An exploration of how working in the Improving Access to Psychological Therapies

(IAPT) programme, might affect the personal and professional development of

counsellors: An Analytical Autoenthnographic Study

Word Count (4829)

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Abstract

Background: Since implementing the Improving Access to Psychological Therapies (IAPT) programme in 2008, provision of counselling and other idiographic approaches to psychological therapy in the English National Health Service (NHS) has been reduced to several manualised therapies supported by NICE guidelines for depression and anxiety. Many counsellors who previously provided psychological therapies in the NHS subsequently left or retrained in IAPT compliant models of treatment. This study explores the effect that working in IAPT services over an eight-year period had on the professional and personal development of the primary author, resulting in a strong exhortation for counsellors to take advantage of, and influence the professional development opportunities it presents.

Method:

This study takes an analytical autoenthnographic approach, undertaking the thematic analysis of naturally occurring data, taken from previously published opinion columns in a professional journal, and an unpublished doctoral assignment to illuminate previously unrecognised narrative.

Findings:

Themes of ideological resistance, and being out-group resulting in a sense of professional loss, uncertainty and cessation of professional development preceded acceptance of the IAPT nomothetic ideology. After which, a sense of being in-group facilitated a sense of gain, certainty, and the re-implementation of professional growth.

Conclusions

Counsellors in IAPT may be prejudiced by their idiographic ideology. Professional uncertainty and a sense of loss could inhibit professional development. Development of a pluralistic ideological stance, and integrative approach to treatment is encouraged. Counsellors who accept a Cinderella like status in IAPT, are exhorted to adapt, influence from within, and thrive in IAPT.

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Introduction

The English IAPT programme was implemented from 2007, seeking to achieve a vision that 'Successful psychological therapies ensure that the right number of people are offered a choice of the right services at the right time with the right results' (Department of Health, 2007). Within the IAPT treatment paradigm, psychological distress is perceived as a medical issue, as opposed to a function of the human condition, and is diagnosed and treated with a manualised approach. The programme seeks recovery from mental ill health, rather than relief and personal growth through therapeutic engagement. It might be argued that the IAPT programme is a relevant and valuable response to society's growing reliance on counselling and psychological therapy (Clark, 2011), whilst others would argue that it is a perverse reactionary distortion to the field of psychological therapies (Rizq, 2012, 2014). IAPT has impacted the profession of counselling and psychotherapy, not least through the development of manualised forms of traditional psychodynamic; humanistic-existential; cognitive-behavioural; integrative and pluralistic approaches. At present that effect has not been fully explored or perhaps even fully understood (Reeves & Mason, 2018), one aspect of that effect is the personal and professional development implications for counsellors working in IAPT. This paper seeks to illuminate that area of interest.

The IAPT programme is based on a stepped care model in which clients are offered the least intrusive treatment with the best chance of recovery first, which can equate to low intensity guided self-help, or the higher intensity traditional counselling-psychotherapy approaches. An alternative strategy is that all clients seeking therapy are offered the lower intensity approach first, and then progress through to higher intensity if necessary. Theoretically, the latter is more expedient, owing to the greater availability of low intensity resources and the shorter treatment times involved (Roth & Pilling, 2007). In keeping with the Department of Health vision, those two strategies seek to match the therapy choice with the client need, at the time of need. To apply such a strategy, the programme needed to adopt therapeutic modalities which were deemed to be effective, and reliable. Therefore, a key political requirement of investment in the IAPT programme was that funding was applied to therapies which met the requirements of the National Institute for Health and Care Excellence (NICE).

NICE is committed to the use of evidence-based practice; a medicalised treatment paradigm which seeks to demonstrate that the model has been subjected to a randomised control trial (RCT), which necessitates that treatment is delivered consistently by all the practitioners involved. To achieve validity in such trials manualised interventions are developed and applied. Adopting the NICE treatment paradigm for the IAPT programme assumes that every IAPT practitioner across the country will adhere to the treatment protocols, and service users can expect a level of certainty regarding its effectiveness when applied to their symptoms of depression and anxiety. In practice, there is a need for therapists to balance their previous experience, knowledge, and personal philosophy, with the evidence-based method for this to

succeed. Sanders and Hill (2014) also make the point that such an approach does not mean that therapists working outside of an evidence-based treatment paradigm are ineffective, only that there is a lack of generalised evidence to support the predictability of such treatment.

There is a surfeit of published, practitioner opinion regarding counsellors' experiences of working in the Improving Access to Psychological Therapies (IAPT) programme. However, at the time of writing, there appears to be a shortage of published research on the subject. It is arguable that this imbalance in the IAPT literature, invalidates and nullifies the rich experience that informs the published opinion of those counsellors who have worked in IAPT. We would suggest that a larger volume of research products on the subject could support practitioner opinion and carry more validity across the subject area.

Brewer (1999) identifies positive discrimination accorded to certain groups in highly segmented, hierarchically organised societies. These favoured groups are referred to as in-groups, identifiable by the favouritism accorded them in relation to other groups, who are referred to as out-groups. Within IAPT, a highly segmented, hierarchical organisation, demonstrable through its existence within the NHS and its stepped care model, I would argue that counsellors, in comparison with other practitioners, are treated as out-group. Of the identified published studies, two main themes of ideological conflict, and out-group status are obvious. Altson, Lowenthal, Gaitanidis, & Thomas (2015) highlighted themes of counsellors feeling outside of, and excluded from IAPT, for which they suggested ideological conflict as a primary source. Owen-Pugh

(2010) discussed how ideological differences might create resistance issues for counsellors training in IAPT-compliant modalities. These findings echo themes in the practitioner opinion literature of being out-group (Howard, 2012), and ideological conflict (Rizq, 2011, 2012).

In recent years counsellors have been encouraged to undertake research on their practice, not just to generate research products, but also because of its importance with regards to personal and professional development (McLeod, 2015). It appears that counsellors do not recognise or value the relevance of research practice (Murray, 2009; McGothlin & Davis, 2004) and see it as the domain of other professionals, such as psychologists (Mellin, Hunt & Nichols, 2011). Widdowson (2012) found counsellors willing to engage in research but holding negative perceptions of the process; yet counsellors are keen contributors of practitioner opinion with regards to IAPT. We argue that the dichotomy between knowledge presented as practitioner opinion, and knowledge presented as research findings, might be addressed through greater adoption of Analytical Autoethnography (AA); a research methodology that Anderson (2016, p.374) proposes, not as traditional, evocative autoethnography, but as a subgenre of that approach, that has advantages and limitations. An advantage being that practitioner opinion can be transformed into a research product. A limitation being its betwixt and between methodological, and epistemological stance; a discussion worthy of addressing outside of this paper.

This study addressed the question of how working in the English IAPT programme, affected me (as the first author) from both personal and professional development

perspectives, whilst working as a counsellor in IAPT services between 2008 and 2015. Adopting an analytical autoenthnographic approach, adapted from the model proposed by Anderson (2006), this paper aims to transform my practitioner opinion into a research product in the hope it will be more acceptable to the autoethnographically sceptical reader. References to 'I' throughout this paper will refer to the perspective of the first author in relation to the process of their engagement with AA.

Methodology

The challenge of how I might recognise and manage any positive or negative bias towards IAPT was worthy of consideration. Whatever bias was present was addressed in the process of this study, as I clarified my understanding of the challenges of the IAPT programme from a personal and counselling perspective. A key factor in choosing to research this subject, using AA as a methodology, was because I wanted to explore my understanding, including my bias, of my journey through IAPT, and then compare it to the literature. Autoethnography as a genre appeals to me as a researcher because it permits me to exercise my critical realist stance; I accept that there is a real out there, but this is how I perceive the world.

Analytical Autoethnography

In applying an analytical approach to this autoethnography I highlight my epistemologically critical realist stance, an openness to the concept of real, but a tacit acceptance that it cannot be generally exposed. My attraction to experimenting with AA was the promise of enhancing the generalisability of the data; eschewing reliability,

and validity for alternate terminology such as trustworthiness, representative, or legitimate (Guest, MacQueen, & Namey, 2012, p. 83) more suitable to qualitative methods. In AA, I hoped to avoid the narcissistic turn suggested by Leicht (2001) who, amongst other things, implied that autoethnography fails to analyse the data, and dumps it on the reader. Autoethnography as a methodology attracts an 'anything goes' reputation, along with an implicit invitation to do and write experimentally (Humphries & Learmonth, 2012, p.325). In choosing AA, being both researcher and participant, I was aware of being personally immersed in the data and was concerned to establish and maintain trustworthiness; even face validity, with the reader (Guest, MacQueen, & Namey, 2012, p. 80-81). In this respect AA, presents a different challenge to the qualitative researcher, in balancing objectivity and subjectivity. The key to this challenge was the use of previously written biography, in the form of a doctoral assignment, and previously published journal columns of an opinion based nature. Using such naturally occurring data as source documents, served to facilitate an inter-subjectivity, satisfying my desire for trustworthiness, legitimacy, and convincing representation of my experiences across the range of epistemologically broad readership.

AA was chosen over the traditional evocative autoethnographic approach, a good example of which is Kidd & Finlayson (2010), because of the perceived acceptability and value placed on a more 'scientific' approach. However, it is accepted that the evocative value of the approach requires recognition, to balance the analytical discipline with the story telling (Ellis and Bochner, 2006; see also Learmonth and

Humphries, 2011). Ultimately, it is unclear, and a challenge with AA as to whether the resultant findings read as a narrative, an analysis or something between.

To achieve an acceptable level of 'validity' or trustworthiness in this autoethnography, I adopted the guidance offered by Anderson (2006), in which he suggests five key features that distinguish an AA approach, from a traditional evocative autoethnographical approach. These being: complete member researcher (CMR) status; analytic reflexivity; narrative visibility of the researcher's self; dialogue with informants beyond the self; and a commitment to theoretical analysis.

Analytical Approach

The process of analysis followed guidance given by Braun and Clarke (2006). The data corpus was made up of naturally occurring data from a university assignment reviewing personal and professional learning (Mason, 2016), along with sixteen columns reflecting on my experience as an IAPT Counsellor, and published in *Healthcare Counselling and Psychotherapy* Journal, between 2012 and 2015. This data demonstrated complete member researcher status, albeit retrospectively, and narrative visibility of the researcher's self. Three documents were identified from this corpus as data items for analysis (Mason, 2016; Mason, 2015a; Mason, 2015b), from which 158 data extracts were used to generate 13 initial codes at a latent level. The codes were collated into potential themes, which were refined through ongoing analysis, until a clear definition of 4 themes emerged; demonstrating analytical reflectivity, and a commitment to theoretical analysis. Dialogue with informants beyond the self was achieved, due to the retrospective nature of the study, through

published practitioner opinion in the literature base; reflecting the themes identified in the analysis.

I am aware that the value I have placed on the analytical model proposed by Anderson (2011), may thus far, have leveraged against the evocative value of a traditional autoethnography. In moving from introduction and methodology to findings, I am hoping to re-balance the analytical discipline with the story telling (Ellis and Bochner, 2000; see also Learmonth and Humphries, 2011) required of an autoethnography.

Findings and Discussion

If, within this study, I was searching for absolute certainty regarding my IAPT experience, I did not find it. What I achieved through the process of analytical autoethnography was a clearer understanding of my journey and relationship with IAPT over the period.

I maintain that seven years of life can never be represented in such terms, so don't be fooled into thinking this is real; it reflects my current reality. These overarching categories of: Loss, Uncertainty, Gain, and Certainty, pervade the whole story of my journey through IAPT and whilst clearly attributable to IAPT, I cannot dismiss the influence of other, external, and unexamined, life influences during that period. Therefore, it is worth noting that these themes reflect my circumstances and environment, of which IAPT was partial and not the whole. An interesting narrative that runs alongside is the effect that each of the categories has in relation to my professional developmental motivation; in humanistic terms, simply self-actualisation

Maslow (1943). I therefore, considered Maslow (1943) theory of human motivation to compliment my analysis, but found it unsuitable. The stages of change, provided by Norcross, Krebs, and Prochaska (2011): pre-contemplation; contemplation; preparation, and action, aligned better with the themes. Aligning this model to my analysis illuminated the change process, it became clear that acceptance of the IAPT paradigm, facilitated my ability to 'contract' my relationship with IAPT, for mutual benefit. A decision was made to highlight the stages of change alongside the theme headers, within the findings section, by way of further illuminating the growth aspect of the journey.

Theme 1: The Loss of a counsellor's validity after the implementation of IAPT. (Pre-Contemplation/Contemplation)

The subject of my loss is ideological, as opposed to material; analogous to the monkey trap ("Monkey Trap", n.d.), whereby the need to hold onto a banana results in an inability to escape capture from a cage. In my story, it is not a banana, but my counselling ideology that I was unable to release, resulting in my losing the ability to develop professionally within the IAPT paradigm. IAPT came as a shock to me: I had no idea that it was coming. I was, pre-IAPT, contented, secure and naively unsighted.

> '[I was] happy to be in paid, secure employment working in a therapy
>
> service that reflected person centred values in its management and
>
> delivery of service.'
>
> (Mason, 2016, p. 2)

In my experience, IAPT was implemented without engagement; almost 'as if' the

practitioners that it would affect did not need to be consulted and engaged in the

process. Ironically, this nomothetic approach to change management appears to

mirror the IAPT manualised treatment paradigm, in contrast to the counsellor's

idiographic approach.

> 'With the implementation of IAPT came the immediate introduction of
>
> a hierarchy, to what had been a relatively flat organisational structure'
>
> (Mason, 2016, p. 2)

> 'Managers from counselling backgrounds were replaced for managers from
>
> Mental Health Nursing and Psychology backgrounds' (Mason, 2016, p. 2)

> 'It felt 'as if' IAPT had been inflicted as opposed to introduced' (Mason, 2016,
>
> p.3)

Perren (2009, p.28) wrote of the process at the time;

> 'normal processes of consultation, though strongly advocated by IAPT, have
>
> been curtailed. Counsellors have often been overlooked or excluded from
>
> consultation, giving them no opportunity to engage and inform commissioners'

In these early years, I only felt that IAPT was somehow wrong: a sense of dissonance rather than knowing. There was loss, shifting between the edge, and the centre of, my awareness. Not understanding IAPT caused me to resist its implementation. I buried my head in the sand; it wasn't happening.

> 'This enforced change of practice without consultation was unwelcome, challenging my core beliefs about therapy and creating an internal resistance towards IAPT' (Mason, 2016, p. 11)

I wanted to fit in, and belong, but felt vulnerable, unable to share my feelings within my peer group, for fear of being shunned as an IAPT collaborator. I found myself supporting the anti-IAPT rhetoric, purposely adopting a wounded stance, offended, discriminated against, penalised for being a counsellor. I feared, and believed that I was unwelcome in IAPT. The harder I clung to this sense of purpose, the more difficult it was to adapt to my circumstances. It seems that this sense of imposition and the threat to my professional identity was shared amongst my colleagues,

> 'This has led to counsellors becoming alienated from the IAPT process, and taking up defensive or antagonistic positions. In some areas, they have become identified as troublemakers' (Perren 2009, p.28).

IAPT had 'occupied' primary care mental health. I missed the old ways, and felt invalidated. Clark (2011), paints an entirely opposing perspective, one of

overwhelming success and progress; challenges related to funding, rather than counsellor integration. Responsibility for service provision, outside of IAPT, abandoned to local Clinical Commissioning Groups (CCGs), thereby setting counsellors adrift to fend for themselves; adrift and fending for myself would describe this period of my IAPT experience.

Theme 2: The Uncertainty of counsellor's being 'out group' in IAPT (Contemplation/Preparation)

The introduction of IAPT was a masterpiece in political strategy. The authors had manufactured consent through the influential London School of Economics (LSE) publication, The Depression Report (LSE, 2006), leading to the development and implementation of IAPT (Department of Health, 2008). The programme had secured cross party support from politicians, clinical commissioning groups, and NHS decision makers. Proposing and applying its own worldview, defining the nature of itself, how it would judge its own success or failures, what would be valid, or invalid; it became a treatment paradigm. Bryman (2012, p.714) describes a paradigm as: 'a cluster of beliefs and dictates that for scientists in a particular discipline influence what should be studied, how research should be done, and how results should be interpreted' (see also O'Reilly & Kiyimba, 2015). Even though I was a valued and effective practitioner, serving in an NHS setting, this paradigm, that clashed so obviously with my professional worldview, created a deep sense of uncertainty; feeding internal messages of inability and underqualification.

> 'Coupled with the introduction of the IAPT doctrine and its
>
> associated diminishment of counselling, I developed a felt sense
>
> of being under qualified to be an NHS psychological therapist.'
>
> (Mason, 2016, p. 2-3)

I discovered that the new order had its own way of communicating: language was different. I discovered that a formulation was a point in time, when the problem was defined. A treatment plan was then agreed and employed; recovery could then be expected in 50% of all cases. In my world, there were similarities: formulation was ongoing; treatment was exploratory and collaborative; and improvement was facilitated. This language gap contributed to my dissonance.

> 'An unintended consequence of inheriting counsellors in IAPT
>
> services was that the organisation had no shared organisational
>
> ontology (or worldview) through which to communicate its
>
> changed philosophical approach to the treatment of patients
>
> with anxiety and depression' (Mason, 2016, p. 8)

In trying to bridge this gap in understanding I discovered a proposal for a person-centred formulation (Simms, 2011), which I adapted to my work.

> 'I decided to utilise a clinical practice which the
>
> positivists used … I considered the need for formulation

within my PCA [Person Centred Approach].' (Mason,

2016, p. 12)

This adjustment made my PCA more understandable to the manualised therapists, making it easier for me to describe what I did in the clinical space, and contributing to my acceptance amongst colleagues. However, it appeared that my uncertainty and sense of being out-group was not unique. I discovered that IAPT had issued a paper to clarify the relationship between counselling and IAPT, highlighting counselling as NICE approved for mild to moderate depression, asserting that while counselling was important, any other use of counselling was outside of the IAPT programme. Counsellors were encouraged to extend their skills by training in Cognitive Behavioural Therapy (CBT) (IAPT, 2009). It would have been a clarification to state that counsellors must train in CBT or leave IAPT. I wanted to remain in the NHS.

Theme 3: The Gain that comes with acculturalisation into the IAPT programme (Preparation/Action)

My sense of loss and uncertainty led to a decision. I realised that IAPT was not going to accommodate me, so I had to accommodate IAPT, or leave.

'This vulnerability led me to consider re-training in order to secure my

future as an NHS therapist in IAPT' (Mason, 2016, p. 12-13)

I let slip the metaphorical banana of ideology, creating the freedom to grow again;

being selected to train and subsequently qualifying in Interpersonal Psychotherapy

(IPT) for depression. Under the IAPT training scheme, this was the vehicle that

provided security, belonging, and professional esteem. This acceptance of IAPT

ideology is referenced by House (2012, p. 59) 'with the inexorable rise of IAPT …

experienced GP counsellors have often responded by taking further training …'

> 'Accreditation as an IPT practitioner secured my 'place' in IAPT' (Mason, 2016,
>
> p. 8)

Although secure in my IAPT employment status, the struggle between ideological

approaches remained. I had though, realised that I could tolerate my working

environment.

> 'Struggling with the tension between my worldview, the IAPT corporate
>
> ontology and the IPT theoretical paradigm became a daily and
>
> consuming issue … I have been able to achieve a balance in that regard
>
> and demonstrate IAPT ontologically 'successful' traits as a therapist'
>
> (Mason, 2016, p. 13- 14)

The IAPT manualised training programme was not without criticism. Marzillier and Hall

(2009) had cautioned against training therapists 'to work in one particular way' (p.

399), such as CBT or IPT, and the expectation that anxiety and depression are 'like

measles that can reliably diagnosed and treated' (p. 397) was a flawed strategy based

on economic imperatives. However, accreditation as an IAPT therapist brought

opportunity, facilitating a career move to another service, much closer to home. This

demonstrated the value of being 'in group', contributing a positive and welcome

change to my work life balance, and validating my actions; IAPT was becoming a place

in which I could thrive. Emotionally, I had found a place from which I could balance my

negative bias towards IAPT, recognising the conflation of treatment paradigm, and

business model and confident enough to share that view, without the fear of being

framed as a collaborator.

> 'I reflect upon IAPT and the level of activity-measuring that is
>
> demanded, the effect that the measures and the rules applied to the
>
> work has on some therapists working in IAPT, and how it can taint their
>
> experience of working in primary care.' (Mason, 2015b, p. 27)

My worldview had shifted, I had become 'in group', commenting on the 'out group'. I

could take advantage of working in the IAPT programme. With this shift in thinking

came certainty.

Theme 4: The Certainty that comes with being 'in group' within IAPT (Maintenance)

Having gained IPT accreditation, I enjoyed 'in group' status; my understanding of IAPT

was refreshed. I knew what was required of me, because the programme was designed

for manualised therapies and I could now deliver a manualised therapy in IPT.

> 'I now understand why I struggled with IAPT and IAPT struggled with me because of the differences between our ontological or worldview perspectives' (Mason, 2016, p. 8)

I voiced my understanding in my column

> 'I have realised that I spent a long time in my previous roles labouring under the misapprehension that I was a counsellor working in a counselling service called IAPT'. (Mason, 2015a, p. 41)

When I stopped fighting the paradigm and accepted that it treated everyone the same, I adapted and thrived in that challenging environment. Like Spencer-Chapman (1949) and his experiences of the Malay jungle during WW2, who wrote of how his beliefs about the jungle being hostile had initially resulted in physical and emotion suffering; when he realised that the jungle was neutral, and adapted to his environment, he thrived. I realised that the IAPT 'jungle' was neutral. Counsellors working in IAPT can be prejudiced by their idiographic ideology. The relentless drive of the IAPT programme, the diminishing recruitment, and increasing resignations of counsellors compared with the continuous supply of cognitive behavioural, high intensity practitioners, was analogous to Plutarch's description of the situation of Pyrrhus in his wars with the Romans.

'… he saw that his allies in Italy [counsellors] were becoming

indifferent, while the army of the Romans [IAPT], as if from a

fountain gushing forth indoors, was easily and speedily filled up

again' (Plutarch, ca Perrin, 1920, p. 417)

Once I had recognised the pyrrhic defence of counsellor's beliefs and values,

and its emotional cost, I had accepted the inevitable, and became IAPT

compliant.

Conclusion

Pyrrhus wasn't the only historical leader to discover the futility of resisting the growth

of the Roman Empire: the Celtic tribes of ancient Britain followed a similar strategy. In

modern Britain, the many tribes of counselling do not face Rome, we face IAPT. One of

the lessons from history could be to aculturalise and accept the IAPT programme,

taking advantage of the opportunities that nomothetic order provides, whilst still

maintaining the strengths of the idiographic approach. The principal author asserts his

growth through the experience of IAPT; growth that has enabled him to become a

better counsellor, ideologically pluralistic and integrative in approach.

Many counsellors feel vulnerable and threatened by IAPT, and are perhaps attracted to

the option of training in an IAPT and NICE compliant model of treatment, like the

primary author, to relieve the sense of being out-group as a counsellor, enjoying the

in-group privilege of training, status, and purpose that IAPT provides. However, there

are some who seek compliancy as a means of IAPT survival. Proctor and Hayes (2017)

speak of counsellors training in the IAPT model of Counselling for Depression, and through this developing the skills to survive the IAPT environment.

We argue for counsellors to reject survival as a limitation, reminiscent of Maslow's (1962, p.15) psychopathology of the average, a sickness in which counsellors, and counselling, have somehow accepted that it is normal to be under-privileged – a phony profession – living out an illusion of, even relishing the role of victim in IAPT. We encourage counsellors to thrive in the role of moral, principled, and scientifically validated professionals dedicated to human growth and achievement, uniquely capable of operating in diverse paradigms of worldview, and treatment approaches, celebrating the reality that counselling changes lives. Only by embracing, and respecting the nomothetic ideology of the IAPT programme, will counsellors and counselling be able to influence and evolve this most defensive and protective of treatment paradigm from within. Pilecki and McKay (2016, p. 32) pose the question:

'would you prefer to see a physician who is well-versed in the research regarding a particular disease and its treatments? Or would you rather see a physician who ignores large-scale studies and instead relies on personal experience and the study of individual cases?'

In recognising that both have validity, they make the case for a physician who embraces both approaches. We make the case for such a counsellor: a valued resource, professionally developed to embrace both non-manualised (idiographic) and manualised (nomothetic) ideologies, flexible and integrative, a model for future IAPT

practitioner development. Some might perceive the primary author as naïve to enjoin

in a Faustian relationship with IAPT, risking the soul of his ideological stance; others a

triumph of personal growth and empowerment despite the complexities of IAPT with

its hidden agendas, and barely concealed aversion to counselling. This study is an

autoethnography, a singular insight into another reality, offering choice beyond the

polarised battle of good and evil, in which IAPT is the persecutory jungle to blame for

counselling's plight. The primary author once perceived IAPT as being inflicted on him,

and in doing so failed to see the opportunity that it presented for professional

development. IAPT is a challenging environment for all its practitioners, but counselling

and counsellors can, do, and must realise that they can thrive in IAPT. As a

consequence, IAPT might grow into an authentic programme no longer projecting the

illusion that it fully improves access to psychological therapies.

References

Altson, C., Del Loewenthal, A.G., & Thomas, R. (2015). What are the Perceived

　　　　Implications, If Any, For Non-IAPT Therapists Working in an IAPT Service? *British*

Journal of Guidance & Counselling, 43(4) 383-396, DOI:

10.1080/03069885.2014.962485

Anderson, L. (2006). Analytic Autoethnography. *Journal of Contemporary Ethnography,*

35(4), 373-395. DOI: 10.1177/089124160528044

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative*

Research in Psychology, 3 (2), 77-101. DOI: 10.1191/1478088706qp063oa

Brewer, M. B. (1999). The Psychology of Prejudice: Ingroup Love or Outgroup Hate?

Journal of Social Issues, 55(3), 429-444.

Bryman, A. (2012). *Social research methods*. (4th ed.). Oxford: Oxford University Press.

Clark, D. M. (2011). Implementing NICE Guidelines for the Psychological Treatment of

Depression and Anxiety Disorders: The IAPT Experience. *International Review of*

Psychiatry, 23 (4), 318-327. DOI: 10.3109/09540261.2011.606803

Department of Health (2007). *Commissioning a brighter future: Improving Access to*

Psychological Therapies. London: Department of Health.

Department of Health. (2008). Improving access to psychological therapies

implementation plan: National guidelines for regional delivery. Retrieved from

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.g

ov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digital

asset/dh_0831 68.pdf

Ellis C. S., & Bochner, A. P. (2006) Analysing Analytic Autoethnography. *Journal of*

Contemporary Ethnography, 35(4,) 429–449. DOI: 10.1177/0891241606286979

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis.* London:

Sage.

House, R. (2012). General Practice Counselling Amidst the 'Audit Culture': History,

Dynamics and Subversion of/in the Hypermodern National Health Service.

Psychodynamic Practice, 18 (1), 51-70. DOI:10.1080/14753634.2012.640157

Howard, S. (2012). The Portable Therapist: The Challenges for Therapists Working in

Primary Care Settings. *Psychodynamic Practice, 18*(1), 93-104.

Humphries, M., & Learmonth, M. (2012). Autoethnography in organizational research:

Two tales of two cities. In G. Symon & C. Cassell (Eds.), *Qualitative*

organisational research: Core methods and current challenges. London: Sage.

Improving Access to Psychological Therapies. (2009). The relationship between

counselling and Improving Access to Psychological Therapies. Retrieved from

http://webarchive.nationalarchives.gov.uk/20100409151126/http://www.hert

spartsft.nhs.uk/_uploads/documents/gp-area/whats-the-relationship-between-counselling-and-iapt-statement-may-09%5B1%5D.pdf

Kidd, J. D., & Finlayson, M. P. (2010). Mental illness in the Nursing Workplace: A Collective Autoethnography. *Contemporary Nursing, 36*(1-2), 21-33.

Learmonth, M., & Humphries, M. (2011). Autoethnography and Academic Identity: Glimpsing Business School Doppelgangers. *Organisation,19* (1), 99-117. DOI: 10.1177/1350508411398056

Leicht, K. T. (2001). From the Editor. *The Sociological Quarterly, 42* (1), vii-xi. DOI: 10.1111/j.1533-8525. 2001.tb02371.x

London School of Economics and Political Science. (2006). *The depression report: A new deal for depression and anxiety disorders.* Retrieved from: http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf

Mason, R. S. (2015a). If It Walks Like a Duck. *Healthcare Counselling and Psychotherapy Journal, 15*(2), 27.

Mason, R. S. (2015b). How to Ruin a Good Walk. *Healthcare Counselling and Psychotherapy Journal, 15*(1), 41.

Mason, R. S. (2016). *Review of personal and professional learning. (Unpublished doctoral assignment).* University of Chester, United Kingdom

Marzillier, J., & Hall, J. (2009). The Challenge of the Layard Initiative. *The Psychologist, 22*(6), 396-399.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review, 50* (4), 370–396. http://dx.doi.org/10.1037/h0054346

Maslow, A. H. (1962). *Toward a psychology of being.* (2nd ed.). Princeton: Van Nostrand.

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor Professional Identity: Findings and Implications for Counseling and Interprofessional Collaboration. *Journal of Counseling Development, 89* (2), 140-147.

McGothlin, J. M., & Davis, T. E. (2004). Perceived Benefit of CACREP (2001) Core Curriculum Standards. *Counsellor Education & Supervision, 43* (4), 274-285. DOI: 10.1002/j.1556-6978. 2004.tb01852.x

McLeod, J. (2015). *Doing research in counselling and psychotherapy.* London, United Kingdom: Sage.

Monkey Trap. (n.d.). In *Wiktionary*. Retrieved January 07, 2017, from

   https://en.wiktionary.org/wiki/monkey_trap

Murray, C. E. (2009). Diffusion of Innovation Theory: A Bridge for the Research-Practice

   Gap in Counselling. *Journal of Counseling and Development, 87* (1), 108-116.

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of Change. *Journal of

   Clinical Psychology, 67* (2), 143-154.

O'Reilly, M., & Kiyimba, N. (2015). *Advanced qualitative research: A guide to using

   theory*. London: Sage.

Owen-Pugh, V. (2010). The Dilemmas of Identity Faced by Psychodynamic Counsellors

   Training in Cognitive Behavioural Therapy. *Counselling and Psychotherapy

   Research, 10* (3), 153-162. DOI: 10.1080/14733141003750574

Perren, S. (2009). IAPT: The Impact on Counselling. *Healthcare Counselling and

   Psychotherapy Journal, 9* (4), 28-30.

Perrin, B. (1920). *Plutarch lives: Demetrius and Antony Pyrrhus and Caius Marius* (B.

   Perrin, Trans.). Cambridge, Massachusetts: Harvard University Press.

Pilecki, B., & McKay, D. (2016). Evidence-Based Therapies, Evidence-Based Practice,

   and the Intersection of Nomothetic and Idiographic Foundations of

Psychotherapy Research and Application: A Reply to Shean. *Psychodynamic Psychiatry, 44* (1), 25-38.

Proctor, G., & Hayes, C. (2017). Counselling for Depression: A Response to Counselling Education in the Twenty-first Century. Ethical Conflicts for a Counselling Approach Operating Within a Medicalised Bureaucratic Health Service. *British Journal of Guidance and Counselling,* DOI: 10.1080/03069885.2016.1274377

Reeves, A., & Mason, R. S. (2018). Other key approaches. In A. Reeves *An introduction to counselling and psychotherapy: From theory to practice* (2nd ed., pp. 135-155). London: Sage.

Rizq, R. (2011). IAPT, Anxiety and Envy: A Psycho-analytic View of NHS Primary Care Mental Health Services Today. *British Journal of Psychotherapy, 27*(1) 37-55. DOI:10.1111/j.1752-0118.2010.01221. x.

Rizq, R. (2012). The Perversion of Care: Psychological Therapies in a Time of IAPT. *Psychodynamic Practice, 18*(1), 7-24. DOI:10.1080/14753634.2012.640161

Simms, J. (2011). Case Formulation Within a Person-Centred Framework: An Uncomfortable Fit? *Counselling Psychology Review, 26* (2), 24-36.

Spencer Chapman, F. (1949). *The jungle is neutral*. London: Chatto & Windus.

Widdowson, M. (2012). Perceptions of Psychotherapy Trainees of Psychotherapy

Research. *Counselling and Psychotherapy Research, 12* (3), 178-186. DOI:

10.1080/14733145.2012.697473