A Critical Analysis of the changes to the January 2022 edition of the SCoPEd Framework

(To be viewed in addition to the CTUK July 2020 full critical analysis here)

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This short report looks at the criterion set out within the SCoPEd framework with a focus on the criterion that have been divided between the 3 columns laid out within the framework.

Under each section within the framework, the team have been careful to note that any counsellor can use competencies within in any column if they feel they have the competence to do so. At this moment in time, counsellors are not being asked to specifically evidence individual competencies. This means that this framework is no different to the system we had before, simply working to your known competencies as outlined within the ethical framework.

However, there are changes which mean that the framework is not in line with the ethical framework of the membership bodies involved. In particular, the inference that a qualified counsellor would not be able to recognise a change in the emotional state of their client. The most basic of skills.

Another point to highlight is that these competencies do not need to be evidenced with CPD, yet. Without an impact assessment it cannot be said whether this will become necessary to protect counsellors against claims of malpractice, or any other potentially negative outcome.

In summary of the analysis below, the framework still fails to meet appropriate standards when it comes to understanding the core competencies of a qualified counsellor and if this is due to relying upon the assessment frameworks of the courses highlighted within the methodology paper, then this suggests that these framework need updating to correctly represent the skills required of a qualified counsellor. We cannot have an official document say this it is okay if counsellors don't understand emotions and don't respond to client's emotions. That is extremely harmful to our profession and harmful to the clients who may stay in that harmful therapy believing it is ethical practice. There are points where the SCoPEd framework is confusing and contradicts itself which suggests that these competencies have been separated for the sake of separation, especially where the minor change in context results in a large change in competence.

1.13: Everyone can work as a team; but not within a multidisciplinary team

According to the framework Column A therapists cannot work within multidisciplinary teams to enhance therapeutic outcomes. They do not possess the ability to be an active member of the professional community. Based on what evidence?

In competence 2.9, all counsellors and psychotherapists are able to communicate and collaborate with relevant parties about client/patient risks and needs in order to improve therapeutic outcomes. It is unclear why Column A counsellors experience this deficit in one context but not another. Particularly when the latter (criterion 2.9) is describing a high-risk professional context.

2.1: Everyone can assess a client/patient's suitability to be in therapy but not apply that assessment through the lens of a theoretical approach.

It is unclear why a trainee loses the ability to critically apply the theory they have just been studying as soon as they qualify, only to pick it up again 2+ years later. It is even less clear why only Column C therapists have been given the competence of being able to conceptualise and (or) formulate ways of working with clients/patients with chronic and enduring mental health conditions. Very few theoretical approaches limit their intended clients to a specific grouping. Separating this competence denies that various modalities, including person-centred, are not time specific or client presentation specific. These modalities do not fit neatly into the culture of treating an illness not a person, but this does not mean that there is no ability to conceptualise ways of working with people experiencing chronic and enduring distress (mental health conditions).

2.5: Everyone has the ability to draw upon knowledge of common mental health problems and symptoms of psychological distress (with due understanding of cultural norms) during assessment and throughout therapy. Not all therapists can conceptualise and evaluate functioning and coping styles. Even less therapists possess the ability to understand the language and discourse around diagnosis, psychopathology and mental disorders.

Not all therapists want to conceptualise psychological distress in this way! This framework ignores the growing anti-psychiatry movement completely and ignores its validity as a critical discourse for therapists to participate in.

"Column A therapists cannot conceptualise and evaluate functioning and coping styles". Then how can they safely work with clients/patients? How can they conceptualise and formulate appropriate interventions and use of their counselling skills if they cannot comprehend human functioning?

2.8: Everyone possesses the ability to make initial and ongoing risk assessments regarding clients' or patients' and (or) others' safety, and comply with safeguarding guidance, appropriate to the therapy setting taking into account own limits of competence. Not all therapists can devise and use a comprehensive risk assessment strategy. Even fewer can make complex judgements about ongoing work with high-risk clients/patients and take appropriate action as needed.

However, everyone can collaborate with their clients/patients (and other relevant parties) to assess risks, needs and strengths when working with imminent and ongoing high-risk behaviours or environments (2.9).

Competence 2.9 contradicts the conclusions of competence 2.8 by inferring this is somehow less complex work. The examples given are active risks where a client/patient is thinking about or actively engaging in self-harming behaviours and (or) suicidal behaviours. An area where professionals at all levels can be surprised by the completed suicide of their client/patient. An area where intensity of injury can be unpredictable.

Then there is the example of domestic abuse. One of the highest potential risk areas that any professional can work in. An area where the interagency working is widespread across all disciplines.

Whether you are working with the victim or the perpetrator this is specialist work that requires the ability to make complex judgements and take appropriate action as needed. Again, with self-harm and suicidal behaviours, this requires the ability to make complex judgements and take appropriate action as needed.

So, which is it? Can therapists do this or not? If not, counsellors may as well be pulled from all school settings and any work with children and young people, as this is the largest population for self-harm. If qualified and accredited counsellors cannot make complex judgements and act upon them then this surely has impact on trainees. You cannot in any sense of the word, claim that trainees have this competency so can work with children and young people but as soon as they qualify, they will never have this competency unless they retrain under Column C.

2.11: Everyone is able to make an initial and ongoing assessment of the risks for both parties specific to the environment of technologically mediated therapy. Not everyone can identify and respond to the impact of the technologically mediated environment on issues of identity and presence, including fantasies and assumptions about the client/patient.

If Column A therapists cannot identify and respond to the impact of the therapy they are delivering, then they cannot work safely and ethically. This would mean ALL Column A therapists and trainees cannot deliver online, telephone and VR therapies.

The SCoPEd team would also need to acknowledge that "technologically mediated therapy" is not standard to all core training. Theoretical and practical knowledge is currently delivered as non-core training. During the national lockdown from the COVID-19 pandemic all practitioners of psychological therapies had to "make-do" because of this lack of core training across the disciplines. It is therefore misleading to the public, employers and other stakeholders to suggest otherwise. If the plan is to implement this into core training, then it needs to be clear to those stakeholders, employers and clients that pre-2024 therapists (for example) can gain this competency through additional learning/experience.

3.10: Everyone has the ability to recognise, understand and work with issues of power and how these may affect the therapeutic relationship but not all therapists can work with these issues as expressed by the 'unconscious' or 'out of awareness' processes of a client/patient in the therapeutic process. Even fewer can communicate about the harm caused by discriminatory practices and aim to reduce insensitivity to power differentials within therapeutic service provision, training, and supervisory contexts.

It is a surprise to see this remains in the current iteration of the framework. You do not need a master's qualification to understand discrimination, the harms it can cause or have an understanding of how to reduce insensitivity to power differentials. It is astounding that this remains because it is discriminatory practice within itself! Its inclusion as a competence in this manner strikes heavily as tone deaf on the practices it states to reduce insensitivity on. The barriers to post-compulsory education are higher for those who are in marginalised and/or minority groups, and (or) come from impoverished backgrounds…. people who are more than able to communicate effectively about the harm caused by discriminatory practices. This is all without addressing the medicalisation of distress.

Additionally, criterion 3.23A says that all therapists have the ability to address difficulties related to equality, diversity, and inclusion in order to repair any damage to the therapeutic relationship. How

is this possible if Columns A and B cannot communicate the harms of discrimination? If they lack the ability to reduce insensitivity? Lack of that knowledge in a broader community sense is likely to mean lack of knowledge and self-awareness on an individual level. It is much more likely for someone to be aware of issues "out there" than to have the full awareness of their own part in that. This is why training in areas such as anti-racism work is so confronting to people – it challenges the idea of that discrimination being an "out there" phenomenon and says it is an "in me" too thing.

This competency needs urgently addressing. There was never a need to artificially create this separation. Even less so in the wake of a national and international awakening to racism, violence against women and a growing awareness of the barriers and hate that marginalised groups face.

3.13: Everyone has the ability to establish, sustain and develop the therapeutic relationship and to engender trust and authentic connection. Column A therapists cannot critically reflect on the client's or patient's process to enhance the client's or patient's self-awareness and understanding of themself in relationship. Column A therapists do not possess the ability to be aware of, and respond to, emotional shifts occurring in each session, with the aim of maintaining a level of emotional engagement appropriate for each circumstance.

A therapist who is not aware of emotional shifts?

A therapist who is not aware of emotional shifts in clients/patients yet has been allowed to qualify and practice? The same therapist is also not able to help their client/patient increase their self-awareness and yet, again, has still qualified to work with clients/patients?

Has this conclusion been reached because the entire team working on this framework have forgotten about counselling theories? Person centred therapy: use of the therapeutic relationship to achieve greater self-awareness, in order to facilitate change. Cognitive behavioural therapy seeks to increase self-awareness of thought processes and their impact, in order to facilitate change. Psychodynamic therapy seeks to bring awareness to unconscious processes, also to facilitate change. All therapies seek to increase self-awareness in one form or another in order to facilitate change. This does not happen if the therapist providing that therapy is unable to reflect upon the work with their client/patient. If this is not happening, the therapist in question is not providing therapy, they are providing an unskilled chat. In other words, they are not a therapist at all. It seems that multiple memberships involved in the development of this framework are happy to say that thousands of therapists within their memberships are not therapists at all. That they have validated their qualifications, allowed them a place on their Accredited Registers and presented them to the public as safe and competent therapists, despite them not possessing the most foundational of therapeutic skills.

3.16: All therapists possess the ability to be aware of and manage their own emotional or physical responses to the client or patient. Column A therapists cannot actively use their own responses to the client/patient in a way that is therapeutic and consistent with the theoretical model or approach.

Again, we ask why Column A therapists are being allowed to qualify if they do not possess this competence? If the framework would really like to address awareness of harms in therapy, then it should start right here in this criterion because this is where the insidious types of harm start. If a therapist is unaware of the nature of transference and is unable to conceptualise it correctly, then

the consequence is therapists with reduced boundaries and a potential for higher rates of harmful behaviours. For example, the provision of care and compassion reduces when the therapist is unable to reframe “this client is making me feel so bad” to “what is going on here and how can we work together to break this reaction to each other”. If a therapist is unable to critically evaluate their responses along with other information from the relationship, they may miss important signs of the client’s experience. For example, the therapist’s somatic responses being indicative of a client’s dissociation. As dissociation is a coping skill all people use to varying degrees, this is also an important level of incompetence should the therapist not at least possess the core skill or that evaluation; even if the link to dissociation or other phenomena is learned through experience and additional training.

3.21: Everyone has the ability to recognise and respond to difficulties or ruptures in the therapeutic relationship, but Column A therapists lack the ability to use this as an exploratory moment with the client/patient’s experience of their difficulties. Only Column C can conceptualise the work using awareness of and skills associated with ‘unconscious’ or ‘out of awareness’ processing.

This is another arbitrary division when Column B are able to use their knowledge of the ‘unconscious’ and ‘out of awareness’ process in the realm of power dynamics (3.10) but now cannot use it to work with therapeutic ruptures. This makes little sense when power imbalances often factor into difficulties and ruptures within the therapeutic process.

3.23: Column A therapists cannot analyse and address difficulties [in the therapeutic relationship] in the immediacy of the therapeutic encounter to find ways to overcome such difficulties.

This is a ridiculous statement. This framework is supposed to put the public, employers and stakeholders at ease, but it also is saying that the **majority** of therapists have no idea how to deal with an issue in the moment; they have to go phone a friend. How does this work in practice? Are therapists being told to tell clients/patients they will get back to them in the next session?

3.24: Everyone can clearly communicate about endings with clients or patients, and work to ensure these are managed safely and appropriately. Column A therapists cannot consider and manage complex issues arising when ending therapy in the light of the client’s or patient’s previous experience of endings.

Again, this a ridiculous statement to make. How can an ending be managed safely without the ability to manage the complex issues that can arise in light of a client/patient’s previous experience of endings?

4.2. Everyone possesses an understanding of and the ability to apply the theory and practice of therapy from assessment to ending. Column A therapists are unable to critically appraise a range of theories underpinning the practice of counselling and psychotherapy. Only Column C therapists have the ability to critically appraise the history of psychological ideas, the cultural context, and relevant social and political theories to inform and evaluate ongoing practice.

Which courses exclude comparative theories from their core training? What about integrative trainings? Trainings are likely to have differing levels of depth on history, culture, socio-political theories and therefore how they can be applied to ongoing practice. This tends to be an academic skill that increases through academic levels, but all therapists should possess an ability to apply theory to practice. As seen below with everyone being able to apply theory of suicidal behaviours to practice.

4.3: Everyone has the ability to apply understanding of suicidal behaviours, and (or) self-harming behaviours, to work collaboratively with clients or patients. Column A therapists cannot work with suicidal risk and the often-complex nature of suicidal ideation and (or) other self-harming behaviours and associated 'unconscious', or 'out of awareness' processes and perceptions.

Is this meant to be a division based purely on modality? The framework has already established that all therapists can work with suicidal ideation and self-harming behaviours. Or is this criterion trying to say that Column A therapists can work with people who are actively attempting suicide or self-harming but not work with them around the accompanying ideation? This makes no sense and would actively harm clients/patients to tell them they can talk about what they did but not what they think and feel.

4.9: Everyone can use skills and interventions for the benefit of clients or patients that are consistent with underlying theoretical knowledge. Column A therapists cannot reflect upon the complex and sometimes contradictory information gained from clients or patients and to coherently describe their present difficulties and the potential origins using a clear theoretical model or approach. Only Column C therapists can understand the nature and purpose of therapy to evaluate and use theory to conceptualise how 'unconscious' or 'out of awareness' processes in both client or patient and therapist, may shape perceptions and experiences and influence the therapeutic process.

When there is little representation of person-centred theory in the ERG and TAG personnel, what happens is this erasure of a core concept such as incongruence. The ability to reflect upon incongruence in order to appropriately respond to it is key to person-centred therapy and may well be a concept in others. This would be at the point of qualification.

Yet again, the ability to do anything with the 'unconscious' or 'out of awareness' has been set as a Column C competence even though there is an acknowledgement elsewhere in the framework that this competency expands to Column B. Either Column B therapists understand the concept or not. But the framework states this phenomenon as if it were a universal theoretical fact that all should gain awareness off – hence why it is included as a competency. Not all theories believe this phenomenon exists, so the framework unfairly deskills them for having alternative beliefs. As it does for those who don't believe in the psychiatric model of therapy.

4.11: Everyone has the ability to reflect upon their own identity, culture, values and worldview, and the capacity to work and communicate authentically in a non-discriminatory and anti-oppressive manner. Column A cannot recognise and explore with the client or patient the assumptions that underpin understanding of identity, culture, values, and worldview. Only

Column C can integrate relevant theory and research in the areas of diversity and equality into clinical practice.

If this is not part of core training, why is it not? The ability to integrate relevant theory and research is the underpinning for exploring assumptions of identity and culture. We know this because it is research that developed the challenge to westernised therapies being used in different populations where it was less effective or harmful. In 4.16, the framework says that everyone can apply research to their practice. So, which is it? There seems to be a strong belief that only Column C can understand diversity, as though all therapists are not given mandatory training in their placements on discrimination and diversity. If it is training that is needed to evidence this, all therapists receive it. If we can all apply counselling research, then we can all research diversity and apply that.

5.1: Everyone has the ability to make use of personal development, self-awareness and supervision to reflect on, learn from and enhance therapeutic practice. Column A therapists cannot be emotionally prepared for intense and complex work, which requires sustained reflexivity. Column A do not have the ability to work with 'unconscious' and 'out of awareness' processes. Only Column C can evidence reflexivity, self-awareness and the active use of self to work at depth in the therapeutic relationship and throughout the therapeutic process.

Reflexive practice is the ability to utilise self-awareness to inform responses within the therapeutic relationship. Not for the first time this framework suggests that Column A therapists do everything as a reflection (after the fact) and cannot react in the moment. It is the ability to react in the moment that unpins reflectivity. Here it goes even further to suggest that even if a Column A therapists could do this, they could not do it long enough to make them safe to practice. If a therapist cannot emotionally prepare for the work, then they cannot do the work, because the risk is too high for vicarious trauma, burnout, and harm to clients/patients via poorer boundaries, unhealthy transference and more. So, when the framework says that Column A therapists can work with suicidal, self-harming and domestically abused clients, does it mean it?

And this is despite, 5.2 stating that all therapists can use awareness of self during therapy to enhance the therapeutic process.

On the basis of this, we are unsure why it was felt necessary to say that only Column C therapists can evidence their practice, when one would expect that this is a competency shown in the accreditation applications; as the accreditation process appears to suggest? (Accreditation being criteria to be placed in Column B). The use of supervision would also be integral here, as this competency could also be evidenced in that relationship. However, the framework does not extend to supervision.

5.4: Everyone can understand the significance and impact of their own identity, culture, language, values, and worldview in work with clients or patients. Column A cannot critically challenge their own identity, culture, values, and worldview.

Which courses do not have a personal development module? That is the only explanation for suggesting that Column A therapists have no ability to critically evaluate and then challenge themselves.