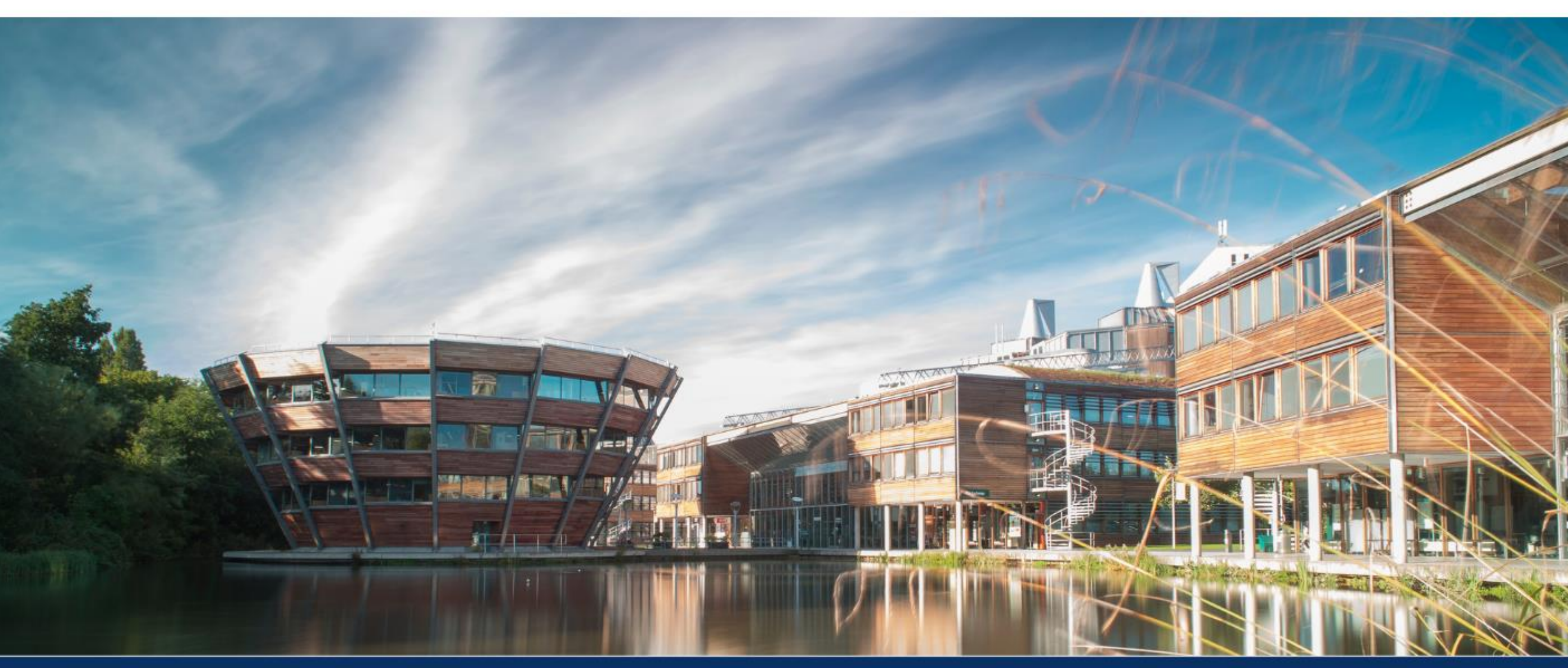
School of Education

Counselling Cluster

Person-Centred Experiential Counselling for Depression (PCE-CfD)

Course Handbook



Assistant Professors: Emma Tickle, Richard Doyle, Andrea Williams
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Person-Centred Experiential Counselling for Depression Training

We are delighted to welcome you to the PCE-CfD programme at the University of Nottingham (UoN). We hope that you will enjoy the course.

We have provided this handbook to guide you through the entire programme. We hope it will be a helpful resource to support your learning and development over the period of training. This handbook is intended mainly to be a guide. Course content and learning resources are found on UoN Teams and Moodle.

Welcome to the Team

Assistant professors in counselling:

Emma Tickle

Emma is the PCE-CfD course leader. Emma trained as a Person-Centred Experiential therapist at Diploma and Masters level at the University of Nottingham. Emma was awarded the Teresa Duffy Memorial prize for her work on the latter. Emma has taught modules on the BA and Masters Programmes at the university, since 2013. A teacher for 20 years Emma has taught counselling at introductory, certificate, and diploma level. As well as counselling education Emma has taught Psychology, co-produced and delivered courses for the NHS Recovery College and provided professional development and clinical supervision. Emma has clinical experience working as a person-centred experiential counsellor in multi-disciplinary teams in education, health and corporate contexts, and runs a small private practice. Emma is currently undertaking her PhD investigating PCE as a resource towards Social Justice while applying a Social Justice lens to decolonise the PCE approach. Emma contributes to the Centre for Research in Human Flourishing at the University of Nottingham.

Doyle R. J., Arnold L., Tickle E. (2022). Interitem and interrater reliability of the PCEPS-10 as used in the assessment of adherence on the PCE-CfD training programme.
Cornelius-White, J.H.D., Kanamori, Y, Murphy, D., Tickle, E. (2018) Mutuality in Psychotherapy: A Meta-Analysis and Meta-Synthesis. Journal of Psychotherapy Integration
Tickle, E. (2017 Out of Time. By Lynne Segal. Journal of Psychotherapy and Politics International
Tickle, E (2017) Encountering the young person as expert. BACP Children & Young People Journal, June (4): 29-33
Tickle, E and Joseph, S. (2017) Using attachment theory in person-centred therapy. 186-198 in The Handbook of Person-Centred Therapy and Mental Health: Theory, Research and Practice. Ed Joseph, S. PCCS Books
Tickle, E & Murphy, D (2014**)** A journey to client and therapist mutuality in person-centred psychotherapy: a case study**.** Person-Centered & Experiential Psychotherapies. 13(4), 337-351

Richard Doyle

Richard holds a postgraduate diploma in person-centred counselling from the Norwich Centre. He has experience as a therapist in the voluntary sector and a student counselling service, as well as in private practice. Richard has facilitated sessions on research for students at the University of Suffolk BA in Person-Centred Counselling, and was a tutor on the postgraduate diploma at the Norwich Centre for two years. Having joined the University of Nottingham in November 2021, Richard now tutors on the PCE-CfD course as well as on the MA in Person-Centred Experiential Counselling and Psychotherapy. Before becoming a counsellor, Richard worked in scientific research and teaching environments for over 15 years, having gained a PhD from the University of Warwick in 2006. He has contributed to the following presentations at the annual BACP Research Conference.

Doyle R. J., Arnold L., Tickle E. (2022). Interitem and interrater reliability of the PCEPS-10 as used in the assessment of adherence on the PCE-CfD training programme.
Broadway R., Doyle R. J., Ford N., Kitcatt C. (2019). A person-centred retrospective comparison of the effectiveness of counselling in adult clients using PSYCHLOPS data.
http://www.psychlops.org.uk/file/research-conference-poster-final-may-2019-print-versionpdf

Andrea Williams

Andrea successfully achieved an MA in Person-Centred Experiential Counselling and Psychotherapy at the University of Nottingham and is a member of the British Association of Counselling and Psychotherapy (BACP). Andrea offers counselling to adults from various backgrounds with their personal growth and development.
Andrea holds a Professional Certificate in Pastoral Supervision, and currently undertakes supervision.
Andrea has over 20 years' experience of learning and workforce development within Local Government, and over 35 years working within the voluntary sector.

Emma and Richard have presented papers at conference related to the PCE-CfD Counselling for Depression programme and are involved in on-going research in this area.

Awa S. Ottiger

Awa trained as a person-centred experiential counsellor and psychotherapist at the University of Nottingham. Since graduating, Awa has worked as a therapist in various settings in- and outside the UK. She is dedicated to promoting authenticity and human flourishing in individuals and groups and does so as a therapist in private practice, as a tutor on the PCE-CfD course at the University of Nottingham, as a tutor on the MSc Person-centred Experiential Psychotherapy at the Sherwood Institute and as a researcher. Lately, Awa has

conducted research on authenticity and ecological-sensitivity and contributed to various conferences on that matter. Awa is a BACP accredited psychotherapist.

Ottiger, A. S. & Joseph, S. (2020). From ego-centred to eco- centred: an investigation of the association between authenticity and ecological sensitivity, Person- Centered & Experiential Psychotherapies, DOI: 10.1080/14779757.2020.1846600

Ottiger, A. S. (in press). Authenticity, Heroism, and Humanistic Person-Centered Psychology. In Allison T.S. (Ed.) Encyclopedia of Heroism Studies, Springer.

Ottiger, A. S. (2021) Authenticity and Ecological-Sensitivity? Research Day, Institute for Mental Health, University of Nottingham, May, 2021, Nottingham.

Ottiger, A. S. (2023) Authenticity – Key to Survival? 15th World Conference for Person-Centred and Experiential Psychotherapy and Counselling, July, 2023, Copenhagen.

Administrative support:

Tatiana Woolley - Senior Operations Officer for PCE-CfD

Tatiana provides administrative support to all PCE-CFD staff, supervisors and delegates. She deals with applications, course extension requests, issuing of certification, HEE funding and liaison with NHS Talking Therapies service providers. You can contact Tatiana with any query on how to enroll on our PCE-CFD courses, HEE funding available or the application process.

Joanne Hawkes – Operations Officer

Joanne provides administrative support to PCE-CfD by dealing with certification, bookings, invoices and supervisors.

Introduction to the PCE-CfD Programme

The Department of Health, Improving Access to Psychological Therapies (IAPT) Programme (renamed NHS Talking Therapies in 2023) commissioned the British Association for Counselling and Psychotherapy (BACP) to develop the curriculum for a PCE therapeutic manual.

This curriculum describes a programme that trains counsellors to provide a depression-specific form of therapy for individual clients in an NHS Talking Therapies setting. The PCE-CfD competences are drawn from a number of NICE-endorsed research studies and from key texts identified by the Humanistic Psychological Therapies Expert Reference Group that describe the modality and underpin its effectiveness. These studies and associated literature are of Person-Centered Counselling and Emotion-Focused Therapy. These two areas of therapeutic work have much in common, both theoretically and in terms of their practice. The development of the PCEPS-10 is the result of keeping the PCEPS items that therapists from both approaches offer their clients and discarding those specific to one or other modality. The first iteration of the PCE-CfD textbook referred to Person-Centered**/**Experiential Therapy suggesting an integration of two distinct approaches. However, we now understand Person-Centered Experiential therapy as the most contemporaneous evolution and expression of the person-centred approach where the experiential is more clearly articulated in the relational encounter. (See Murphy,D. Person-Centred Experiential CfD 2019).

What is Person-Centered Experiential Counselling for Depression (PCE-CfD)?

PCE-CfD is Person-Centered Experiential Therapy, a modality specific, evidence based, therapeutic approach. For the context of the NHS talking therapies the PCE-CfD manual is informed by the competences required to deliver effective humanistic psychological therapies (Roth, Hill and Pilling, 2009). PCE-CfD is drawn from those humanistic approaches with the strongest evidence for efficacy, based on outcomes of randomised controlled trials (RCTs). For the purposes of the NHS stepped care process, the PCE-CfD manual has been specifically designed to articulate how the PCE approach is an effective therapeutic intervention for working with depression and for delivery within the context of the IAPT programme.

Equality Diversity and Inclusion

A Growth model: Social Justice Issues (SJI), Equality, Diversity and Inclusion (EDI)

As a radical approach that aims to empower the person through mutual encounter, whether this is in one-to-one therapy, education, group process, or working with intergroup conflict, the approach is well suited to encounter SJI and provide EDI in practice. As a team we understand this to be a work in progress, a vigilant reflexive process, and are proactively exploring how to decolonize the curriculum and develop PCE's capacity as a resource towards social justice and EDI. As Tutors we are keen to interrogate our own biases, assumptions, intersecting identities, power and privileges and how these might present themselves in the curriculum, learning resources and learning encounters on the programme.

We aim to create a safe and inclusive environment and welcome delegates and colleagues to share experiences of privilege, power and oppression, in whatever form these experiences might take. Whether this is in the form of racism, heteronormativity, ableism, transphobia, misogyny, classism, food and shelter poverty and so on. The is not intended as an exhaustive list, but more of a 'broaching' of what you might want to explore in relation to the programme.

We understand the freedom of the PCE is only as authentic as our willingness to acknowledge the *response-ability* that comes with that freedom.

*"Nobody can do everything,
but everyone can do something"*
(Gil Scott Heron)

*"Psychotherapy is Political or
it is not Psychotherapy"*
(Peter Schmid)

Programme Structure

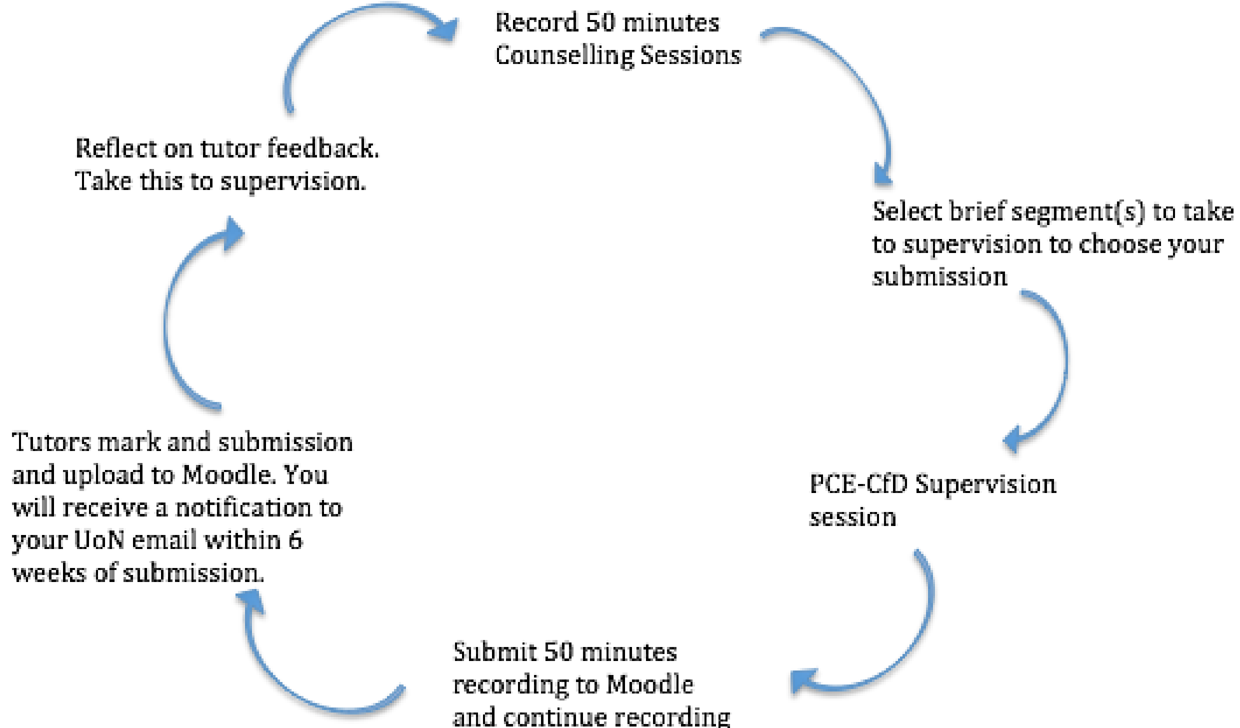
The length of the PCE-CfD programme is up to **18 months**. It is possible to complete in 4 months, but this is exceptional.

The full 18-month programme consists of:

- ✓ 5-day taught course (delivery might be online, face to face or a mix of both).
- ✓ A 20-minute Learning Experience assessment at the end of the 5 days.
- ✓ Allocation of PCE-CfD Supervisor for 1-1 and/or Group Supervision .
- ✓ Log a minimum of 4 and maximum of 8 PCE-CfD supervision hours (minimum of 8 to 16 for group supervision).
- ✓ Submission of between 4-6 recorded sessions uploaded to Moodle for assessment.
- ✓ Log 80 client hours (“therapeutic hours”, can be 50-minute sessions) where you have offered the PCE-CfD counseling relationship.
- ✓ Upload the Client and Supervision Logs and the Supervisor’s Report to Moodle.
- ✓ When you have reached adherence on 4 submissions and uploaded your logs and report then you will be issued your PCE-CFD Certificate.

All of the elements above aim to support your reflective engagement with the PCE-CfD model so that your adherence to the PCEPs is an outcome of an authentic understanding and way of being with your clients.

LEARNING CYCLE: RECORD, SUPERVISION, SUBMIT, FEEDBACK, REFLECT…



To support you to complete the full license we will consider extensions and Voluntary Interruptions of Study (VIS) where necessary. There is more information about both in this handbook.

Accessibility

Please let us know if there is anything we can do to ensure you have access to appropriate learning resources in order to flourish on the course, for example, this might mean letting us know about neurodiversity, such as dyslexia, visual or hearing impairments, or access to the building.

Course curriculum, Content and Delivery

The following modules will be covered in the 5-day taught course. Please take into account that your engagement with the content is expected to run across the 12-18 months of practice beyond the 5 days. This is to support a reflexive learning cycle so that theory, learning resources, clinical practice, feedback, and supervision constantly inform one another. The modules below have been adapted from the original IAPT curriculum document (which you will find a copy of on your Moodle page) to better reflect the learning aims and your experience of the programme.

Modules

Module 1 - NHS Talking Therapies, Background and Context

Much of the content of this module will be covered through the pre-reading and online resources you will have access to. However, your experience of working in the NHS as a therapist will be a valuable learning resource too. We invite a critical engagement with the 'IAPT' agenda, the medical model, it's disease metaphor for the human experience of depression, and the tools that are used to measure recovery. The social justice issues that this context raises for you and your client's will be explored through self-reflection, group dialogue and process.

- Working as a therapist in the NHS Talking Therapies (previously known as IAPT)
- Rationale for and development of NHS Talking Therapies
- Medical model of depression, DSM, PHQ9
- MDS outcomes, targets
- Social Justice Issues – e.g., empowering the client and the therapist in a medical model context, 2022 'NHS race review' demonstrating institutional racism in terms of a lack of referrals for black patients to NHS talking therapies.

The content for this module is largely as pre-course reading, and it will be interwoven throughout the taught 5 days and throughout the 18-month programme. There is a wealth of online resources made available to you on Teams and Moodle. We will also relate all modules to the NHS Talking Therapy context it is located within. It is hoped that the learning on the course, the PCEPs and the competencies offer a way of articulating PCE-CfD manual within a multi-disciplinary team and to clients.

Module 2 - Orientation to the PCE-CfD Competencies Framework and the PCEPS

This module acknowledges, and values, that you are a qualified and experienced counsellor, with established ways of working that are unique to you and effective for your clients. It is also true that the NHS Talking Therapy context may have shaped how you have been/will be working with clients. Our programme wants to honour this practice wisdom and offer up the space for you to explore your current therapeutic orientation, theoretical framework and practice. From here we will invite you to engage with the PCE-CfD competency framework and consider which competencies you recognise in your own current practice and those you might wish to develop further. You will also be invited to orientate your current theoretical and therapeutic practice in relation to the PCE-CfD model and the PCEPS. This congruent inquiry of your current therapeutic practice is intended to provide reference points for an authentic orientation towards adhering to the PCE-CfD model.
This module will include:

- Identifying your current Theoretical Orientation
- Becoming familiar with the competency framework the PCE-CfD manual is informed by.
- Gaining an understanding of the Person-Centred Experiential Psychotherapy scale that measures your adherence to the PCE-CfD manual
- Orientating your current Theoretical Orientation and Practice to the competencies and PCEPs
- Social Justice Issue: Exploring the westerncentric origins of the approach and how this relates to cultural similarlities and differences, the universal ontology of the person and the extreme inequality of lived experience..

Through experiential learning activities, reflexive theoretical orientation measures, group discussion, skills practice and demos, your will be invited to symbolise and articulate your current theoretical orientation. This is the start of your journey of developing a coherent therapeutic PCE-CfD model and authentic relationship to the PCEPs. This is the cornerstone of Treatment Integrity, i.e. a coherent, accountable, measurable theoretical orientation. Treatment Integrity is closely associated with the *Common Factors* known related to successful client outcomes, across all therapeutic modalities..

A brief description of the PCE-CfD manual and competency framework:

The primary aim for PCE-CfD therapists is to be congruent in the relationship with the client, whilst valuing and trying to empathically understand the client. It is based on the Actualising Tendency, the therapist's trust in the client's process and the therapist's non expert stance.

Additionally, specifically within the framework of these therapist attitudes, the aim is to help clients access underlying feelings, make sense of them, and draw on the new meanings which emerge to make positive changes in their lives. This approach draws on the notion of ‘self-discrepancy’ or incongruence between how a person feels they actually are and how they feel they should be. This way of conceptualizing depression from within the Person-centred theoretical framework has been shown to be associated with a range of standardised measures of depression (Watson, Bryan and Thrash 2013).

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 that can reduce the intensity of their distress and, in turn, the degree of self-discrepancy. The net result of this is a reduction in depressed mood, enhanced social functioning and a greater sense of satisfaction within the self.

The PCE-CfD competences provide a framework for this work. The Basic Competences describe the therapists' relational stance and associated therapist attitudes (Rogers 1959) and actions, including the communication of empathy, unconditional positive regard and congruent personal presence or authenticity. This stance enables the depressed client to explore and clarify depression-related experiences, helping them develop a more accurate, experientially-based awareness of self.

The specific competences from Emotion Focused Therapy (EFT) provide the basis for the identification of, and focal interventions with, the various emotional processes associated with client identified self-discrepancy. Such interventions help clients to access underlying feelings, reflect on their emotional experiencing and replace self-criticism with self-compassion (see Greenberg and Watson, 2006).

This combination of a coherent therapeutic stance with more specific focal interventions enables counsellors to work effectively with depression. As a form of psychological therapy recommended by NICE for the treatment of depression, it is particularly appropriate for clients with persistent subthreshold depressive symptoms and for mild to moderate depression where 6 to 10 sessions are recommended over a period of 8 to 12 weeks. For more severe or complex presentations, up to 20 sessions of PCE-CfD are recommended.

Module 3 - From Doing to Being - PCE-CfD Principles and Values

This module engages with the principles and values of person-centred experiential therapy. The PCE approach is contingent on therapist attitude and intentions, their *way of being* rather than adopting a prescriptive set of techniques or therapeutic interventions, i.e. a *way of doing.* This can be a profound shift at the level of the therapist's self-concept. As such, PCE education often involves a degree of vulnerability in the learning process as it involves the same values and principles as the PCE therapy. This value based, way of being, can feel at odds with the target driven, problem-focused approach promoted in the NHS Talking Therapy context, as such you will have opportunities in this module, as with all of the training, to explore this tension at some depth. This module invites you to consider your beliefs about the causes of mental distress and the model you hold of what it is to be a person. As such, the philosophical and phenomenological basis of the Actualising Tendency and the therapist's trust in the client to direct their own process will be further explored. You will be encouraged to develop your embodied empathy and an appreciation of the centrality of experiential and emotional processes as the source of growth and flourishing. As such you will gain an appreciation and understanding of the following:

- the philosophy and values that inform the person-centred approach
- person-centred theories of human growth and development and the origin of psychological distress
- the necessary and sufficient conditions for therapeutic change
- the person-centred theory of emotions and the centrality of experiential processes
- ways that the PCE approach can engage with Social justice and EDI in practice. e.g: *power with*, rather than power over; mutuality in the therapeutic relationship; client as expert of their own experience; broaching social justice issues with clients and colleagues; cultural comfort, humility and skill, facilitating situated experiential process rather than abstracting experience out of context and stripping it of social meaning.

This module offers practice in small groups to reacquaint yourselves with the necessary and sufficient conditions of person-centred therapy (Rogers 1959), how they facilitate and nurture connection to the emotional experiencing of clients and the significance of that for PCE-CfD. This will be achieved through watching demos of PCE relationships and using the PCEPS to rate the clips.

We recognise that therapists attending this course are skilled and experienced practitioners. The sessions are an invitation to review and develop, amongst experienced colleagues, our capacity for creating a person-centred relationship.

By using small groups and becoming acquainted with the PCE-CfD adherence scale, therapists will have the invaluable experience of peer support and feedback as you experiment with your own unique way of being as a therapist working with the competencies for PCE-CfD.

All group work encourages you to use your own material and confidentiality will be expected within these

groups.

PCE: A Growth Model

The work of Carl Rogers marked a revolutionary approach in therapy; rebalancing power away from an expert analysing a client, to client and therapist engaging in mutual encounter. The approach supports the view of the person as engaged in a self-actualizing process of becoming. The therapy is the co-creation of the relationship and the client is the change agent. The therapist's expertise is in offering the 6 necessary and sufficient conditions that facilitate this relational process of growth.

Person-Centred Experiential Therapy is the most contemporaneous iteration of the approach an evolution of the relational and experiential informed by Emotion Focused Therapy (EFT) developed by Greenberg, Watson, Goldberg and Elliott (Elliot et al 2004, Greenberg and Watson 2006). The research carried out by Friere, Elliot and Westwell (2013) forms the evidence base for the PCEP adherence scale. This has allowed us to articulate what this relationship sounds like in a therapeutic encounter.

PCE: Personal values and Social Justice Issues

This module will provide an opportunity for therapists to unpack their own values and beliefs in relation to professional practice. We will ask you to consider your beliefs about reasons for distress, what helps people who are distressed and your aims as a therapist.

You can then explore how compatible the values and beliefs of PCE-CfD are with your own personal values and beliefs.

This module will also provide you the opportunity to encounter and engage with issues of social justice, such as:- Racism, Abelism, Poverty, Climate Crisis, Gender, Transphobia, Homophobia, Classim etc. The aim here is to open up our own experiencing to the ways that power, priviige and opressions, systemically create intersectional societal coniditons of worth that intersect with our lived experiences how these related to distress and how they are present in the therapeutic encounter.

You will be invited to reflect on how these issues impact you, your clients and world of counselling as a profession.

You will have the opportunity to consider what resources you need to support your personal and professional development in relation to these issues.

Module 4 - PCE-CfD in the Context of NHS Talking Therapies, for Anxiety and Depression

This module explores how your theoretical orientation intersects with offering the PCE-CfD manual in practice, in the context of NHS Talking Therapies. The aim in this module is to bring your understanding of the PCE values and practices and your experience of the conditionality of NHS Talking therapies as a medical model, to explore what all of this further implies for you as a PCE therapist in practice and in relationship with the client. For example, working briefly appears contradict a person-centred open ended way of working, however, in practice time limted work necessitates and promotes the importance of immediacy to faciliate working at experiential and emotional relational depth.
This module will explore the following:

- The medical model as context.
- Depression as a set of symptoms, i.e. a deficit model
- PCE Conceptualisation of Depression – e.g. stuck and critical experiential process
- The Minimum Data Set e.g. PHQ9
- PCE Outcome and assessment measures
- Working briefly with time limited counselling
- Parity within a multi-disciplinary team, Evidence and articulating the PCE-CfD approach.

The medicalisation of distress is ubiquitous and is the dominant lens for understanding depression. You will have the opportunity to explore the Diagnostic Statistical Manual's conceptualisation of depression as an illness through pre-reading and online resources, however this will also be present in discussion and in contrast to the PCE approach. The main focus in this module will be the PCE conceptualisation of distress in general as a growth model of distress, and of depression specifically.

This module builds on Module 3 in that it offers a PCE conceptualising of depression as a stuck or an incongruent process. Looking at how conditions of worth are experienced as a critical process, possibly as critical internal dialogue, sometimes with different configurations of self. The PCE understands distress as being meaningful, an experience to be empathised with and accepted. The more of our experience is accepted and brought into awareness due to a lack of threat in the therapeutic relationship, the more likely we are to be able to process our experience and respond to our internal and external environments with increasing congruence and a sense of agency in our lives and relationships.

These conditions of worth of what it is to be of value as a person, to be loved, from significant others are introjected in to the self-concept which we can experience as being part of us, as 'natural'. These introjected conditions of worth can also be societal 'oughts' ranging from implicit biases to, systemic, institutional, discrimination, to varying degrees of trauma. The individual's experience of societal conditions of worh will be intersectional and unique to them. The PCE is best placed at working with intersectionality as we aim to

understand experiences of oppression and discrimination from the client's own frame of reference which mitigates the potential damaging effects of working from generic categorical assumptions, even when with the best intentions. Empathically and tentatively broaching social justice issues, power and oppression, if implied in the client's experiential process and/or the therapeutic encounter is key to empowering the client. The therapist's cultural comfort and cultural humility is the basis for working with difference and diversity authentically, a necessary aspect of being congruent in the relationship. This module and the programme in general invites you to reflect on your own social location and your relationship to difference and diversity.

This module gives you the opportunity to compare how NHS talking therapies target driven approach can create conditions of worth for yourself, the relationship and the client. You will be offered the space to explore how to work with these tensions towards a greater sense of empowerment and agency for yourself and your client. Gaining an appreciation of PCE outcome and assessment measures you will have the opportunity to consider how you can incorporate them or at least their conceptual basis into your way of working with clients and colleagues.

As such this module will help you to achieve a sense of competence and parity within a multidisciplinary team, equipped with a coherent PCE model of depression as an evidence-based way of working with clients.

Working with emotional processes and the PCE conceptualisation of depression

- Understanding possible causes of depression from a PCE theoretical framework
- Ability to help client access and express emotions
- Ability to help client articulate emotions
- Ability to help client reflect on and develop emotional meanings
- Ability to help client make sense of experiences that are confusing and distressing

Use of the NHS Talking Therapies minimum dataset:
Minimum data sets:
PHQ9
GAD 7,
The Phobia Scale,
Employment question,
WSAS.

Working briefly
The challenge of offering effective brief therapy is explored and what elements can help this. These include therapists' ability to:

- be fully present to clients
- be aware of the importance of the beginning

- discuss time limits with clients
- identify the core aspect that the client wishes to bring
- help regulate the clients emotional experiencing and expression
- work towards the ending of therapy
- end the therapy

PCE Assessment and Outcome Measures

- 6 necessary and sufficient conditions
- 7 stages of awareness
- Personal Quesitonnaire
- Unconditional Postive Self-Regard
- Authenticity Scale
- 14-item Scales of General Well-Being (14-SGWB)

Module 5 - PCE-CfD Learning Process

5- Day Taught Course

The mode and schedule of delivery varies from one cohort to another. The 5 days can be scheduled across one week or run across 5 weeks. The mode of delivery can be online, face to face or a blend of the two. Hopefully, you will be able to choose the mode and schedule of delivery that best suits you. However, all of the 5-day taught programmes offer the opportunity of experiential learning and reflective engagement with the curriculum.

Experiential Learning

The PCE-CfD programme is a relational and experiential encounter, congruent with the model itself. As such it holds a similar tension of offering a PCE client lead approach within the NHS Talking Therapy as both are contexts which already determine the structure and boundaries of the relationship to a large degree. As such, a significant aspect of the experiential learning is your own contribution to co-creating the relational conditions necessary for experiential learning and authentic encounter. As tutors we will offer a variety of resources, such as, experiential and reflective activities, skills practice, power points, and group process to meet the learning aims in a way that we hope you find engaging and empowering. PCE learning is a way of being in the same way as PCE therapy, ie. It is a relational, experiential approach which understands growth and transformation to occur at the level of the self-concept.

A significant aspect of the programme is skills practice with peers. We encourage a sense of community that will hopefully exist beyond the five taught days so that you might support one another through the submissions process too. We recognise that being assessed and observed can be daunting so we strive to create a supportive safe relational environment so that you can learn from this process as individual learners and flourish together as a group.

Assessment of therapist competence

The PCEPs aim to articulate what the approach looks and sounds like in practice. Each of the 10 scale items unpacks and articulates an aspect of the approach in relationship with a client. This is essentially a very helpful learning tool, that you can also use for reflexive practice, and to communicate the approach to clients and colleagues. In the context of the course, it also allows us to make a judgement as to whether your practice adheres sufficiently to these item descriptors so that we can confidently say that you are offering PCE-CfD therapy. From this we can more confidently assume that outcome measures are a result of a particular practice and develop a more valid and reliable approach.

You will be asked to record a 20-minute skills session called The Learning Experience to stress that this is not a pass/fail assessment but to help you to gain an awareness of where your practice is now in relation to the

PCEPs.

Over the following 12-18 months you will record your client sessions so that you can select with your supervisor which sessions you wish to upload to moodle for assessment. You need to pass on 4 out of a possible 6 sessions. There is an example client consent form for recordings. Normally you will use one provider by your employer.

Supervision and clinical practice

Your PCE-CfD supervision is additional to your clinical supervision or case management and is perhaps best thought of as part of the learning process of the course, as it the educational goals of PCE-CfD supervision is foregrounded to support you on the course. You will be matched with a PCE-CfD supervisor, and you can have between 4-8 one to one sessions, or you might have the opportunity for group supervision depending on availability. A group supervision is 2 hours long for a group of 4 supervisees. Each 2-hour session accounts for 30 minutes of your 4-8 hours, so in theory you could have between 8 and 16 group supervision sessions depending on availability.

We will provide you with logs for your client work and attendance of supervision. Examples are at the end of this handbook.

You will have the chance to review how this approach will fit in to your workplace and explore any concerns or considerations you may have in regard to the next stages of the training.

Working online

Teams

If part or all of your taught course is online it will be offered via Teams. You will receive joining instructions to register and log in. **It is vital that you log on to Teams before the start of the course**. Even if your course is solely or initially face to face, in person, on campus you will still need to access Teams. Regardless of delivery you will also need to enroll on to **Moodle**. Details for this are also included in your 'starter' email. Any queries please contact tt-pce-cfd@exmail.nottingham.ac.uk and/or itservicedesk@nottingham.ac.uk

Online protocol

A chance to share and discuss best practice online: such as cameras turned on, when to mute microphones, appropriate and confidential environment, etc.

Quality of presence

An exploration of the strengths and challenges of person-centred approach when working online, therapeutically and educationally.

Review and evaluation

We will welcome your written and spoken feedback, which will be used to inform the development of the PCE-CfD course.

As with the previous aspects of the course it is requested the speaker brings something authentic to share. The therapist having revised the theoretical and philosophical approach throughout the five days will be able to demonstrate their understanding of attitudes depicted in the PCEPS scale. Written feedback will be provided by the trainers a few weeks later. This will highlight what is observable in the 20-minute recording in regards to the PCEPS. Recordings are uploaded to Moodle, and feedback will be delivered by Moodle with email notification when this is available.

Appendix

Person-Centred Experiential Psychotherapy Scale (Therapist Version)

PERSON–CENTRED & EXPERIENTIAL PSYCHOTHERAPY SCALE-10-T

(THERAPIST VERSION, V. 1.1, 16/09/2016)

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Client ID:		**Therapist:**	
Session no:		**Date:**	

Rate the items according to how well you think you did on each during this therapy session.

---

1 CLIENT FRAME OF REFERENCE/TRACK:

How much did my responses convey an understanding of my client's experiences as they themselves understood or perceived these? To what extent was I following my client's track?

Rating Notes: Did my responses convey an understanding of my client's immediately expressed inner experience or point of view? Or conversely, how did my responses impose meaning based on my own frame of reference?
Were my responses right on client's track? Conversely, were my responses a diversion from my client's own train of thoughts/feelings?

1	**No tracking**: My responses conveyed no understanding of my client's frame of reference or added meaning based completely on my own frame of reference.
2	**Minimal tracking**: My responses conveyed a poor understanding of my client's frame of reference or added meaning partially based on my own frame of reference rather than my client's.
3	**Slight tracking**: My responses came close but don't quite reach an adequate understanding of my client's frame of reference; my responses were slight "off" of my client's frame or reference.
4	**Adequate tracking**: My responses conveyed an adequate understanding of my client's frame of reference.
5	**Good tracking**: My responses conveyed a good understanding of my client's frame of reference.
6	**Excellent tracking**: My responses conveyed a highly accurate understanding of my client's frame of reference in which I added no meaning from my own frame of reference.

2 PSYCHOLOGICAL HOLDING:

How well did I metaphorically hold my client when they were experiencing painful, scary, or overwhelming experiences, or when they were connecting with their vulnerabilities?

Rating Notes: High scores refer to me maintaining a solid, emotional and empathic connection even when my client was in pain or overwhelmed.
Low scores refer to situations in which I avoided responding or acknowledging painful, frightening or overwhelming experiences of my client.

1	**No holding**: I was oblivious to my client's need to be psychologically held; I avoided responding, acknowledging or addressing their experience/feelings.
2	**Minimal holding**: I was aware of my client's need to be psychologically held but was anxious or insecure when responding to client and diverted or distracted them from their vulnerability.
3	**Slight holding**: I conveyed a bit of psychological holding, but not enough and with some insecurity.
4	**Adequate holding**: I managed to hold my client's experience sufficiently.
5	**Good holding**: I calmly and solidly held my client's experience.
6	**Excellent holding**: I securely held my client's experience with trust, groundedness and acceptance, even when they were experiencing, for example, pain, fear or being overwhelmed.

3 EXPERIENTIAL SPECIFICITY:

How much did I appropriately and skillfully work to help my client focus on, elaborate or differentiate specific, idiosyncratic or personal experiences or memories, as opposed to abstractions or generalities?

Rating Notes: E.g., by my reflecting specific client experiences using crisp, precise, differentiated and appropriately empathic reflections; by asking for examples or for my client to specify feelings, meanings, memories or other personal experiences.

1	**No specificity**: I consistently responded in a highly abstract, vague or intellectual manner.
2	**Minimal specificity**: I had the concept of specificity but didn't implement it adequately, consistently or well; I was either somewhat vague or abstract or generally failed to encourage experiential specificity where appropriate.
3	**Slight specificity**: I was often or repeatedly vague or abstract; I only slightly or occasionally encouraged experiential specificity; sometimes I responded in a way that pointed to experiential specificity, but often I failed to do so, or did so in an awkward manner.
4	**Adequate specificity**: Where appropriate, I generally encouraged client experiential specificity, with only minor, temporary lapses or slight awkwardness.
5	**Good specificity**: I did enough of this and did it skillfully, where appropriate trying to help my client to elaborate and specify particular experiences.
6	**Excellent specificity**: I did this consistently, skillfully, and even creatively, where appropriate, offering the client crisp, precise reflections or questions.

4 ACCEPTING PRESENCE*:*

How well did I convey unconditional acceptance of whatever my client brought?

Rating Notes: Did my responses convey a grounded, centered, and acceptant presence?

1	**Explicit non acceptance**: I explicitly communicated disapproval or criticism of my client's experience/ meaning/feelings.
2	**Implicit nonacceptance**: I implicitly or indirectly communicated disapproval or criticism of my client's experience/meaning/feelings.
3	**Incongruent/inconsistent nonacceptance**: I conveyed anxiety, worry or defensiveness instead of acceptance; or I was not consistent in communicating acceptance to my client.
4	**Adequate acceptance**: I demonstrated calm and groundedness, with at least some degree of acceptance of my client's experience.
5	**Good acceptance**: I conveyed clear, grounded acceptance of my client's experience; I did not demonstrate any kind of judgment towards my client's experience/behavior
6	**Excellent acceptance**: I skilfully conveyed unconditional acceptance while being clearly grounded and centred in myself, even in the face of intense client vulnerability.

5 CONTENT DIRECTIVENESS:

How much did my responses intend to direct my client's content?

Rating Notes: Did my responses introduce explicit new content? e.g., did my responses convey explanation, interpretation, guidance, teaching, advice, reassurance or confrontation?

1	**"Expert" directedness**: I overtly and consistently assumed the role of expert in directing the content of the session
2	**Overt directiveness**: My responses directed my client overtly towards new content.
3	**Slight directiveness**: My responses directed my client clearly but tentatively towards a new content.
4	**Adequate non directiveness**: I was generally nondirective of content, with only minor, temporary lapses or slight content direction.
5	**Good non directiveness**: I consistently followed my client's lead when responding to content.
6	**Excellent non directiveness**: I clearly and consistently followed my client's lead when responding to content in a natural, inviting and unforced manner, with a high level of skill.

6 EMOTION FOCUS:

How much did I actively work to help my client focus on and actively articulate their emotional experiences and meanings, both explicit and implicit?

Rating Notes: E.g., by helping my client focus their attention inwards; by focusing my client's attention on bodily sensations; by reflecting toward emotionally poignant content, by inquiring about client feelings, helping my client intensify, heighten or deepen their emotions, by helping my client find ways of describing emotions; or by making empathic conjectures about feelings that have not yet been expressed. Lower scores reflect ignoring implicit or explicit emotions; staying with non-emotional content; focusing on or reflecting generalized emotional states ("feeling bad") or minimizing

emotional states (e.g., reflecting “angry” as “annoyed”).

1	**No emotion focus**: I consistently ignored emotions or responded instead in a highly intellectual manner while focusing entirely on non-emotional content. When my client expressed emotions, I consistently deflected my client away from them.
2	**Minimal emotion focus**: I understood emotion focus is but didn’t implement it adequately, consistently or well. For example, I generally stayed with non-emotional content; I generally but not always deflected my client way from their emotion; I reflected only general emotional states (e.g., “bad”); or I minimized my client’s emotions.
3	**Slight emotion focus**: I often or repeatedly ignored or deflected my client away from emotion; I only slightly or occasionally helped my client to focus on emotion; while I sometimes responded in a way that pointed to client emotions, at times I failed to do so, or did so in an awkward manner.
4	**Adequate emotion focus**: Where appropriate, I generally encouraged my client to focus on emotions (by reflections or other responses), with only minor, temporary lapses or slight awkwardness.
5	**Good emotion focus**: I did enough of this and did it skilfully, where appropriate trying to help my client to evoke, deepen and express particular emotions.
6	**Excellent emotion focus**: I did this consistently, skilfully, and even creatively, where appropriate offering the client powerful, evocative reflections or questions, while at the same time enabling the client to feel safe while doing so.

7 DOMINANT OR OVERPOWERING PRESENCE:

To what extent did I project a sense of dominance or authority in the session with my client?

Rating Notes: Low scores refer to situations in which I was taking charge of the process of the session; acting in a self-indulgent manner or taking over attention or focus for myself; interrupting, talking over my client, being silence or controlling the process; or acting in a definitive, lecturing, or expert manner.
High scores refer to situations in which I offered my client choice or autonomy in the session, allowing my client space to develop their own experience, waiting for them to finish their thoughts, being patient with them, or encouraging them to feel empowered in the session.

1 **Overpowering presence**: I overpowered my client by strongly dominating the interaction, controlling what they talked about or did in the session; clearly made myself the center of attention; or was patronizing toward my client.
2 **Controlling presence**: I clearly controlled my client's process in the session, acting in an expert, or dominant manner.
3 **Subtle control**: I subtly, implicitly or indirectly controlled what and how my client was in the session.
4 **Non-controlling presence**: I generally respected my client's autonomy in the session; I did not try to control my client's process.
5 **Respectful presence**: I consistently respected my client's autonomy in the session.
6 **Empowering presence**: I clearly and consistently promoted or validated my client's freedom or choice, allowing them space as they desired.

8 CLARITY OF LANGUAGE:

How well did I use language that communicated simply and clearly to my client?

Rating Notes: E.g., my responses were not too wordy, rambling, or unnecessarily long; I did not use language that was too academic or too abstract; my responses did not get in my client's way.

1 **No clarity**: My responses were long-winded, tangled, and *confusing*.

2 **Minimal clarity**: My responses were wordy, rambling or *unfocused*.
3 **Slight clarity**: My responses were *somewhat clear*, but a bit too abstract or long.
4 **Adequate clarity**: My responses were *clear but a bit too long*.
5 **Good clarity**: My responses were *clear and concise*.
6 **Excellent clarity**: My responses were very clear and concise, even *elegantly* capturing *subtle* client experiences in a few choice words.

9 CORE MEANING:

How well did my responses reflect the core, or essence, of what my client was communicating or experiencing in the moment?

Rating Notes: My responses were not just a reflection of surface content but showed an understanding of my client's central/core experience or meaning that was being communicated either implicitly or explicitly in the moment; my responses did not take away from the core meaning of my client's communication.

1 **No core meaning**: My responses addressed **only** the cognitive content or stayed **exclusively** in the superficial narrative.
2 **Minimal core meaning**: My responses addressed **mainly** the cognitive content or the superficial narrative but brought occasional **glimpses** into the underlying core feeling/ experience/ meaning.
3 **Slight core meaning**: My responses **partially but incompletely** addressed the core meaning/feeling/ experience underneath my client's expressed content.
4 **Adequate core meaning**: My responses were **close** to the **core** meaning/feeling/ experience that was underneath my client's expressed content, but did not quite reach it.
5 **Good core meaning**: My responses accurately addressed the **core** meaning/feeling/ experience that was underneath my client's expressed content.
6 **Excellent core meaning**: My responses addressed with a high degree of accuracy the **core** Meaning/feeling/ experience that was underneath my client's expressed content.

10 EMOTION REGULATION SENSITIVITY:

How much did I actively work to help my client adjust and maintain the level of emotional arousal they needed for productive self-exploration?

Rating Notes: Client agency is central here; this is not to be imposed by me. There are three possible situations:

(a) If my client was overwhelmed by feelings and wanted help in moderating them, did I try to help my client to manage these emotions? E.g., By offering a calming and holding presence; by using containing imagery; or by helping my client self-soothe vs. allowing them to continue to panic or feel overwhelmed or unsafe.

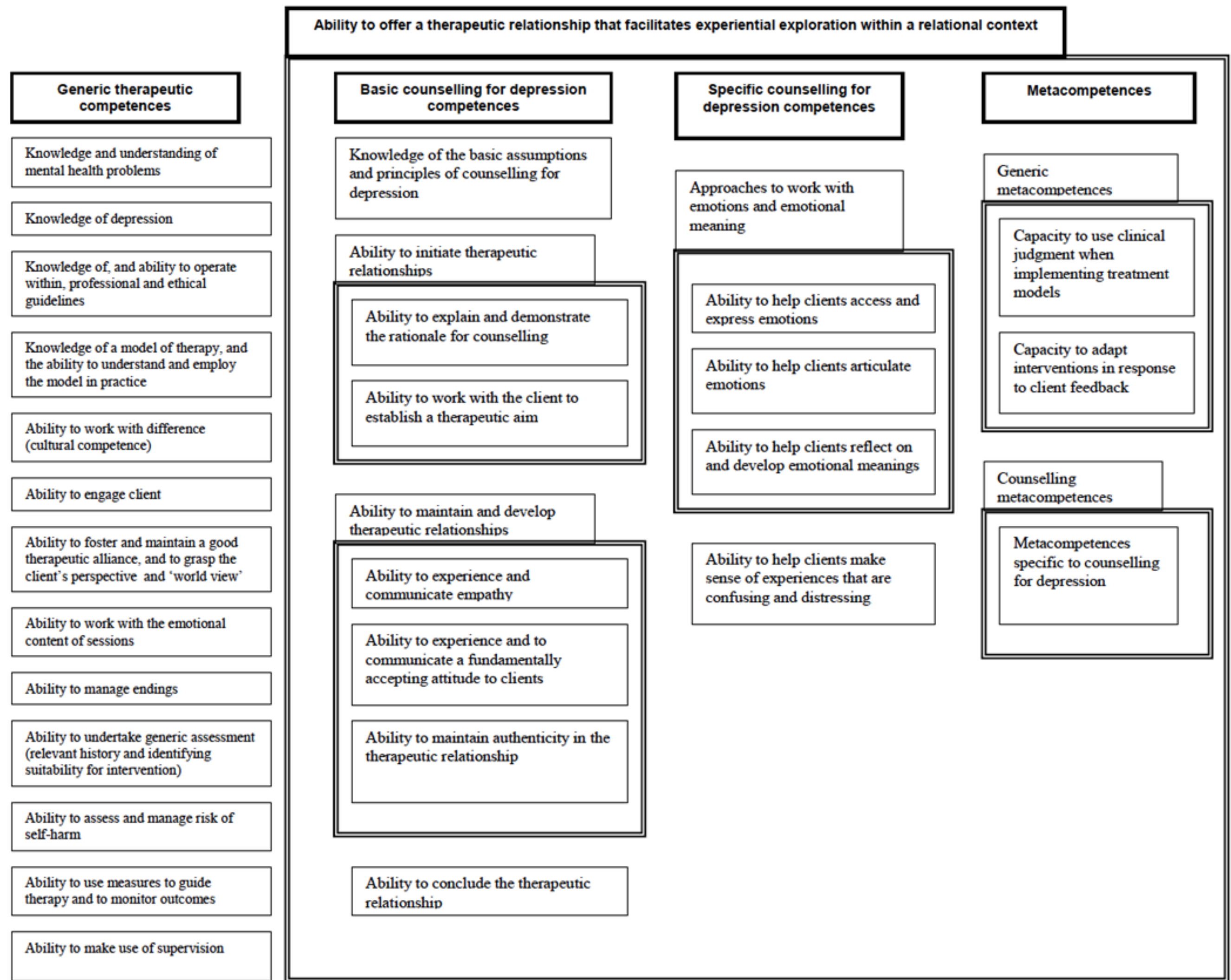
(b) If my client was out of touch with their feelings and wanted help in accessing them, did I try to help them appropriately increase emotional contact? E.g., by helping them review current concerns and focus on the most important or poignant; by helping them remember and explore memories of emotional experiences; by using vivid imagery or language to promote feelings vs. increasing distance from emotions.

If my client was at an optimal level of emotional arousal for exploration, did I try to help them continue working at this level, rather than either heightening or flattening their emotions?

1	**No facilitation**: I consistently ignored possible concerns about emotional regulation on the part of my client, or generally worked against their client regulating their emotions, that is by allowing them to continue feel overwhelmed or distanced.
2	**Minimal facilitation**: I understood the principle of facilitating client emotional regulation but didn't implement it adequately, consistently or well; I generally ignored my client's desire to contain overwhelmed emotion or to approach distanced emotion; or I sometimes misdirected my client out of a productive, optimal level of emotional arousal, into either stuck or overwhelmed emotion or emotional distance/avoidance.
3	**Slight facilitation**: I often ignored or deflected my client away from the level of emotional regulation they experienced as productive for self-exploration; or I only slightly facilitated productive self-exploration. While I sometimes responded in a way that facilitated client productive emotional regulation, at times I failed to do so, or did so in an awkward manner.
4	**Adequate facilitation**: Where appropriate, I generally encouraged client emotional regulation (e.g., by helping them approach difficult emotions or contain excessive emotional distress as they desired), with only minor, temporary lapses or slight awkwardness.
5	**Good facilitation**: I did enough emotional regulation facilitation and did it skillfully and in accordance with my client's desires, where appropriate trying to help them to maintain a productive level of emotional arousal.
6	**Excellent facilitation**: I did this consistently, skillfully, and even creatively, where desired by my client, offering them evocative or focusing responses to help them to approach difficult emotions when they were too distant or to contain overwhelming emotions when these were too much, all within a safe, holding environment.

Competencies

Map of the PCE-CfD Competence Framework



See also: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-7

Medical model measures: Minimum Data Set

PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	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 a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ-9 total score			

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GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

GAD-7 total score

WSAS

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0 1 2 3 4 5 6 7 8 N/A

_ --- --

Not at all Slightly Definitely Markedly Very severely, I cannot work

0.

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

3. **SOCIAL LEISURE ACTIVITIES -** With other people, e.g. parties, pubs, outings, entertaining etc.

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

4. **PRIVATE LEISURE ACTIVITIES –** Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

5. **FAMILY AND RELATIONSHIPS –** Form and maintain close relationships with others including the people that I live with

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

W&SAS total score

Employment Status Questions

Please indicate which of the following options best describes your current status:

Employed full-time (30 hours or more per week)		Full-time student	
Employed part-time		Retired	
Unemployed		Full-time homemaker or carer	

Yes	
No	

Are you currently receiving Statutory Sick Pay?

Yes	
No	

Are you currently receiving Job Seekers' Allowance, Income Support or Incapacity Benefit?

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Phobia Scales

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation.

0 1 2 3 4 5 6
7 8

Would not Slightly Definitely Markedly
Always

Avoid it avoid it avoid it avoid it
avoid it

☐

Social situations due to a fear of being embarrassed or making a fool of myself

☐

Certain situations because of a fear of having a panic attack or other distressed symptoms (such as loss of bladder control, vomiting or dizziness)

☐

Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying)

Person-centred experiential measures for assessment and outcomes

Person-Centred Assessment and Outcome Measures

Six Necessary and Sufficient Conditions

Carl Rogers stated that ‘for constructive personality change to occur, it is necessary that these [six] conditions exist and continue over a period of time.' The conditions are:

1. Psychological contact between counsellor and client
2. The client is incongruent (anxious or vulnerable)
3. The counsellor is congruent
4. The counsellor shows unconditional positive regard towards the client
5. The client receives empathy from the counsellor
6. The client perceives acceptance and unconditional positive regard

The six necessary and sufficient conditions are ‘the hypothesised conditions by which the therapist facilitates constructive personality change’ (Tudor and Merry, 2006: 23-24).

7 stages of awareness

Stage 1

People will not speak about feelings openly, and tend to blame others for causing their pain, rather than take responsibility for themselves: ‘If only my friend would stop doing that, I’d feel better.’ It is rare to see a client at this stage: ‘The individual in this stage of fixity and remoteness of experience is not likely to come voluntarily for counselling’ (Rogers, 1961: 132).

There is an unwillingness to communicate self. Communication is only about externals.
E.g. ‘Well, I’ll tell you, it always seems a little bit nonsensical to talk about one’s self except in times of dire necessity.’

Feelings and personal meanings are neither recognised nor owned. Close and communicative relationships are construed as dangerous. No problems are recognised or perceived at this stage.
There is no desire to change.

There is much blockage of internal communication.

'The ways in which he construes experience have been set by his past and are rigidly unaffected by the actualities of the present. He reacts 'To the situation of now by finding it to be like a past experience and then reacting to that past, feeling it.'

Stage 2

There is slightly less rigidity, with a small movement towards wondering whether responsibility should be taken by self, but not actually doing so: 'It's not my fault; it's theirs – isn't it?' It may be possible to start working with a client at this stage, through offering the core conditions, trusting the client's process, and so allowing the client to find their own way forward.

Expression begins to flow in regard to non-self topics.

E.g., 'I guess that I suspect my father has often felt very insecure in his business relations.'

Problems are perceived as external to self -
E.g. - 'Disorganisation keeps cropping up in my life.'

There is no sense of personal responsibility in problems.

Feelings are described as unowned or sometimes as past objects.

E.g. - Counsellor - 'If you want to tell me something of what brough you here...' Client - 'The symptom was - it was - just being very depressed.'

Internal problems can be perceived and communicated about as entirely external. The client is not saying 'I am depressed' or even 'I was depressed.' Their feeling is handled as a remote, unowned object, entirely external to self.

Feelings may be exhibited, but are not recognised as such or owned.

Personal constructs are rigid and unrecognised as being constructs, but are thoughts of as facts -
E.g. - 'I can't ever do anything right - can't ever finish it.'

'On Becoming a Person' - Carl Rogers - Constable & Robinson, 1967 Page 133/34

Stage 3

The person is beginning to consider accepting responsibility for self, but generalises, and focuses more on past than present feelings: 'I felt angry, but then everyone does, don't they?' This is quite a common

stage to enter therapy; it is important to use unconditional positive regard to accept the client just as they are, supporting them to feel safe to explore their feelings.

There is a freer flow of expression about the self as an object -
E.g. - 'I try hard to be perfect with her - cheerful, friendly, intelligent, talkative - because I want her to love me.'

There is also expression about self-related experiences as objects -
E.g. - 'And yet there is the matter of, well, how much do you leave yourself open to marriage and if your professional vocation is important and that's the thing that's really yourself at this point, it does place a limitation on your contacts.'
Here, her self is such a remote object that this would probably best be classified as being between stages two and three.

There is also expression about the self as a reflected object, existing primarily in others -
E.g - 'I can feel myself smiling sweetly the way my mother does or being gruff and important the way my father does sometimes - slipping into everyone else's personalities but mine.'

There is much expression about or description of feelings and personal meanings not now present. Usually, of course, these are communications about past feelings. E.g. - There were 'so many things I couldn't tell people - nasty things I did. I felt so sneaky and bad.' And 'This feeling that came into me was just the feeling that came into me was just the feeling that I remember as a kid.'

Personal choices are often seen as ineffective -
E.g. - The client 'chooses' to do something but finds that his behaviours do not fall in line with their choice.

'On Becoming a Person' - Carl Rogers - Constable & Robinson, 1967 PP 134-136.

Stage 4

The client begins to describe their own here-and-now feelings, but tends to be critical of self for having these: 'I feel guilty about that, but I shouldn't really.' While the client is willing and actively seeks involvement in the therapeutic relationship, they may lack trust in the counsellor. The counsellor also needs to take care not to collude with a client's use of humour to distance themselves from the full impact of here-and-now feelings.

The client describes more intense feelings of the 'no-now-present' variety.

E.g. - ‘Well, I was really - it hit me down DEEP.’

Feelings are described as objects in the present -

E.g. - ‘It discourages me to feel dependent because it means I’m kind of hopeless about myself.’

Occasionally feelings are expressed as in the present, sometimes breaking through almost against the client’s wishes -
E.g. - A client, after discussing a dream including a bystander, dangerous because of having observed his ‘crimes’ says to the therapist - ‘Oh all right, I DON’T trust you.’

There is a tendency toward experiencing feelings in the immediate present and there is distrust and fear of this possibility -
E.g. - ‘I feel bound - by something or other. It must be me! There’s nothing else that seems to be doing it. I can’t blame it on anything else. There’s this *knot* - somewhere inside of mee... It makes me want to get mad - and cry - and run away!’

There is little open acceptance of feelings, though some acceptance is exhibited.

Experience is less bound by the structure of the past, is less remote and may occasionally occur with little postponement.

There is an increased differentiation of feelings, constructs, personal meanings, with some tendency toward seeking exactness of symbolisation.

There is a realisation of concern about contradictions and incongruences between experience and self -
E.g. - ‘I’m not living up to what I am. I really should be doing more than I am. How many hours I spent on the john in this position with Mother saying ‘Don’t come out ‘till you’ve done something.’ Produce! That happened with lots of things.

There are feelings of self responsibility in problems, though such feelings feelings vacillate.

Though a close relationship still seems dangerous, the client risks himself, relating to some small extent on a feeling basis.

E.g. - ‘I don’t trust you.’

‘On Becoming a Person’ - Carl Rogers - Constable & Robinson, 1967 PP 137-139

Stage 5

Clients express that they are seeing things more clearly, and take ownership of their situation, being prepared to take action: 'I'm not surprised I'm angry with my boss after what I've been through. So I've quit my job.' This is a very productive stage in therapy, as the client can express present emotions and begin to rely on their own decision-making abilities. The counsellor is likely to see the client taking action in their life.

If the client feels himself received in his expressions, behaviours and experiences at the fourth stage, then this sets in motion still further loosening and the freedom of organismic flow is increased.

Feelings are expressed freely as in the present.

E.g. - 'I expected kinda to get a severe rejection - this I expect all the time... somehow I guess I even feel it with you... It's hard to talk about because I want to be the best I can possibly be with you.'

Feelings are very close to being fully experienced. They 'bubble up', 'seep through' in spite of the fear and distrust which the client feels at experiencing them with fullness and immediacy.
E.g. - 'That kinda came out and I just don't understand it. (Long pause) I'm trying to get hold of what that terror is.'

E.g. - Client is talking about an external event. Suddenly she gets a pained, stricken look.
Therapist - 'What's hitting you now?'
Client - 'I don't know. (She cries)... I must have been getting a little too close to something I didn't want to talk about or something.' Here the feeling has almost seeped through into awareness in spite of her.

E.g.- 'I feel stopped right now. Why is my mind bland right now? I feel as if I'm hanging onto something and I've been letting go of other things - and something in me is saying 'What more do I have to give up?'

There is a beginning tendency to realise that experiencing a feeling involves a direct referent.
E.g. - The examples above.

There is a dawning realisation that the referent of these vague cognitions lies within hime, in an organismic event against which he can check his symbolisation and his cognitive formulations. This is often shown by expressions that indicate the closeness or distance he feels from this referent. E.g. - 'I don't really have my finger on it - I'm just kinda describing it.'

There is surprise and fright, rarely pleasure, at the feelings which 'bubble through' -

E.g. - Client, talking about past home relationships - ‘That’s not important any more. Hmm. (Pause) That was somehow very meaningful - but I don’t have the slightest idea why... Yes, that’s it! I can forget about it now and - why, it isn’t that important. Wow! All that miserableness and stuff!’

E.g. - Client has been expressing his hopelessness. ‘I’m still amazed at the strength of this. It seems to be SO much the way I feel.’

There is an increasing ownership of self feelings and a desire to be these, to be the ‘real me’.
E.g.- ‘The real truth of the matter is that I’m not the sweet, forbearing guy that I try to make out that I am. I get irritated at things. I feel like snapping at people and I feel like being selfish at times and I don’t know why I should pretend I’m NOT that way.’

Experiencing is loosened, no longer remote and frequently occurs with little postponement.
E.g. - ‘I’m still having trouble trying to figure out what this sadness - and the weepinesss - means. I just know I feel it when I get close to a certain kind of feeling - and usually when I do get weepy, it helps me to kinda break through a wall I’ve set up because of things that have happened. I feel hurt about something and then automatically this kind of shields things up and then I feel like I can’t really touch or feel anything very much... and if I’d be able to feel or could let myself feel the instantaneous feeling when I’m hurt, I’d immediately start being weepy right then - but I can’t.’

The ways in which experience is construed are much loosened. There are many fresh discoveries of personal constructs as constructs and a critical examination and questioning of these.

E.g. - A man says ‘This idea of needing to please - of HAVING to do it - that’s really been kind of a basic assumption of my life. It’s kind of, you know, just one of the very unquestioned axioms that I HAVE to please. I have no choice. I just HAVE to.’

There is a strong and evident tendency toward exactness in differentiation of feelings and meanings.
E.g. - ‘...Some tension that grows in me, or some hopelessness or some kind of incompleteness - and my life actually is very incomplete right now...I just don’t know. Seems to be, the closest thing it gets to is hopelessness.’

There is an increasingly clear facing of contradictions and incongruences in experience.
E.g. - ‘My conscious mind tells me I’m worthy. But some place inside I don’t believe it. I think I’m a rat - a no-good. I’ve no faith in my ability to do anything.

There is an increasing quality of acceptance of self-responsibility for the problems being faced and a concern as to how he has contributed. There are increasingly freer dialogues within the self, an improvement in and reduced blockage of internal communication.

E.g. - 'Something in me is saying 'What more do I have to give up? You've taken so much from me already.' This ME talking to ME - the ME way back in there who talks to ME who runs the show. It's complaining now, saying 'You're getting too close! Go away!'

E.g. - Frequently these dialogues are in the form of listening to oneself, to check cognitive formulations against the direct referent of experiencing. Thus a client says 'Isn't that funny?' I never really looked at it that way. I'm just trying to check it. It always seemed to me that the tension was much more externally caused than this - that it wasn't something I used in this way. But it's true - it's really true.

'On Becoming a Person' - Carl Rogers - Constable & Robinson, 1967 PP 139-145

Stage 6

The client recognises their own and others' process towards self-actualisation: 'I accept that pain within me, and what I and others did. I feel a warmth and compassion towards myself and them for where I am at.' Once at this stage, the client is unlikely to regress. They may choose not to continue with therapy, now being able to treat themselves with self-care and love.

A feeling which has previously been 'stuck' - has been inhibited in its process quality, is experienced with immediacy now.
A feeling flows to its full result.
A present feeling is directly experienced with immediacy and richness.

This immediacy of experiencing and the feeling which constitutes its content, are accepted. This is something with is, not something to be denied, feared or struggled against.

E.g. - 'I could even conceive of it as a possibility that I could have a kind of tender concern for me... Still, how could I be tender, be concerned for myself, when they're one and the same thing? But yet, I can feel it so clearly... You know, like taking care of a child. You want to give it this and give it that... I can kind of clearly see the purposes for somebody else... but I can never see them for...myself, that I could do this for me, you know. Is it possible that I can really want to take care of myself and make that a major purpose of my life? That means I'd have to deal with the whole world as if I were guardian of the most cherished and most wanted possession, that this I was between this precious me that I wanted to take care of and the whole world... It's almost as if I loved myself - you know - that's strange - but it's true.'

Therapist - 'It seems such a strange concept to realise. Why it would mean 'I would face the world as though a part of my primary responsibility was taking care of this precious individual who is me - whom I love.'
Client - 'Whom I care for - whom I feel so close to. Woof! That's another strange one.'

Therapist - 'It just seems weird.'
Client - 'Yeah. It hits rather close somehow. The idea of my loving me and taking care of me. That's a very nice one - very nice.'

There is a quality of living subjectively in the experience, not feeling about it.

Self as an object tends to disappear.

The self, at this moment, IS this feeling. This is a being in the moment, with little self-conscious awareness, but with primarily a reflexive awareness as Sartre terms it. The self is, subjectively, in the existential moment. It is not something one perceives.

Experiencing, at this stage, takes on a real process quality.

E.g. - One client, a man who is approaching this stage, says that he has a frightened feeling about the source of a lot of secret thoughts in himself. He goes on - 'the butterflies are the thoughts closest to the surface. Underneath, there's a deeper flow. I feel very removed from it all. The deeper flow is like a great school of fish moving under the surface. I see the ones that break through the surface of the water - sitting with my fishing line in one hand, with a bent pin on the end of it - trying to find a better tackle - or better yet, a way of diving in. That's the scary thing. The image I get is that I want to be one of the fish myself!'

Therapist - 'You want to be down there, flowing along too.'

Another characteristic of this stage of process is the physiological loosening which accompanies it. Moistness in the eyes, tears, sighs, muscular relaxation, are frequently evident. Often there are other physiological concomitants. I would hypothesise that in these moments, had we the measure for it, we would discover improved circulation, improved conductivity of nervous impulses.

The moment of full experiencing becomes a clear and definite referent.

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In this stage, there are no longer 'problems', external or internal. The client is living, subjectively, a phase of his problem. It is not an object.
The best description is that the client neither perceives his problem nor deals with it. He is simply living some portion of it knowingly and acceptingly.

'These moments of immediate, full, accepted experiencing are in some sense almost irreversible.

'On Becoming a Person' - Carl Rogers - Constable & Robinson, 1967 PP 145-151

Stage 7

We are likely to see a fluid, self-accepting person who is open to the changes that life presents: 'After the profound and irreversible experiences of stage six, there is going only to be growth, and it is unlikely the client will feel they need a counsellor to facilitate this' (Kelly, 2017: 72).

Authenticity Questionnaire (AQ)		
Please read of the following statements and rate how well each describes you, where 1 = "Does not describe me at all" and 7 = "Describes me very well".		
1	I think it is better to be yourself, than to be popular	
2	I don't know how I really feel inside	
3	I am strongly influenced by the opinions of others	
4	I usually do what other people tell me to do	
5	I always feel I need to do what others expect me to do	
6	Other people influence me greatly	
7	I feel as if I don't know myself very well	
8	I always stand by what I believe in	
9	I am true to myself in most situations	
10	I feel out of touch with the 'real me'	
11	I live according to my values and beliefs	
12	I feel alienated from myself	

Name:____ Date:____________________

To calculate your self-alienation score, add up your answers to items 2, 7, 10 and 12. If you scored above 8 you probably feel at least a niggling sense that life is not as it should be.

To calculate your external-influence score, add up your answers to items 3, 4, 5, 6. If you scored above 8 you probably feel that you are doing things for other people and that you would like more choice about your own life.

Now add up your scores on items 1, 8, 9 and 11 to calculate your authenticity score. If you scored above 20 you are probably the sort of person who knows what they like and you stand your ground when you need to.

Reference: Wood, A. M., Linley, P. a., Maltby, J., Baliousis, M.., & Joseph, S. (2008). The authentic personality: A theoretical and empirical conceptualization and the development of the authenticity scale. *Journal of Counselling Psychology, 55*, 385-399.

14-item Scales of General Well-Being (14-SGWB)

Instructions

Below you'll find fourteen statements about your experiences. Please indicate how true each statement is regarding the EXPERIENCES IN YOUR LIFE OVERALL. There are no right or wrong answers. Please, choose the answer that best reflects your experience rather than what you think your experience should be.

	Not at all true	A bit true	Somewh at true	Mostly true	Very true
1. I feel happy	☐	☐	☐	☐	☐
2. I feel energetic	☐	☐	☐	☐	☐
3. I feel calm	☐	☐	☐	☐	☐
4. I'm optimistic	☐	☐	☐	☐	☐
5. In my activities, I feel absorbed by what I'm doing	☐	☐	☐	☐	☐
6. I'm in touch with how I really feel inside	☐	☐	☐	☐	☐
7. I accept most aspects of myself	☐	☐	☐	☐	☐
8. I feel great about myself	☐	☐	☐	☐	☐
9. I am highly effective at what I do	☐	☐	☐	☐	☐
10. I feel I am improving	☐	☐	☐	☐	☐
11. I have a purpose	☐	☐	☐	☐	☐
12. What I do in my life is worthwhile	☐	☐	☐	☐	☐
13. What I do is consistent with what I believe I should do	☐	☐	☐	☐	☐

14. I feel close and connected to the people around me	☐	☐	☐	☐	☐

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the Personal Questionnaire (PQ) is an expanded target complaint measure which is individualized for each client. It is generated from the PQ Problem Description Form, completed by the client during the screening process. It intended to be a list of problems that the client wishes to work on in therapy, stated in the client's own words.

Materials

4" x 6" Index Cards
Blank PQ Form (for writing in items)
Problem Description Form (completed)

Procedure

1. Generating Items. The items generated for the PQ should be the most important in the client's view. However, an attempt should be made to include one or two problems from each of the following areas:
   - Symptoms
   - Mood
   - Specific performance/activity (e.g., work)
   - Relationships
   - Self-esteem

   This means that if the client does not list a problem in a particular area, the interviewer should ask the client if s/he has any difficulties in that area that s/he wants to work on in therapy. If, however, the client does not wish to have an item for this area, the researcher does not insist on it.

   This part of the procedure should be thought of as a brainstorming session, generating as many potential items as possible (around 15 is preferable). If the client has difficulty coming up with 10 problems, the interviewer can use other screening measures as sources of possible problems. For example, if the client has completed the SCL-90-R, the interviewer can ask the client about items with "3" or "4" ratings.

2. Refining the PQ items. Next, the interviewer helps the client to clarify his/her items and, if necessary, to rephrase the goals into problems. If necessary, the number of items is reduced to around 10.

- In this part of the procedure, the interviewer begins by writing each problem onto a separate index card, revising it in the process. Refining PQ items is not a mechanical procedure, but requires discussion with the client to make sure that the PQ reflects his/her chief concerns. It takes careful, patient communication to make sure that the PQ items truly reflect the client's experience of what is problematic.

  PQ items should be present problems or difficulties, and should be worded "I feel," "I am," "I can't," "My thinking," and so on. It is useful to think of the list as things the client wants to change through therapy. A good PQ item has the following characteristics:

  - It reflects an area of difficulty, rather than a goal (e.g., "I am too shy" rather than "I want to be more outgoing").
  - It is something that the client wants to work on in therapy.
  - It refers to a specific problem; that is, general, vague problems are specified.
  - It refers to a single problem; that is, items referring to multiple problems (e.g., "I'm uncomfortable around other people and have trouble talking about myself.") are divided up into multiple items.
  - It is in the client's own words, not the interviewer's.
  - It is not redundant with another PQ item.
- After the interviewer writes down the items, s/he then asks the client if anything has been left out, adding further items as needed, until the client feels that the list is complete.
- The interviewer next reviews the items with the client, asking the client to revise or confirm them. If the client has generated more than 10 items, the interviewer asks the client to delete or combine repetitive items. If there are still more than 10 items, the interviewer asks the client is s/he wants to drop any. The interview should not force the client to generate exactly 10 items; but try to obtain 8-12 items where possible.

3. Prioritizing the items. Next, the interviewer asks the client to sort the index cards into order, with the most important concern first, the next most important second, etc. The rank order of the item is written on the card.
4. Rating the PQ. After prioritizing, the interviewer gives the client a blank PQ form and the rank-ordered index cards, and asks the client to use the blank form to rate how much each problem has bothered him/her during the past week. These ratings become the client's initial baseline score for the PQ.
   - 4a. Optional: Duration ratings. In addition, at this first administration of the PQ, the interviewer may want to find out how long each problem has bothered the client at roughly the same level or higher as it does now, using the Personal Questionnaire Duration Form. This can be useful for establishing a retrospective baseline for the PQ.

5. Prepare the PQ. Finally, the interviewer types or writes the PQ items onto a blank PQ form, making at least 10 copies for future use. In doing so, it is a good idea to leave 2 spaces blank for the client to add more items later, in case his/her problems shift over time.

Client ID:

Today's date:

Problem Description Form: Do this one first!

1. Please describe the main problems you are having right now that led you to seek treatment.

2. If you are seeking psychotherapy, please list the specific problems or difficulties that would like assistance with. Please feel free to add to your list as you fill out other forms.

PERSONAL QUESTIONNAIRE

School of Education, Dearing Building, University of Nottingham
Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB

Client ID

Today's date:

Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today.

	Not At All	Very Little	Little	Moderately	Considerably	Very Considerably	Maximum Possible
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7

Additional Problems: 11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Personal Questionnaire Duration Form

Client ID

Today's date:

Instructions: Please rate how long each of your problems has bothered you at roughly the same level (or higher) as it does now.

	less than 1 month	1 - 5 months	6 - 11 months	1 - 2 years	3 - 5 years	6 - 10 years	more than 10 years
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7

5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Unconditional Positive Self-Regard Scale (UPSR Scale)

Section 2: *Below is a list of statements dealing with your general feelings about yourself. Please, respond to each statement by circling your answer using the scale "1 = Strongly Disagree" to "5 = Strongly Agree".*

		Strongly Disagree	**Disagree**	**Unsure**	**Agree**	**Strongly Agree**
1	I truly like myself.	1	2	3	4	5
2	Whether other people criticise me or praise me makes no real difference to the way I feel about myself.	1	2	3	4	5

3	There are certain things I like about myself and there are other things I don't like.	1	2	3	4	5
4	I feel that I appreciate myself as a person.	1	2	3	4	5
5	Some things I do make me feel good about myself whereas other things I do cause me to be critical of myself.	1	2	3	4	5
6	How I feel towards myself is not dependent on how others feel towards me.	1	2	3	4	5
7	I have a lot of respect for myself.	1	2	3	4	5
8	I feel deep affection for myself.	1	2	3	4	5
9	I treat myself in a warm and friendly way.	1	2	3	4	5
10	I don't think that anything I say or do really changes the way I feel about myself.	1	2	3	4	5
11	I really value myself.	1	2	3	4	5
12	Whether other people are openly appreciative of me or openly critical of me, it does not really change how I feel about myself.	1	2	3	4	5

Scoring Key for the UPSR Scale*:

Strongly Disagree = 1

Disagree = 2

Unsure = 3

Agree = 4

Strongly Agree = 5

School of Education, Dearing Building, University of Nottingham
Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB

*Items 3 & 5 are reverse scored.

Scores on the total scale have a possible range of 12 to 60, and a possible range of 6 to 30 on each of the two subscales. On the 'Self-Regard' subscale, high scores indicate presence of positive self-regard while low scores indicate absence of positive self-regard. On the 'Conditionality' subscale, high scores indicate *unconditionality* of self-regard, while low scores indicate *conditionality* of self-regard.

Subscales:

Items 1 + 4 + 7 + 8 + 9 +11 = Self-Regard Subscale

Items 2 + 3 + 5 + 6 + 10 + 12 = Conditionality Subscale

Reference:

Patterson, T. G., & Joseph, S. (2006). Development of a measure of unconditional positive self-regard. *Psychology and Psychotherapy: Theory, Research, and Practice* (in press).

Correspondence to:

t.patterson@nhs.net or thomas_pattersonuk@yahoo.co.uk

Guidance for recording and submitting ‘remote’ sessions

This guidance is a response to the necessity of offering online and telephone counselling due to the pandemic.

We accept both online and telephone counselling as valid for submission for your PCE-CfD license. There are a few points that are vitally important to observe, these are:

- Even if you are offering online counselling on a platform such as Zoom, only audio recording is acceptable. It is vitally important that we protect clients ‘privacy as much as this assessment process allows. However, we appreciate that it may not always be possible to convert a video to audio file for submission. It is essential that you have secured the appropriate level of client consent for submitting video recordings for assessment.
- The audio recordings are sufficiently clear and audible.
- That the same process of consent for being recorded face to face is undertaken for telephone or online counselling.

Submissions of Video and Audio Assessment via Moodle

All assessments can now be uploaded to the University of Nottingham’s secure intranet, ***Moodle***.

While we would prefer audio recordings of counselling sessions with NHS clients, from September 2023 we will accept online recordings where we can see the client and therapist. It is the therapist’s and their Service lead’s responsibility to ensure that the appropriate consent is sought from clients to submit and upload video recordings to Moodle.

Once you have been registered online and have received your associate username and password you can log on to Moodle.

https://www.nottingham.ac.uk/studentservices/services/moodle.aspx

There is also a Moodle App that you can download.

The PCE-CfD Moodle page lists the learning modules related to the course curriculum. Modules 9 and 10 have the facility for you to upload the recording learning experience for assessment and the 4-6 audio submissions respectively.

Moodle provides instructions and help pages to take you through the process of uploading your media assignments.

You can get help and support by emailing: itservicedesk@nottingham.ac.uk

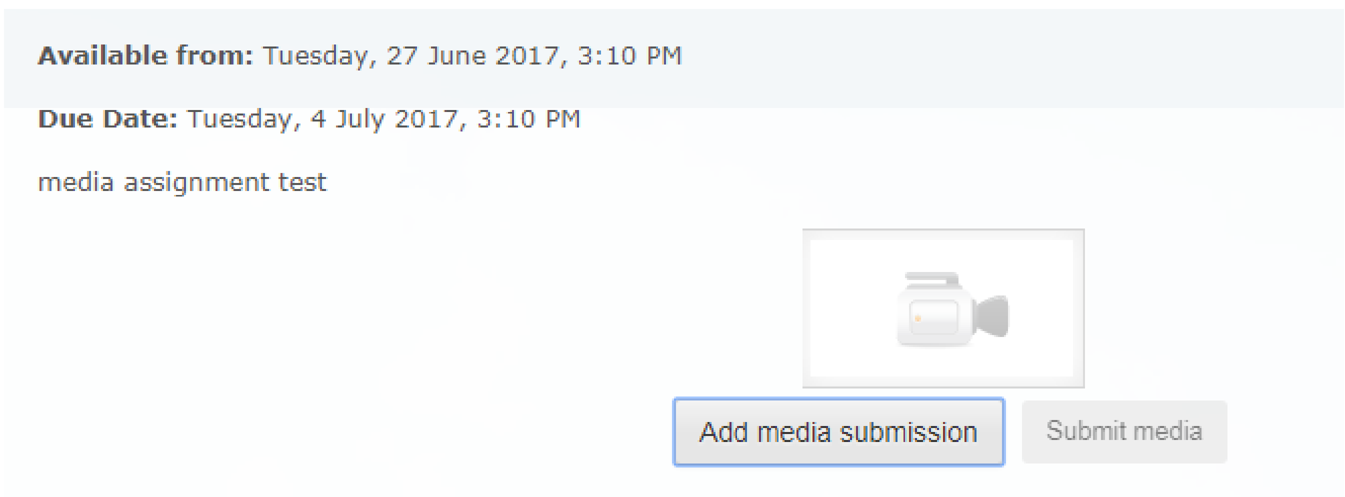
There are also tutorials on Moodle: http://workspace.nottingham.ac.uk/display/StudentMoodle/How+to+submit+a+Media+Assignment

An example of a relevant help page is copied below…

Students create and submit their Media Assignment submissions as follows:

- Log into Moodle, go to your module, and click on the **Media Assignment** to enter it.

You can upload a **Video** or **Audio** file.

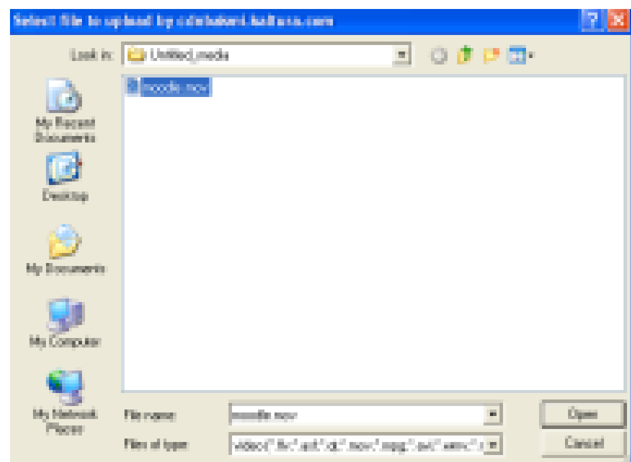


- Click **Add media submission**

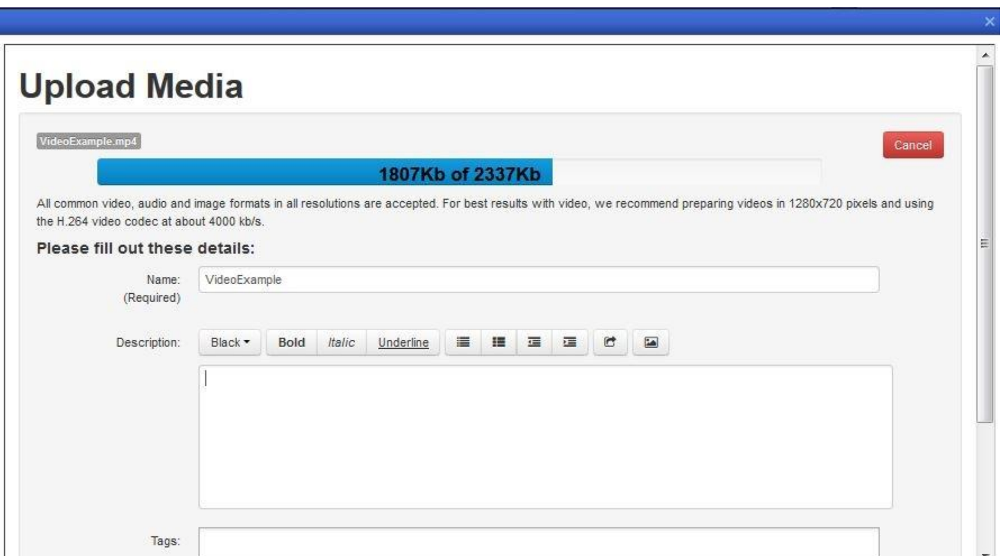
To upload a media file (or embed media you uploaded earlier)

- From the **Add New** dropdown menu (top right of next screen), select **Media Upload**

- In the resulting window, click on '**+ Choose a file to upload**' and Select a media file from your computer to upload. The system accepts all common video and audio file formats.



As the file uploads, you will see a progress bar like this one:



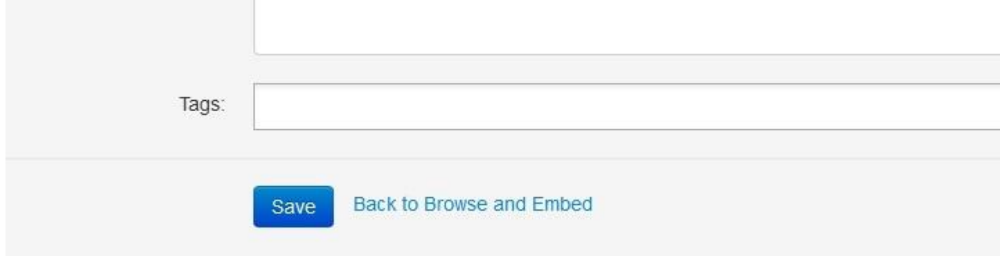
- While the file is uploading, enter a **Name, description** and any search **Tags** for the video and click **Save**. These additions will make the video easier to find in media Space but will NOT appear in the Media Assignment. Do not use for appending notes to your tutor.

PLEASE NOTE: Uploading large video files can take a long time depending on the current available network bandwidth, so please be patient. We recommend that you upload large videos at a time when there are less people using the network.

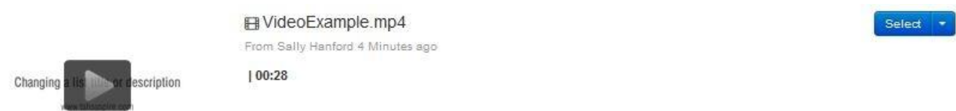
If it says "No Source video was found - entry in process" do not worry, it is still processing.

Do not navigate away from the page until the upload is complete, or your upload will be cancelled.

- When the upload is finished, click on the **Back to Browse and Embed** hyperlink.
- **DO NOT JUST CLICK SAVE**. YOU MUST FOLLOW THE INSTRUCTIONS to click on the **Back to Browse and embed** hyperlink.



- Click on the **Select** button to the right of the media to upload it to your assignment. You can also use this method to add media that you uploaded earlier.



- Optionally, you can set the frame size. The default size is Medium. Click the down arrow next to Select to change it - do not click Select.

After the media is uploaded, it is converted for optimal playback. You cannot preview or publish the media if it is still converting.

- Click **Submit media** (or if you need to, **Replace media** and go through the steps again))

Once submitted, you will see a confirmation screen with the following text:

If you do not see this screen please perform the steps again

Please discuss feedback from your end of course recording with your supervisor. Each subsequent recording you submit will receive written feedback. Each recording needs to be from different clients and at different stages of therapy. It is advisable to await that feedback and discuss it with your PCE-CfD supervisor before submitting another recording. You need 4 client tapes to reach adherence to PCEPS to gain the PCE-CfD License. You have 6 opportunities to submit recordings. Generally we try and send feedback within 6 weeks of receiving the data stick - this is to take in to account staff leave, term times etc. All the marking is undertaken by Emma and Kate, with marginal fails independently double marked.

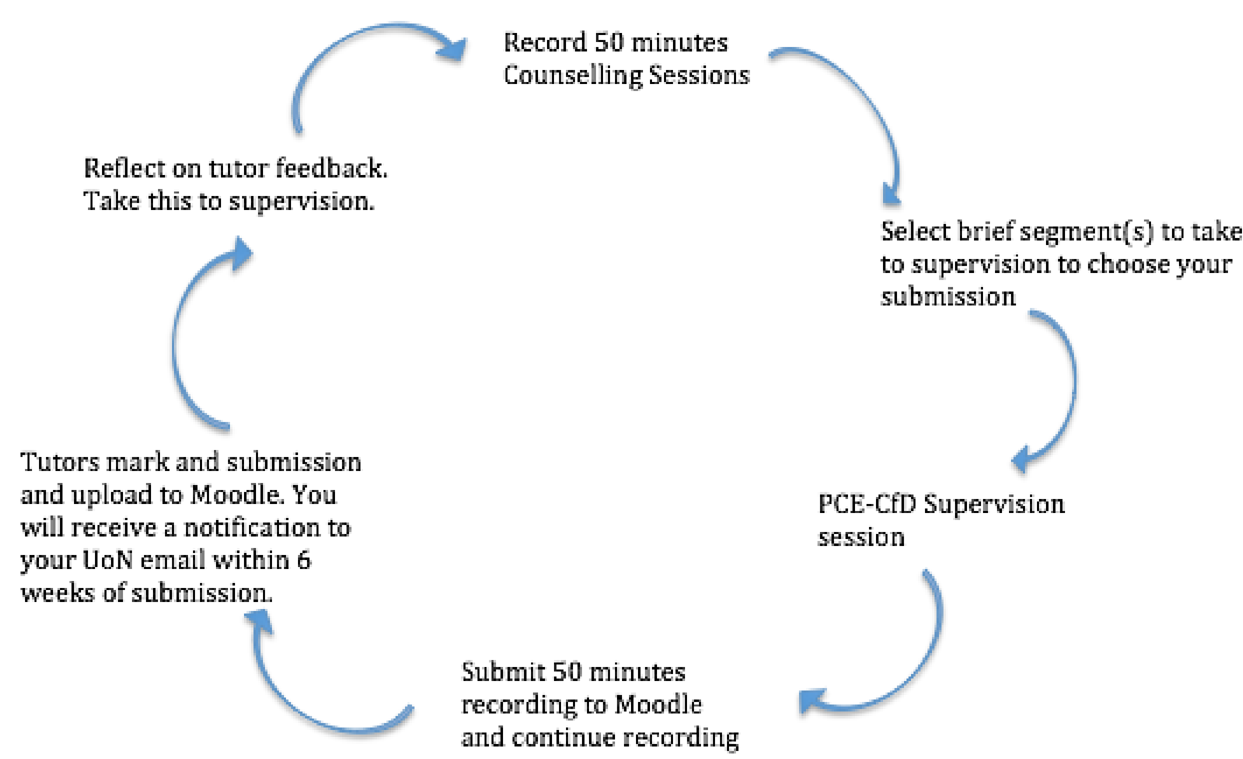
Deadlines and submissions

Summary

- **The course deadline is 18 months from the start date of your course, with the possibility of extension, not exceeding 36 months.**
- **You need to have reached adherence on 4 submissions, and you have 6 opportunities to submit.**
- **Each submission must be an audio recording at least 50 minutes long.**
- **You will receive your feedback within 6 weeks of submitting it.**
- **You can have between 4 and 8 PCE-CfD supervisions.**

All of the above is outlined in more detail in the Course Handbook and on your Moodle page. The *counseling, supervision, submission cycle* below provides a sense of the programme as a cyclical and formative learning process. The *Submission Table* is intended only as a guide. It is more than possible to complete earlier than the schedule suggests.

Counselling, Supervision and Submissions Cycle



To ensure that you have sufficient time to have all six recordings assessed you need to submit one recording around every 8 weeks. This is to accommodate all the processes in the cycle above, that is:- recording sessions with your clients, selecting a segment(s) to take to supervision, submitting a recording to Moodle, waiting for tutor assessment, reflecting on tutor feedback to take to supervision, and to inform practice with clients, who you record, selecting from these recordings to take to supervision.

Counselling, Supervision and Submissions Cycle

To ensure that you have sufficient time to have all six recordings assessed you need to submit one recording around every 8 weeks. This is to accommodate all the processes in the cycle above, that is:- recording sessions with your clients, selecting a segment(s) to take to supervision, submitting a recording to Moodle, waiting for tutor assessment, reflecting on tutor feedback to take to supervision, and to inform practice with clients, who you record, selecting from these recordings to take to supervision.

Month 1: Start recording sessions. Make contact with supervisor. Select recording to take to supervision, along with your assessment feedback. Supervision (1) Date:	**Month 2:** Submit 1st Recording for Assessment Submission date**:** PCEPs score:	**Month 3:** Tutors receive a notification of your submission. Tutors will listen to the recording and provide written feedback with a PCEP score. This can take up to 6 weeks.	**Month 4:** Take new recording and assessment feedback to supervision Supervision (2) date:
Month 5: Submit 2nd recording for assessment Submission date:	**Month 6:** Take new recording and assessment feedback to supervision Supervision (3) date:	**Month 7:** Tutors receive a notification of your submission. Tutors will listen to the recording and provide written feedback with a PCEP score.	**Month 8:**Submit 3rd Recording for assessment Submission date:

PCEPs score:		This can take up to 6 weeks.	PCEPs score:
Month 9: Take new recording and assessment feedback to supervision Supervision (4) date:	**Month 10:** Submit **4th** recording for assessment Submission date PCEPs score:	**Month 11:** Tutors receive a notification of your submission. Tutors will listen to the recording and provide written feedback with a PCEP score. This can take up to 6 weeks.	**Month 12:** Take new recording and assessment feedback to supervision Supervision (5) date:
Month 13: Submit 5th* recording for assessment Submission date PCEPs score:	**Month 14:** Take new recording and assessment feedback to supervision Supervision (6) date	**Month 15:** Tutors receive a notification of your submission. Tutors will listen to the recording and provide written feedback with a PCEP score. This can take up to 6 weeks.	**Month 16:** Submit 6th* recording for assessment Submission date PCEPs score:

You can have up to 8 supervision sessions if you require it.

Submit logs and supervisor's report when you reach adherence for 4th recording.

Consider making an extension request if you haven't yet submitted 4 recordings

Deadlines, Extensions and Extenuating Circumstances Policy

To gain the PCE-CfD license delegates need to be assessed as adherent on four, out of a possible six, recordings.

This needs to be achieved within **18 months** of the course start date.

If you require an extension beyond the 18 month deadline you need to apply for an extension by completing the extension form (see below) and emailing it to tt-pce-cfd@exmail.nottingham.ac.uk. You will need to provide some evidence to support your extension request.

Criteria to Support Extensions Request

For a **6-month extension** to be awarded PCE-CfD delegates have to provide evidence of at least three of the criteria below:

- Ongoing attendance of the PCE-CfD (course) supervision sessions
- Evidence of being employed, or, self-employed to practice counselling
- Professional Indemnity Insurance
- Evidence of adhering to an ethical guideline (BACP, UKPCE etc)

Feedback for submissions during the extension period will be **pass/fail** assessments. This means there will not be a specific mark and there will be no written tutor feedback.

The School reserves the right, in light of exceptional and unforeseen circumstances (for example family bereavement or serious illness) to grant an extension beyond 6 months.
In all instances delegates are encouraged to contact the course tutors for advice and support.

It is possible to apply for a maximum of three extensions in total over the life of the programme. **There are no available extensions beyond 36 months of the course start date.**

If you did want to continue beyond 36 months you would need to re-apply to the programme again, and attend the taught element again, with new funding attached.

If you think that you might need additional time before the 18-month deadline you could consider a **Voluntary Interruption of Study (VIS)**. If you apply for a VIS (See for below) this can be up to 12

months long. After that time you can re-engage with the programme. As with the extension, a VIS does not extend the course beyond the 36 months from the start date of your course.

Interrupting your study on this course

Delegates on the PCE-CfD course may, for a variety of reasons, want or need to interrupt their studies – taking a break from the course to pick up at a later date. We have a process managing these requests and for their approval. There is also defined limits to the duration of an interruption (and cumulative total of multiple interruptions).

A delegate who interrupts their study will not receive any academic input, access online resources such as Moodle or take any assessments for the duration of the interruption.

If the period of interruption, or cumulative total of multiple interruptions, exceeds the maximum agreed then participation on the course will cease.

Process

1. Delegates should make any request to interrupt their studies in writing to the PCE-CfD tutors on cfd-tutors@nottingham.ac.uk. It is for the PCE-CfD team to decide whether to agree to the interruption of study. The tutor team will follow the guidance below. Requests to interrupt must be made in advance of the interruption. Retrospective requests to interruptions of study will only be granted in exceptional circumstances.
2. The PCE-CfD team may request supporting evidence (for instance a letter from the delegate's clinical or PCE-CfD supervisor) before agreeing to an interruption.
3. Tutors will confirm the decision to the delegate in writing, with either a rationale (if declined) or a deadline for return to study (if agreed).
4. To return to study the delegate should contact the PCE-CfD team to confirm return to study.

Criteria for agreeing or declining requests to interrupt studies

The decision to *agree* to an interruption request is based on at least one of the following specific criteria:

- Is the interruption inevitable due to unforeseen and exceptional circumstances. For example, injury, illness or unavoidable family commitments?
- Is there loss or interruption of the employment required to gain recordings for assessment?
- Are there other circumstances which will impact on the delegate's personal capacity to pursue study?
- The decision to *decline* an interruption request may be based on one of the following specific criteria:
- Will it be still possible for the student to complete their studies within the maximum 36-month period?
- Is this a second or further request which will take the maximum period of interruption requested over 12 months?

Agreeing the duration of interruption

An interruption should, wherever possible, be for an agreed defined period. Where it is not viable to designate a date of return to studies, the PCE-CfD team may confirm that interruption is for an indefinite period and set a date for further review and confirmation of return date. A return date should be agreed as soon as possible.

Maximum total duration of interruption and maximum period of study from start of course

The standard duration for the PCE-CfD course is 18 months. The maximum period of study in which delegates must complete the course is 36 months from the start of the face-to-face element of the course.

The maximum duration of an individual interruption, or cumulative total of multiple interruptions, is 12 months.

Returning to study

On or before the end of the agreed interruption period, the delegate should contact the PCE-CfD team contacting about returning to study and their readiness to return. If, by the due date of return, no contact has been made with the PCE-CfD team, the PCE-CfD team will contact the delegate to request confirmation of return or, if possible, query whether the delegate wishes to extend their period of interruption. This would be managed as a new request to interrupt studies and would follow the normal process and decision criteria.

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Extension Request Form for PCE-CfD Delegates

- This form is to request an extension to your submissions deadline
- Your course deadline is one year post your 30 hour PCE-CfD training
- We allow a three month extension

Student Details

Full name	
Month and year course attended	
Number of recordings submitted so far	

Evidence to supply (three out of the following):

- **Appointment with PCE-CfD Supervisor (email will do)**
- **Membership of a professional body**
- **Professional Indemnity Insurance**
- **Employment or self-employment as a counsellor**

Declaration

I confirm that I wish to complete my PCE-CfD qualification

Signature…………………………………………………………………..……………………… Date…………………………………

Please submit signed form to tt-pce-cfd@exmail.nottingham.ac.uk..

- **We will contact you with a revised deadline within three weeks of receipt.**
- **In the meantime please continue with any recordings and with supervision.**

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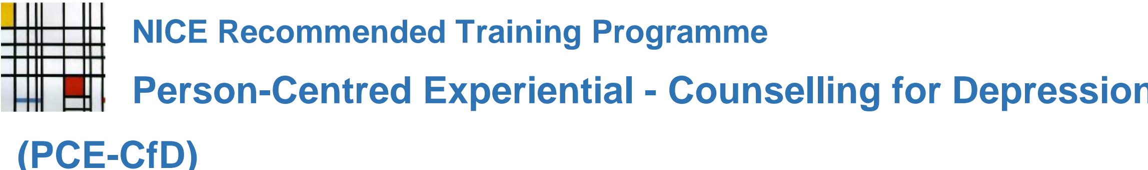
Please check the PCE-CfD website for any refresher days that may support you with completion.

- **e will contact you with a revised deadline within three weeks of receipt.**
- **In the meantime please continue with any recordings and with supervision.**

Please check the PCE-CfD website for any refresher days that may support you with completion.

Logs and Report



NICE Recommended Training Programme

Person-Centred Experiential - Counselling for Depression (PCE-CfD)

Client Log, Supervision Log and Report

This document includes:

1. Supervision log, individual and/or group
2. 80-hour client log
3. Supervisor's report

Supervisee's name:	
Start date of the course:	
Supervisor's name:	
Supervisor's address:	
Supervisor's telephone:	
Supervisor's email:	

In order to evidence that the requirements for successful completion of the full licence has been met, both the Supervisee/delegate and PCE-CfD Supervisor need to complete and sign this form. The **delegate** must then **upload the completed and signed form to moodle. Please see below:**

- If you are unable to provide a signature, digitally, scanned, or otherwise, please type in your name(s) in the space provided at the bottom of this document. In this instance the supervisee needs to email this signed and completed document to their supervisor copying in tt-pce-cfd@nottingham.ac.uk. The supervisor's response to that email, acts as confirmation of the

signatures. **You do not need to email this document to the university. The delegate needs to upload the document to Moodle**.

- Once the document is completed and signed the **delegate needs to upload this to Moodle.** It is ok to upload to any of the submission spaces for supervision documents, which you will find under Topic 12, or 13, depending on your cohort.
- Submitting the document on Moodle sends automatic email to tutors and to PCE-CfD administration. Tutors will review the paperwork and if satisfactory the PCE-CfD administration will email the delegate/supervisee their certificate copying in the tutors and the supervisor. This way all parties will be informed of the successful completion of the programme.

1. Supervision log, individual and/or group

INDIVIDUAL SUPERVISION

Number of Supervision sessions	Date of session	Length of session
1		
2		
3		
4		
5		
6		
7		
8		
Total no hours		

GROUP SUPERVISION

Number of Supervision sessions	Date of session	Length of session
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
Total no hours		

INDIVIDUAL SUPERVISION
Supervisees must complete a minimum of 4 one-hour PCE-CfD supervision sessions and may have up to a maximum of 8.

GROUP SUPERVISION
Each 2-hour PCE-CfD group supervision of 4 supervisees, counts as 30 minutes. This means that supervisee must complete a minimum of 8 group supervisions and a maximum of 16 group supervisions.

While we would like supervisees to choose if they have either 1-1 or group supervision, or a mix, this is dependent on availability

Individual Total Hours	
Group Total Hours	
TOTAL	

2. 80-hour client log

for supervised practice period

Number	Date	Length of client session	Session no with client	Client ID
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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80				

Total number of hours [ ]

Sheet summary:

3. Supervisor's report

for the supervised practice period

The PCE-CfD supervisor and supervisee should complete this form together when the 80-hours PCE-CfD supervised practice period is complete.

Total 1-1 supervision hours		No. of recordings submitted	
Total group supervision hours			
Supervision hours in Total		No. of recordings reaching adherence	
Total Client hours			

Supervisor comments

Please comment on the supervisee's adherence to the PCE-CfD model:

Please comment on the supervisee's general reliability, attendance, and punctuality:

Please comment on the supervisee's openness and willingness to engage in the supervisory process:

Any other comments from the supervisor:

Signatures

Supervisee's signature:	Date:

Supervisor's signature:	Date:

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Guidance on consent for recording counselling sessions

Guidance on consent to audio recording of IAPT PCE- CfD Therapy Sessions (example)

Purpose of recordings

Your therapist has recently undertaken training in the IAPT Person-Centered Experiential Counselling for Depression (PCE-CfD) modality (a 30 hour Continued Professional Development activity for existing experienced and qualified practitioners working in a healthcare setting). Your consent is sought to record therapy sessions for the purposes of assessing the therapist's adherence to the PCE-CfD competences. The recordings form a part of the therapist's final assessment for certification as a PCE-CfD Counsellor.

Access to recordings

The assessor will listen to the recording and mark the therapist for therapy adherence. Recordings will not be accessed by any third party. Neither the University nor the assessor have access to any identifying information about the client.

Ownership of recordings

The anonymised recordings become the property of UoN and their sole purpose will be for the assessment of therapist competence.

Protecting confidentiality

The recordings should be anonymised by the therapist and care should be taken to ensure that they do not contain any information that may identify the client.

Data Protection

Clients should be given time between sessions to consider the request to record, prior to giving consent. Clients also have the right to withdraw consent prior to the recording being sent.

For further information on recording sessions of counselling/psychotherapy, please refer to **BACP INFORMATION SHEET G14**. This is available to BACP members at the web link below (non-members should email bacp@bacp.co.uk).
http://wam.bacp.co.uk/wam/login.aspx?redirect=http://www.bacp.co.uk/information/index.php

Consent form for recording counselling sessions (example)

Therapist name:

Contact details:

Client reference:

- I (the client) consent to my therapy sessions being recorded for the specific purpose described in the guidance above, made by any means of video and/or audio recording. The purpose of recording these sessions has been fully explained to me by the therapist and I consent to this recording for that purpose. My consent is given with regard to the therapist's training, following their 30 hour Continued Professional Development activity in the IAPT PCE-CfD modality.

- I agree that there is to be no financial reward to me for the use of the recordings. I also understand that I will not be penalised in any way if I do not wish a particular session to be recorded. I understand that I may ask for the recording to stop or be erased at any time during my sessions. Therefore, my consent in this matter is given freely and willingly.

- I understand that I may request to access the recording with the therapist before it is sent. I further understand that I may ask for the recording to be destroyed prior to its dispatch. If I choose to request this, I will present a written statement to this effect to the therapist within five days following my access to the recording.

- I permit the therapist named above to use the recordings of my sessions for the training assessment purposes described.

- I hereby give up my rights to any interests that I may have in the recordings once they have been sent.

Client signature: Date

- I (the therapist) have discussed the issues above with the client. I have no reason to believe that my client is not fully competent to give their informed and willing consent.

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Therapist signature:		Date	

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