EDI Informed PCE-CfD Practice: Curriculum and CPD opportunities

Person-Centred Experiential Counselling for Depression is a growth model, situated within a medical context as a high intensity manual, within NHS Talking Therapies. Offering PCE therapy through the NHS increases accessibility to counselling which hopes to "*serve and reflect … diverse patients, people and communities"*.[1] PCE-CfD and NHS share the belief that well-being should be accessible to all. To support this shared commitment the PCE-CfD team at the UoN is developing an Equality Diversity and Inclusion (EDI) informed curriculum, including the offer of additional Continuing Professional Development (CPD) for NHS Talking Therapy Counsellors.

The Curriculum

Our Course Handbook offers some insight into what this might look like in practice. The curriculum retains the original IAPT course content, reassembled and situated within the contemporary context of Social and Climate Justice issues, and rationalised in to 5 broad themes. This year we are creating resources that are more diverse and inclusive to support equity and belonging. We will continue to review and update the curriculum whilst ensuring fidelity to the manual. The PCE approach understands that our environment and relationships facilitate or limit our capacity to flourish. ***Whatever our social location our experiential processing of lived experience is always situated in a larger socio-cultural context.*** In Person-Centred terms there are always Societal (or Situational) Conditions of Worth present. Elaborating how the PCE approach and EDI are related enhances our understanding of both enabling competent and ethical practice.

Continuing Professional Development (CPD)

The planned CPD event(s) will focus on developing clinical competence for encountering Social Justice Issues, such as, racism, and heteronormativity, therapeutically through EDI informed PCE practice. ***The aim is to become more congruent, empathic and accepting towards our own and our client's experiencing of intersecting identities, privileges and oppressions, and how this plays out in the therapeutic relationship***. Expanding therapist's

congruence in this way encourages therapist's cultural humility, comfort and ability to broach and respond to *cultural opportunities*[2] skilfully as they emerge in the relationship. These attitudes have been shown to be vital for working with socially marginalised experience, oppression, difference and diversity.

It is the therapist's own congruence of their social location and intersecting identities that is the initial locus for this training. ***A willingness to know ourselves is essential for a willingness to know the other, and for them to know us.*** This is how mutuality is developed in the therapeutic relationship. Co-creating empathy empowers the client to have a renewed sense of their relational efficacy, a sense of self that can shift the *stuckness* of depression. It involves the meta-competencies identified in the competency framework[3] that inform the PCE-CfD manual.

Research consistently demonstrates the importance of mutuality, in the therapeutic relationship for good client outcomes.[4] ***Mutuality is limited when client's keep 'difficult' experiences out of the relationship.*** These experiences are often about the client's experience of the relationship, how they think the therapist sees them. Research shows that clients will often keep 'marginalised' experiences out of the therapeutic relationship rather than risking being misunderstood. This strongly suggests that an increased sensitivity and awareness of implicit EDI and SJIs are essential for good client outcomes. It also implies the potential for harm if we do not have this 'situated sensitivity' as therapists.

In summary, the conceptual framework that is being formulated here is an integration of the most up to date PCE research, with Multi-Cultural Counselling Competencies (MCCC), such as the Multi-Cultural Orientation Framework (MCO) and the Multi-Dimensional Model of Broaching Behaviour (MMBB)[5] for the purpose of EDI.

Four *'Situations'* - The Self, The Client/Other, The Relationship, The Context

Learning experiences for therapists are organised around encountering the self, the client and the therapeutic relationship as situated experiential processes, as a reflexive praxis. PCE learning is understood to be transformative at the level of the self and this is key in developing authentic relational, embodied and ethical MCCC. ***These competencies can be***

mapped on to the PCEPS to articulate EDI informed practice that is not just compatible but enhances PCE-CfD practice and adherence. The 6 necessary and sufficient conditions for therapeutic change, outlined by Carl Rogers in 1957, fundamental to adherence on the PCEPs.[6] within which EDI is implicit.

<table>
<tr><th colspan="3">PCE-CfD EDI INFORMED PRACTICE</th><th>Broaching Styles</th></tr>
<tr><th>Who</th><th>Task</th><th>MCO</th><th>MBB</th></tr>
<tr><td>Self</td><td>Understanding our own social location, privileges and oppressions.</td><td rowspan="3">Cultural humility

Cultural skill

Cultural comfort</td><td rowspan="3">1.Avoidant
2. Isolating
3.Continuing - Incongruent
4. Integrated - incongruent
5. Infusing</td></tr>
<tr><td>Client</td><td>Understanding our client's worldview and their intersecting multiple identities.</td></tr>
<tr><td>Relation ship</td><td>Developing mutuality in the relationship; working relationally and experiential with EDI and SJIs</td></tr>
<tr><td>Context</td><td colspan="3">Understanding social, historical and material factors as situated experiential process, within and between clients and therapists intersecting frame of references. Including the context of the counselling relationship itself.</td></tr>
</table>

<u>Background and Context</u>

It is not possible to do justice here to all the social injustices and intersecting climate crisis that continue to proliferate and amplify social and mental health inequities. Grenfell, George Floyd, the Windrush scandal, the Hostile Environment, Child Q, to name just a few of the contemporary social injustices related to racism. Movements such as, Black Lives Matter and Me Too, are contemporary demands for social justice. Injustices that have their roots in historic systems of power that still structure our world today. Whilst this destructive impact is unevenly distributed along the lines of race, class, gender, sexuality, disability and so on we are all implicated by it in some way. This context disrupts '*business as usual' bolted-on* approaches to the EDI and MCCC in counselling practice and education, making it central to our way being, theory, and practice.

These social injustices and the attendant inequities in wellbeing proliferate in concert with the EDI strategies to address them. This association between the two is a paradox that invites us to think freshly to understand how well-being and EDI intersect with one another and the wider context they are situated in. Whilst there is a decrease in stigma around mental health there has been an increase in reported mental distress. It is also true that reported incidents of mental distress are higher for people who experience multiple social and economic disadvantages.[7] All of which suggests that the structural issues related to EDI, the context that our wellbeing is situated within, are not being sufficiently accounted for in relation to our capacity to flourish. This paradox is reflected in NHS England's intentions towards EDI that

> "Referral pathways have been specifically developed to promote access and equality." NHS England: 2022[8]

Whereas the 2022 NHS Digital[9] report found that race is a significant barrier to accessing counselling. If you are from a racial and ethnic minority background you are more likely to be referred through the criminal justice system, far less likely to see a therapist from your own background or enjoy the same degree of positive outcomes as white clients. This is at odds with the NHS's earnest objective to be a universal service for a diverse community demanding that…

> "*The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms"* NHS people plan 2022[10]

At the same time the NHS' 2022 Race and Health Observatory review reports there are

> "…clear barriers to seeking help for mental health problems rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare." [11]

The world of counselling and counselling education does not fare much better in terms of the discrepancy between Multi-Cultural Competency (MCC) and EDI intentions. Racially and ethnically minoritized students report that when EDI and Race is 'bolted on' to counselling curriculum it serves to both re-centre whiteness and create the emotional labour of educating white peers and tutors. This isn't about a deficit of good intentions but a deficit of learning opportunities. White therapists report that meaningful learning about white privilege and racism occurred outside of training and instead happened on their placements, in supervision, the workplace and serendipitous encounters.[12]

Leaving this learning to chance is even more problematic when you consider that black academics and therapists are underrepresented. This has at least three damaging consequences that compound one another; firstly, the toll this takes on racially and ethnically minoristised therapists and academics sense of belonging; secondly, if you are white, you are less likely to become aware of your white privilege; and thirdly white experience will continue to inform and dominate the curriculum. Dominant experience, such as whiteness, ableism, heteronormativity, in general does not see itself. This is why the first step of EDI is to disrupt and decentre it, though developing awareness of our privileges and oppressions. This can be supported through experiential practices that deepen our self-awareness. This in turn can be supported through an increased awareness about how SJI intersect with wellbeing.

The World Health Organisation (WHO) reports that Covid saw a 25% increase in reported anxiety and depression.[13] This increase intersects with geographical location, for example, NHS data reveals that 1 in 3 adults in Nottingham were prescribed SSRIs in 2022, the 3rd highest in the country.[14] Implicit in geographical location are multiple issues related to race, class, gender, ableism and age, that intersect to increase the likelihood of depression and limit our capacity to flourish. These disparities have a long history and are often intergenerational. Social mobility, health and life expectancy are in reverse in some parts of England for some people. If you live in a more affluent area of the UK you can expect to live 19-years longer. Research also show how the least affluent areas of the uk also suffer the worst air quality and pollution with devastating consequences for our quality of life.[15]

At the time of writing the Centre for Mental Health have released a report recommending that government policies, such as Austerity and the Hostile Environment, should factor in the cost of mental distress as a moral and socio-economic issue[16]. This all describes how contemporary universal ideals that inform EDI and wellbeing agendas are re-structured by larger systemic inequalities that are often institutional and historic. Little wonder that this manifests as mistrust of services at an embodied level acting as a barrier to accessing the very services that hope to help. In this context MCC and EDI can no longer be treated as a peripheral concern for counselling education and practice. Dr Habib Naqvi the Director of the NHS' Race and Health Observatory offers this powerful statement that demands action in the face of the overwhelming avalanche of evidence of health inequities related to race and ethnicity,

> *"This report is the first of its kind to analyse the overwhelming evidence of ethnic health inequality through the lens of racism. A process that, until recently, our leaders have shied away from. I believe, however, that we are living through a time of change, where racism and racial inequality are on the agenda like never before for leaders in our health service. This report should be a tool for them; highlighting the best quality evidence across our priority areas, and making concrete recommendations for change. There is no excuse for inaction."* Rapid Review, 2022[17]

The PCE-CfD team's Frame of Reference

The PCE-CfD team, supported by the School of Education's EDI strategy[18] is committed to an authentic exploration of what this all means for the curriculum. As a team we are committed to working with the tension of intentionally encountering EDI and then disrupting the unintended consequences that often befall these actions. This requires understanding EDI work as an ongoing process as opposed to a series of discrete events and solutions. We want to support NHS Talking Therapies in its aim to offer an equitable, inclusive service to diverse clients, who often face the most oppression and marginalisation. Being in the business of wellbeing this context has prompted a lot of soul searching within the counselling profession as the inequality 'out there' is most often reflected in the therapeutic encounter. How can it not when it is all around us, literally in the air that we breath? Taking

these concrete steps of infusing the curriculum with an EDI lens is a way of recognising our privileges and response-ability as a training provider.

My Own Frame of Reference

I realise that all this *bad news* is pretty depressing from a therapist who is meant to be skilful in working with depression and facilitating growth! It is a therapeutic cliché to say 'trust the process', but it is only through *leaning-in* to this difficult space that paths towards growth through social justice action are implied. This is the paradox at the heart of therapeutic change; i.e. authentic transformation happens when you fully become who and what you are experiencing. In PCE theory 'who you are' changes in response to internal and external environments. This understanding offers me the potential Unconditional Positive Self-Regard[19] needed to ask myself:

> "How am I implicated as a PCE therapist, researcher and educator in perpetuating the status quo e.g. racism?"
>
> "How do my privileges and oppressions as a white, working-class, cis-woman intersect towards social (in)justice practices?"
>
> "What is my response-ability towards social justice and EDI?"
>
> "How can PCE therapeutic and learning relationships encounter these large macro themes that are 'out there'?"
>
> "How do we maintain the uniqueness of the individual and the freedom of the approach when addressing historical, contemporary, environmental, structural and systemic issues?"

While I don't have the answers, I know that asking the questions is an ethical imperative. One thing that I have learnt so far is that intentionally *leaning-in* to gain a more congruent awareness of my own privileges and oppressions, that is to *situate* myself, this is the first step in a creative embodied process. I have learned that this '*situatedness'* is both unique to me and structural. The latter implies I have no choice in having some response-ability for this situation, the former that I can perceive this and choose to act. Appreciating that my frame of reference is partial and situated helped me to develop an embodied sensitivity of this *situatedness*. I hope as a result this will enable me to offer more congruent empathy and

embody cultural humility. The radical approach proposed here is challenging as a tutor as it questions not just what is learnt and how, it also examines the social locations of who is delivering the learning experience. Being open to this scrutiny in the learning context offers mutuality that we know is ethical and transformative in the therapeutic relationship.

This makes me aware of the tension around being a white academic and therapist writing about race and centring whiteness by default. However, I am sure that not writing about this to avoid 'getting it wrong' is not an ethical option. It would be an exercise in privilege in even imagining I could 'opt out' of this responsibility. Regulating away from the risk of feeling incompetent, guilty or ashamed is what white fragility describes. If I am experiencing white fragility, I am protecting myself from how I might be implicated in a racist structure that privileges me. This incongruent way of relating to the self and other does great harm manifesting as microaggressions and creating a constant disavowal of oppressive and traumatic experiences of racism.

> "Prevailing counselling psychology training … will serve to perpetuate this trend so long as they condone a human "sameness" perspective that ultimately presents multiculturalism as an "add-on." Cross and Reinhardt 2017: 731 [20]

Hearing from you

I welcome hearing your thoughts about the ideas and issues written here, particularly to give voice to what I can't know because it is not in my lived experience. Audre Lorde argued, with such grace and power, that we must learn to encounter difference and even each other's anger as a creative process that unifies without erasure.

> "Difference must not be merely tolerated but seen as a fund of necessary polarities between which our creativity can spark like a dialect." Audre Lorde 1982:18[21]

Emma Tickle 26th September 2023

I am currently undertaking PhD research exploring PCE as a Social Justice resource and how in turn a Social Justice lens reveals more about the approach. If you are interested in collaborating in some way please get in touch.

I look forward to hearing from you.

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[8] NHS England » NHS equality, diversity, and inclusion improvement plan **Date published**: 8 June, 2023: **Date last updated**: 8 June, 2023

[9] NHS England » NHS equality, diversity, and inclusion improvement plan **Date published**: 8 June, 2023: **Date last updated**: 8 June, 2023

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[10] Psychological Therapies: reports on the use of IAPT services, England, January 2022 Final including a report on the IAPT Employment Advisers pilot - NHS Digital

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[12] Major Contribution – Project White Allies The Counselling Psychologist 2017,Vol.45(5)

[13] COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide (who.int)

[14]Office for Health Improvement and Disparities Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk).

COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide (who.int)

[15] Dirty air affects 97% of UK homes, data shows | Air pollution | The Guardian

[16] A mentally healthier nation | Centre for Mental Health

[17] RHO-Rapid-Review-Final-Report_Summary_v.4.pdf (nhsrho.org)

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[20] Cross and Reinhardt 2017: 731 Whiteness and Serendipity: Major Contribution – Project White Allies, The Counselling Psychologist 2017,Vol.45(5)

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