [My emphasis.]

Andy's argument for a conversion course was challenged, in an email correspondence, by Rodney, a Person-Centred trainer and therapist from the Midlands. Rodney had a senior position at a Midlands university and was known for his advocacy of a close adherence to Rogers' key texts. He was popular within the Person-Centred community through several popular books he had written. Rodney expressed the view that CfD candidates should be schooled in the Person-Centred approach from the beginning of their training in counselling and psychotherapy. He had opposed a generic foundation course based on a history of the emergence of counselling and psychotherapy, including psychoanalysis and phenomenology, on the grounds that it might 'give trainees the wrong ideas' before they have had a chance to 'experience the client deeply and without preconceptions'.[21] Rodney responded to Andy's suggestion of a conversion course:

> A five-day training is likely to give a clearer route for those who, having completed integrative or humanistic trainings, have gone on to find and become *passionate* about the Person-Centred approach. It is less likely to prove sufficient to retrain someone whose training and practice diverges too far and perhaps very unlikely to unless they are genuinely motivated to grasp the theory and practice of the approach rather than because they are motivated to acquire the IAPT licensing.[22] [My emphasis.]

Rodney's focus on 'passionate' motivation remained an obstacle to agreement on entry standards for CfD trainees, and it soon became clear that the issue would remain unresolved until regional trainers met and found a compromise. Since I was participating in the 'course management' with

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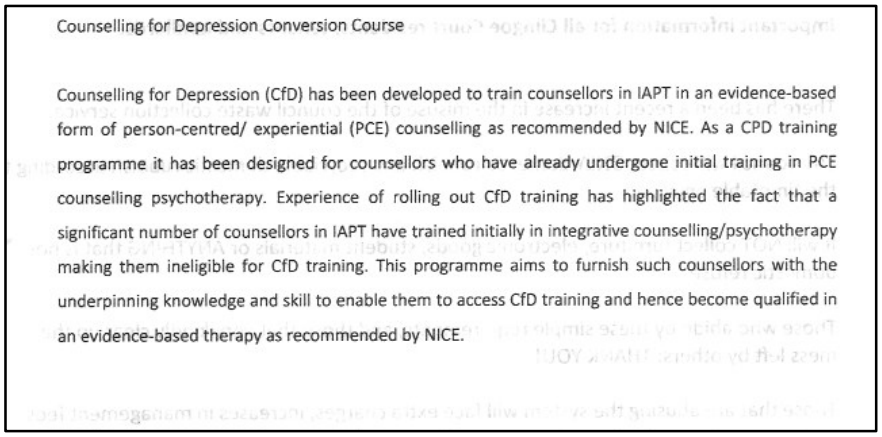
[18] Interpersonal Psychotherapy for depression, and Dynamic Interpersonal Therapy (field notes).
[19] Brief Dynamic Interpersonal Therapy, a brief form of psychodynamic therapy (field notes).
[20] Personal email correspondence.
[21] Personal email correspondence.
[22] Ibid.

a group of trainers 'delivering CfD', Andy invited me to a preliminary meeting in a West London hotel. He had written a brief outline for his proposed 'Counselling for Depression Conversion Course', which he hoped the trainers would agree on (see Figure 7.3).

Figure 7.3: Front page of the CfD Conversion course



Counselling for Depression Conversion Course

Counselling for Depression (CfD) has been developed to train counsellors in IAPT in an evidence-based form of person-centred/ experiential (PCE) counselling as recommended by NICE. As a CPD training programme it has been designed for counsellors who have already undergone initial training in PCE counselling psychotherapy. Experience of rolling out CfD training has highlighted the fact that a significant number of counsellors in IAPT have trained initially in integrative counselling/psychotherapy making them ineligible for CfD training. This programme aims to furnish such counsellors with the underpinning knowledge and skill to enable them to access CfD training and hence become qualified in an evidence-based therapy as recommended by NICE.

Source: CfD trainer group meeting agenda

The outline suggested separate categories for 'aims', 'objectives' and 'outcomes'. 'Teaching' and 'learning' were subsumed under one heading. The group did not engage with the task in the way that Andy had hoped. Rodney dominated the discussion, opposing Andy's suggestion of a conversion course and reiterating his well-known advocacy of the sufficiency of the Person-Centred approach and the importance of an 'extended immersive training' in it. Offering clients 'core conditions of empathy, genuineness and unconditional positive regard' was, he proposed, 'sufficient to facilitate positive therapeutic change'. This would therefore exclude engaging with clients' personal histories and social contexts, which, he argued, was a distraction, placing his faith in a humanism that '...empowers the client towards self-actualisation and autonomy'. This reading of Rogerian therapy is suggestive of a universal humanism, blind to social justice and diversity: 'Far from being a positive, this is seen to lead, morally, to a dangerous self-absorption, narcissism and selfishness; and, politically, to justify the excesses of the free markets of a *laissez-faire capitalism*.'[23]

During the discussion, Rodney acknowledged that working in multi-disciplinary teams with a diversity of people in distress in NHS settings could lead to some 'regrettable contamination of technique'. Rodney said that he hoped the CfD training would 'help re-establish Rogerian therapy

[23] Plummer, K. (2001) *Documents of life 2: An invitation to a critical humanism,* p. 257.

in the NHS'. He seemed to regard CfD as a Trojan horse in his 'passionate' advocacy of Rogers. He was worried a conversion course could pave the way for shorter, 'lightweight' trainings:

> My angle on this is that it might give the impression that person centred modality can be learned from scratch by a therapist of any modality in a matter of days and this may in turn negatively impact on how PC counselling and CfD is perceived compared with CBT, IPT DIT....[24]

Tony, who subscribed to a pragmatically eclectic therapeutic approach (and later dropped out of the CfD training programme), made a point:

> You can't have it both ways. If you accept that in CfD person-centred interventions can be written down as competencies and then, if one student or another can get it straight away, can pass the adherence criteria etc., then how can you then argue that a proper training has to take years?[25]

The group was stuck. By restricting the scheme to the limited number of candidates with an exclusively Person-Centred training, it seemed unlikely that the CfD programme would be viable due to a lack of suitably trained candidates. Rodney had vetoed the prospect of a conversion course to enable a wider range of therapists to become eligible for CfD training, thereby putting the scheme at risk of collapse. After further discussion, Rodney offered a way out of the impasse:

> Would it be possible for those who don't tick the boxes to give them an option to submit a tape of client work in order to determine suitability for CfD training?[26]

The day had been a long one; it was raining, past seven in the evening and the group members were tired and wanted to go home. They agreed on the final option—that the conversion course proposal be abandoned. CfD Programme Leaders from each of the regions would be able to use audio recordings of sessions with clients as evidence to reject applications in cases of doubt about an applicant's 'passion for the Person-Centred approach'. I walked to the tube station with Tony, who said: 'It'll make no difference in the end; the old modality allegiances are being replaced by tick-box generic competencies.'

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[24] Field notes taken during a CfD trainer meeting.
[25] Ibid.
[26] Ibid.

Rodney had insisted that the sanctity of his favoured therapeutic approach would prevail, but at some cost. By conceding his original demand for a substantive immersion in the Rogerian approach as a basis of eligibility for CfD training, he left open the possibility that someone with no training in the Person-Centred approach could get lucky and, with a bit of coaching, submit a taped therapy session as an alternative to providing evidence of three years of training, contradicting the premise of Rodney's original objection.

Jane

With no conversion course as an obstacle, Kathy enrolled twenty-two therapists employed by ThinkAgain onto the course, the only entry requirement being that they had completed a Humanistic or Person-Centred training. The use of audio recordings of client work to check students' suitability for CfD training did not take place, since Kathy provided supporting references for those therapists she said 'would make good use of the training'. Kathy told me that she did not agree with the audio recording suitability check as it was both highly subjective and susceptible to manipulation (there was no way of knowing that 'clients' were not actors). Kathy's view was that her personal knowledge of each student comprised a more rigorous and fair basis for selection than the audio test, appearing to ignore the fact that she had contradicted herself.

I joined the training team as a participant observer for a course planning meeting a few weeks before the Essex Strategic Health Authority CfD course was due to start. Eleanor, the course leader, worked as a Person-Centred training consultant and was a qualified Person-Centred supervisor. Jane and Chris both worked part-time as lecturers in counselling at a local college and in private practice as therapists and therapy supervisors. Each member of the team had studied the CfD curriculum in advance and were initially opposed to the CfD concept. Their objections centred on, as Chris put it, '...dumbing-down training into simplistic steps and turning clients into objects'. Jane described CfD as the 'Sunny Delight' of therapy, like the ill-fated marketing strategy of a brand of juice which '...looked like orange juice, tasted like orange juice and even had extra vitamins, but it wasn't orange juice; it didn't have any oranges in it', adding that CfD did not look like any kind of therapy she could support in 'good faith'.[27] She angrily challenged the way counselling skills were being reformulated as competency statements:

[27] Field notes from a CfD planning meeting.

> It is one thing being able to observe good practice; this doesn't mean it can be turned into an abstract competence, as though it's a real thing to measure against.[28]

(Eighteen months later she changed her mind, having witnessed the effect that CfD training had in raising the profile of the Person-Centred approach in the CBT-dominated working environment of IAPT:

> Well, I think it has been a real delight for people that were Person-Centred who have been stripped of their Person-Centredness to become CBT therapists; it has given them a legitimacy, I think.[29])

With some support from Eleanor, Jane and Chris did eventually concede that the intention behind CfD was to promote Person-Centred counselling as a viable therapeutic modality and equivalent in status to CBT by meeting NICE criteria for 'evidence-based treatment'. They agreed that if there were no job opportunities for their trainees then the future for Person-Centred counselling in the NHS looked bleak. This would put tutors' jobs at risk too. Eleanor divided the 'delivery' of the five training days between the members of the training team. Each day was scripted, with a balance of group activities, lectures, films and role-plays.

The chosen location for 'programme delivery' was The Dolphin Hotel, overlooking a stretch of the North Sea between Clacton and Jaywick, Essex, and providing sumptuous décor and frequent refreshments as well as a three-course lunch. The hotel, an island of relative prosperity adjacent to a golf course and private aerodrome, had considerable experience in providing spa breaks and corporate hospitality. Later, in course feedback, students said they felt comfortable and well looked after. Candidates gathered in the reception area for registration and mingled with the staff, eating Danish pastries and chatting about work in IAPT. Many of the students and staff knew each other; the event seemed to have the makings of a reunion. Some said the course felt like a welcome break from work and 'was a bit of a holiday'. Lorraine, a cheerful woman in her sixties who had recently moved from East London, said, waving her hand towards the tables covered with cake and cups: 'All this bribery; they want us to go along with something.'

ThinkAgain had agreed to pay them a full week's wages to attend the programme, which meant in most cases they would earn more than in a normal week's work. All the candidates were employed

[28] Field notes taken during a CfD trainer meeting.
[29] Interview 18.

within the NHS on zero-hour contracts and some had only very few hours' therapy work per week. Because of the rapid turnover of clients, and the potential for burnout caused by so much human distress, some said they would not last much longer in the NHS and would either give up being a therapist altogether, or try to establish a private practice. Several of the therapists expressed a hope that CfD might give them a fresh start.

Figure 7.4: The Dolphin Hotel

Source: Personal archive

Eleanor

Eleanor had worked for over twenty years as the 'programme lead' on a course in Person-Centred counselling in a College of Further Education in East Anglia. She was a strong advocate of humanistic therapy, with a belief in the ethic of seeing the world from another's perspective, but was critical of 'Person-Centred fundamentalists' who she described to me as 'rule-bound and not capable of the humanity they espouse'. This five-day training took place towards the end of her final year before retirement; fluent in French, she had plans to move near to Marseille and to set up a private psychotherapy practice. Eleanor told me she was saddened by the 'management culture' overtaking counselling and psychotherapy, but she maintained an optimistic outlook.

The students sat in a 'horseshoe' arrangement in a large Rococo-styled conference hall with deeply folded crimson curtains framing windows that looked out to a flat, grey sea, littered with wind turbines. The floor was an expanse of raspberry carpet and there was gold-coloured gesso detailing on the furniture. One student pointed to a mirrored ball slowly rotating in the middle of the room and giggled to her companion. Eleanor stood on the small stage and introduced herself as the Course Director, and began with an outline of the training over the next five days.

She started by describing a political landscape within the NHS in general and IAPT in particular, where the dominance of 'evidence-based practice' was advantageous to CBT therapists, who 'cherry-picked' clients to demonstrate the efficacy of their brand, in the context of a system in which there appeared to be a hierarchy of evidence, dominated by randomised controlled trials. Counsellors and psychotherapists, she said, had failed to 'market their product', and they had 'looked the other way while CBT therapists scooped up referrals'. Eleanor then described Emotion Focussed Therapy as a new technique students would learn on the course. EFT, she said, is a variant of Person-Centred therapy, attributed to Leslie Greenberg, with an 'emphasis on the client's emotion'. Eleanor explained how his approach views the 'self' as 'composed of multiple sub-selves which are in communication with each other in relative degrees of harmony or disharmony'; the focus on emotion helps 'bring these selves into line'. Eleanor stressed the point that this 'model' of therapy has been included in CfD because it has empirical support,[30] and meets NICE criteria for recommendation as a '*bona-fide* therapy within the IAPT suite of interventions'.

Eleanor then moved on to the final part of her introduction. She seemed nervous, and hesitated before explaining how each student's next six months of therapy work in the NHS would be subjected to a new form of assessment, the 'Person-Centred and Experiential Psychotherapy Scale, PCEPS', saying: 'The assessments will be carried out externally; sessions with your clients have to be recorded, encrypted and sent to an examiner for marking.'

[30] The study of thirty-four adults diagnosed with major depression compared Person-Centred therapy with EFT; Greenberg, L. & Watson, J. (1998) Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research,* 8, pp. 210–224. It reported greater improvement in self-esteem for subjects having Emotion Focus Therapy compared with pure Person-Centred therapy.

Hands were raised by some students, and others spoke loudly, protesting that nobody had heard of PCEPS before. Ruby, a heavily tattooed student with orange hair, said: 'Having confidential sessions recorded and sent off for marking contradicts the Person-Centred approach; it's judgemental.' Eleanor fielded the protest by reminding the group that: 'This is the way it is; it's the only way we'll be able to get work within the NHS.' The next piece of information did not go down well either. When the group had settled, Eleanor explained an additional task: each student would be filmed in a role-play therapy session on the fifth day of training and the recording would then be examined for adherence to PCEPS. Makeshift studios had been set up in an annexe of the hotel for the purpose, with professional video-recording equipment and a specialist technician hired in. Candidates failing to meet the PCEPS adherence pass mark on this exam would not be allowed to complete the programme through the six-month supervised practice period.

> 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 video-recorded and rated by one of the trainers using the therapy adherence scale.[31]

The prospect of having their work observed and evaluated antagonised some students. Ella said the assessment '...undermines the ethos of the Person-Centred approach. How are we supposed to perform *as if we are genuine*, that's a [...] contradiction'. Ella's anger spread through the group of students and the earlier mood of optimism evaporated. What the group had hoped would be an enjoyable and valuable learning experience had been transformed into a potentially humiliating ordeal.

Chris, who looked nervous, tried to bring calm by assuring the group that it would be virtually impossible to fail the assessments as candidates could resubmit the filmed test. She added that it would be 'okay to coach students submitting recordings' during the assessment period until they provide responses which would meet the PCEPS pass mark, an average score of 5/6. She reminded the group that at a cost of £6,000 per head, the Essex Strategic Health Authority would expect everyone to pass, and said 'we'll make sure of that'.

On the morning of the second day Eleanor introduced the students to a demonstration of Emotion Focused Therapy, with a film of Professor Greenberg providing therapy to a distressed young woman. After the screening Lorraine asked, without a trace of irony: 'Is this how *not* to do it?'

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[31] CfD Curriculum p. 17.

She said the therapist neglected the client's story by responding exclusively to expressions of anger, sadness or bewilderment, 'What is the point of telling a story only to have it ignored?' Eleanor replied: 'I'm afraid that you can only respond to clients' feelings while using the emotion focus; the PCEPS scale does not account for any other type of intervention.' It seemed that the students' protests would have negligible impact on a predetermined training with rigid 'criteria' and little space for creativity; the course was not negotiable, and 'learning' was being reduced to compliance.

After lunch on the second day, Eleanor divided the students into groups of three, comprising a client, a therapist and observer, for thirty-minute role-plays, and allocated a 'breakout' room to each group. She suggested that the client be modelled on someone the therapist had worked with, saying: 'Please don't be yourselves as the client; we need to get to the end of the week in one piece.' She said those taking the role of the therapist should attempt to practise Emotion Focused Therapy and model their 'interventions' on the DVD demonstration by Professor Greenberg, restricting their comments to the clients' feelings—for example: fear, hope, anger and shame. An 'intervention' that did not refer to feelings would be outside the frame of reference of the PCEPS. Eleanor said that for the rest of the day, the threesomes could practise EFT and offer each other feedback on their efforts.

On the morning of the third day Chris gave a PowerPoint lecture on the Person-Centred and Experiential Psychotherapy Scale, explaining how it was based on research[32] compliant with NICE guidelines, and underpinned the legitimacy of CfD as a licensed treatment under IAPT for the 'assessment of therapists' modality adherence and the competence' of therapists in training. Citing Friere,[33] Chris explained how the development and testing of psychotherapy trials—comparing 'modality-specific interventions', for example—requires standardised methods to assess adherence to 'interventions prescribed by the manual':

[32] Funded by the BACP seed corn Research Funding (personal correspondence BACP's Research Dept.).
[33] Freire, E., Elliott, R, Westwell, G. (2013) Person-Centred and Experiential Psychotherapy Scale (PCEPS): Development and reliability of an adherence/competence measure for person-centred and experiential psychotherapies. *Counselling and Psychotherapy Research*.

> The assessment of treatment integrity is an essential component of psychotherapy trials. Tests of treatment integrity have typically included assessment of both adherence and competence, that is, whether therapists accurately followed the therapy manual and also whether they did so in a competent manner.[34]

The CfD manual, given to students at the start of the five-day training, provided tables of competences, denoting an 'ability to' perform a specific action or behaviour, or 'knowledge of' an aspect of therapy on which 'competent' performance is grounded. The capacity to implement these CfD specific competencies is 'evidenced', Chris told the group, with a PCEPS score based on an assessment of the students' audio or video recordings. She made the point that the PCEPS methodology, originally devised for research purposes, has been repurposed for the 'assessment of students' competence as CfD therapists'. Chris told the group that their recordings would be rated by Person-Centred external examiners who were 'highly competent':

> Critically, the therapeutic competence of the rater is likely to be crucial for the validity of the results. For instance, only a rater who is more empathic than the therapist would be able to assess adequately the therapist's level of empathy. Moreover, it is possible that a rater trained in the classical tradition of the Person-Centred approach would provide different ratings than a therapist trained in the experiential tradition.[35]

Where a set of therapist performances are reified and routinised into 'competences', examiners are in a position to impose a numerical assessment, on a ranked scale, of 'quality', where their own subjective interpretations of Rogers' core conditions for person-centred therapy (such as empathy, authenticity and warmth) are the basis for rating competence. This suggests an opinion beneath a veil of objectivity, predicated on the 'evidence-base of the competences', which is reliant on the 'therapeutic competence of the rater' for which no rating is given.

Following a coffee break, Chris asked the students to work in pairs to discuss ways in which they might be able to achieve a good score on the PCEPS. The following example of one of the 'criteria', 'PC4 WARMTH', requires an examiner, listening to an audio recording, to rate the therapist's tone of voice for warmth. Minimal warmth, scoring three points, conveys 'a bit but not nearly enough warmth'. Scoring more, at four points, the therapist may be conveying 'too much warmth'. The top score of six can be achieved by conveying 'excellent warmth'.

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[34] From CfD Training PowerPoint slide.
[35] Ibid.

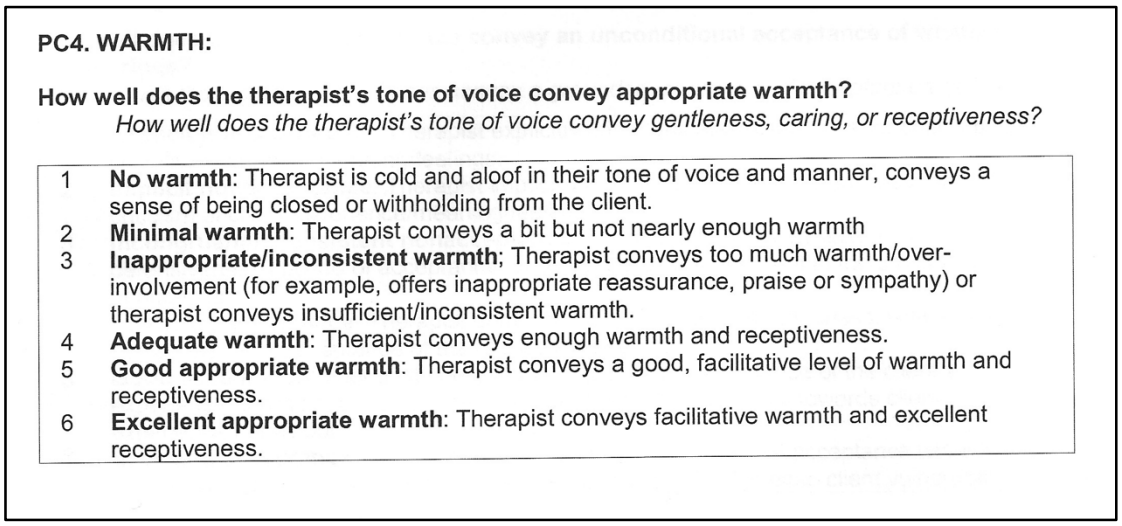
In figure 7.4, PC4 'WARMTH' is based on the problematic assumption that warmth is a measureable, universal and desirable human attribute with fixed recognisable features. It does not take account of idiosyncrasies of communication such as tone of voice, facial communication, linguistic characteristics or accent. It does not engage with cultural differences, appearing to be based on a narrow Anglo-Saxon spectrum of emotionally-informed behaviours. It is blind to nuance and the implicit, although arguably these are inextricable from an engaged and helpful therapeutic encounter. In a study of psychotherapy and complementary alternative medicine, Michael Hyland proposed:

> The majority of research in psychotherapy is designed to *demonstrate the superiority of one set of specific factors over another*, or in contrast to the common factors. [...] However efficacy research in psychotherapy is confounded by the researcher's allegiance to a therapy (and consequently the therapist's allegiance), and allegiance correlates with outcome. When allegiance is taken into account, meta analyses lead to the conclusion that all *psychotherapies are equally effective*.[36] [My emphasis.]

If the therapist's skills, which the scale purports to address, were measurable in any valid way—given that the subjective means of evaluation is itself problematic—those capacities are likely to be insignificant compared with the 'contextual factors' cited by Hyland: 'It is commonly accepted that therapists make a difference, but this acceptance obscures the fact that we do not understand the underlying mechanism.'[37]

[36] Hyland, M. E. (2005) A tale of two therapies: psychotherapy and complementary and alternative medicine (CAM) and the human effect. *Clinical Medicine,* 5, p. 366.
[37] Ibid. p. 366.

Figure 7.5: 'Warmth' section of the Person-Centred Experiential Scale (PCEPS)



PC4. WARMTH:

How well does the therapist's tone of voice convey appropriate warmth?
How well does the therapist's tone of voice convey gentleness, caring, or receptiveness?

1	**No warmth**: Therapist is cold and aloof in their tone of voice and manner, conveys a sense of being closed or withholding from the client.
2	**Minimal warmth**: Therapist conveys a bit but not nearly enough warmth
3	**Inappropriate/inconsistent warmth**; Therapist conveys too much warmth/over-involvement (for example, offers inappropriate reassurance, praise or sympathy) or therapist conveys insufficient/inconsistent warmth.
4	**Adequate warmth**: Therapist conveys enough warmth and receptiveness.
5	**Good appropriate warmth**: Therapist conveys a good, facilitative level of warmth and receptiveness.
6	**Excellent appropriate warmth**: Therapist conveys facilitative warmth and excellent receptiveness.

Source: CfD course materials

The next example, 'E4. Client Self-development' (see Figure 7.6), focuses on the therapist's ability to facilitate 'client new awareness, growth, self-determination or empowerment'. To pass this section, a therapist will need to demonstrate that they can focus on the '...client's emerging sense of inner strength...' or '...accurately reflect the longing for change in client despair...'. To reach the pass mark of 5, a therapist should demonstrate (through the medium of a recorded session with a person in distress who has approached the NHS for help) the ability to be '...offering client choices or implicitly or explicitly communicating trust in the client's process'. The score increases to 6 when the therapist can '...convey trust in the client's self-development potential...', reifying 'self-development potential' as a valid and recognisable entity.

Figure 7.6: Client Self-development of the Person-Centred Experiential Scale (PCEPS)

E4. *Client Self-development*: How much does the therapist actively work to facilitate client new awareness, growth, self-determination or empowerment?

Does the therapist reflect toward, support, or symbolize emerging new aspects of client emotions or other experiences? E.g., This may include offering the client choices; by reflecting/emphasizing client agency, focusing on the client's emerging sense of inner strength or emerging new client changes or insights or ways of experiencing self or others; or accurately reflecting the longing for change in client despair without dismissing the client's pain. Lower ratings are used when the therapist ignores new awareness, insight or shifts, or focuses on client despair or stuckness.

1 **No client self-development**: therapist consistently ignorores client new awareness, agency or emerging changes, or generally responds instead to client despair or stuckness. When the client expresses new, emerging experiences, the therapist consistently deflects the client away from them.

2 **Minimal client self-development**: therapist has the concept of client self-development focus but doesn't implement it adequately, consistently or well; therapist generally stays with old or stuck content; or often deflects client away from new experience or agency.

3 **Slight client self-development**: therapist often or repeatedly deflects client away from emerging new experiences or agency; therapist only slightly facilitates client self-development; while they sometimes respond in a way that points to client self-development, at times they fail to do so, or do so in an awkward manner.

4 **Adequate client self-development**: where appropriate, therapist generally encourages focus on emerging client experiences or agency (by either reflections or other responses), with only minor, temporary lapses or slight awkwardness.

5 **Good client self-development**: therapist does enough of this and does it skilfully, where appropriate trying to help the client to focus on emerging new experiences or agency, perhaps by offering client choices or implicitly or explicitly communicating trust in the client's process.

6 **Excellent client self-development**: therapist does this consistently, skilfully, and even creatively, where appropriate; for example, offering responses that accurately identify client hope in the midst of despair or implicitly convey trust in the client's self-development potential.

Source: CfD course materials

During this exercise, several students voiced their dislike of the PCEPS concept. Chris reminded them that there was no other option and that the examiners recognised some limitations in the scheme and would be 'generous in their assessment of recordings' of students' work as therapists. Ruby said: 'I find the whole thing very disappointing; it's a complete misrepresentation of psychotherapy's values.'

PCEPS imposes a universalising authority where adjectives such as 'good', 'excellent', 'slight' and 'minimal' are deployed with a numeric certainty, in conjunction with emotional characteristics such as 'warmth' or abstractions like 'self-development', in an unproblematic way.

Norman

On the final day, Eleanor produced a list of students paired for filming to assess how well they demonstrated Emotion Focus Therapy. Any student not meeting the PCEPS pass mark would not be allowed to complete CfD training. Each student would take turns to be a therapist or client for

a twenty-minute session. Four studios had been set up by the team the evening before, with professional cameras mounted on heavy tripods. Extra lighting gave the illusion of a film set. While waiting their turn in the conference room students conversed in hushed exchanges, some going outside to smoke. I was told, on more than one occasion: 'I'll be glad to get this over with.'

While filming was in progress, Norman, the BACP Quality Moderator, arrived. Eleanor had been anxiously anticipating Norman's visit all week. She told me she had been awake much of the night before, and having taken some diazepam to help her sleep in the early hours, she now felt 'dozy'. Jane looked pale and told me that the day could not be over soon enough. Norman described himself as an '...old hand in quality assessment', was cheerful and friendly, and had a fixed, rigid smile. He looked approvingly through the course handouts, books and DVD covers the team had arranged into a display on a long table. He asked Eleanor if she could find some students who might volunteer to be interviewed by him, in order to 'have their say about the course'.

While preparing for the course, Eleanor's course outline had been closely monitored by the BACP, who, in alignment with NICE, and with an increasing emphasis on 'Quality Audit', had made a strategic shift away from the organisation's established role as an arm's-length accrediting body towards ownership and control of licensed training schemes. The 'Training License Agreement' (see Figure 7.7) sets out terms of use for the CfD 'product' to ensure ownership and control of intellectual property generated within the BACP or in collaboration with partner organisations. The issue of licences and 'Quality Assurance' checks generate revenue for the BACP.

Figure 7.7: CfD Training 'License'

TRAINING LICENSE AGREEMENT FOR APPROVED DELIVERY of CfD TRAINING

Agreement between:

X University, thereafter referred to as The Training Provider

The Licensor = BACP

LICENSE
The CfD Counsellor/Supervisor *Training Programme (* delete as applicable to specify which) including all its materials, products etc etc and thereafter referred to below as 'The Programme', is protected by intellectual property laws and treaties. The Programme is licensed to the Training Provider, not sold.

Source: CfD course documentation

Getting a 'license to deliver CfD training' was contingent on BACP's 'endorsement'. Eleanor had completed the first, paper-based, stage. The second stage of 'endorsement' required a 'quality

assurance visit' by Norman. A selection of students' recordings marked against PCEPS by the course team, then sent to the BACP for 'sampling of assessments', constituted the third and final stage of the 'Procedure for Endorsement'. The BACP, acting as franchiser, had set the CfD training up in a way that prevented universities and colleges making their own awards.

Figure 7.8: Endorsement procedure

Procedure for Endorsement of CfD CPD training

All Counselling for Depression (CfD) training delivery must be subject to assessment, to ensure that its content, delivery and assessment adheres to The Curriculum for Counselling for Depression (hereafter referred to as 'CfD Curriculum').

The CfD CPD endorsement process consists of 3 stages:

1. A paper-based assessment of the course's CfD CPD Endorsement Scheme application
2. A BACP quality assurance visit to verify the Endorsement application
3. Sampling of assessments

There is a fee for each formal endorsement of a CfD training course: £1,500 + VAT, plus additional expenses at cost for the assessment visit.

Source: CfD course documentation

After he had looked through the documentation, observed some of the filming sessions and talked to six students, Norman departed during the tea break before the final plenary at the end of the last day. Norman had taken Eleanor aside and told her that the course had 'passed comfortably', and that his full report would follow soon. Students were positive in their comments about the course, and, on their feedback forms, seemed to have forgotten the angst generated by the PCEPS assessment task of the first day. After Norman had gone, the students and staff met for a final gathering and farewell. Most students said they had enjoyed the week, but they had not really learned anything new, but some said they hoped they might 'get some more work out of it'.

Norman's report arrived a few days later. He commended the training team for organising a session during which students met their proposed supervisors, an arrangement he had not encountered on fledgling CfD trainings in other regions. Norman recommended the session be incorporated into all trainings in future '...to ensure mutual commitment':

> Establish contact and make arrangements for supervision venues, dates, frequency and group composition, to provide continuity between the course and the supervised practice and to ensure mutual commitment.[38]

Norman's report concluded that the training was of 'a high standard'. He noted that a number of students had asked him: 'Why are we doing this?', 'What are we trying to prove?' and 'If it's what we're already doing, why are we here?' Another recommendation he made was:

> It would be useful, at an early stage in the programme, to give trainees an 'overview', to show the context for the introduction of Person-Centred Experiential therapy as an alternative to CBT and other forms of therapy, as recommended by NICE, i.e. to provide a 'rationale' or justification for the CfD programme and for the trainees' attendance on the course...*to ensure their commitment to the programme*.[39] [My emphasis.]

In a 'post-mortem' meeting after the course, Chris, having read through Norman's report, remarked: 'You only need to rationalise or justify something that isn't self-evident.' With this observation, Chris offered a glimpse into the transformation of tacit knowledge into explicit, codified and non-negotiable rules for correct therapist conduct. The surveillance, monitoring and authoritarian enforcement of 'correct' conduct is the subject of the next chapter.

[38] Endorsement of IAPT CfD Quality Assurance Report on the Delivery of CfD training: (Recommendation 10) (personal correspondence).
[39] Quality Assurance CfD-QA-Verifier Report (2012) p. 4 (personal correspondence).

Chapter 8

Monitoring Adherence

I continued in my role of participant observer by working alongside the trainers and 'clinical' supervisors who had 'delivered' the Dolphin Hotel CfD course. Students who had completed their week-long training returned to work at ThinkAgain, searching for referrals of clients 'diagnosed with depression', so they could put their new skills into practice and start building up the eighty hours of supervised therapy required for course completion. The 'type of client' recommended in the CfD literature as 'most suitable' for this phase of the training should not be too well, or too unwell: 'It is particularly appropriate for people with persistent sub-threshold depressive symptoms or mild to moderate depression where 6–10 sessions are recommended over a period of 8–12 weeks.'[1] For most therapists this training will have imposed an expectation that they 'implement' a diagnostic language and psychological disorder categorisation characteristic of DSM-IV,[2] and psychologists' semantic fields. This in contrast to their trainings, generally antithetical to diagnostic language and based on non-directivity and a collaborative search for meaning. The CfD literature mandated that four out of the eighty sessions had to be recorded by CfD candidates working with 'depressed clients' and assessed by a member of the training team using the PCEPS 'assessment tool', introduced during the five-day training. The course handbook states:

> Following the five-day training course, and during the supervised practice component of the training, competence will be assessed through:
>
> 1) 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, PCEPS.
> 2) Regular attendance of supervision sessions and engagement in the supervision of all cases which make up the 80 hours of practice.[3]

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[1] IAPT/BACP Information sheet (personal correspondence BACP Research Department, March 2015).
[2] American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders: DSM-IV*.
[3] Hill, A. (2011) *Curriculum for Counselling for Depression,* p. 17.

Jane agreed to undertake the task of rating students' audio recordings, which she described this way:

> I can hear when they are working well with their clients. When they do I just give them enough points to pass without taking much notice of the [PCEPS] scale; if it is quite difficult to find any evidence I just ask for another recording, making sure I told them what to emphasise, and what to leave out. I make sure they get through because I know they're okay. You just have to be careful about the ones that are sent off.[4]

Jane felt she had to exercise caution when selecting recordings for 'monitoring' by CfD management, who, taking a literal approach to the use of PCEPS scales, might not find the 'evidence of efficacy' they were looking for. Jane therefore coached her students, in whom she had confidence, into 'demonstrating adherence', aligning their recordings with the PCEPS scale—in effect working backwards from the 'evidence' to a retroactively reconstructed therapy session, aligned with the PCEPS assessment 'tool'.

With students' PCEPS adherence strategy in place, CfD management turned their attention to supervision of the supervisors. This was problematic for the CfD management, who knew that for experienced therapy supervisors the notion of 'ensuring adherence' could be seen as normative and therefore inimical to a holistic collaborative supervisory encounter. Norman (the 'Quality Assessor') had proposed to the tutors that CfD supervisors should be assessed prior to their taking on CfD supervision. In effect this amounted to a measure of their degree of compliance with the PCEPS. Attempting to accommodate CfD management, Joy, on behalf of the BACP, proposed that Eleanor, Jane and Chris provide the mandated supervision for the CfD trainees, subject to their attending a 'tailor-made one-day workshop to align their supervisory practice to the CfD model'.

Joy's proposal was met with resistance by Eleanor, Jane and Chris, who had worked as supervisors of counselling and psychotherapy for many years. Eleanor has a Master's Degree in Person-Centred supervision and has published journal articles in which she explores supervision in the context of 'relational depth', a form of tacit knowledge alluded to as:

[4] Field notes taken during a CfD course meeting.

> A feeling of profound contact and engagement with another, in which the therapists experienced high levels of empathy, acceptance and transparency towards their clients, and experienced their clients as acknowledging their empathy and acceptance in a genuine way.[5]

Eleanor felt her experience and training, as well as her chosen focus on relational depth, made her adequately qualified to apply the discrete 'Emotion Focus' component of CfD within her supervisory role without the need for a 'workshop'. Eleanor, Jane and Chris met at a CfD supervision meeting to discuss the 'tailor-made one-day workshop'. Jane and Chris said that their more-than-adequate level of experience as supervisors[6] suggested that further training was 'demeaning'. Eleanor said that therapy supervision[7] was 'evolving into line-management' and that a demand that the team 'align their supervisory practice to the CfD model' was part of a strategy aimed at 'industrialising therapy'. Eleanor said that she advocated for the supervision of counselling and psychotherapy as a means to 'ensure therapists work to high standards and maintain their Person-Centred stance', but did have some concern about how the role of supervision has evolved:

> So, from my point of view it sounds like the BACP are trying to use the medical model of supervision and put that on counselling. It would be more a kind of line-managerial type thing. They have suggested that clients contact the counsellor's supervisor if they want to complain. Lots about safeguarding of the client, less about working with what the client brings, more about a kind of surveillance. In a way, the work with the supervisee is keeping the profession regulated in some way.[8]

Eleanor's reservations about the role of supervision shifting towards a managerial function turned on the value of trust in helping relationships:

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[5] Cooper, M. (2005) Therapists' experiences of relational depth: A qualitative interview study. *Counselling and Psychotherapy Research,* 5, pp. 87–95.

[6] Supervision of counselling and psychotherapy, once limited to the training phase of a therapist's education, has become a cornerstone of therapy praxis. 'Clinical' supervision is required by the BACP on a 1.5 hour per month basis as a condition of membership. Supervisors are expected to monitor therapists' fitness to practice in relation to the BACP Ethical Framework; see: BACP (2002) *Ethical framework for good practice in counselling and psychotherapy.*

[7] A review of the BACP Ethical Framework in 2014 sought to strengthen supervisors' accountability for their supervisees' practice by incorporating a yearly appraisal into the arrangement: 'We will clarify who holds specific responsibilities to our clients between the practitioner, supervisor and any line managers and review how well these responsibilities are working in practice. This review will take place in supervision as required, and at least once annually.' (Personal correspondence with BACP Research Dept.).

[8] Interview 19.

> For me, the supervision as we know it is unique to our profession. No other professions use it in the same way, or value it in the same way, so why do we want to change that and make it more managerial? I see it as a profession in its own right but not as a manager although there might be some kind of managerial aspect to it but it needs to be about trust. There's something about us trusting; that's the bit that feels like it's missing. It feels like we can't trust our supervisees and we need to check up on them. As if the clients can't trust the counsellor unless they've got this, that and the other, and actually what we know about it is that trust is the main thing, the humanity of it rather than 'you can trust me because I'm registered and I'm accredited and I'm senior this' and all the rest of it.[9]

Despite Eleanor's reservations, Joy insisted the supervisors attend a 'one-day workshop' at Therapy Associates in West London for a fee of £6,450, which seemed to Chris to be 'a complete and totally pointless rip-off'. The Therapy Associates Centre was situated in a large Victorian house set well back from a tree-lined road. The building, housing a range of therapy trainings, was divided into areas based on modalities. The largest area, the ground floor, was dedicated to the Person-Centred approach, the first floor accommodated Integrative-Humanistic psychotherapy, and the top floor provided a space for Transactional Analysis, providing a spatial metaphor for the tribal character of therapy modality factionalism.

Considering the £6,450 fee for four supervisors for one day, Eleanor said she hoped the group would be well looked after—with some cake, perhaps, after the long drive. On our arrival, the smiling receptionist, wearing a name-badge, gold-embossed, saying 'Lois', escorted us to a communal eating and drinking area. One side of the room was taken up with colourful rows of mugs on racks, three dishwashing machines and two industrial-looking stainless steel sinks. A double-door refrigerator contained milk and snacks, labelled with individual student names. A visitors' section provided us with what we needed to make tea and instant coffee. We found some biscuits and sat on one of the long wooden benches. Chris said she wanted to go home. Jane said she was not sure whether to laugh or cry, but reminded us that in four or five hours the 'ordeal' would be over. Eleanor divided £6,400 by four out loud, 'That's sixteen hundred pounds each. I could have done with that.'

After about twenty minutes, Lois led us to a high-ceilinged, ground-floor room with three long brown leather sofas, high windows looking out across the road to a park, and brightly coloured cushions scattered over the beige hessian matting floor. The pale-blue walls were covered with

[9] Interview 19.

large gouache paintings depicting sun-drenched white buildings and indigo-coloured sea, with scarlet flowers in high contrast. Pots resembling amphorae and containing tropical-looking plants had been placed next to the sofas. Taking care with our hot drinks, we sank into the soft sofas and awaited the arrival of Stephen and his partner Roxy. Stephen, who had a background in management, oversaw the Person-Centred Division of Therapy Associates. He was an experienced Person-Centred Life Coach in corporate environments and a staunch advocate of Carl Rogers. Stephen was strongly supportive of moves by the BACP, using randomised controlled trials, to advance the status of the Rogerian approach within the NHS. He had played a role in writing the CfD manual and was licensed by the BACP to provide CfD supervisor training. Roxy had originally trained in Art Therapy and had met Stephen on a residential course, since when they had worked as a pair.

Stephen arrived grinning. He was tall and thin with long shiny curling hair, and he wore a dark blue velvet jacket and an open-necked white shirt revealing a gold chain and pendant. After lengthy introductions, Stephen guided us, with charm and wit, to the key point of the day. Roxy smiled silently and nodded in emphasis as Stephen made his points. The aim of CfD supervision was, he said, to monitor 'supervisor adherence' to the therapy manual using PCEPS. 'Effective supervision' had been mandated by the CfD curriculum without defining what form it might take, and therefore a specific 'tool' to measure 'effective' supervision had not been created. The important thing, Stephen emphasised, was that evidence for CfD therapeutic competencies meeting NICE standards could be measured by observing or listening to therapists using the PCEPS 'tool', which was already being used for therapy. If it could measure therapy, he argued, surely it could measure supervision without the need to specify what it was measuring, as long as something was being measured 'effectively'. Apparently unaware of the absurdity of this position, Stephen did concede that an 'inconsistency' lay in the fact that 'clinical' supervision was essentially a different process to therapy, and with different aims, but in the absence of an alternative he had decided to use the PCEPS, as: 'It's the only tool in our box, and PCEPS has high inter-rater reliability.'

Eleanor's voice trembled as she asked 'Why does supervision have to be assessed? We are already highly experienced. Isn't that enough? Surely the quality of the therapists' work is already being assessed by us by listening to their recordings; you check that as well. And who assesses us?' Stephen did not answer this, saying he would explain later. He then grinned and suggested we took

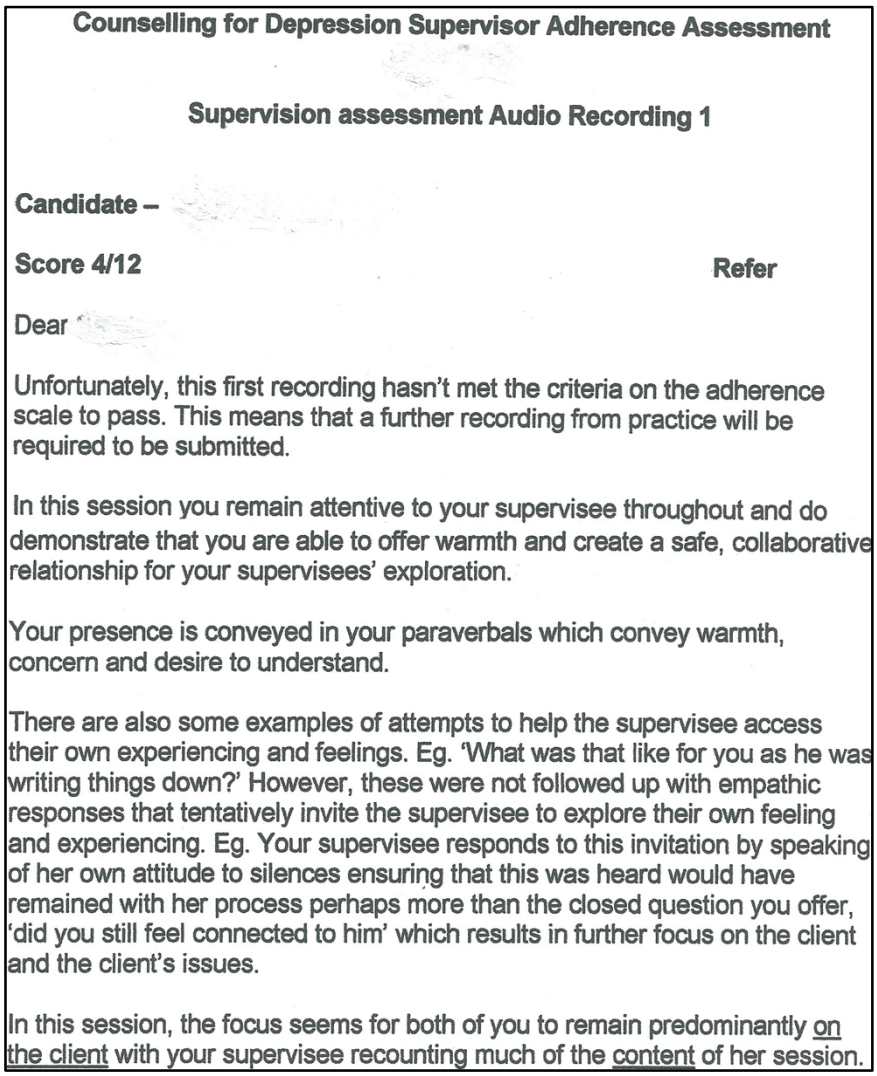
a break. Stephen had forgotten to order the lunch that was part of the ‘training package’; he said he would get sandwiches from Waitrose while we made drinks.

One of Eleanor’s questions was answered after lunch: Stephen assessed the supervisors himself. He had certified himself as the sole arbiter, in the UK, for CfD supervisor qualification. He outlined the arrangements whereby supervisors would need to audio-record four supervision sessions. Stephen said he would rate these sessions using the PCEPS, and award a pass to supervisors who scored over fifty percent for each recording. Those who did not meet this standard could either attend retraining on a one-to-one basis with Stephen for a reduced fee of £2,500 per day, or pass their supervisory case-load to a colleague who met the PCEPS criteria. Eleanor, Jane and Chris seemed defeated by this information and did not ask any further questions.

On the return journey, Chris asked: ‘What gives Stephen the right to judge whether we are good enough at something we’ve been doing longer than him? He uses the whole PCEPS thing to justify his plan to control us.’ Chris seemed to have grasped the essence of Stephen's propensity to monitor adherence by appropriating a reliable but misplaced methodology, which he did not appear to fully understand, thus emboldening his sense of legitimacy and authority.

In the weeks following the one-day training, Eleanor, Jane and Chris submitted encrypted audio recordings to Stephen for marking. Eleanor failed her first submission. In the ‘Counselling for Depression Supervisor Adherence Assessment’ she was given a low score of 4/12; Stephen commented: ‘In this session you remain attentive to your supervisee throughout and do demonstrate that you are able to offer warmth and create a safe, collaborative relationship for your supervisee’s exploration.’ (See Figure 8.1.) He further noted that Eleanor’s presence conveyed ‘warmth, concern and desire to understand’.

Figure 8.1: Stephen's feedback on Eleanor's first supervision recording



Counselling for Depression Supervisor Adherence Assessment

Supervision assessment Audio Recording 1

Candidate –

Score 4/12 **Refer**

Dear

Unfortunately, this first recording hasn't met the criteria on the adherence scale to pass. This means that a further recording from practice will be required to be submitted.

In this session you remain attentive to your supervisee throughout and do demonstrate that you are able to offer warmth and create a safe, collaborative relationship for your supervisees' exploration.

Your presence is conveyed in your paraverbals which convey warmth, concern and desire to understand.

There are also some examples of attempts to help the supervisee access their own experiencing and feelings. Eg. 'What was that like for you as he was writing things down?' However, these were not followed up with empathic responses that tentatively invite the supervisee to explore their own feeling and experiencing. Eg. Your supervisee responds to this invitation by speaking of her own attitude to silences ensuring that this was heard would have remained with her process perhaps more than the closed question you offer, 'did you still feel connected to him' which results in further focus on the client and the client's issues.

In this session, the focus seems for both of you to remain predominantly on the client with your supervisee recounting much of the content of her session.

Source: Eleanor

Eleanor was perplexed: 'I just don't get it'. Stephen's narrative feedback seemed positive, yet he had awarded a low mark. 'Was this not what I was supposed to be doing? Focussing on the supervisee in a safe, warm and collaborative relationship?' With an MA in Person-Centred supervision and twenty-three years' experience, Eleanor said she felt '...undermined and humiliated'. Telling me about how she thought the PCEPS measure had impacted on her supervisees, she said:

> I think it has the potential to be really undermining. I mean I've heard that from several of my counselling supervisees, that they've all said that they have anxiety around it; are they going to be able to do it? And we kind of talk about it, talk about it in terms of: 'Are they required to be doing anything they wouldn't ordinarily

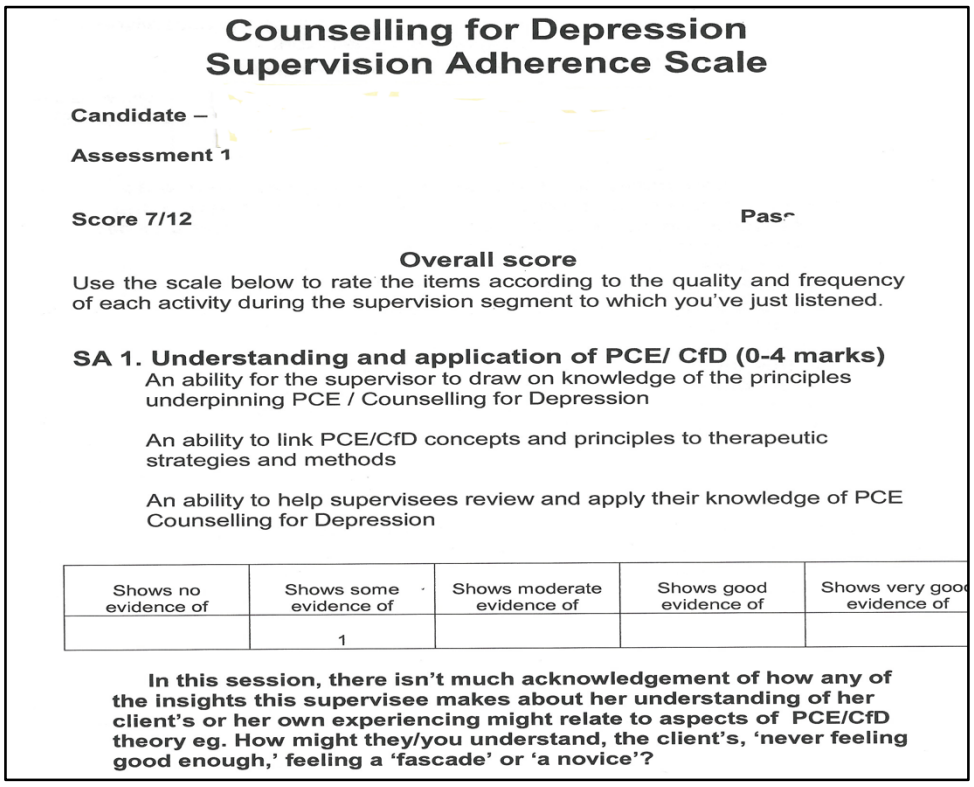
> do?' My sense is that they shouldn't be. There is a need for assessment but the assessment process then becomes a part of that undermining, I think.[10]

Eleanor's experiences during retraining as a 'CfD-approved supervisor' suggests that the use of therapy supervision has shifted, in the context of 'evidence-based' therapy, from a collaborative and exploratory encounter, a 'space for thinking',[11] to a didactic process whereby 'adherence' is monitored in a coercive climate of emotional governmentality. Her competence as a therapist supervisor was disregarded in the feedback she received on tape-recordings of her work.

Jane managed to pass her first attempt at meeting CfD supervision adherence criteria, following some suggestions from Eleanor, scoring seven out of a maximum of twelve for the recording she submitted to Stephen. The feedback stated that '...there isn't much acknowledgement of how any of the insights this supervisee makes about her understanding of her client's or her own experiencing might relate to aspects of Person-Centred Experiential /CfD theory...'. On the subject of Stephen's interpretation of PCEPS, Jane said: 'To pass you have to make the client fit the theory; that's what he's looking for. The adherence scale is designed to evaluate therapy anyway, not supervision; we're not supposed to be giving therapy to our supervisees.'[12]

[10] Interview 21.
[11] Shipton, G. (1997) *Supervision of psychotherapy and counselling: Making a place to think*, p. 24.
[12] Interview 24.

Figure 8.2: Stephen's feedback for Jane's CfD supervision



Counselling for Depression
Supervision Adherence Scale

Candidate –

Assessment 1

Score 7/12 **Pass**

Overall score

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

SA 1. Understanding and application of PCE/ CfD (0-4 marks)

An ability for the supervisor to draw on knowledge of the principles underpinning PCE / Counselling for Depression

An ability to link PCE/CfD concepts and principles to therapeutic strategies and methods

An ability to help supervisees review and apply their knowledge of PCE Counselling for Depression

Shows no evidence of	Shows some evidence of	Shows moderate evidence of	Shows good evidence of	Shows very good evidence of
	1			

In this session, there isn't much acknowledgement of how any of the insights this supervisee makes about her understanding of her client's or her own experiencing might relate to aspects of PCE/CfD theory eg. How might they/you understand, the client's, 'never feeling good enough,' feeling a 'fascade' or 'a novice'?

Source: Jane

Although Jane passed her first supervision assessment, she said: 'I'm gutted.' Jane was confused by the implicit demand to theorise 'never feeling good enough,' saying 'it's [....] obvious'. Later, she told me she was cross with herself for allowing Stephen to rile her, saying: 'I can't imagine how that might feel if I couldn't rely on my own sense of what I am doing and why, how I am doing it, to account for it really.'[13]

Chris failed her first attempt at meeting the PCEPS 'criteria', but was not surprised. She said: 'This whole thing is so far from reality that I don't care anymore. I'll tick their boxes and pass.' Chris did pass subsequent attempts, suspending her disbelief as a strategy helping her endure the extensive emotion management[14] she was required to demonstrate in order to align her therapy supervision to the abstractions of the PCEPS 'tool'.

[13] Interview 19.
[14] Hochschild, A. R. (2003) *The managed heart: Commercialization of human feeling, With a new afterword*.

Jane, Chris and Eleanor eventually became Qualified CfD Supervisors, and they each received a certificate. The sessions where supervisees wept audibly obtained the highest marks and the strongest praise from Stephen, who had lost sight of the original purpose of PCEPS, part of a clinical trial[15] to assess 'treatment integrity'.[16] This 'competent' practice was, in effect, based on an ideological representation of one phenomenological approach that had been repurposed into a codified assessment 'tool'. Stephen's students were able to articulate the paradox that evaded Stephen; the very 'tool' designed to foster objectivity served to legitimate his own subjective preferences. Eleanor told me she never once thought she would have to induce her supervisees to cry to in order to demonstrate her competence as a counselling supervisor.

The newly qualified 'CfD Trained Supervisors' continued to work with the group of students from the Dolphin Hotel CfD training, one of whom had dropped out, having decided to give up working as a therapist in the NHS. The remaining twenty-one therapists completed the training and continued working for ThinkAgain for six months—until the funding ran out. A new 'provider' called Healthy Minds set up as a new 'IAPT provider' in the same refurbished supermarket formerly occupied by ThinkAgain. All the therapists had to re-apply for their zero-hour contracts.

Prior to the arrival of CfD, 'clinical' supervision of counselling and psychotherapy was conceived by therapists as a space for thinking,[17] a collaborative arrangement between therapist peers to address the needs of their clients, help deepen understanding of the therapeutic relationship, and provide support in the face of difficult and emotionally challenging work. Phil Mollon describes some of the challenges faced by supervisors in preserving this thinking space:

> This thinking is not linear, logical 'left-brain' cognition, but a kind of free-associative mulling over, perhaps more characteristic of right-hemispheric functioning. Wishes to understand quickly, to appear competent, or compete with peers or with the supervisor can all interfere with this thinking space.[18]

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[15] Freire, E., Elliott, R, Westwell, G. (2013) Person-Centred and Experiential Psychotherapy Scale (PCEPS): Development and reliability of an adherence/competence measure for person-centred and experiential psychotherapies.
[16] Waltz, J., Addis, M. E., Koerner, K. & Jacobson, N. S. (1993) Testing the integrity of a psychotherapy protocol: assessment of adherence and competence. *Journal of consulting and clinical psychology,* 61, p. 620.
[17] Shipton, G. (1997) *Supervision of psychotherapy and counselling: Making a place to think*.
[18] Mollon, P. in: Shipton, G. (ed.) (1997) *Supervision of psychotherapy and counselling: Making a place to think*, p. 33.

By contrast, the BACP framed the process in a managerial lexicon, emphasising 'professional standards', with the final responsibility for care resting on the supervisee:

> When supervising qualified and/or experienced practitioners, the weight of responsibility for ensuring that the supervisee's work meets professional standards will primarily rest with the supervisee.[19]

The formerly collaborative approach to therapy supervision was displaced by CfD management's foregrounding of therapist 'measurement tools'. This change led to the introduction of a managerial role being passed onto CfD therapist supervisors, in common with other 'manualised' NICE approved therapies within the NHS, such as CBT and DIT.[20] The CfD curriculum[21] replaces a collaborative, free-associative conception of supervision with a prescriptive monitoring role for supervisors, ensuring compliance to prescribed therapist behaviours and undermining their autonomy and capacity to exercise judgement. In place of a peer-to-peer discussion centred on the therapist's experience with her client, the CfD supervisor is obliged to steer the meeting towards implementing CfD specific supervision competencies emphasising, for example, the primacy of the 'client's affective experience':

> 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 developing immediate solutions to problems.
>
> 4.3 An ability to employ empathic understanding to sense the supervisee's perceptions, experience and responses to their work.
>
> 4.4.1 An ability to help the supervisee in maintaining a primary focus on clients' affective experience.[22]

The extension of deep emotion management from the therapy role into the exercise of supervision is a distinguishing feature of CfD, and a departure from Rogerian Person-Centred Therapy, the modality on which it is putatively based. This shift requires a CfD supervisor to coach their supervisee into a focus on their personal 'experience of the client', in place of an exploration of their client's experience of distress and personal problems, as shown in Eleanor's report where she fails her 'adherence assessment' because of her focus on 'the client and the client's issues'. This change of priorities is an effect of the importation of the PCEPS measurement scale into the

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[19] BACP (2015) *Ethical Framework for Good Practice in Counselling and Psychotherapy*, p. 11, available at http://www.bacp.co.uk/ethical_framework/ (accessed 20 October 2016).
[20] Dynamic Interpersonal Therapy.
[21] Hill, A. (2011) *Curriculum for Counselling for Depression,* p. 82.
[22] Ibid.*,* pp. 85–86.

supervisory relationship. PCEPS was originally deployed to assess the extent to which therapists could align their practice to the manualised skills set out in the CfD course documentation. The scale was redeployed for use in therapy supervision 'adherence' in a climate in which the measurement of all behaviours took precedence over thinking. In adapting to the constraints of this formulaic representation of a helping relationship, Chris and Eleanor were obliged to substitute their own compassionate concern for people with a prescribed illusion. Commenting on institutional emotion management, Hochschild comments:

> Officials in institutions believe they have done things right when they have established illusions that foster the desired feelings in workers, when they have placed parameters around a worker's emotion memories, a worker's use of the *as if*.[23]

The suspension of disbelief required of the workers, the therapists, is secured by the authority of their managers' confidence in and devotion to the certainties of emotion measurement.

Maria

A year after my participant-observation of CfD training, I interviewed Maria, who had passed the CfD course and was working for Healthy Minds, providing therapy under the IAPT scheme. I asked her how her work was going.

Maria told me she had become quite despondent about IAPT since the CfD course. Although she managed to hang on to her job, several colleagues had left the NHS to try and make a living in private practice. She told me that the qualification had helped her get more referrals but had not changed the way she worked; she said that she continued to adapt her responses to each client using whatever she knew about human suffering to 'try to understand them and help them feel less isolated'. She told me that sticking rigidly to a therapy technique, like CfD or CBT, seemed to make 'some therapists feel secure, but I doubt it helps'. Many of her clients were experiencing difficult situations, including bereavement, separation, unemployment, illness and poverty. For the last eighteen months, Maria had been working with war veterans suffering multiple trauma, but:

[23] Hochschild, A. R. (2003) *The managed heart: Commercialization of human feeling, With a new afterword*, p. 49.

> To qualify for the IAPT service in Northeast Essex individuals who experience moderate to severe levels of common mental health problems, which include depression, anxiety, panic disorder, obsessive compulsive disorder and phobias as well as post-traumatic stress disorder, have to be diagnosed with single event trauma. Who has had just one event trauma? I use my veterans as an example. So, say a guy's gone out to Afghanistan and he got combat trauma when he gets back. He's seen several IEDs[24] and attacks and they say, well you can't see him. I say well he's not suicidal, he's not going to get into secondary care, but you're excluding him because that's multiple trauma, more than one IED. It's disgraceful. One IED you can come in! Or you can some into the service but only work with one event. Multiple trauma would fall in the gap. The NHS is risk averse—they don't want to take on clients that may kill themselves? Absolutely.[25]

Maria explained that inclusion criteria for IAPT referrals are based on DSM-IV defined diagnostic categories, such as 'Major Depression' or 'Obsessive Compulsive Disorder'. She described exclusion criteria, on the other hand, as more general and vague, making reference to social context and avoiding psychological diagnostic language—such as, for example, 'Poor functioning in more than one domain of life' or 'Individuals not registered with a GP'. She felt this was a way of rationing the service and having control over outcome statistics by 'cherry-picking' clients who fit diagnostic criteria and then go on to meet recovery targets. She mentioned the 'Payment by Results' scheme:

> There are certain elements to the Payment by Results and it doesn't come down to an individual therapist level, it comes down to a service level thing. We, each IAPT service, have to hit a target of 15% of the believed prevalence of people with mild to moderate depression in the area where they work. So, let's keep the figures simple. Say there were 100,000 people who, according to the data that they look at, believe will be suffering from mild to moderate depression. Out of that 100,000 they must get 15,000 come through the service in a year. That's their target—they must do that. To my knowledge, not one IAPT service will hit that target this year, not one.[26]

Maria described a strategy used by Healthy Minds' management to reduce demand by clients who may not fit the inclusion criteria. The strategy, she said, meant therapists put extra stress on clients by extending the waiting time before they were able to start receiving it. They did this by substituting the expected face-to-face therapy with a phone call:

> Management looked at the waiting lists and said, everybody stops working with clients for a two-week shutdown and everybody on this waiting list is going to be rung for a three-hour phone call. Some of the

[24] Improvised Explosive Device.
[25] Interview 33.
[26] Interview 33.

> people have been waiting on this waiting list for two or three months. So you can imagine, you've put in for your referral, you haven't heard anything for two or three months and then you get a telephone call checking, tell me what's wrong, to be told 'oh no sorry you are not appropriate for this service, you're too ill for this service'. 'Well, where do I go?' 'That's not our problem; you need to go back to your GP.' Get them off the system that way. Or if they demonstrated high levels of suicidal ideation, then they were kicking them off the waiting list, because, and this is my observation, 'we don't deal with this; go back to your GP'. [27]

To qualify for 'Payment by Results', clients needed to demonstrate 'Clinically Significant Change'.[28] Maria said this is the extent to which therapy moves someone 'outside the range of the dysfunctional population or within the range of the functional population'. Maria was not convinced that the 'assessment tools' detected the positive changes she helped facilitate with her clients:

> A score of PHQ-9, 10 or over, is deemed significant enough to be admitted to the service, so you could in theory have someone coming in with score 11, and see a high intensity therapist for twelve weeks maybe, twelve sessions and come out with 9 and that will be deemed a successful outcome. Alternatively, you may have someone, within exclusion criteria, slip through the net, which they do quite often, and come in with a score of 27, maximum of everything, see them for twelve weeks, finish with a score of 11, so a substantially reduced level of depression, much more than the former example, but be recorded as an unsuccessful outcome. [29]

Maria helped the clients she could by assisting them complete PHQ-9 to bring them below the threshold for exclusion:

> If people come in who have suicidal ideation and higher scores and you are getting them back in functioning and going back to work but they might still on paper be over that threshold, it will be recorded as an unsuccessful outcome. I presented this data to management and they are aware of it; they know. Their argument is, 'What can we do?' Myself and my supervisor propose: Do a mix. Say people who come in at over 20 – assess, then give the patient a chance to do it again, to tick the boxes that needed ticking. Are you sure you're a 3, maybe? And try and bias it that way. [30]

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[27] Interview 33.
[28] Jacobson, N. S. & Truax, P. (1991) Clinical significance: a statistical approach to defining meaningful change in psychotherapy research, *Journal of consulting and clinical psychology,* 59, p. 12.
[29] Interview 33.
[30] Ibid.

Towards the end of our meeting, I asked Maria what she thought the future held for her work as a psychotherapist. She said she would continue to work with veterans if she could. She told me of her lifelong interest in fishing, and how she might combine it with therapy:

> I found something in America called Rivers and Recovery. It has an American bent to it but it's veterans-based and they do it on rivers in Utah and I liked some of the evidence very much. They spend a day on the canoe fly-fishing but it's also yoga and mindfulness in the evenings and they had some fantastic results. I got in contact with them and initially I was going to go over there and experience it with them; they started with good intentions but now they've lost the budget for research. The woman who was doing it at the University has lost her position, is looking for another job. The guy who was the chair, the director, he's moved on, so it's kind of fallen by the wayside. [31]

In a final comment, Maria said: 'It's sad the way things are turning out. I was so hopeful when I first started as a therapist; I wanted to make things better. Now I'm quite pessimistic.'

Maria, in common with other NHS therapists, participated in a pre-determined, non-negotiable 're-training' regime, hoping to improve her capacity to work with distressed people and keep her job. Instead, she has become disaffected by the number-centric, outcome-measuring, payment-by-results culture of monitoring within a therapy economism that has become established in the NHS.

In an article written for the BACP in-house magazine, *Therapy Today*, Catherine Jackson explores therapy in the 'NHS marketplace', citing Emma Howitt, the Chief Executive of Middlesbrough and Stockton Mind as '...not comfortable with working in a competitive marketplace'.[32] In a commodified therapy environment of 'payment-by-results', Maria described her experiences with 'caseness'[33]:

> We are paid upfront but there are financial penalties for waiting times and if people don't make enough improvement. The problem with that is, if someone comes to us very unwell they may make real progress, but still be considered 'above caseness' at the end of sessions. So, we get penalised. The measures being used are really superficial.[35]

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[31] Interview 33.
[32] Jackson, C. (2013) Patients by numbers. *Therapy Today,* 24, p. 10.
[33] 'Caseness' is defined as: '...the threshold at which it is appropriate to initiate treatment'. Recovery is defined as 'movement to a score below caseness from a score of caseness or above', available at www.iapt.nhs.uk/pbr/currency-model-description/clinical-outcomes/ (accessed 9 June 2016).
[35] Interview 33.

'Marketplace' ideology reifies constructs of 'outcome measurement' and 'caseness' with the effect of restricting help to those who are less seriously impacted by deprivation, but provide good 'outcome data'. People most in need of help have the dice loaded against them, as only those with 'mild' needs provide sufficient payment to keep the NHS 'service' running:

> But for everyone who needs eight to ten sessions, we lose money, which we have to try to offset with clients with less serious problems who will cost us less to treat. In an area like this, with high deprivation and a lot of problems, we aren't seeing enough of the people with mild needs who would make fewer demands on the service.[36]

Polly

Polly, who had completed the Dolphin Hotel course, told me a story about a client who had been working in a bank in an Essex coastal town. She said that the client had been bullied by an oppressive manager and subjected to disciplinary action for accounting errors amounting to a few pence. The client had become very anxious, and as a result he had made further minor errors. He was overworked, often staying late, and was sleeping badly. The strain was beginning to affect his relationship with his wife and two sons, and his GP had given him a one month's 'sick' note, prescribed anti-depressants and referred him to Healthy Minds, where Polly worked. She told me how angry his situation made her feel:

> As I realised how unfair this poor man's situation was, I became more and more angry. I know I was supposed to help him find a way of reframing his feelings so he could cope in his job, and accept his boss's criticisms in a constructive way. I shouldn't have done, but I started exploring alternative employment options with him. As I did, his low mood seemed to lift and he seemed to relax. After three sessions, he told me that he, with a wealth of IT knowledge and a love of gardening, was going to leave the bank and start an online garden business. He told me he did not mind if he was poorer; he said if he carried on at the bank he would probably end up dead. By the last, sixth, session he had handed his notice in and built a website. He said he felt optimistic, was sleeping okay, and had the support of his family.[37]

Polly had avoided collusion with the CfD narrative, which explicitly proscribes attention to social context with its focus on internal feeling states. She had become more attentive to the client's

[36] Interview 33.
[37] Interview 51.

prevailing social conditions and given him an alternative perspective from which he was able to confront his oppressor.

‘Counselling for depression’ was conceived as a way of bringing person-centred therapy, a phenomenologically-informed, non-directive therapy approach, into the instrumentally-driven culture of ‘outcome measurement’ prevailing within an NHS mental health provision dominated by cognitive behavioural therapy. The effect of this importation is that many humanistic, as well as psychoanalytic, therapists have found that they have to work hard on deep emotion management to meet targets and ‘monitor adherence’, affecting compliance while working in good faith to help those in distress. Some of these therapists have expressed anger and humiliation, and some continue to resist, placing the needs of those they help above their own sense of injustice. Other therapists have found certainty in collaboration with the new culture, seeing no alternative and regarding passive resistance as too costly in uncertain times, although with some notable exceptions, which are discussed in chapter twelve.

Chapter 9

The Gold Book

By 2009 the BACP had distilled parts of the Core Curriculum[1] into a document,[2] known as the 'Gold Book', which provides a specification for BACP accredited training courses. This document:

> Seeks to empower educators in their aspiration to provide a robust and reliable basis for the development of the next generation of practitioners.[3]

The BACP intended the 'Gold Book', with its connotations of treasure, permanence and singularity, to be a guide for trainers on counselling and psychotherapy courses in universities, colleges and private institutions, which may adapt it to suit their theoretical modality, the needs of the local community and the educational level of trainees. The standards for therapy training set out in the 'Gold Book' are generic and not tied to any of the mainstream paradigms informing therapy practice in Britain such as humanism, psychoanalysis or existentialism. This leaves some room for interpretation. Public sector universities and colleges have the resources for autonomy in the creation of degree schemes. By contrast, private training organisations are more dependent on the BACP and external moderators, representing commercial examining boards, for their capacity to provide certification.[4]

A BACP researcher expressed concern about the future of training:

> I worry about the future of good quality training. I think that it will struggle to survive in the university sector. There's no longer favourable funding for foundation degrees. It's too costly to survive as a single discipline as an undergraduate degree. The staff/student ratios are too high and

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[1] Dunnett, A. C; Wheeler, S; Balamoutsou M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy*.
[2] BACP (2009) *Accreditation of training courses*.
[3] Ibid., p. 4.
[4] Therapy Solutions qualifications are endorsed by ABC awards, available at: www.abcawards.co.uk/employers/quality-licence-scheme/, (accessed 11 November 2016).

> the costs are too great. So, it may survive at post-graduate level but the fees will have to go up massively. I think the FE sector.... there are loans available but I don't see a massive increase in the take-up of training in FE, and the quality's variable. Some... it depends very much on the tutors; some are very good, some courses are excellent, and some teaching the same thing are not. And the private sector, many of which have gone for university franchises or validations, I'm not sure they'll survive because if they are not paying their way the universities will drop them.[5]

Therapy training organisations which had been stable for many decades have been facing difficult times.

Frank

Frank is the Director of Therapy Solutions, a business offering training in counselling and psychotherapy. In the early summer of 2010, Frank asked me if I would help him out by taking a teaching post in his organisation, Therapy Solutions, established in the early 1980s. In their promotional literature, the 'core business' of the organisation is the provision of counselling and psychotherapy to 'Service Users' who are willing to enter into a 'Counselling Contract' for fifty-minute sessions priced at forty-five pounds each. The 'Client Information Pack' indicates that the sessions could last from a few weeks to a few years and defines therapy as:

> A process which involves skills of caring, listening and prompting, the person is helped to find the inner resources and strengths so that they can cope more *effectively* with life by making *appropriate decisions* and taking *relevant action*.[6] [My emphasis.]

The information pack seemed to advertise a pragmatic and decisive approach, an action-oriented version of Rogerian non-directive therapy. I knew Frank fairly well from meetings and conferences where, in coffee breaks and over evening meals, we had discussed the joys and trials of our work as therapy trainers. We were classmates during therapist training, didn't agree much on counselling theory, but got along well, having more in common in travel than work. Frank was aware of sociologically-informed research. The recent unexpected departure of a tutor on the final year section of his flagship BACP Accredited Course in Humanistic Therapy left a gap he was not able to

[5] Interview 28.
[6] Therapy Solutions Client Information Pack, p. 2.

fill for the next academic year. The course handbook, conflating 'the normal personality' with 'organisation', outlined the Philosophy and Culture of the course in the Handbook:

> Humanism asserts the overall dignity and worth of human beings and their capacity for self-realisation. Humanistic theorists oppose what they see as the pessimism and despair of the psychoanalytic perspective and the 'robot' conception of human beings offered by behaviourism... The normal personality is characterised by unity, integration, consistency and coherence. Organisation is the natural state, and disorganisation is pathological.[7]

We arranged to meet at his office. He was smartly dressed, wearing a jacket and tie, his long hair tied into a pony-tail. In the past I had known him as a confident extrovert, but now he seemed tired, sallow and serious. I wanted to help, and the prospect of observing a privately-run counselling and psychotherapy training centre was a great opportunity for me. We made a deal. I would work for one year as a part-time tutor (with a participant observer role) on alternate weekends. This would give him time to find a permanent member of staff. Frank expected me to facilitate group seminars as well as observing role-plays. He produced a lengthy 'Staff Service Schedule' for me to sign. The bulk of the contract comprised a list of office protocols concerned with maintaining up-to-date documentation, being alert to Health and Safety Issues, keeping the 'Day-to-Day Diary' up to date, and:

> To ensure all equipment & furniture is returned to its original location, that the heating, lights and photocopier are not left on unnecessarily and that the building is secured & locked up as per the locking up procedure.[8]

The only mention of the teaching aspect of my role was: 'To deliver the course programme on all the allocated course dates.' A catch-all clause at the end of the contract provided: 'Also anything else that is considered reasonable to do so by the Course Director.' I would be given the chance to interview any willing students-in-training as part of my research, and was expected to contribute something useful from my experience to the structure and content of the course.

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[7] Therapy Solutions Course Handbook, p. 3.
[8] Therapy Solutions Staff Service Schedule, p. 3.

Frank said he had become isolated and anxious about recent changes imposed by the BACP. He felt Therapy Solutions was at a disadvantage compared to FE and HE courses in the public sector, which were better funded since students could get grants and loans. The 'Gold Book' is neutral to theoretical orientation and aims to identify the values and behaviours of therapists in the shape of 'generic competencies', a concept he said he found difficult to grasp. Meeting the requirements of the 'Gold Book' was a challenge to Frank who has sincerely held beliefs in clients' capacity to find their own way to well-being without therapists' expert knowledge.[9] He was wary of theoretical abstractions in general and told me he was 'not good on theory'. Frank was closely aligned with a humanistic perspective on the client as the sole expert in their own subjectivity, an ardent proponent of self-empowerment, self-actualisation and personal autonomy. To avoid criticisms of self-referentiality,[10] and following efforts made by the core curriculum consortium to justify a departure from single modality approach to training, the Gold Book section B3.2 states:

> There must be sufficient theory, drawing upon relevant social science disciplines to enable students to make explicit and critically appraise the philosophical assumptions that underpin counselling and psychotherapy and its historical development.[11]

Frank's interpretation of B3.2 is found, in the handbook, under Course Philosophy and Theoretical Orientation:

> I am convinced that it is premature to advance any one integrative system, just as it is inappropriate to select any one all-purpose pure form psychotherapy system. We emphasise the humanistic school in the attitude taken towards the client, with the establishment and maintenance of the core conditions necessary to develop a therapeutic relationship. The core values of the course derive from the humanistic tradition with importance given to client empowerment, autonomy, individuality, empathy and respect, at an interpersonal level. We also emphasise awareness of the social and cultural context of counselling, referring to the values of justice, citizenship, inclusion, and de-individualism.[12]

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[9] Mair, K. (1992) *The myth of therapist expertise.*
[10] This was a contentious topic in the writing of the Core Curriculum, narrated in chapter four.
[11] BACP (2009) *Accreditation of training courses*, p. 7.
[12] Therapy Solutions Course Handbook, p. 2.

The marketing, administration and management of Therapy Solutions was carried out by Frank, who was assisted by Joan, a part-time administrator. Brian, the Health and Safety Officer, carried out the routine maintenance of the building. He also provided lectures to students, teaching staff and therapists on a regular basis to ensure everyone was familiar with the latest Therapy Solutions Health and Safety policy. Brian and Joan had trained at Therapy Solutions. All of the thirty-two working therapists were alumni who paid on a sessional basis to rent rooms, providing the centre with a valuable income stream.

Courses at Therapy Solutions had run smoothly with little interference from external regulatory bodies for thirty years, but the advent of IAPT and the prospect of statutory regulation imposed new and unwelcome expectations. Frank felt many demands made by the BACP were unreasonable, but he was diligent in meeting them. He found his role as director anxiety-provoking, and he worked long evenings and weekends. He lived alone in an apartment near the Therapy Solutions, with a small dog, and seemed to have little time for friends and relaxation. He had not been out of London for two years. I wondered why he kept going; he had enough money to stop work at any time.

The Therapy Solutions setting

Therapy Solutions occupies a large, Victorian, white stucco terraced building in a residential part of east London that is undergoing gentrification. It is situated in a quiet tree-lined street where it is easy to find parking nearby. The building is on four floors, including a basement. Posters advertising short courses and cut-price therapy by trainees adorn the front entrance. Mandala and Pentagram images hint at a New Age culture.

Doors in the main hall lead to consulting rooms, each of which is named after a flower: Rose, Lilac, Peony, Daffodil.... One room marked ‘Office’ has a coded lock on the door. This is Therapy Solutions’ engine room, containing three desks and six locked filing cabinets. The room is cream in colour, lit by four fluorescent tubes and is very neat, clean and tidy. One of the desks has a plain office chair each side and is reserved for formal occasions when students hand portfolios of achievement in, for scrutiny by Frank—who has the final word on progress and graduation. His role is to ensure that each of the hundreds of course criteria are self-certified by the student, witnessed by fellow students, countersigned by a course tutor, internally verified and externally moderated.

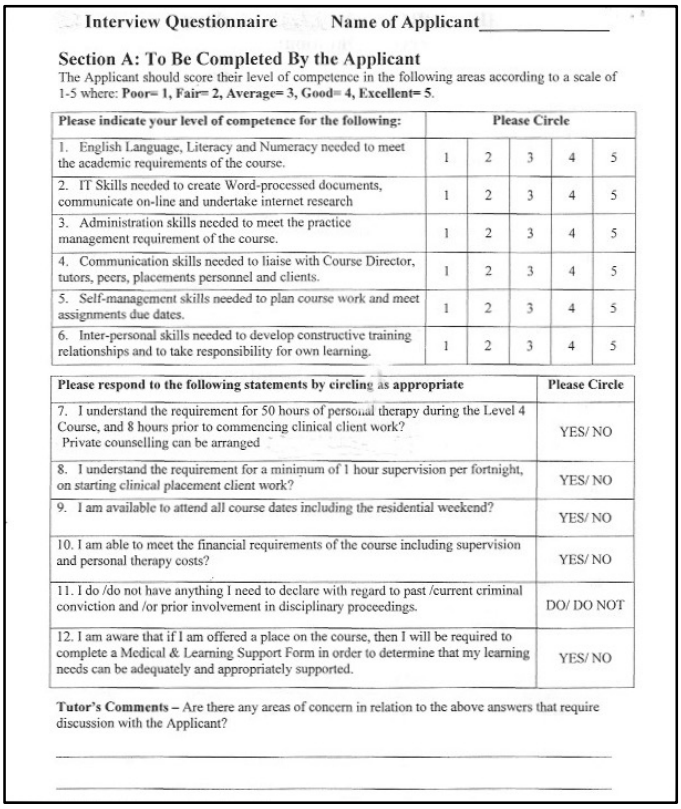
The first floor has a kitchen where students can make drinks and heat food in a microwave oven. The building has ten consulting rooms, the management of which is orchestrated via a paper-based booking system on a table in the main hall. Provided they are not used for therapy, any room can be used by tutors and students on the course for small group-work, role-play, tutorials and clinical supervision. The walls are covered with woodchip wallpaper and pastel colours. Central rose pendants give out a flat, shadowless light. Each room has a notice board outside with fire safety instructions and an 'engaged' sign, to be turned over when the room is in use. Further signs prohibit the movement of hot drinks from one part of the building to another, the importance of silence, advice of fines payable if the heating is left on in unoccupied rooms or if they are left unlocked. Each room has a key kept in a central safe near the room booking table. Every room contains three chairs. Two are facing each other, but slightly turned away so clients and therapists don't stare at each other. The third chair is primarily an observer chair but may occasionally be used by therapists working with couples. A clock facing the therapist chair is set on a small table. Tissues are placed near the client chair. Some of the windows facing other buildings have plastic film over them to maintain privacy.

A door off the top landing, next to the toilets, leads to a small library of books by Carl Rogers, Irvin Yalom and Brian Thorne, clustered into sets of multiple copies from the prescribed reading list. Other books on the shelves include *Managing Madness*, *Take Effective Control of Your Life*, *The Inner World of Fitness,* and *Problem-Solving*. The books are contained in a glass-fronted cabinet, which is locked. A notice announces the seven-day maximum loan time and fines for exceeding this. An A4 poster informs borrowers that to obtain library access it is necessary to email Frank or the administrator, and to complete a request form which is countersigned by a course tutor before access can be authorised. When I questioned Frank about this he said that unfortunately a number of books had gone missing and he had to make them more secure. He said students were better off buying their own books anyway and the library was mainly there to comply with the Gold Book requirements on resources for students.

The students

The events narrated in this chapter are populated by students in their final year of Counsellor/Psychotherapist training. The training offers a competitively priced route to paid therapy practice, compared to degree-based schemes offered elsewhere. The students included in this chapter have all reached a stage where they want to work independently as fully qualified therapists and will be eligible on completion of their training for entry on the BACP Register for Counsellors and Psychotherapists. They will also be eligible for BACP Accreditation, subject to the assessment of a portfolio of evidence. Access to this final stage of Therapy Solutions training requires an interview to which students bring an Interview Questionnaire that they are asked to complete first. The interviews, carried out by Frank and Brian, are based on a discussion of the responses made by candidates on the Interview Questionnaire (see Figure 9.1), which provides a numerical rating scale for skills in Literacy, Numeracy, IT, Administration, Communication, Self-management and Inter-personal skills:

Figure 9.1: Therapy Solutions Interview Questionnaire



Interview Questionnaire **Name of Applicant**_____

Section A: To Be Completed By the Applicant

The Applicant should score their level of competence in the following areas according to a scale of 1-5 where: **Poor= 1, Fair= 2, Average= 3, Good= 4, Excellent= 5**.

Please indicate your level of competence for the following:	**Please Circle**				
1. English Language, Literacy and Numeracy needed to meet the academic requirements of the course.	1	2	3	4	5
2. IT Skills needed to create Word-processed documents, communicate on-line and undertake internet research	1	2	3	4	5
3. Administration skills needed to meet the practice management requirement of the course.	1	2	3	4	5
4. Communication skills needed to liaise with Course Director, tutors, peers, placements personnel and clients.	1	2	3	4	5
5. Self-management skills needed to plan course work and meet assignments due dates.	1	2	3	4	5
6. Inter-personal skills needed to develop constructive training relationships and to take responsibility for own learning.	1	2	3	4	5

Please respond to the following statements by circling as appropriate	**Please Circle**
7. I understand the requirement for 50 hours of personal therapy during the Level 4 Course, and 8 hours prior to commencing clinical client work? Private counselling can be arranged	YES/ NO
8. I understand the requirement for a minimum of 1 hour supervision per fortnight, on starting clinical placement client work?	YES/ NO
9. I am available to attend all course dates including the residential weekend?	YES/ NO
10. I am able to meet the financial requirements of the course including supervision and personal therapy costs?	YES/ NO
11. I do /do not have anything I need to declare with regard to past /current criminal conviction and /or prior involvement in disciplinary proceedings.	DO/ DO NOT
12. I am aware that if I am offered a place on the course, then I will be required to complete a Medical & Learning Support Form in order to determine that my learning needs can be adequately and appropriately supported.	YES/ NO

Tutor's Comments – Are there any areas of concern in relation to the above answers that require discussion with the Applicant?

_____

_____

Source: Therapy Solutions Course Handbook

The form prioritises skills of management and administration over the personal qualities commonly associated with an aptitude for counselling and psychotherapy.

A learning day

A typical learning day starts at 9.00 am with a group check-in where participants, sitting in a circle, narrate their anxieties and preoccupations. I sit between one of my co-tutors, Bev, a tall smiling woman in her mid-fifties with closely cropped fair hair, and Tracey, a part-time group facilitator, who has a sullen expression and is avoiding eye contact. I have no idea if anything is wrong. A tearful woman in her twenties living with an abusive man tells the group how lonely, desperate and stuck she feels. Others take it in turns to offer consolation, advice and tissues as more tears are shed. After an hour, a tea break, and a rearrangement of the chairs, Bev narrates a PowerPoint presentation on Boundary Issues and Risk.

Study topics are in a Course Handbook setting out an hour-by-hour guide to teaching and linked clusters of criteria to be applied to all aspects of training, assessment, placement and progression. This definitive document contains details of, for example: risk assessment; health and safety; critical incident procedure; client contracts; placement contracts; placement feedback; disciplinary procedures; appraisal meetings; assessment criteria; role-play observation; the student awareness-group contract; criteria for the provision of evidence of self-development through journal writing; and supervision contract requirements.

The assessment and management of risk is high on Therapy Solutions' agenda. In the Therapy Solutions course handbook, 'Health and Safety Policy' states:

> We aim to achieve health and safety excellence through statutory compliance. We believe effective health and safety management is a vital activity and we therefore rank health and safety equally important as other organisational objectives.[13]

[13] Therapy Solutions Handbook for Staff and Students, p. 33.

Students are expected to be proactive about risks arising from any change of circumstances to themselves or their clients. The 'Types of Concern(s)' and 'Potential Risk' are summarised in a table (see Figure 9.2) aimed at helping students decide when to make a risk assessment. For example, the risks of tripping over stairs and falling over are described as separate types of self-injury. Drugs and alcohol are cited a number of times under categories of 'Harm to Others' or 'Illegal/Criminal Activity'. The table advises that procedures put in place to reduce risk can include 'working through issues within counselling sessions', so that risk management becomes integral to the therapy, prioritising management imperatives over personal distress.

Figure 9.2: Therapy Solutions Health and Safety Policy

Type of Concern(s)	Potential Risk
Harm to Self 1. Suicide e.g. taking overdose 2. Self-harm e.g. cutting 3. Medical condition e.g. epilepsy 4. Disability e.g. on crutches 5. Other e.g. pregnancy	 1. Self-harm or death 2. Bleeding and infection 3. Seizure, unconsciousness and self-injury 4. Falling over and self-injury 5. Tripping on stairs and self-injury
Harm to Others 1. Violent outbursts e.g. drunken behaviour	 1. Attending inebriated and harming counsellor and/or others
Illegal / Criminal Activity 1. Drug dealing e.g. supplying or taking drugs	 1. Attending under the influence of drugs
N.B. Clients presenting with more than one type of concern could result in a complex situation which is more like to require a Risk Assessment to be carried out e.g. a learning disability plus another type of concern.	
ii) Identify the persons at risk e.g. the client themselves, student counsellor, members of the public, clients family including children. iii) Depending on the probability and severity, determine the level of risk as **mild, moderate or severe** e.g. client becomes violent when drunk = severe risk. iv) The student counsellor is then required to put procedures in place in order to minimise the risk by working through issues within the counselling sessions, setting boundaries and possibly adding extra clauses to the Client Therapy Contract. Student counsellors should also consider the needs of the client in relation to disclosure and/or specialist services. **(Ref. Disclosure Policy and Guidance Notes Regarding Suicide)** v) Next the student counsellor is required to reassess the level of risk once the client has agreed to procedures being put in place e.g. now mild risk. Following supervision students in particular should note that for safety reasons they may be advised not to continue their work with a client, but to refer them back to the placement organisation.	

Source: Therapy Solutions Course Handbook, p. 34

In the event of a risk assessment being required, Therapy Solutions have provided an algorithm, 'Probability+Severity=Risk', to help document and manage the risk(s)

identified. The guise of a mathematical formula, while not actually based on quantities, promotes an illusion of scientific precision and certainty. The form requires checking by the trainee's supervisor, as well as the 'Health and Safety Officer', in addition to signatures from the client and counsellor. The design of the form (see Figure 9.3) precludes narration as the boxes do not provide much space.

Figure 9.3: Student Risk Assessment Form

Probability + Severity = Risk

Student Risk Assessment Form
Private & Confidential

Type of Concern	Potential Risk	Persons at Risk	Level of risk (Mild/moderate/ severe)	Procedures to be put in place to minimise the risk

Checked by Supervisor ☐ **Date** _____ **Checked by H&S Officer** ☐ **Date** _____

Client's Signature _____ **Counsellor's Signature** _____ **Date** _____

Print Name _____ **Print Name** _____ **Date** _____

Source: Therapy Solutions Course Handbook, p. 34

After lunch, an administrative half-hour is scheduled for tutors to hand back assignments that have been checked against course criteria. Most students' first submissions are 'referred', for failing to meet one or more of the criteria set out in the Course Handbook. The Referral Procedures for Personal Development Evaluation state that on first Re-Submission:

> The student should write an addendum of 200 words for each referred criteria, [sic] which must be submitted at the 1st session after the return of referred work. If the first re-submission still does not meet all the criteria and is re-referred, the student has one final submission opportunity. If the

> second re-submission still does not meet the criteria, the student will be deemed to have failed this unit.[14]

There is little space for nuance. Students either do or do not meet each criterion and Bev has neither the time or interest for discursive essays. Numerous documents attesting to satisfactory completion of other parts of the course require counter-signature, which I was empowered to perform, although in effect I simply concurred with students' self-certification.

Sam, a final year student who had recently given birth to her first child and was struggling to stay on the course, found herself in a contradictory position:

> In terms of written work, you seem to have to adhere to a particular view or you end up rewriting parts of the essays. You are given what's called a referral, which means you haven't met that particular criterion, and you have to write that in a particular number of words and then its reassessed, and, again, you could fail that and resubmit it, and if it doesn't pass that time you fail the course. I think what they want is compliance. I mean, I was accused of 'criteria rebellion' so they didn't want me to challenge the criteria, which I did at the very beginning of the essay, where I sort of pointed out that despite the fact this is meant to be an essay where we were exploring our own view of therapy, it actually specified that we had to do that within in a humanistic framework and we have to subscribe to a humanistic view of therapy, so I pointed out immediately that there was an inconsistency there and the essay didn't sort of go down very well.[15]

By mid-afternoon, turns are taken to perform role-plays in groups of three, with students alternating between roles of observer, client and therapist. The material for discussion comes from students' own personal experience, so feels very real and emotionally laden, with displays of sorrow or anger often caused by difficulties on the course. Boxes of tissues are left prominently on tables throughout the building, inviting tears. I felt uncomfortable about the obvious lack of confidentiality, and about the experience of witnessing someone in distress so that therapist interventions could be marked off on a check-sheet. Each term students have to submit two completed check-sheets (see Figure 9.4), and sometimes need to plan and rehearse required behaviours before the dreaded audio-recorder light shines red. In some examined role-plays, 'clients' may have to

[14] Therapy Solutions Course Handbook, p. 17.
[15] Interview 20.

abandon or modify their narrative to allow the counsellor to exhibit behaviours such as 2.2/2f: 'Tracking and end-point highlighting', 'The 'Appropriate Use of Questions', 2.2/3, can include (3a), 'Absence of questions'. I was often asked to clarify these skills, preferably with examples, before the role-play would start. My response was that it did not make sense to me to separate the skills from their context; my comments would be general and aimed at the impact of the session on the client. When students playing the counsellor-role had realised I was not interested in their performance, they relaxed, becoming less self-conscious and gave more attention to their client.

Figure 9.4: Counselling Skills Assessment Sheet

ABC	L-F	Skills	Yes	Comments
2.1		**1. Starts Session Appropriately**		
	1a)	Offer an appropriate setting		
	1b)	Hold clear time boundaries		
	1c)	Explain and respect confidentiality		
2.2		**2. Active and Accurate Listening**		
	2a)	Attentiveness, minimal encouragers and rapport building		
	2b)	Reflecting content and feelings		
	2c)	Clarifying content to understanding meaning		
	2d)	Awareness of discrepancies/incongruence's		
	2e)	Paraphrasing and summarising content		
	2f)	Tracking and end point highlighting		
2.2		**3. Appropriate Use of Questions**		
	3a)	Absence of questions		
	3b)	Use of open ended questions		
2.2		**4. Effective Use of Silence & Pacing**		
2.2		**5. Immediacy Skills/Working with Resistance**		
	5a)	Use of congruence		
	5b)	Focusing		
	5c)	Challenge		
	5d)	Invitation		
2.2		**6. Enabling Deeper Exploration**		
	6a)	Conveying empathy, warmth and acceptance		
	6b)	Engaging with client/working alliance		
	6c)	Using understanding hypothesis to guess underlying feelings		
	6d)	Using linking hypothesis to connect past and present, identify patterns/themes		
	6e)	Using explanatory hypothesis to make sense of it all		
	6f)	Reflecting Process		
	6g)	Enable client to explore choices		
	6h)	Use of metaphors		

Source: Therapy Solutions Course Handbook, p. 45

During tea breaks I had the option of retreating to the office with Bev and Tracey or chatting with the students, which would often result in a discussion about problems they

were encountering in their lives and on the course. Polly, a primary school teacher, was very critical of role-play in therapy training. She gave me her journal entry, saying 'please publish it if you get the chance':

> When we're observing each other in trio work—and don't get me started on the muddled thinking that could ever claim that counselling fellow-students, with all the hopeless entanglement of social and therapeutic boundaries that entails, is a good use of the time we have together—is it more important to attempt to engage with what is actually happening in the room, or should we be anxiously listening for summary or paraphrase, so that we can place a reassuring tick in that all-important box? Sure, if our clients are looking for primary school English skills, then being able to summarise and paraphrase is vaguely useful. But do clients really want or need a therapist who has been programmed to halt whatever spontaneous exchange of thoughts and feelings about the client's world and experiences of it and in it is going on, and to impose a repetition of what has been said, just so that a small collection of parallel and perpendicular lines on a white rectangle of paper can have a differently-angled line drawn inside it?[16]

The students seemed to treat me as their confidante and hopeful advocate. Bev regarded me with expressions of overt warmth and a badly concealed suspicion that I might complicate the training by introducing dangerous and superfluous ideas, complexity apparently being unwelcome in a culture of precarious certainty.

David

David questioned the generalisability of mental health labels applied to immigrant groups. Bev became exasperated, telling David (who had a background in social work and spent much of his working life amongst the Bangladeshi community in Tower Hamlets in east London) that there was not enough time to go into 'that sort of detail'. David had little time for normative constructions of mental health and struggled against an expectation of compliance towards the course-approved version of authenticity/congruence:

> I felt very disillusioned because I suppose if I thought that as it was a course to do with counselling, the word they used throughout this humanistic framework is 'authenticity'. They keep going on

[16] Polly's journal entry, (added to my field notes with consent).

> about congruence so I naively thought that they would want congruence in the written work as well, but it turned out the opposite was the case. The only way I passed my essay was jumping through the hoops that they prescribed for me, which meant not being congruent, but obviously, the hoop jumping was more important to them than congruence. Initially it made me very angry and frustrated; now it's left me feeling disengaged with the course and I want to finish it as quickly as I can. I suppose what's been most disappointing is that we've been given some very mixed messages. We have been told as individuals we need to have a certain amount of personal therapy, we are instructed to reflect, to be authentic, but there doesn't seem to be that same level of rigorous scrutiny within the course itself.[17]

Demonstrations of self-awareness were required in written work, group activities, seminar discussions and role-plays. The framing of students' subjectivity within a confessional narrative[18] was elicited by the regular submission of reflective journals. Self-development and progress at Therapy Solutions required the monitoring and narrating of 'personal inadequacy'. Bev 'identified' positive change by the extent of students' deepening alignment with Therapy Solutions' representations of 'Humanistic Counselling' for the Personal Journal Section E: Self Awareness for Counsellors, which states that:

> 1) Students should reflect on their ability to fully participate in all areas of the course and describe any emerging themes they recognise with regard to their own self-awareness and inner development.
> 2) Students should describe how their inner development is impacting on their lives and their relationships with others and identify any changes they are striving to make as a consequence of this.[19]

Several students found that their journal entries were marked by Bev for referral despite their best efforts to conform to the guidelines. David put it this way:

> The journals we have to write as the course goes on, so those are supposed to be a record of our thoughts and feelings about professional practice issues as they call them, about things that have cropped up in our placement, about theory and so on. So, they're supposed to be a written record of how we've responded to those things. I was criticised in mine for not presenting a view, and

[17] Interview 20.
[18] See Gilbert, T. (2001) Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing,* 36, pp. 199–205.
[19] Therapy Solutions Course Handbook, p. 11.

> apparently, the view that I took wasn't, quote, 'balanced enough', so it felt as if the journal police were out then as well. Because I had thought that the journal was meant to be a space where we were allowed to reflect, where there weren't criteria we had to meet in that, but it felt as if I offended at some level by not representing my views in a certain way, so even that feels as if something was being imposed on it, and again the thing that is being imposed on it is not even being scrutinised by the people running the course..... The desire to render things sort of simple and also manageable and measurable, and all of that seems to mitigate against what's really valuable in therapy.[20]

David was not alone in his emerging role as a sociologist. He distanced himself from his situation, trying to comprehend the contradictions as he encountered them by writing a subversive journal entry in an act of resistance. He passed a copy to me, but did not include it in his 'Portfolio of Evidence':

> Apparently, within this highly authentic reflective statement—because rules always lead to authenticity(!)—I am required to describe how I 'managed' any difficulties I encountered. Again, I call upon my online dictionary; again, it obliges. 'To manage' is to 'direct or control the use of'. Right. So emotional difficulties need to be 'managed'? No doubt that explains the parallel use of 'contracts', and 'aims', and 'progress reviews', and all the other poisonous business-speak currently being injected surreptitiously into the world of therapy. It's hard to tell who suffers most; the client or the counsellor.[21]

Nora

The 'Personal Development Group' at the end of each day, run by an 'external facilitator', provides a space for resistance. In one session Nora pointed out that being humanistic should at least feel humane, after she had been given a warning for missing three sessions due to an infection. Nora became tearful and angry, telling Bev she was 'worse than my mum' for suggesting her illness was 'malingerent' [sic], despite the presentation of a doctor's note. Later that day, Nora was summoned, without notice, to a disciplinary meeting with Bev and Tracey:

> It was quite extraordinary—they were even commenting on their impression that my body language seemed disengaged as grounds for disciplinary action, and then waved the student

[20] Interview 19.
[21] Ibid.

> contract at me and tried to claim I wasn't sticking to it. They were so clearly out of their depth, though. If they'd given me the sheet of paper ... was frantically writing on to sign, I could have written something so damaging, there was almost palpable relief that it didn't come to that. I think this way was best though. They didn't have the ego strength to cope with conceding and I did, partly because I know that what I've conceded to is so pathetic as to be laughable. This can't be humanism, even thinking about the etymology; it's not remotely humane.[22]

As students made their way through the course, they built up a portfolio of 'evidence', consisting of essay assignments, journal entries, essays, supervision reports, role-play observations and tutorial records. Each piece of evidence was associated with a report-form setting out criteria the student was required to meet in order to pass. The task of assessment consisted of checking the boxes where the evidence meets the criteria. These sheets were internally verified by course tutors and re-checked by an external moderator who could cross-reference by criterion number and look at selected parts of a student's work. The impending arrival of the Moderator was given as an incentive to ensure portfolios were up to date and correctly indexed. Before the day of the visit, the whole building was given an extra clean. The filing was updated and nothing was out of place. By the time the Moderator arrived, Frank was smiling tensely and wearing a dark suit. An aroma of fresh coffee infused the building. Students' portfolios were neatly laid out in the largest room on long tables so the Moderator could make random selections of their work to inspect. David put it this way in a journal entry, which he did not submit but shared with me: [23]

> An orgy of ticked boxes is what we need to produce for the all-powerful, criteria pimping moderator, as evidence of our ability to interact with the human beings who bring us their stories of pain, bereavement, abuse and courage. Person-centred, or centred around deference to a system that places systems above people, criteria above critical thinking, and the organisational staving off of anxiety over keeping clients and therapists safe, which we can do far more effectively by recognising not just their individuality but also our commonality. The training course I would relish would be one that recognises this toxic imposition of criteria and their ilk as the common enemy. Instead this course embraces it. And it doesn't just embrace it, it buys it dinner and gets

[22] Interview 22.

[23] After the end of my time at Therapy Solutions I interviewed David. He told me that being able to send me some of his rants, and knowing that I would understand, 'made the course more bearable'.

> into bed with it, rather than encouraging us, as trainee therapists, to recognise the desire to judge, to measure, to quantify as the core of the problem not, in any shape or form, its solution.[24]

After the visit, Frank showed me the Moderator's glowing report, a two-page list of standards she had signed off and a brief note to the effect that Therapy Solutions remains one of the most well-managed of the centres she visits. He looked relieved, but not happy. Frank's management of Therapy Solutions seemed to bring him little satisfaction. By attempting to nail every detail of therapy training, retreating from uncertainty by way of a very literal compliance with the Gold Book, his task became endlessly unrewarding.

Prospero

Prospero had taught Philosophy at a University in Madrid before a relationship breakdown and period of grief, during which time he had contemplated suicide, led him to seek therapy, after which he moved to London and decided on a career change to psychotherapy. Prospero made many lengthy protests against what he described as a perverse and simplistic misrepresentation of humanism, citing Husserl, Heidegger and Ricoeur, amongst others, to sustain his sometimes complex and highly abstract arguments.

Bev did not understand what he was saying; she seemed to resent Prospero's criticisms and told him that he was 'intellectually defended'. A few students said he was taking up too much time. Most of the group lost interest in his lengthy and elaborate speeches. Although I did what I could to support him, he became isolated and over the course of a few weeks retreated into an angry silence.

Alice

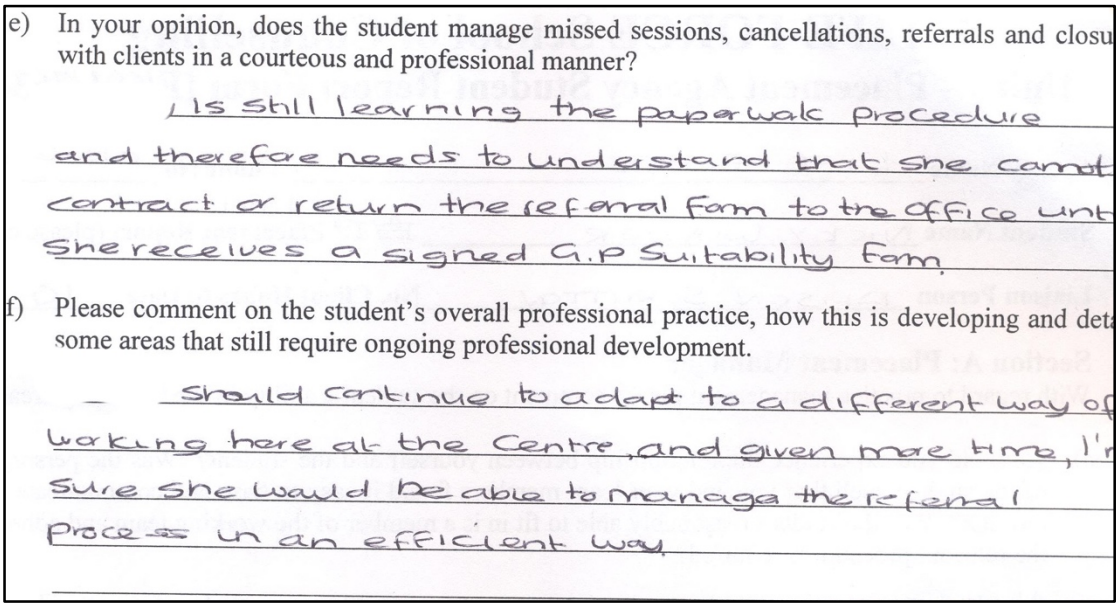
Alice asked me if I could help her through a difficulty. She was fearful, quite near the end of her training, and thought that she might fail this task although she was so near completion. Her sleep was disturbed, she was waking at three or four a.m. with thoughts about years of study being wasted, she was feeling stupid in front of friends and family,

[24] David's journal entry (added to my field notes with consent).

and, worst of all, was fearing being a failure as a therapist. I told her I'd be happy to meet and see if I could help.

Alice had worked for a year on a placement in a women's refuge where she heard survivors' disturbing stories of abuse and neglect. Work with these clients, although challenging, was deeply rewarding to her and helped validate her sense of vocation as a therapist-in-training. Alice showed me a report in which Sally, her clinical supervisor, praised her capacity to form deeply engaged relationships with distressed clients who were able to recall awful experiences in a calm and safe space. Over the year Alice's clients told her they found the therapy helped them feel less anxious and more confident. At the end of each placement, students are provided with feedback (see Figure 9.5) by Joan, the administrator for Therapy Solutions. The comments on her feedback forms indicated a concern with 'paperwork procedure':

Figure 9.5: Placement Feedback


e) In your opinion, does the student manage missed sessions, cancellations, referrals and closu with clients in a courteous and professional manner?

Is still learning the paperwork procedure and therefore needs to understand that she cannot contract or return the referral form to the office unt she receives a signed G.P Suitability Form.

f) Please comment on the student's overall professional practice, how this is developing and det some areas that still require ongoing professional development.

- Should continue to adapt to a different way of working here at the Centre, and given more time, I'm sure she would be able to manage the referral process in an efficient way.

Source: Alice

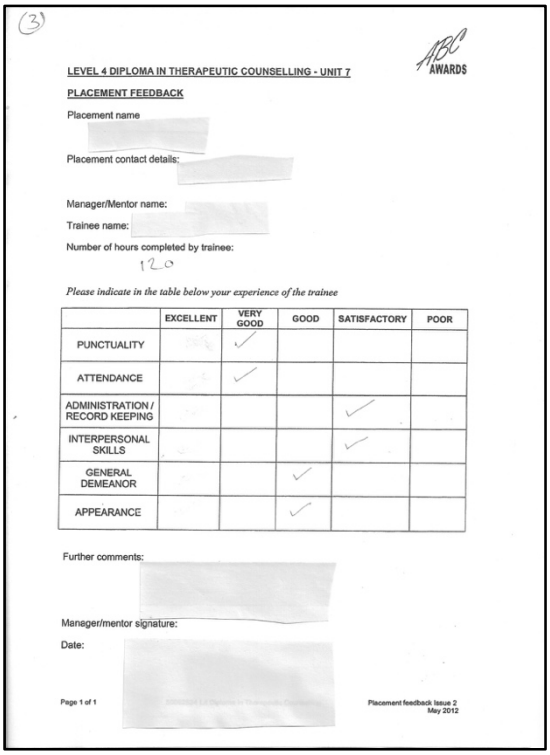
Alice responded, as required, to Joan's feedback with the following:

> My client had difficulty in obtaining a GP referral form and I made a number of efforts to secure this, although for me it was a deeply problematic situation, as the requirement to obtain the form made my client feel 'humiliated', and this has caused me to reflect on my own relationship to organisational policies. This placement report focuses on my adherence to systems and procedures

> (having its corollary in the fact that I have been asked about my client work only in the light of forms, letters, signatures and room bookings) and the experience of reflecting on it has therefore sharpened my awareness of the potential of organisations to reveal their own underlying values through the areas they choose to emphasise through their policies and communication style – I see this as an important lesson.[25]

Alice's analysis of Therapy Solutions' priorities is framed within a confessional narrative as 'sharpened awareness' and a 'lesson'. Alice's implication, that Joan was more concerned with paperwork than people, was ignored by Therapy Solutions. An expectation that trained counsellors will work in organisational settings and need to model themselves on corporate expectations of appearance and demeanour is conveyed in the feedback form provided by ABC Awards:

Figure 9.6: Placement Feedback.



(3)

ABC AWARDS

LEVEL 4 DIPLOMA IN THERAPEUTIC COUNSELLING - UNIT 7

PLACEMENT FEEDBACK

Placement name

Placement contact details:

Manager/Mentor name:

Trainee name:

Number of hours completed by trainee:

120

Please indicate in the table below your experience of the trainee

	EXCELLENT	VERY GOOD	GOOD	SATISFACTORY	POOR
PUNCTUALITY		✓			
ATTENDANCE		✓			
ADMINISTRATION / RECORD KEEPING				✓	
INTERPERSONAL SKILLS				✓	
GENERAL DEMEANOR			✓		
APPEARANCE			✓		

Further comments:

Manager/mentor signature:

Date:

Page 1 of 1

Placement feedback Issue 2 May 2012

Source: Alice

Unfortunately for Alice, her supervision and placement reports were not sufficient evidence to meet all the course criteria, since, having worked exclusively with women, Alice did not fulfil the 'Diversity Criteria' [sic]. The Course Handbook mandated that the

[25] Text of Alice's 'student response to feedback'.

preferred way to meet this criterion was to work with both men and women. Other forms of difference, such as ability, mobility, ethnicity, age or sexuality, all of which Alice had worked with, were inadmissible. Although she had exceeded the requisite 100 hours' practice, Alice was now required to undertake a further twenty sessions with a male client. This seemed illogical to her, so she contacted an advisor in the ethics section of the BACP to obtain some clarification. He judged the situation to be 'out-dated', and told her that if she wanted to take it further she would need to make a formal complaint.

Alice now had a dilemma: complain to the BACP and fall out with Therapy Solutions, who, she was sure, would name her as non-compliant and look for reasons to justify the label (which she was sure they would find), or go along with the twenty-hour requirement. Reluctantly, fearful and with heavy heart, Alice declined the opportunity for vindication and agreed to Therapy Solutions' terms in the hope of graduating and 'getting away from the place as soon as possible'.

Another placement was set up and Alice started working with Vince (not his real name), a twenty-one-year-old man labelled with 'challenging behaviour' (code for being angry) who was sometimes violent towards those trying to help. Vince had spurned earlier attempts at psychotherapy on the NHS, where he felt the meeting of targets was top of the agenda. He was also not happy about having been told he had a 'personality disorder'. During the first session with Alice, he described how, in his previous counselling, he was asked to change a two-out-of-ten suicide risk rating to zero, because his therapist openly admitted that she had to meet targets set for the reduction of suicidal ideation on discharge. He soon formed a good therapeutic relationship with Alice where he seemed relaxed, responsive and engaged. Alice afforded Vince the credibility and understanding so lacking in his previous encounters with help. He seemed insightful, and, Alice told me, could see parts of himself in some of Shakespeare's characters.

One obstacle remained. Self-referred clients, and Vince was one of them, had to be assessed by their GP as suitable for work with trainees within the first three counselling sessions. The BACP did not ask for this; it was a measure put in place by Therapy Solutions to ensure students were not overwhelmed by people labelled with mental illness, raising questions about the point of therapy. In effect, the GP was required to sign a form providing legal protection for Therapy Solutions in case a patient's illness resulted

in an unspecified catastrophe. Alice contacted the BACP once more in the hope of a resolution. This time her contact described the situation as ‘absolutely ludicrous’, but, again, there was nothing that could be done without a formal complaint.

The earliest available doctor's appointment was two weeks away for non-urgent cases. Frank was asked to adjudicate; he decided that sessions should be discontinued to encourage Vince to chase up the GP. On the basis of the work to date with Alice, there was every reason to believe that Vince would make good use of therapy, thus making the form redundant. Alice felt a delay would undermine the relationship they had built and be in breach of the BACP Ethical Framework by putting bureaucratic barriers ahead of a clients’ best interests. Alice was also worried Vince might stage a loud protest at the surgery and therefore get labelled as unsuitable for therapy. Eventually Vince did get an appointment for his clinical assessment. He entered the consulting room and handed the doctor the GP Suitability Form. The doctor, who had never met Vince before, simply said: ‘Where do I sign?’ This episode suggests that organisational authority and management’s interests are prioritised over clients’ well being.

Kirsty

Part of my ‘Job Specification’ required me to provide tutorial sessions for students. Kirsty, a middle-aged woman with an infectious laugh and a strong Glasgow accent, had been warned about plagiarism by Bev, who had previously told me that Kirsty was ‘trouble’ and on her way to being kicked off the course due to her ‘attitude’. I met Kirsty and she explained her rationale for presenting the text of another student’s work as her own, saying: ‘He said what I would have said if I could, he put it so well.’ She elaborated on this by pointing out that the course handbook required evidence for specific criteria to be presented in a written format, and Kirsty felt she had followed this to the letter. Kirsty made no attempt to disguise the material the other student had given to her electronically, retaining the original formatting.

Since I was a relative outsider, Bev thought it would be helpful if I spent some time with Kirsty to help her write in her own words. I was only partially successful in this, as Kirsty said she had often copied other people’s work because she suffered from dyslexia and did not think it mattered as long as she understood the material and signed the assignment

cover sheet confirming that she had met Therapy Solutions' criteria. I got the feeling that there was a bit more to it than this. Kirsty asked me to try and persuade Bev to accept her work, which I felt was unlikely. She refused to resubmit.

I discussed this with Bev, who had become very agitated and adopted a victim role in relation to Kirsty. She felt that her authority had been undermined too many times and the relationship had broken down irreparably. Bev, with a sound grasp of the crime of plagiarism, felt it was time for Kirsty to be removed from the course due to her non-compliant attitude. A difficulty lay in the fact that Frank did not have any written policy regarding plagiarism; he had assumed that the assessment methodology was sufficient in itself. He admitted to me that he was not really concerned with originality; his view was that so long as students met the criteria (originality not being one of them), all would be well. In this sense, Kirsty had followed the instrumental spirit of Therapy Solutions' assessment criteria, where originality was discouraged.

The matter was raised at the next Team Meeting where a decision was made to give Kirsty one last chance to resubmit an essay on the condition it was her own work. Bev was quite happy with this since she believed there was no chance Kirsty could comply and therefore would have to leave the course.

Frank invited Kirsty to a meeting without telling her in advance what it was about. Bev and I were asked to attend. Kirsty was furious that she had been tricked into believing that the meeting was routine and not a final warning. Frank told her he thought she would not come if she knew what it was about, which made matters worse. Frank proposed that I provide more tutorial support for her since she had refused to work with Bev or Frank, but seemed to get along with me.

Four weeks later, I was agreeably surprised to read something Kirsty had written that appeared to be both original and sufficient. During tutorial support, I had listened to her descriptions of how much Bev had reminded her of a nun at Braidfauld Convent near Glasgow, who had repeatedly told her, 'You must have done something very bad to be sent here', while a large metal crucifix was dangled in front of her face. Perhaps Kirsty's plagiarism was a subversive act that Bev was unable to grasp beyond the undermining effect it had on her sense of authority? Once Kirsty made the link, she was able to see

compliance as another form of attack. She knew Bev wanted rid of her, so she found a way to stay. Bev passed the assignment and did not see any irony in the topic of Kirsty's short piece on the power dynamics of a helping relationship. During our meetings, Kirsty had demonstrated a grasp of the play of power in her relationship with Bev. By being able to reframe and narrate the relationship as informed by the collision of their respective histories, Kirsty thus demonstrated therapeutic capacities that were not listed in the ‘Gold Book’.

Chapter 10

Conclusion

> 'A systematic presentation removes ideas from the ground that made them grow and arranges them in an artificial pattern. If the pattern pleased influential people they will write books about it, make it required reading in their university courses, arrange their examinations accordingly, and very soon the pattern will appear to be reality itself.' Paul Feyerabend.[1]

Storytelling and listening to stories may coexist with expressions of sorrow, acts of confession, curiosity, compassion and solidarity, the counsel of experience and the advocacy of personal autonomy in the face of oppression. These are commonplace social activities which have been appropriated and shaped in Britain and elsewhere by the social practices of counselling and psychotherapy. With roots in the moral therapy of nineteenth-century asylums and post-war welfare policies, talking therapy has been represented by humanistic and psychoanalytic psychotherapists as hermeneutically-oriented, inherently virtuous and inclined towards social justice. More recently, I argue, talking therapy within Britain's NHS has been increasingly subjected to instrumental reason. The social space created by a therapy encounter is, in a sense, both private and public. It is a private space in which sadness, shame, hate and longing can be articulated within a legally-sanctioned setting where therapists maintain the confidentiality of their clients' narrative, and public in the sense that the therapy praxis, with both technical and normative elements, exists in the public domain and is subject to political and economic interests. This chapter addresses some effects of the impact of instrumentalism on psychotherapy and counselling: Firstly, a colonisation of the psychotherapeutic space by psychological instrumentalism with reference to psychotherapy's involvement with the reproduction and maintenance of neoliberal identities; and secondly, the transformation, commodification and marketisation of therapy knowledge within higher education.

Underpinning the social actions described in earlier chapters has been the influence of an evidence-based approach to human distress, introduced in chapter one, originally conceived to bring instrumental reason to health workers' professional expertise and improve standards of treatment

[1] Feyerabend, P. (2011) *Tyranny of science,* p. 12.

and care by substituting professional opinion with empirical evidence. The ethnographic material narrates the instrumental use of targets, privileging political priorities over local need, for the training and monitoring of therapists and for the 'recovery' of service users—part of a trend where '…the shift to accountability through performance management has promoted a focus on the use of evidence to demonstrate achievement of targets'[2], targets which themselves collapse into measures. These actions are supported by economistic conditions legitimating job insecurity amongst NHS therapists through the imposition of self-employment, zero-hour contracts and 'payment by results'.

In the introduction, three research questions were raised:

1) What are the political and economic conditions impacting on psychotherapists and therapy praxis at the turn of the twenty-first century?
2) How have therapists responded to these conditions?
3) How has the practice of therapy been shaped during the period 2006–2015?

In addressing the first question, some of the political and economic conditions impacting on psychotherapists and counsellors have been identified in chapter one (an introductory social history of counselling and psychotherapy in Britain), and inform the social actions narrated in the ethnographic material in chapters three to nine. This chapter will address aspects of the second and third research questions through an interpretation and discussion of some observations arising from the empirical chapters, revisiting the ethnographic material and identifying emergent themes within a changing therapy field.

An outsider perspective

The social conditions of my childhood seem to have had a bearing on what in adulthood appeared to be a sensitivity towards (and a curiosity in) exclusion, arising from the impact of a cross-cultural, colonial world. The 'Third Culture Kid' (TCK) may see life differently to their peers:

> When TCKs return to their home culture, or when they grow up in countries where they physically resemble the majority of the citizens of that country, they appear like those around them, but internally these TCKs

[2] Sanderson, I. (2004) Getting Evidence into Practice, *Evaluation,* 10 (3), p. 372.

> view life through a lens that is as different from the dominant culture as any obvious foreigner. People around them, however, presume they are the same as themselves inside, since they appear the same outside.[3]

An expatriate childhood, including my experiencing of the cloak of secrecy that surrounded my father's work, have resonated in different iterations throughout my life, leading me to find it difficult to feel as much a part of British culture as others appear to, my lack of cultural understanding propelling my curiosity as an outsider looking in. As an adult seeking understanding in what I had hoped to be the clarifying wisdom and emancipatory potential of psychotherapy, firstly as a client and, later, through training as a therapist, I became surrounded by a bewildering array of paradox, ideology, self-referentiality and faith, some of it bad faith insofar as certain facts were being ignored, or so it appeared to me. In an effort to see beyond the individualising ethos of therapy discourse I have applied a sociological perspective to better comprehend the activities in which therapists were engaged, activities which my sense of being an outsider left me unable to join without equivocation: 'Distance – not being completely there – can provide perspective and freedom to speak.'[4] Therapists' self-representations as virtuous agents collaborating with distressed people in the search for solace and meaning, while at the same time actively reducing complex and diverse abstractions to tangible and glib statements of 'competence', or individualised 'psychological issues', seem in retrospect to have been ideological to the extent that these representations were both self-serving and contradictory.

The ethnographic material records a period during which psychotherapy training was experienced through a quasi-metaphysical narrative of redemption, with roots in religion and metapsychological, therapist-centred dogma. This contrasts with the Habermasian conception of psychoanalysis as a model for an emancipatory form of communication,[5] where methodological self-reflection protects a public sphere of human interest in autonomy and responsibility, suggesting that psychoanalytically-inclined therapy may have some value as a form of coercion-free speech. In the therapy encounter, however, normative aspects of psychoanalytic interpretation, reducing clients' narratives to Freud's metapsychology, may in fact serve to entrench existing power relations between client and therapist, and fail to address the effects of twenty-first century social conditions. Where methodological self-examination becomes mechanised within the

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[3] Pollock, D. & Van Reken, R. (2010) *Third culture kids: Growing up among worlds*, p. 54.

[4] Westbrook, D. A. (2009) Navigators of the contemporary: Why ethnography matters, p. 49.

[5] Habermas, J. (1987) *Knowledge and Human Interests.*

imperatives of neoliberal culture, it loses any traction it might have had to engage critically with precarious employment,[6] homelessness and poverty. These observations helped lead me to this research, and to gain a position as a participant observer where I could record samples of social actions which were taking place in response to structural changes in the field of counselling and psychotherapy.

The merging of managers' and therapists' symbolic capital

Behind the production of the Core Curriculum there were three factors: Firstly, the professionalising strategies by the BACP, who were taking a lead role in legitimating a standardised and modularised representation of counselling and psychotherapy knowledge (an opportunity created by the expectation of statutory regulation); secondly, the media attention that was being directed towards the purported risks of therapy given by unregulated therapists; and thirdly, the drive towards the commodification of therapy knowledge within Higher Education settings. The Core Curriculum document represents counselling and psychotherapy as a 'profession', and recommends that the standard for training be set at a minimum of an Honours Degree. Acknowledging the diversity of therapeutic perspectives extant in Britain, the core curriculum aimed to reach '...the best possible consensus from a wide range of different perspectives and opinions so as to resource the professional association in its future negotiations'.[7] The task of creating a singular representation of therapy knowledge required the 'Core Curriculum Consortium' to abstain from the idiomatic use of language and concepts related to their own therapeutic habitus, leading to the production of a universalistic therapy lexicon. The urgency of the task, with a short deadline, was accompanied by an atmosphere of enthusiastic collaboration, where the stripping out of complexity through their negotiations helped eliminate dissensus between the different factions of therapists leading to conformity and consensus. The ethnographic material relating to the production of the Core Curriculum describes a group of therapists distancing itself from a nuanced and pluralistic portrayal of therapy praxis. A parsimonious representation of therapy was achieved through the privileging of explicit and instrumentalised therapist behaviours over the tacit and implied, rendering these visible, measurable, countable and commodifiable, and therefore legitimate under the aegis of a naïve empiricism.

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[6] See Standing, G. (2011) *The precariat: The new dangerous class.*

[7] Dunnett, A. C; Wheeler, S; Balamoutsou, M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy,* p. 4.

The reduction of interpersonal phenomena to observable behaviours compromises the explanatory adequacy (by the exclusion of emergent properties) of the Core Curriculum's representation of counselling and psychotherapy praxis:

> The ideal of parsimony is problematic when it is taken to trump the criterion of explanatory adequacy, so that inferior explanations are preferred on the grounds that they are simple and elegant, even though they fail to resolve problems explained by more complex accounts.[8]

The group transposed the complexity of therapy skills and knowledge from a wide range of sources into a neat conceptual framework of four 'key domains of knowledge', a construction which they did not challenge, perhaps in deference to one of the senior members of the group (who had devised the format). For this conception to prevail, the consortium had to accept uncritically a number of constructs as inherently valid—for example, the representation of therapy as a 'process', 'performance criteria', 'professional development' and 'personal development'. Some parts of the curriculum mandated compliance in corporate environments, framing therapy as a commodity for 'delivery': 'Work with managers and clients in the delivery, monitoring and evaluation of services.'[9] The Core Curriculum normalised the use of reified constructs to frame human distress in a language of individualism, self-objectification and 'psychological functioning'. Although the group could have subjected most of these constructs to a deeper analysis, and some qualification, their ontological status was not called into question. The 'core requirements for any training course' were expressed in the form of the sixty-eight learning outcomes the group produced for the final edit. Following this, students on courses shaped by the 'Gold Book' (derived from the Core Curriculum) were required to demonstrate that they had 'achieved the learning outcome', having been mandated to agree with a statement describing a facet of therapy praxis (as described in chapter nine) with no option for argumentation. The concretising, action-oriented privileging of doing over thinking provides a non-negotiable representation of therapy praxis with a minimum of abstraction or tentativity.

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[8] Sayer, A., in Lee, R. E. (ed.), (2010) *Questioning Nineteenth-Century Assumptions about Knowledge, II*, p. 13.

[9] Dunnett, A. C; Wheeler, S; Balamoutsou M; Wilson, C; Hill, A; Randall, S; Pugh, V; & Nowell-Smith, R. (2007) *Towards Regulation: The standards, benchmarks and training requirements for counselling and psychotherapy,* p. 26.

The commissioning of the Core Curriculum was part of an ongoing professionalising strategy implemented by the BACP, aimed at securing professional status and job security for its members. In September 2000, the BACP, in a provocative usurpatory closure strategy,[10] added 'psychotherapist' to its organisational name. By creating a singular representation of therapy praxis, based on visibility and action, under the rubric of a 'core' curriculum, the BACP was able to defeat exclusionary strategies based on the theoretically-grounded discretionary specialisation[11] of 'clinical autonomy' emerging from organisations representing psychotherapists, creating a hiatus in the long-standing factional dispute between counsellors and psychotherapists.

One effect of the implementation of the Core Curriculum for counselling and psychotherapy appears as the displacement of a diverse array of explanatory and hermeneutic perspectives of psychotherapy by a list of imperatives framed as 'professional requirements'. A second consequence is that the framing of counselling and psychotherapy in atheoretical and non-specialist language renders therapists more amenable to corporate culture and authority, a theme resonating through the case studies. Managers who are seeking to professionalise their own domains within neoliberal culture may contest the symbolic capital (and the benefits that accrue) generated by the various factions engaged in the furtherance of professional autonomy. In their article, 'Professional Capital Contested: A Bordieusian Analysis of Conflicts between Professionals and Managers', Noordergraff and Schinkel argue that 'professional capital is appropriated by managers in order to distinguish "new" from "old" professional work in larger economised fields of power'.[12] They suggest that dichotomous accounts of the social actions of professions and managers are insufficient, appearing self-referential and neglectful of the economistic context managers and professionals occupy. Managerial representations of evidence-based therapy practice, in the context of a process-oriented industrialised framing of therapy-as-a-service, had been embraced by therapy umbrella organisations such as the BACP and the UKCP, especially with the prospect of increased legitimacy through statutory sanction in sight. This Bordieusian analysis of professionalisation strategies suggests that the social fields of actors in the broad economistic context of state-sanctioned therapy are interdependent. The Core Curriculum

[10] Witz, A. (1990) Patriarchy and professions: The gendered politics of occupational closure, *Sociology,* 24, 675–690.
[11] Freidson, E. (1999) Theory of professionalism: Method and substance, *International review of sociology* 9, pp. 117–129.
[12] Noordegraaf, M. and Schinkel, W. (2011) Professional capital contested: A Bourdieusian analysis of conflicts between professionals and managers, *Comparative Sociology*, 10 (1), p. 97.

transcribed therapy praxis into a social field, merging the professional interests of therapists and managers working in higher education and public health. The conflation of therapy praxis with corporate interests, sustained by the positivistic narrative of evidence-based medicine is a theme running through the case studies and participants' accounts.

Digitally-Taylorised therapy knowledge

As narrated in chapter five, the 'Competent Practitioner Licence' (CPL) was conceived as an online test aimed at therapists who had not yet demonstrated the 'competencies' which would show they had met the minimum standards of practice to be included on the expected statutory (later voluntary) register of counsellors and psychotherapists. In common with the strategy used by the BACP to create the core curriculum, the group that was convened to create the CPL comprised a selection of therapists representative of a range of counselling and psychotherapy paradigms (outside CBT), including psychoanalysis, Gestalt and Rogerian approaches. The group chosen for this task were already working as trainers in further and higher education and were therefore accustomed to a culture of uncertainty generated through the prospect of statutory regulation. Although there was some resistance to the task of creating an examination of therapist proficiency through a digital medium, with the departure of some disaffected members, the group worked over a seven-year period to develop, pilot and implement the test. In a meeting in 2014, the first year of testing, it was reported that 12,000 candidates achieved a pass rate close to one hundred percent, with an implication that the exam did little more than confirm the adequacy of existing standards of practice. Although aligned to the therapeutic competencies informing the 'core curriculum', the CPL was grounded in therapists' job descriptions of knowledge, skills and abilities, under the presumption that what was inherently 'effective' in the praxis of therapy could be rendered visible, described in a generic language (without reference to modality-specific theory) and codified in preparation for digital formatting. The claimed-for 'credibility' of this repurposing of therapy praxis rests on a circular logic, whereby a reductive description of 'what therapists do' assumes an ontological equivalence with what happens in a room where therapists meet distressed people, because it is based on a 'job analysis'.

An effect of this circular logic is that codified representations of skills and knowledge (which are moderated by adjectives such as 'suitable', 'appropriate' and 'adequate') mask opinions and beliefs. The 'resolution of a case' is a concept that may appeal to managers, but in the lived

experience of therapy practice it is rarely attainable; the best that can usually be hoped for is a relative reduction of distress, or a return to a normal sadness.[13] The componentising of distress, with binary outcomes such as 'recovered' or 'referred', inform the 'generic competencies' central to the CPL management's claims of legitimacy, which are based on an assumption that competencies can be 'observed and rated through audio or video sessions with clients'. The ethnographic material in chapter five narrates samples of social actions leading to the substitution of idiosyncratic contextual factors from a discursive representation of therapy (including non-linguistic elements of interaction) by modularised iterations of 'competent interventions' and 'decisions', which can be deployed in a digitised online multiple-choice exam.

The recasting of therapy knowledge into a digitised format is a practice that may be viewed through the perspective of Digital Taylorism. Anell and Wilson have argued that a reliance on individual talent and knowledge has placed knowledge-intensive firms at a competitive disadvantage over those which can codify and replicate that knowledge: the competitive advantage '…consisted of the ability to transform employees' various competencies into coded, explicit and packaged knowledge…'.[14] The ethnographic material narrates how the idiosyncratic knowledge of therapists captured through the 'job analysis' exercise is analysed, codified and componentised within the framework of a measurable assessment 'instrument'. As a means to credentialise therapists in accordance with the requirements of the expected statutory register, the CPL helped legitimate a new domain of codified knowledge, part of a larger economistic context where Digital Taylorism '…incites a power struggle within the middle classes, as corporate re-engineering reduces the autonomy and discretion of some but not all managers and professionals'.[15]

The digitisation of therapy praxis for the purposes of the CPL can also be seen in the context of psychological instrumentalism, whereby a demarcation between means and ends privileges the former over the latter. The ethnographic material narrates the attention given to the means by which the CPL was written and deployed. An instrumental strategy is part of '…a ubiquitous and driving aim in psychology',[16] and is characterised by an abrogation of responsibility for the

[13] Horwitz, A. V. & Wakefield, J. C. (2007) *The Loss of Sadness,* p. 7.
[14] Wilson, T. L., & Anell, B. I. (2004) Project Management as a Competitive Prescript: 88 years of experience at Boeing. *Competitiveness Review: An International Business Journal*, 14 (1/2), pp. 26–33.
[15] Brown, P. Lauder, H. & Ashton, D. (2010) *The global auction: The broken promises of education, jobs, and incomes*, p. 81.
[16] Fowers, B. (2010) Instrumentalism and Psychology, *Theory and Psychology,* p. 102.

objectifying impact that the privileging of means might have on human subjects, provided the ends are justifiable. The ends are framed in vague and generalising statements of efficacy, safety, well-being and positive outcomes (aims which would be difficult to oppose), while the means are subjected to rigorous refinement, stripped of complexity and ripened for quantification. My ethnographic material on the production of the CPL describes exam-writers protesting against what they claimed to be a distortion of competent, ethical therapy practice in the content of the exams. The protestors found that the undertaking was non-negotiable, and had the option of leaving the group, which some did, or of getting on with the task, tacitly accepting '…the ideological portrayal of human action in almost exclusively means-end terms'.[17]

Economised unhappiness

Richard Layard's proposals[18] (supported by CBT academic and Department of Health advisor, David Clark) for improving the nation's happiness are, in their ambition, something that few would disagree with. Yet the means by which he proposed to realise this plan, by recruiting psychologists to 'deliver' CBT, are justified only in an economistic and utilitarian representation of therapy. Layard suggested that income inequality is less important than 'an ethos of mutual respect'.[19] Informing a social reformist approach, utilitarianism is alloyed with science:

> Utilitarianism was also seen as an ethical theory compatible with science. While there may be question marks over whose interests' utilitarianism actually served, what is indisputable and of critical importance to understanding it, is its preoccupation with an almost mechanistic ordering of society and its population through social reform.[20]

Layard and Clark's rationales for therapy, bolstered by positive psychology and funded through savings in income support for distressed individuals, led to the emergence of the Improving Access to Psychological Therapy programme, following publication of the Depression Report by the LSE's Centre for Economic Performance in 2006.[21] The report underplays social context, emphasising an individualist account of 'well-being', with little attention given to the

[17] Ibid., p. 114.
[18] Outlined in chapter 6.
[19] Layard, R. & Clark, D. M. (2015) *Thrive,* p. 111.
[20] Beresford, P. (2016) *All our welfare,* p. 143.
[21] London School of Economics, (2006) *The Depression Report,* available at http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf (accessed 17 October 2016).

disproportionate impact of age, gender and ethnicity on social exclusion and its effects. In the report, distressed people are pathologised by their social circumstances, and poverty is replaced by negative thinking as the cause of mental illness. This emphasis has been accompanied by a shift in economists' focus from GDP as a measure of a nation's happiness to the more problematic concept of 'subjective happiness'. Jerome Kagan[22] identifies two problems with this approach: Firstly, the relative instability of subjective happiness measurements within the complexity of life; and secondly, the assumption of a linear relationship between wealth and happiness. A person's assessment of happiness, according to Kagan, may not be linked to absolute wealth, but to the perception of wealth, and symbolic capital, in changing cultural circumstances. The use of ordinal scales is incommensurate with the measurement of subjective happiness, because, Kagan argues, the numerical values are arbitrary in relation to self-reported subjective states. He cites Einstein: 'Not everything that counts can be counted, and not everything that can be counted counts.'[23] Martin Seligman, the founder of positive psychology, has disregarded poverty as a cause of distress, suggesting that 'Increases in wealth have negligible effects on personal happiness'.[24] A tendency to conflate the values of individualism, enthusiasm, competitiveness and acquisitiveness with subjective happiness is suggested by the emergence of workfare and 'Employee Assistance Programs', psychologising ordinary life, and by 'co-locating' therapists within jobcentres and corporate environments, where they are obliged to nudge their clients back into productivity.

> Happiness therefore, as a technology but also as an enterprise of self-development, represents one of the chief instruments of neoliberal government, the very leitmotif of neoliberal life itself and, I would argue, its most radical extension into the realm of private existence.[25]

William Davies has commented on the relationship between distress and inequality in the workplace, which has become increasingly atomised and insecure:

> Yet evidence from social epidemiology paints a worrying picture of how unhappiness and depression are concentrated in highly unequal societies, with strongly materialist, competitive values. […] We have an economic model which mitigates against precisely the psychological attributes it depends upon.[26]

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[22] Kagan, J. (2009) *The Three Cultures.*
[23] Ibid., p. 125.
[24] Whippman, R., (2016) *Money can't buy happiness? That's just wishful thinking,* available at www.theguardian.com/commentisfree/2016/may/17/money-cant-buy-happiness-wishful-thinking (accessed 20 October, 2016).
[25] Binkley, S. (2014) *Happiness as enterprise: An essay on neoliberal life*, p. 4.
[26] Davies, W (2015) *The Happiness Industry,* p. 9.

The cultivation of neoliberal identities through IAPT and the 'co-location' of therapy services within jobcentres appear to contradict therapists' claims to clinical autonomy and impartiality.

Naïve empiricism

Counselling for Depression (CfD) was designed and promoted as part of a professionalising strategy by managers within therapy organisations, such as the BACP and the UKCP, to challenge the dominance of CBT in the NHS. Underpinning this challenge lies an uncritical acceptance of the factualism of IAPT's explicit endorsement of DSM diagnostic criteria and a naïve empiricist approach to the use of RCTs in the justification for a branded therapy. The Counselling for Depression literature appropriates the positivistically-inclined epistemological capital of clinical psychology. For example, where a normal reaction to exclusion, homelessness and workplace bullying is subjected to psychologists' classificatory analysis, the legitimacy of diagnostic criteria becomes questionable:

> Even the best clinical history taking and diagnostic interviewing or the best research sample selection, experimental design and statistical analysis of data will not produce meaningful results if they use an invalid definition of disorder that mixes normal and abnormal features.[27]

The ethnographic material narrates the 'rollout' of the CfD brand of therapy, which is presented by therapy organisation and IAPT managers within an economistic model, justified by weak claims to science and framed by an 'evidence-based narrative' that is used to justify a monistic representation of humanistic therapy stripped of historical context and meaning. Science, Feyerabend suggests, '…not only does not deal with meanings, it intentionally removes everything that is only vaguely related to them'.[28] This misapplication of scientific method may add a veil of legitimacy to NICE-approved therapies, but purges depth and hermeneutic power from their phenomenological origins.

[27] Horwitz, A. V. & Wakefield, J. C. (2007) *The Loss of Sadness,* p. 8.
[28] Feyerabend, P. (2011) *The Tyranny of science,* p. 6.

Emotional labour

Students on the CfD training were drawn from groups of therapists, many of whom were in precarious employment in therapy call centres and were hoping to learn new skills and improve their chances of getting work by obtaining referrals of distressed people seeking help through IAPT. Some of the candidates described the difficulties they had been experiencing in adapting to an unfamiliar new language of 'assessment tools' and the use of psychological diagnostic criteria. Such representations of therapy practice seemed alien to them and conflicted with the values of non-directivity and non-judgementality that had been cornerstones of their original training and subsequent practice in relational therapies.

The course imposed a number of contradictions on the participants, which they were required to accommodate in order to pass. Many participants demonstrated a sharply-observed grasp of the ways in which they were expected to engage with concepts and values they did not agree with, or which did not make sense to them, while course leaders appeared to justify the training on the grounds of politically-imposed inevitability and objectivism, citing the advantages an alignment to evidence-based practice had brought to the successful and dominant profession of psychology and its leading brand, CBT. The numerical measurement of abstractions such as 'warmth' or 'client self-development' as an objective facticity served to emphasise the power of organisational authority to impose its interests. Tutor participants involved in setting up and 'delivering' CfD objected to the 'simplistic' training, and to 'turning people into objects', but later responded by paying careful attention to the means by which CfD was to be taught, becoming less concerned by the ways in which psychotherapy's symbolic capital was being stripped of its phenomenological capacity and repurposed instrumentally. The question of 'How do we get there?' displaced the more problematic question of 'Where are we going?'. Under these conditions, a narrow focus on therapist behaviours gained precedence over the content of the distressed person's narrative.

The CfD project required candidates to set aside their accumulated knowledge of human distress acquired incrementally over many years of helping people who were experiencing such distress. Instead, they were expected to implement a commodified variant of therapy where an understanding of the client's story was subjected to a regime of numericised emotion assessment. Performances of emotion management are aspects of public and private life over which an actor

has some say, '…the person is the locus of the acting process'.[29] This contrasts with the therapy performances candidates were directed to enact during CfD training, which entrenched organisational authority by substituting a personal locus of acting with an institutional one:

> But something more operates when institutions are involved, for within institutions various elements of acting are taken away from the individual and replaced by institutional mechanisms. The locus of acting, of emotion management, moves up to the level of the institution.[30]

Some CfD trainees had protested about the intrusive impact of filmed role-play, and for it to be ranked against numerical criteria for institutionally-sanctioned displays of emotion. The trainers, acting with the authority of the CfD curriculum, cajoled and warned, nudging trainees into the pragmatic acceptance of their loss of the locus of control. By the end of the week's training, most trainees seemed to have accepted the new status quo. The Dolphin Hotel course, narrated in chapter seven, was judged to have been a success by an 'external' assessor who had advised that argumentation on future trainings could be minimised by a more robust justification of the 'rationale' for the programme to ensure students' 'commitment'.

The segmentation of talent

With the justification of reducing 'therapist variables', CfD management decided to exercise their authority on the supervisors of CfD candidates by applying the only measure they had, the Person Centred and Experiential Psychotherapy Scale (PCEPS), which had not been designed to evaluate supervision, an activity different in purpose and function to therapy. The irrationality of this proposal was not lost on the group of supervisors, one of whom suggested that it led to a loss of trust, and by implication, consent. Attendance at a one-day 'workshop', to 'align supervisors to the CfD model of supervision', was non-negotiable; and this workshop was priced by its organisers, Optimum, at a rate many times more expensive than is usually found on counselling and psychotherapy training courses, amounting to a spend of NHS funds of several hundred pounds per hour for each attendee. The session took place in a slick modern corporate environment, '…intended to inspire our confidence that the service is, after all, worth paying a lot for'.[31] The supervisors were placed in the contradictory position whereby they were required to

[29] Hochschild, A. R. (2003) *The managed heart: Commercialization of human feeling,* p. 49.
[30] Ibid., p. 49.
[31] Ibid., p. 51.

coerce their supervisees to focus on and discuss their own feelings, rather than the feelings of the distressed people they were trying to help. The sense of bewilderment this created amongst the therapy supervisors was increased by the CfD manager's announcement that he would be assessing the supervisors' 'competence' using his own discretion, as the final arbiter of competent practice; he was exempted by his seniority from 'objective' measures. The segmentation and quantification of therapy training, aligned to a hierarchical managerial model, allows an elite to exercise discretion:

> […] it also incites a power struggle within the middle classes, as corporate reengineering reduces the autonomy and discretion of some but not all managers and professionals. It encourages the segmentation of talent in ways that reserve permission to think to a small proportion of elite employees responsible for driving the business forward, functioning cheek by jowl with equally well-qualified workers in more Taylorised jobs.[32]

The managerial assessment of competence, through the supervision of supervisors, had the effect of shifting the locus of control from the relational setting of the supervisory encounter to management, causing the supervisors to attend not to their supervisees' narrative, as they had always done in the past, but to the extent of their alignment to the Supervision Adherence Scale (the PCEPS scale had been renamed specifically for this task). The formerly collaborative practice of supervision had been repurposed into a managerial one, using the Trojan horse of deep emotion management. Prior to working in an IAPT-aligned supervisory role, the participants had not been subjected to any direct form of managerial control over the content of their supervisory practice. Formerly, the practice of supervision had been collaborative and non-hierarchical, where counselling supervisors enjoyed a high degree of autonomy and were able to act broadly within their own interpretation of BACP's Ethical Framework, and in the best interests of their supervisees' clients. This arrangement amongst healthcare workers has been criticised for its reliance on an ethic of self-management. Tony Gilbert has argued that the ubiquity of clinical supervisory practices had been moving to a point where they are beyond question, '...exerting hegemony upon both nursing and other health care professions'.[33] Gilbert is critical of the ethic of self-management, which leads to self-subjugation through a management regime reliant on novel forms of subjectivity, thus producing self-managing individuals. By contrast, the CfD supervisory

[32] Brown, P. Lauder, H. & Ashton, D. (2010) *The global auction: The broken promises of education, jobs, and incomes*, p. 81.
[33] Gilbert, T. (2001) Reflective practice and clinical supervision: meticulous rituals of the confessional, *Journal of Advanced Nursing,* 36, p. 199.

regime appears to weaken the ethic of self-management, pursuing an authoritarian form of numericised emotion control and management, legitimated through the segmentation of talent.

The ethnographic material suggests that where subordinate managers and workers in an IAPT service delivery 'hub' believe they have little meaningful involvement in their work, they may collude, in a target-oriented work environment, to provide data that serves their occupational interests. Through the manipulation of reified categories of 'psychological functioning' and 'recovery', distressed people are objectified and commodified in order to facilitate 'payment by results'. These actions suggest 'a preoccupation with the auditable process rather than the substance of activities',[34] to the detriment of those who are most unwell and in need of the service. An informant working in one IAPT setting close to an Army barracks described how some soldiers, returning from war zones and traumatised by the effects of improvised explosive devices, having seen their comrades blown to pieces, were denied help from this local mental health facility because they seemed unlikely to provide the required 'successful outcome' data for payment within the internal NHS market: they were below 'caseness', too unwell. Another informant described her departure from a 'therapy script', ignoring the CfD focus on emotion by attending to the injustice of her client's employment situation. The effect of this subversive approach was a reduction of distress and sense of empowerment, brought about by helping the client gain 'outsight' on his social world in preference to 'insight' attained through the management of emotion.

Tacit knowledge

Therapy Solutions' interpretation of the 'Gold Book' training manual, based on the Core Curriculum, framed therapy as a 'process', aimed at increasing 'effectiveness' by taking 'appropriate decisions' and 'relevant action'. The action-oriented business language suggests a range of prescribed therapeutic outcomes, de-legitimating the historic therapy territory of the unexpected and the not-known. The course literature details the corporate values of a well-oiled organisation, describing an individual's disorganisation as 'pathological', and suggesting that psychological well-being is realised through an alignment of the self with managerial authority and corporate interests. The course handbook reiterates the importance of safety in a number of instances, with extensive documentation exposing or conjuring danger suggesting that uncertainty

[34] Power, M. (1994) *The audit explosion,* p. 48.

and risk, qualities that are an inextricable part of the human condition and a central focus of psychotherapy, can be banished by fiat. Organisational authority and control are mediated through the bureaucratic systems of charting competencies, which are signed off (self-attested) by students and countersigned by tutors, before 'verification' and moderation. Less attention is given to the content of the training, whereby students demonstrate their knowledge by working through checklists instead of thinking through their understanding of a therapy encounter. Although the Therapy Solutions course espoused the value of 'client autonomy', putatively within a narrative of humanistic psychology, trainees were not credited with the capacity to think and were discouraged from exercising their own judgement within therapy practice—a form of therapy by numbers.

Many of the participants expressed concerns that Therapy Solutions privileged the visible and explicit over hunch and intuition, the latter being displaced by a representation of counselling and psychotherapy as a list of criteria to be 'met' through rote learning. Some students who were critical of Therapy Solutions' educational practices had objected to the disciplinary use of psychotherapy knowledge (requiring a student to attend therapy to gain 'insight' into their transgressions), and an expectation that they abstain from any critique of counselling theory. These objections emerged as a result of group discussions and role-plays, about how the complexity of stories, and the distress so often woven into them, were transposed, with a concomitant loss of meaning and content, into the framework of Therapy Solutions' 'learning criteria'. Students had become frustrated at the priority given to 'criteria compliance' at the expense of listening to clients with an open mind, and a willingness to discover and proceed towards something hitherto unknown. The 'Gold Book's' imperative to look for instances of, for example 'low self-esteem' or 'depression', became a self-fulfilling and tautological categorisation of the clients' story into psychological constructs; depression is caused by 'low mood', which is itself described as a consequence of depression. The 'Gold Book' therefore extinguishes curiosity and avoids problems posed by the unknown, observed by Plato in the Meno,[35] where his character is puzzled by the impossibility of searching for something you do not know. Socrates replies:

> 'Do you realise that what you are bringing up is the trick argument that man cannot try to discover either what he knows or what he does not know? He would not seek what he knows, for since he knows it there is

[35] Plato (1956) [402 BCE] *Protagoras and Meno.*

> no need for the inquiry, nor what he does not know, for in that case he does not even know what he is to look for.'[36]

Arguing that the formalisation of all knowledge 'to the exclusion of tacit knowledge is self-defeating',[37] and with reference to the Meno, Michael Polanyi has suggested that: '…if problems nevertheless exist, and discoveries can be made by solving them, we know things, and important things, that we cannot tell'.[38] The Therapy Solutions training offered a representation of therapy knowledge based on certainty and verificationism. Trainees who had demonstrated curiosity or proffered arguments challenging this representation of knowledge were reminded, by the tutors, of their place in the hierarchy of the authority emanating from the 'Gold Book'. Arendt puts it well:

> Yet authority precludes the use of external means of coercion; where force is used, authority itself has failed. Authority, on the other hand, is incompatible with persuasion, which presupposes equality and works through a process of argumentation. Where arguments are used, authority is left in abeyance. Against the egalitarian order stands the authoritarian order, which is always hierarchical.[39]

The 'predetermined stable place'[40] of the actors within this hierarchy is facilitated by the enhanced legitimacy given to an evidence-based medicine narrative and the ideology of objectivism that sustains it, absolving Therapy Solutions' staff from using argumentation in response to the students' morally-framed protests. In place of judgements, staff implemented a rationalistic documentation of students' compliance with the Therapy Solutions' interpretation of the 'Gold Book', using a regime of check-boxes, role-play observation forms and of tutor signatures and counter-signatures—a modernised rubber-stamping. This instrumental culture helped augment the authority of a syllabus with no space for unproven personal beliefs, a 'humanistic' therapy training without humanity. In his critique of the authority of reason, Polanyi argues: 'But it has now turned out that modern scientism fetters thought as cruelly as the churches had done. It offers no scope for our most vital beliefs and it forces us to disguise them in farcically inadequate terms.'[41]

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[36] Ibid., p. 128.
[37] Polyani, M. (1967) *The Tacit Dimension,* p. xi.
[38] Ibid., p. 22.
[39] Arendt, H. (2006) *Between past and present: eight exercises in political thought,* pp. 92–93.
[40] Ibid., p. 93.
[41] Polanyi, M. (1962) [1958] *Personal Knowledge: Towards a post-Critical Philosophy,* p. 265.

The effect of bureaucracy on a person can, as Robert Merton has proposed,[42] result in a cognitive restructuring leading to timidity, conservatism and technicism, creating what Weber has described as 'Specialists without spirit, sensualists without heart…'.[43] Weber frames vocation as a non-instrumental expressive act, where the activity is an end in itself, leaving the outcome undetermined:

> Vocational activity has as itself nothing of the instrumental; it is an end in itself (thus in some sense moral) but without reference to any grounding or act other than the freely chosen commitment of individuals to their own particular fates.[44]

By contrast, the vocational expectations of Therapy Solutions' students were thwarted by an instrumentalist representation of therapy that was conservative, bureaucratic and technical, composed in a bullet-pointed language of visibility and accountability. The directives of the Gold Book may have some protective effect against the imposition of organisational authority in the form of audits by examination boards and the BACP.

Therapy Solutions' generic statements framing 'good practice' and 'outcomes' in a language of accountability, 'meeting criteria', can be seen as defensive rhetorical devices demonstrating their conformity with authority—effectively mission statements. The documents which collectively make up the training manual on which the course is based are not intended to be used in debate or critique since they contain no argument. In a discussion of these kinds of documents, Marilyn Strathern argues:

> …this kind of language is actively *opposed* to the task of education if education is a matter of providing the tools by which people find things out for themselves, and is opposed to research if this is taken to rest on knowledge, and to scholarship for that matter as a critical enterprise. The enemy within: the textual form in which statements are made about the very issues of education and research undermine the textual means by which such aims are accomplished in real life.[45]

The ethnographic material describing the use of the 'Gold Book' narrates samples of a passive learning strategy deployed by Therapy Solutions that is based on an authoritarian, non-negotiable

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[42] Merton, R. (1957) *Bureaucratic structure and personality.*
[43] Weber, M. (2012) [1905] *The Protestant Ethic and the Spirit of Capitalism,* p. 116.
[44] Weber, M. (2004) *The Vocation Lectures*.
[45] Strathern, M., in: Riles, A. (2006) *Documents: artefacts of modern knowledge,* p. 196.

Gradgrindian[46] representation of therapy, an effect of the instrumentalisation of counselling and psychotherapy praxis. This is part of a wider trend in education that Martha Nussbaum laments: 'What will we have if these trends continue? Nations of technically trained people who do not know how to criticise authority, useful profit makers with obtuse imaginations. […] a suicide of the soul.'[47]

A critique of 'evidence'.

The privileging of evidence-based medicine's positivistic epistemology is maintained by claims which contradict its own tenets. The 'hierarchy of evidence', with randomised controlled trials at the apex, was cited by its advocates as a justification for the Counselling for Depression therapy brand to be made available to service users through the Improving Access to Psychological Therapy scheme. To its proponents, this positioning is self-evident:

> Devisch and Murray argued that for proponents of EBP 'evidence' is that obtained through the (quantitative) measurement of observable phenomena, and that the 'E' of evidence-based practice 'acts as the authoritative cipher, the synonym, for evidence in general: *E=truth=reality'* […] However, when it comes to justifying this type of naïve empiricism, the proponents of EBP are unable to do so and end up falling back on references to 'common sense' and 'intuition'—precisely the types of arguments that they so readily dismiss in others.[49] [Emphasis in original. EBP: Evidence Based Practice.]

The CfD author's comments, narrated in chapter six, recognise evidence-based therapy as a 'game' which 'has to be done', tacitly accepting the institutional authority behind it. The 'game', as a professionalising strategy, has had the effect of aligning humanistic psychotherapy with technical interests more usually concerned with prediction and control (for example, reducing welfare payments through IAPT) than creating a space for distressed people to think and feel in. The impact of this on the CfD representation of therapy has been to displace the original humanistic ontology on which it is putatively grounded (developed from phenomenological perspectives on the lived experience of a therapeutic relationship), and to introduce a set of techniques with which to manage emotion—legitimated by a naïve and rhetorical use of factualism and certainty.

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[46] A soulless character in Charles Dickens' *Hard Times*, preoccupied with cold facts and numbers in the pursuit of profit.
[47] Nussbaum, M. C. (2010) *Not for profit, why democracy needs the humanities*, p. 142.
[49] Chapman, L. (2012) Evidence-Based Practice, Talking Therapies and the New Taylorism, *Psychotherapy and Politics International,* p. 37.

Neoliberal identities

These techniques comprise a form of emotional labour (engaging with the necessities of modern life in the shape of fear, longing and sex), creating a collective and simplistic representation of subjectivity, which helps homogenise the private world into a mass singularity:

> They are all imprisoned in the subjectivity of their own singular experience, which does not cease to be singular if the same experience is multiplied innumerable times. The end of the common world has come when it is seen only under one aspect and is permitted to present itself in only one perspective.[50]

The common world, or public realm, is counterposed by Arendt against intimate lives, which lead '…an uncertain, shadowy kind of existence unless and until transformed, deprivatised, and deindividualised, as it were, into a shape to fit for public appearance'. CfD, which mandates for a detailed and instrumentalised focus on the intimate feelings of distressed people, and (provocatively) their therapists, privileges a narrowed conception of subjectivity disengaged from the unstable and impermanent constituency of public life. CfD's representation of psychotherapy is complicit with a neoliberal culture in which people have been thrust back into their own interior spaces, the 'closed inwardness of introspection':[51]

> The only contents left were appetites and desires, the senseless urges of his body which he mistook for passion, and which he deemed to be 'unreasonable' because he found he could not 'reason,' that is, not reckon with them.[52]

The political space of public discourse is eroded by an enlargement of the '…pseudospace of interaction in which individuals no longer "act" but "merely behave" as economic producers, consumers and urban city dwellers'.[53] Public discourse is then further undermined by the effects of a pseudoscience of subjectivity, wherein people lack a common social world of distinct viewpoints. Instead, they find certainty over complexity by turning inwards, with a focus on the self, and become part of a fraternity of private necessities.

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[50] Arendt, H. (1989) [1958] *The Human Condition,* p. 58.
[51] Ibid., p. 320.
[52] Ibid., 321.
[53] Benhabib, S. (1997) *The Embattled Public Sphere: Hannah Arendt, Jurgen Habermas and Beyond.*

An effect of the privileging of psychological objectivism over social context within the space of counselling and psychotherapy demands that therapists, and their clients, frame their experience of life within a self-objectifying narrative, such as 'depression' or 'anxiety', giving them personal responsibility for pre-existing social conditions of exclusion, isolation, disability and mental ill-health. The conflation of 'productivity' with happiness within the economically deterministic IAPT model,[54] the implementation of workfare suggesting people claiming benefits have therapy, and the effects of precarity, all combine to generate an imperative towards self-commodification. Lonely people isolated by deprivation and experiencing distress are mandated by the IAPT 'stepped-care' model to take up online digitised therapy, deepening their isolation. They would only be eligible to meet a real person 'face-to-face' if their health deteriorated, thereby achieving reified 'outcome' criteria which would help produce targeted 'recovery' rates. The instrumental focus of CfD on emotion management, marginalising social context and life story, adds legitimacy to introspection as the dominant sphere of psychotherapists' interest. This focus adapted existing humanistic and psychoanalytic psychotherapy praxis,[55] from which the Core Curriculum drew its epistemological currency: apolitical, individualistic, and consonant with therapy's teleological imperatives such as 'self-actualisation', 'individuation' or 'ego strengthening'. These qualities, when stripped of the modifying contextual effects of argumentation, critical thinking and philosophical content, in the situation of a non-negotiable training regime, align well with neoliberal identity characteristics and the epistemological capital of evidence-based medicine. A scientistic culture of objective certainty, parsimony, and determinism—the narrowed epistemology brought about through the recasting and repurposing of therapy knowledge—has helped undermine the hermeneutic potential psychotherapy might otherwise have had, inhibiting its possibilities as a space in which to think. These possibilities include the creation of unique and separate viewpoints, from individuals who are distinct from the aggregating effects of a hegemonic neoliberal culture of individualism. The social actions narrated in the case studies include the propagation of competencies, criteria, rules and outcomes, sustained by 'evidence-base' positivism—selective in 'evidence' that aligns with an ethos of individualism, personal responsibility and the reification of diagnostic nomenclature. Arguing that where neoliberalism has displaced a communitarian ethos 'that has made individuals autonomous by curbing external interference',[56] Paul Verhaeghe cites the proliferation of rules by institutions collaborating with

[54] Narrated in chapter five.
[55] See chapter one.
[56] Verhaeghe, P. (2014) What about me? The struggle for identity in a market-based society, p. 248.

neoliberalism leading to '…the first important paradox of the neo-liberal free-market ideology: it invariably culminates in an excess of interference'.[57] His second, and related, paradox points to neoliberal identities:

> The obligation to both succeed and enjoy has turned postmodern consumers into clones of each other's exclusiveness, without the advantage of mutual solidarity. Hence the strange combination of excessive individualism and a collective consumerism in which we all cherish the illusion that we are unique. […] In actual fact, they are being made to think and behave alike to an extent that is previously unparalleled.[58]

The emotion work that is instrumentalised in the 'Gold Book', and implemented through therapy brands such as CfD, helps position therapists and the unhappy people they work with in a collective of emotional isolation, annexed from a public space from which they might otherwise be able to confront and together challenge the circumstances that have given rise to or worsened their distress.

> Specifically, the ideal of the fundamentally self-interested individual curtails any collective transformation of the conditions of existence. It is not that such actions are not prohibited, restricted by the dictates of a sovereign or the structures of disciplinary power, they are not seen as possible, closed off by a society made up of self-interested individuals.[59]

Distressed people in insecure employment and experiencing social isolation (as well as a range of other incapacitating conditions) are highly represented in those seeking help through mental health services; addressing their needs is part of the IAPT remit. Stable identities formerly grounded in home and work have become more fluid and contingent on economic conditions:

> This is where we, the denizens of a liquid modern world, differ. We seek and construct and keep together the communal references of our identities while *on the move*—struggling to match the similarly mobile, fast moving groups we seek and construct and try to keep alive for a moment, but not much longer.[60] [Italics in original.]

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[57] Ibid., p. 248.
[58] Ibid., p. 249.
[59] Read, J. (2009) A Genealogy of Homo-Economicus: Neoliberalism and the Production of Subjectivity, *Foucault Studies,* p. 36.
[60] Bauman, Z. (2004) *Identity*, p. 26.

In a world of precarity, people in insecure employment and challenging social circumstances (which may have dislocating effects on relationships and family life) will have already been immersed in a culture of economism through their contact with jobcentres, housing departments and their experiences of organisational authority. These pressures can give rise to a sense of failure and guilt, providing a narrative with which a therapist can normalise and reinforce guilt as an 'understandable' response to personal failure. Where the 'reserve price'[61] for labour is kept high through welfare payments, unemployment is framed as voluntary within neoliberal narratives advocating personal responsibility and the idealisation of traits such as assertiveness, positivity, enthusiasm, aspiration, competitiveness, goal-directed activity, consumption and an uncritical acceptance of the status quo. Self-esteem as a form of symbolic capital is reified as a social necessity and highly represented in therapy discourse. These traits are part of the symbolic currency within the therapeutic space, which, when 'evidenced' by their clients, therapists are encouraged to normalise as 'evidence of recovery' (see chapter eight, 'Monitoring Adherence'). The diagnostic 'tools' used by therapists before and after 'treatment' describe these traits as evidence of the 'well-being' with which distressed people will be able to cope with the economic and social conditions which had, in the first place, contributed to their misery: 'The imposition of psychological explanations for unemployment functions to erase the economic realities of the labour market and authorises the extension of state-sanctioned surveillance to psychological characteristics.'[62] A defining characteristic of neoliberal identity is that it is other-assigned, framing a person's character within economistically-grounded external assessments.

The Improving Access to Psychological Therapy scheme represents a shift in public policy, in which human distress, manifesting as anxiety and depression, is reframed by the interests of the market as a deficit in the subjectivities constitutive of a neoliberal identity. The subsequent management of subjectivity is part of a remedial state response:

> The protective response which rises against the dehumanisation, persistent commodification, and increasing social dislocation of neoliberalism prompts the construction of provisions of the welfare state, but in an unorganised *ad hoc* fashion, primarily as a result of its spontaneity and pragmatic immediacy, is thus not a systematic creation of social protection measures, but rather a product of the uncoordinated efforts to ameliorate immediate concerns.[63]

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[61] Harvey, D. (2005) A brief history of neoliberalism, p. 53.
[62] Friedli, L. & Stearn, R. (2015) Positive affect as coercive strategy: conditionality, activation and the role of psychology in UK government workfare programmes, p. 43.
[63] Wrenn, M. (2014) Identity, Identity Politics, and Neoliberalism, *Panoeconomicus,* p. 508.

The management of subjectivity through IAPT-driven counselling and psychotherapy has been one facet of this response, part of a deepening alignment of economistic interests with public welfare provision. The ethnographic material, in a number of instances, includes evidence of resistance to these changes by therapists involved in both the production and consumption of codified and digitally-Taylorised representations of therapy knowledge. A theme of resistance emerged from the case studies in the form of objections expressed by the participants to what they believed to be a misrepresentation of the values psychotherapy embodied. There were a few resignations, but the majority of trainees, as well as psychotherapists who were acting as trainers, lecturers and exam writers, pragmatically turned their attention away from what therapy is and its creative possibilities, to the mundane tasks of working within a codified representation of therapy grounded in instrumental reason. This is suggestive of Arendt's analysis of humans becoming labourers in a process over which they have no control, to survive as jobholders:

> The last stage of the labouring society, the society of jobholders, demands of its members a sheer automatic functioning, as though individual life had actually been submerged in the over-all life process of the species and the only active decision still required of the individual were to let go, so to speak, to abandon his individuality, the still individually sensed pain and trouble of living, and acquiesce in a dazed "tranquillised", functional type of behaviour.[64]

Jobholders, lacking leverage over their social conditions, who are drawn to their psychologically-instrumentalised private spaces, turn for help to psychotherapists. The devaluing of psychotherapy's epistemological capital is consigning therapists to the task of labouring with economised depression and anxiety.

Jobholders labouring under conditions of precarity are subjected to a heightened culture of uncertainty and its concomitant affect, anxiety, which leaves them vulnerable to therapeutic management and control. The Institute for Precarious Consciousness[65] has identified three mechanisms, also evident in my ethnographic material, which induce anxiety. Firstly, 'Reactive force in neoliberalism functions through an *obligation to be communicable,* distinct from the

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[64] Arendt, H. (1989) [1958] *The human condition,* p. 322.

[65] Institute for Precarious Consciousness (November 2014) Anxiety, affective struggle, and precarity consciousness raising, *Interface: a journal for and about social movements*, Volume 6 (2): 271–300 (available at: interfacejournal.net, accessed 23 November 2016).

prohibition on speaking of the earlier period'.[66] This communication is, however, only available in ways that subordinate social connections in deference to managerial imperatives, such as an alignment to numericised emotion management. The second mechanism concerns an obligation to maintain an appearance of happiness. The use of 'outcome' scales in IAPT and elsewhere places an obligation to proceed towards 'recovery', and exposes distressed people in therapy to performance anxiety. The third mechanism for anxiety production is manifested in regimes of risk management, producing strategies for risk avoidance, where the active seeking of corporately-construed danger ignores the existential risks of precarity. These sources of anxiety contribute towards the construction of cautious neoliberal identities. Lacking control over their social conditions, anxiously distressed people turn to the management and control of their inner thoughts and feelings, sometimes with the help of instrumentalised therapy.

Therapists' responses to instrumental reason

In this section I will draw on therapists' perspectives and responses to the social actions narrated in the case studies, in the light of some of the interpretations included in this chapter. The reframing of therapy knowledge in a utilitarian formulation of instrumental reason, exercised in response to statutory imperatives, presented challenges and opportunities for therapists.

Members of the core curriculum consortium, in senior positions in the training and regulation of counsellors and psychotherapists, expressed enthusiasm at the possibility of ending long-standing factional disputes, discussed in chapter one, about the relative superiority of specific therapeutic modalities, and the opportunity to identify generic factors which could be seen to account for the 'effectiveness' of counselling and psychotherapy. Furthermore, the group of therapy academics working within HE welcomed an opportunity to generate a form of symbolic capital which, from their point of view, would help to insulate their domains of interest from budget cuts and departmental 'reforms'. The writers of the core curriculum were presented with the prospect of statutory regulation as inevitable – the authority of the final document therefore appeared to them as a unique occasion to preserve, (and enhance) the status of the work carried out by counsellors and psychotherapists. To this end the writers recognised the inevitability of a more singular and codified representation of therapy, a form of knowledge primed for instrumental use, as a price worth paying for the perceived benefits, but with some reservations. The difficulties inherent in

[66] Ibid., p. 275.

organising a wide range of therapy training courses containing diverse and sometimes contradictory accounts and explanations for human distress would, they argued, be met through the use of clear and unambiguous learning outcomes – in line with managerial demands for increasing modularisation within higher education. In this respect, the congeniality and challenge of finding common ground amongst colleagues, and a language with which to represent it, seemed preferable to the group by comparison with the historic zero-sum game of perpetuating modality-specific loyalties. The writers' ambivalence to the task evaporated as they became immersed in the complexities of how to represent the plurality of therapeutic approaches within a single document without recourse to historic psychotherapy discourse. In spite of this the ethnographic material unveils some therapists' strong reservations about the erosion of discrete modalities, for example in arguments about 'a passion for the person-centred approach' in discussions about recruitment for CfD, or the use of 'assessment' for clients in the scenarios written for the Certificate of Competence.

The initial zeal shown by therapists at being invited to become involved in a nation-wide project – the Competent Practitioner exam, (which had been framed as a standard-raising exercise and necessary pre-requisite to statutory regulation), gave way to expressions of indignation, anger, mistrust and disbelief followed by acquiescence and accommodation. Protests based on discrete modality allegiances were made by counsellors and therapists engaged with production of the exam. These objections were countered or overruled by three arguments, firstly political inevitability, secondly scientific rationalisation and legitimation within an evidence-based conception of therapy, and thirdly the attractions of enhanced professional legitimacy. The continued emphasis on the importance of the task and the risks of disengagement quelled objections and dampened resistance to the process. The exam writing group eventually embraced the project, with a few disaffected departures.

CfD was represented by senior managers as a strategy within the BACP in response to the dominance of CBT in one of the few remaining areas of employment outside private practice for therapists – IAPT. The ethnographic material suggests that many counsellors and psychotherapists, outside clinical psychology, had felt resentful about the dominance of CBT, arguing that it was mere technique which did not address clients' existential needs. Many CfD trainees were persuaded by the BACP that by mirroring the 'scientific' explanations for the efficacy of CBT, the use of utilitarian numerical measures for the standardisation of their own practice as well as the

assessment of distress for their clients would work to their advantage. The enthusiasm expressed by trainees at the beginning of the Dolphin Hotel CfD training suggested some initial optimism in the new brand of therapy which would increase their employability. As the course progressed students expressed dismay and anger at the PCEPS scale, the non-negotiable requirement that therapists perform from a formulaic script – 'How are we supposed to perform *as if we are genuine,* that's a […] contradiction'.[67] One trainer had described CfD as 'dumbing-down training into simplistic steps and turning clients into objects'.[68] Several therapists on the CfD training said they recognised that an outward appearance of compliance (through the medium of observed role-plays and taped supervision sessions) to the demands of emotional labour on the course would not alter their practice which would take place in a confidential setting, outside the reach of managerial surveillance. A few therapists welcomed the opportunity to make their work more explicit and accountable. A common sentiment emerging at several points across the case studies was the hope that therapists would finally be able to agree on 'what worked' and that this would help enhance the legitimacy of counselling and psychotherapy as a social practice.

The (sometimes vociferous) challenges to the codification and instrumentalisation of therapy praxis, particularly in the implementation of the Gold Book, were expressed with reference to a pro-social representation of fairness, objections to the arbitrary imposition of authority, being infantilised, and the prioritisation of bureaucratic/corporatist policies and procedures over the needs of distressed people. Phrases used by students to describe the Therapy Solutions' Gold Book-based course included: 'criteria pimping', 'poisonous business-speak', 'not remotely humane', 'an orgy of ticked boxes', 'rules lead to authenticity(!)', 'journal police', and 'muddled thinking'. These comments suggested that several students were unwilling to renounce their resistance to authority, refusing to acquiesce to the literality of the Gold Book. As with the CfD training, many therapists pragmatically framed the Gold Book training as a necessary hurdle to jump over before they could be freed to work in their own way, confidentially privileging their clients' interests, while representing their work as compliant in relation to the managerial authority implicit in the Gold Book. In this form of emotion work cognitive surface acting is reserved for managers and trainers while deep expressive acting and virtuous, hermeneutically-based implementations of counselling and psychotherapy praxis are kept within the privacy of the consulting room.

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[67] Quotation taken from Ella, chapter seven.
[68] Quotation taken from Chris, chapter seven.

Where 'outcome measures' were used for 'payment-by-results' within IAPT settings, some therapists, antagonistic to the scheme, manipulated the results to meet 'recovery targets'. One therapist described her subversion of an authorised therapy script by engaging pragmatically with a client's social circumstances – refusing to pathologise the distress in accordance with the IAPT 'stepped care' model.

These responses suggest that the senior therapy managers described in the case studies who were involved in the production of therapy knowledge were willing to internalise authoritarian imperatives; relayed through the medium of instrumentalised, (and digitally Taylorised), representations of therapy praxis to working therapists and trainees who while helping distressed people in the NHS and elsewhere, appear more likely to persist in their resistance, pragmatic about disguising their work in compliance with authority – keeping their idealism intact.

Final thoughts

An interpretation of the social actions of therapists points up some of the obstacles to thinking critically about therapy when training in a culture where critique by students is interpreted as an attack on protected psychoanalytic and humanistic ontologies.[69] The interviews and participant observations expose an anti-intellectualist bias, privileging pragmatic constraint over argumentation, where a culture of performance anxiety and didactic teaching methods provide fertile soil for a culture of certainty. Some trainers[70] appeared to repurpose the allegiances grounded in their psychotherapy training[71] towards a scientistic justification of a codified form of therapy, such as CfD, which bore little ontological resemblance to its putative humanistic origins. The componentisation of therapy praxis, with a multiplication and proliferation of standards, criteria and competencies, provides a discourse within which expression of the pain of human distress may be transposed and regulated:

> *Through a clinical codification of the inducement to speak.* Combining confession with examination, the personal history with the deployment of a set of decipherable signs and symptoms; the interrogation, the exacting questionnaire, and hypnosis, with the recollection of memories and free association: all were ways

[69] See chapters seven to nine.
[70] Ibid.
[71] See chapter three.

> of transcribing the procedure of the confession in a field of scientifically acceptable observations.[72] [Italics in original.]

Therapy students were encouraged to be 'self-reflexive' and open about their own intimate spaces, to lay themselves bare in a multiplicity of 'appropriate' discourses. An effect of the instrumentalised representation of therapy praxis for training purposes as visible and explicit is that the tacit knowledge of intimacy, relationships and distress students bring to therapy training is repressed. As Foucault said: 'A disparity of this sort would indicate that the aim of such a discourse was not to state the truth but to prevent its very emergence.'[73]

The ethnographic material narrates trainers' reluctance to explore political and social perspectives in the aetiology of anxiety and distress. This seems antithetical to a representation of the ethical teacher (and therapy trainer) who '…confronts social injustices, is not afraid to exercise moral judgement and seeks to mobilise public opinion on behalf of socially disadvantaged groups'.[74] Therapists' focus on the individual and the correlating neglect of social context has, in the training of counselling and psychotherapy provided in Higher Education, contradicted this representation of the therapy trainer. The increasing scientisation of psychotherapy has helped disconnect therapy praxis from the humanities, where argumentation and Socratic pedagogy had, before the advent of the Gold Book, helped to constellate therapy praxis within a broadly social context.[75] The marketisation of therapy knowledge, which the Gold Book facilitates, is brought into question by a critical analysis: 'The ability to think and argue for oneself looks to many people like something dispensable if what we want are marketable options of a quantifiable nature.'[76] A space in which to think, upheld by the principle that 'anything goes',[77] where reasoned argument, in a climate of open-mindedness, respect, candour and integrity, virtues framed as central to therapy praxis in the BACP Ethical Framework[78], has been colonised by psychotherapeutic instrumentalism. A further effect of neoliberal policies in the learning environment, under the mantle of austerity, is the

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[72] Foucault, M. (1978) The History of Sexuality, Volume 1, An Introduction, p. 65.
[73] Ibid., p. 55.
[74] Bailey, M. in: Bailey, Michael, and Des Freedman, eds. (2011) *The assault on universities: A manifesto for resistance*, p. 95.
[75] See Beckford College in chapter three.
[76] Nussbaum, M. C. (2010) *Not for profit, why democracy needs the humanities*, p. 48.
[77] Feyerabend, P. (1993) *Against method.*
[78] BACP Ethical Framework, available at: http://www.bacp.co.uk/events/learning_programmes/ethical_framework/documents/ethical_framework_mono.pdf (accessed September 2016).

divisive effect on academics who are subjected to an enlarging regime of monitoring and assessment: 'Austerity thus pits us all against each other, it undermines genuine scholarship, and it leads to increased stress. It also leads to bad old psychology, which good critical research in the discipline now has the responsibility to explore and challenge.'[79]

Each of the empirical chapters has unveiled samples of the instrumentalisation of therapy knowledge and practice. The reduction and componentisation of therapy praxis into a means-end epistemology prepared the ground for some of the social phenomena which followed, including the coalescence of managerial and professional capital within a state-sanctioned psychotherapy habitus. Some of the professionalising strategies enacted in this context included the creation of an online credentialising examination, using the techniques of Digital Taylorism, to bring therapists within the organisational authority of a national register of counsellors and psychotherapists. Some of these findings have been shown to be generalisable into the broader field of education while some remain specific to the training of counsellors and psychotherapists. The emergence of a new brand of 'humanistic' therapy helped to consolidate a commodified representation of emotional labour within a positivist epistemology. Therapy training, narrowly constrained within the non-negotiable representations of therapy praxis in the 'Gold Book', is an example of education-for-profit that disavows argumentation and dialogue, marginalising tacit knowledge of the human condition in favour of the concrete, explicit and countable.

[79] Parker, I. (2014) Austerity in the university, *The Psychologist, Vol 27, No. 4.*

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