Everyday Counselling Practice

1

What Are the Pros and Cons of Unconditional Positive Regard?

The term 'unconditional positive regard' (UPR) was coined by Carl Rogers and equates with a deep acceptance of the client. Sometimes it is referred to as warmth, non-judgementalism and prizing. It is asserted that no effective counselling can take place without such acceptance, since a counsellor who overtly or covertly transmits their judgement or rejection is reinforcing exactly those negative experiences that others, such as parents, have been responsible for; and no successful counselling is likely to happen in a non-accepting relationship. The 'U' in the UPR connotes an ability to rise above typical social values and prejudices but it is often said that one does not have to approve of all a client's actions and attitudes – rather UPR means that you positively accept him as a person, perhaps sometimes bracketing off his more offensive features or understanding them as part of his best efforts to survive within difficult conditions. Sometimes it is said that UPR resembles the highest Christian form of love or *agape* (a pure concern for others, not based on any moral evaluation). As many religious adherents know, such love and also forgiveness can be extremely powerful, particularly for those who have known very little love or decency in their lives.

When asked at interview whether they have any difficulties with any individuals or groups of people, most candidates for training say something like this: 'No, I get on with everyone, I accept all kinds of people, I have worked in many multicultural settings'. UPR is thus conflated with a 'politically correct' attitude of celebrating diversity, having no conscious prejudices and actively striving to reduce or eliminate any residual ones. It can be too easily taken for granted from the outset that applicants for counselling training do not suffer from judgementalism and do not need much work on fostering UPR. Rigorous person-centred counsellors will insist that UPR is not a superficial

attribute, does not come automatically or easily and requires disciplined personal development work.

The clearest area in which trainees will declare some difficulties is paedophilia. 'I could not work with paedophiles' is quite a common admission. This may be followed closely by rapists and hardcore racists. Paedophilia is often seen as beyond the pale, as impossible to understand or even to try to understand or forgive, as if such an attempt almost condones the paedophilia or lessens its seriousness. Then there is the attempt to suggest that one could accept the person of the paedophile but not his actions. Fundamentally, the paedophile like everyone else is 'good' but has met some challenging life circumstances that have set him on the wrong path. If he experiences UPR, combined with persistent empathy, then in theory he should be able to confront his own actions, accept his own 'pre-paedophilic' self, forgive himself and cease his paedophilia. But paedophilia, like drug addiction, is a hardened condition, frequently with a poor prognosis for positive change. Many trainees and practitioners instinctively know this and will thus avoid such work, and perhaps also feel that they might be contaminated by working with paedophiles. UPR in these circumstances may seem impossible. But others, with a strong faith in human beings, will believe that even the paedophile deserves profound human consideration, or deserves the effort to be contacted at a relational depth. Some counsellors might try to distinguish between paedophiles (or rapists) who are motivated and unmotivated for change.

What other difficulties are encountered in experiencing and offering UPR? Obviously many will feel challenged by those who are openly racist, misogynistic, homophobic and disablist. It is possible to think and even declare 'I do not like your racism (or other anti-social attitude) but I fully accept you as a person'. But things are seldom so straightforward. Such attitudes are often mixed up with personality nuances, incongruence and countertransference. Some people are more likeable than others, whatever their 'failings' or negative attitudes. Some counsellors are themselves not naturally very warm or forgiving, or may have idiosyncratic resistances and reactions to others' foibles. It seems likely that those with a natural openness will find UPR much easier. But it doesn't necessarily follow that openness is always accompanied by an ability for active empathy, or technical creativity or imaginative therapeutic work. It's possible that a highly conscientious and intelligent counsellor may have to work hard at certain aspects of UPR if, say, he comes from a family or culture in which he learned to be judgemental. UPR may be of a bland kind ('I get on with everyone') or of a profound nature. One strong philosophical justification for UPR is that we are all a mixture of 'good' and 'bad' features

and that inside each of us there are remnants of dysfunctional and unloving attitudes and behaviour. Perhaps the luckier ones, with loving parents, a supportive and healthy environment and good genes, largely escaped the need to struggle with problematic and socially repellent behaviours. It can be said (indeed there are Christian precedents for saying) that sinners (or those most obviously antisocial) are most in need of love, or UPR.

Congruence can also seem to be at odds with UPR. At one level I accept, or strive to fully accept, my client. But at another I may have feelings that I cannot deny I have, of anger or irritation, unease or rejection towards my client. I have to decide whether, and when and how, to voice these feelings. Radical honesty as a human being, or a pressure for congruence within therapy, sometimes compels us to tell the other person that we object to their attitude, their language, views, poor hygiene or whatever. We may strive to 'say it nicely' but sometimes it will be experienced as rejecting or conditional. We may be able to work through such difficult moments successfully and sometimes they can even strengthen the therapeutic bond. Sometimes however they will not.

It looks likely that there are shades of UPR, including the somewhat false variety (the superficial 'portrayal' of UPR) at one end of a spectrum and a profound, perhaps spiritual quality of tender UPR at the other. There may be moments when the client might benefit from some straight talking about his or her obnoxious or self-defeating behaviour, when we ought to put aside any pretence of UPR (for example, 'It makes me shudder when you talk about your wife in that hateful and dismissive way'). Psychoanalysts might object that too strong or obvious an experience for the client of UPR might distort her unconscious feelings or their expression, just as some CBT writers have cautioned that too warm an acceptant style could encourage a client to be dependent on the counsellor and increase irrational beliefs about the need for others' love. Others might argue that although professional courtesy is a *sine qua non* of counselling practice, there is no particular onus on practitioners to feel or convey anything as grand or idealistic as UPR. Pragmatically, we might say that a high level of aspirational acceptance is necessary but this must be balanced by honesty, realism and therapeutic constraints.

Further reading

Bozarth, J. & Wilkins, P. (2001) *Rogers' Therapeutic Conditions: Evolution, Theory and Practice. Vol. 3. Unconscious Positive Regard*. Ross-on-Wye: PCCS.

2

How Important are Boundaries in Counselling Practice?

Boundaries or frames are taken to have considerable significance in therapeutic practice, so much so that transgressing some boundaries is tantamount to professional death, while others are open to interesting debate.

The clearest prohibitive boundary is that between the professional and the sexual relationship, discussed elsewhere in this book. Associated with this are boundaries between physical contact and non-contact, and between friendly relations and strictly professional relations. The standard classical psychoanalytic stance is that there should be no physical contact – no reassuring touch on the arm or shoulder, no hugs at times of great distress, and so on. (Some even avoid a simple handshake on first meeting.) There are good reasons for all this, including the avoidance of ambiguity and of unhelpful rescuing. Similarly, friendly and social relations between client and therapist are prohibited in the psychoanalytic tradition in order, again, to avoid ambiguity, and also to ensure the therapeutic relationship is purely focused on in-session transferential dynamics. In most humanistic approaches there may be some relaxing of such boundaries in the interests of authenticity and the judicious use of tactile contact for therapeutic purposes. Some cognitive and behavioural approaches may include a strategic use of out-of-office visits and in vivo therapeutic assignments, such as helping a client not to act out compulsions or to confront phobic objects. Clearly then, boundaries differ across models of therapy.

Boundaries may differ also according to individual therapist attitudes, decisions and risks. For example, what do you do if you see your client in public, or your client offers you a lift when it's raining? If your client has to go into

hospital, has few friends and asks you to visit, will you agree? Some therapists maintain strict 'no compromise' policies for all such scenarios. Others may consider and agree on pragmatic, compassionate or therapeutic grounds. All should, however, carefully weigh up the benefits and costs: small acts can have large unintended consequences or meanings, and if you cross a boundary once, where might it lead?

Consider other boundary challenges. On timekeeping, it is thought very important by most psychoanalytic practitioners to offer consistent appointment times, to monitor clients' behaviour in relation to these and to make interpretations and hold to agreements. Rarely will they vary the session length deliberately or inadvertently. In certain humanistic approaches, however, sessions may be lengthened in order to facilitate and debrief after deep emotional therapeutic work and behaviour therapy sometimes involves long intensive in vivo sessions. In addition, individual therapists may believe that flexibility is useful and simply human. Another well known boundary dictates that therapists should not accept gifts from clients since this introduces unconscious ambiguities associated with bribery and obligation: the therapeutic relationship should remain as purely professional as possible, even where it entails depths of emotion. Other boundaries include accepting only self-referrals and structuring the therapeutic environment so that clients never see each other. Again, different traditions, therapists and circumstances yield different responses to gifts and other scenarios.

So, apart from a universal agreement on the taboo against sexual contact, there are few absolute agreements on boundaries and the discussion seems mainly to reflect differences between traditions and their rationales. We might then ask whether any one approach has a better understanding of boundaries and, more generally, what the place of boundaries should be in counselling and psychotherapy. Undoubtedly some clients are mystified by boundaries that are unexplained, that are socially abnormal and that are perhaps hurtful or offensive. Heyward (1993) for example, reported as an ex-client of psychoanalytic psychotherapy that she had actually felt abused by the rigid distance and coldness she experienced with her therapist. Boundaries, then, may be perceived as unhelpful rather than therapeutic, and we should wonder whether some traditional prohibitions may impact heavy-handedly on clients from different classes and cultures.

Professionalism presumably is important, both in the sense of observing necessary codes of ethical conduct and as a check against over-casual practices and subtle misunderstandings. In other words, boundaries have a real function. On the other hand, with the passing of time and an awareness of cultural

changes and client perceptions, we might stop to consider the extent to which certain boundary traditions are or are not permanently important or adaptable. It is also possible to consider whether a strict adherence to boundaries may be crucial in relation to unconscious dynamics and simultaneously of little importance in the wider scheme of things. In other words, must we sometimes engage in an unavoidable paradox? Critical thinking on these matters shows that we cannot simply dispense with boundaries but neither can our traditions stand still.

Further reading

Heyward, C. (1993) *When Boundaries Betray Us: Beyond Illusions of What is Ethical in Therapy and Life*. San Francisco, CA: HarperCollins.

3

What Form Should Assessment Take?

The term 'assessment' means quite different things to different people, having connotations of school exams, clinical objectification and even unpleasant tax matters. There are often overlaps with and confusions about screening, diagnosis, case conceptualization and clinical hypothesizing. I want to use the term 'assessment' here in the following way. Anyone with an awareness of something not quite right in his or her life makes some assessment of whether it will get better or worse without attention, what it actually *is*, what

its causes and remedies might be, whether others need to be involved and whether now is the time to consider seeing a counsellor. All mental health workers (including counsellors) must formulate some view of each new client, whether this involves an obligatory formal assessment or not. Even the most radically anti-assessment practitioner would have to work hard not to entertain *some* impressions about a new client, based on experience and training. We all make assessments whether minimalist or comprehensive, and the form of our assessments depends on variables of training, profession, theoretical model and personal preferences.

At one extreme, some person-centred practitioners, opposed to any assessment that is perceived as imposed on the client by an expert, eschew assessment altogether: the client knows best and diagnostic assessment is an unnecessary and dangerous labelling exercise. At the other extreme, most psychiatrists and clinical psychologists are compelled to assess, often quite extensively and according to established psychodiagnostic categories, in the belief that treatment must fit rigorous diagnostic assessment. Somewhere in the middle of these extremes, many practitioners probably assess to one degree or another, as seems necessary to the client. For example, many clients using a bereavement counselling service have a 'simple' need to grieve and to feel understood. Yet others may have 'complex bereavement issues' including guilt, post-traumatic stress and other complicating social factors. Arnold Lazarus, the founder of multimodal therapy, acknowledges that in such cases clients probably do not need (or want) his 16-page assessment questionnaire, which at other times however can yield a richness of information to guide the therapeutic process.

Assessment helps to decide whether talking therapy is appropriate (the client may have stubborn psychiatric problems or undetected medical conditions) and whether what the service and counsellor offer matches the client's needs (for example, in terms of 'expertise', time available, etc.). Some psychoanalytic therapists assess for psychological-mindedness and a readiness to benefit from their form of therapy. This need not be done imperiously or 'behind the client's back' but can be done with full discussion and agreement. Indeed it is part of person-centred philosophy to be congruent about any concern that the counsellor has about her ability to be helpful.

Ongoing co-assessment is sometimes commended. In other words, any assessment of initial needs and aims can be done mutually. Another take on assessment is that we have far too little of it or far too little solid information to guide us. I find it surprising that so many counsellors take an anti-assessment stance, and seem much more interested in the client's history, in the depths of the therapeutic relationship and in insight and emotion. Assessment can be

seen as looking at the client's terrain, as if co-creating a map of relevant details. It need not be an interrogative exercise couched in clinical terminology. I think it is responsible to clarify what the client needs and what she brings, as well as clarifying all possible areas of concern and helpfulness. Relevant areas can include the following:

- The presenting concern or concerns (and associated details).
- A pertinent personal and family history or narrative and current circumstances.
- Previous medical and psychological problems and any help received.
- The client's general preoccupations and fantasies, however apparently random.
- The client's own assessment of the causes of the current problem and related variables.
- The client's strengths, characteristics and general limitations.
- Related factors (religious, cultural, employment, financial, political, etc.).

These items help to create a picture of what is going on and possible causes. They need not all be applied but it is useful to keep them in mind. They help to generate hypotheses. They remind us that not everything is psychological (some emotional problems have medical causes). They should expand our understanding of the client. Potentially, they should also stimulate therapeutic thinking that goes beyond our approach-specific traditions of dysfunctional parenting, traumatic incidents and irrational thinking. They should help us to formulate tentative ways forward and also any indications for referral elsewhere. Of course further assessment items can be added and this can and should be done in a way that avoids a haphazard bombardment of questions. While some believe that therapist-initiated assessment is necessarily expertise-bolstering and undermines clients' existing strengths and self-healing, many do not believe this: assessment can be co-operative, iterative and 'light-touch'.

Further reading

Buckroyd, J. (2003) Using action research to develop an assessment system in a voluntary sector counselling service. *Counselling and Psychotherapy Research,* 3 (4): 278–284.

Feltham, C. (2006) Conceptualising clients' problems. In C. Feltham and I. Horton (eds), *The Sage Handbook of Counselling and Psychotherapy* (2nd edn). London: Sage.

4

Is Eclecticism as Bad as the Bad Press it's Had?

Since eclecticism has been referred to as an undisciplined, haphazard 'mish-mash' and BACP adopted its principle of core theoretical models for accredited courses and individuals, eclecticism has been eclipsed by integrationism. Eclecticism has been portrayed as the haphazard process of throwing around techniques with no coherent rationale and with likely poor results for clients. By contrast, integrative models are portrayed as coherent theoretical blends of other models, preferably no more than two models elegantly brought together in, say, a new, probably hyphenated model. Eclecticism is unskilful, resting on inadequate training and hit-or-miss practice, runs the argument, while integrationism is a skilful, defensible endeavour. A major consequence of this perception or belief is that models and practitioners referred to as integrative have flourished (a majority of practitioners now identify as integrative) while eclecticism and eclectic counsellors seem to have gone underground or extinct, or expediently refer to their work as integrative.

What's in a name? According to some, 'integrative' is simply a more elegant and acceptable name for eclecticism. During many discussions on this topic, I have found that a lot of students and supervisees feel strongly that they need and want to respond to each of their clients in a unique and tailored manner. Most feel strongly that the imposition of a 'pure' model would ignore important individual differences between clients. In this analysis of matters, it is the inflexibly delivered pure model that constitutes poor practice, while eclecticism is an attempt to choose those techniques (and relationship styles) that best fit client needs. Some of these same students concede that it could be the case that a hard won integrative approach – for example, by spending many years training in two or more models – might ultimately help clients better.

This view seems to be based on the anxiety that techniques utilized without a thorough familiarity with their underlying theories might not be quite as skilful as otherwise. However, there seems to be no evidence that this is true. And there is an obvious case against this approach, which is its cost and elitism: very lengthy training must usually be paid for by practitioners themselves (therefore only those affluent enough to do so could pursue this path) and eventually these costs might well be passed on to clients.

Another argument against lengthy training for integrative practice is its randomness. In other words, almost any two (or more) approaches might be trained in regardless of their effectiveness or the likelihood that they would work well together. Such integrationism might appear thorough and beyond reproach but would seem to place such integrationism in a similar position to eclecticism (in its maligned form); that is, you may choose any combination you like, willy-nilly. We would here be elevating appearance over reality when our main concern should always be what clients actually need. In principle our best guidance for this should be evidence gleaned from rigorous research but there is still relatively little in the way of randomised control trials comparing a significant number of therapies.

Back to eclecticism itself. It is not necessarily the case that eclectic practice is haphazard. 'Theoretically consistent eclecticism' rests on the choice of techniques from any approach that can be rationalised as fitting into the blueprint of the practitioner's principal model. Gerard Egan has at times referred to his 'skilled helper' approach as systematic eclecticism. Arnold Lazarus calls his multimodal therapy 'technical eclecticism' in order to emphasize his belief that it is techniques (what therapists do) rather than theories that effect therapeutic change. Lazarus furthermore uses a framework (the BASIC ID) for deciding on technique selection. Just to add to this catalogue of perspectives on eclecticism, Sol Garfield entitled a major textbook *Psychotherapy: An Eclectic-Integrative Approach*. This reflects both the wisdom of taking the best from many approaches and integrating them but also reflects the fact that some cultures are simply not as negatively excited as the British about eclecticism. It is probably inconceivable in the UK counselling scene that such a hyphenated term could even be used.

It is quite possible that some practitioners are inadequately trained and that when they use techniques wildly, in an ill-judged manner – particularly potentially damaging techniques (such as regressive interventions) – they represent a threat to clients and subsequently to the profession. But isn't it equally possible that some who have trained very thoroughly in one approach, or indeed in two approaches, may inappropriately attempt to fit clients with those models? Much more thought and honesty is needed about the pros and cons involved here.

Further reading

Garfield, S. (1995) *Psychotherapy: An Eclectic-Integrative Approach* (2nd edn). New York: Wiley.

5

What are the Pros and Cons of Short-term, Time-limited Counselling?

In the 1980s very few in the UK talked about time-limited counselling. This was because for decades most counselling and psychotherapy, and certainly all psychoanalysis, was presumed to be open-ended. That is, it took as long as it took, and this usually meant at least many months and often many years. A combination of factors forced the time-limited agenda on to the counselling community. The development of certain humanistic and cognitive behavioural therapies challenged the dominance of psychoanalytic practice from around the 1960s and 1970s. The emergence of managed care and employee assistance programmes (EAPs) in the USA obliged therapists to consider how long their work took. Research began to emerge showing that a majority of clients often wanted, and benefited from, around six sessions rather than much longer. Many sought 'symptom relief' in the shortest possible time rather than extensive exploration of putative, multiple, subtle psychological factors. Students using free university counselling services, for example, tended to take up on average only four or five sessions (Feltham, 1997). The growth of counselling in the NHS (and also in EAPs and elsewhere) gradually forced the question of

funding in relation to resources and effectiveness, and the problem of waiting lists had to be faced. It was in the interests of private practitioners not to think about short-term therapy, which self-evidently means higher throughput of clients and therefore harder work as well as, perhaps, less job satisfaction.

It is much more obvious what the advantages of time-limited therapy are to clients than to practitioners. Let's put aside those relatively affluent clients who seek long-term therapy in order to reflect in a leisurely and perhaps aspirational manner on their lives. Most people feel impelled to seek help in a crisis or when things have gone wrong yet again. While psychoanalysts and psychoanalytic therapists themselves internalize a model of long-term, purportedly in-depth self-examination in their own mandatory and costly training therapy, most clients (or so I argue here) wish for a reasonably rapid reduction in bad feelings, distressing thoughts and unhelpful behaviours. While psychoanalytic practitioners warn against 'flight into health' and 'symptom substitution', an increasing majority of clients and counsellors in the NHS and other funded settings want to ease suffering promptly and provide emotional support and constructive insights. Presumably person-centred practitioners respect every client's self-determined pace and are ready to end whenever the client is ready. It so happens that the psychoanalytic practitioner profits financially from lengthy therapy as well as believing in its necessity, and the person-centred practitioner may benefit financially if in private practice but believes very strongly in following the therapeutic process and refraining from the introduction and use of any technical shortcuts.

Now consider the funder, whether the NHS or other organization. Even if these were persuaded that long-term therapy was necessary and beneficial in most cases, funding could not be made available for unknown quantities of long-term therapy. And while a relatively small number of clients might get added benefits from lengthier therapy, many would languish on waiting lists. I am not addressing here the equation involving a saner world society in which, say, the abolition of expensive weaponry could perhaps offset the cost of better healthcare. If we took that route we would still need to weigh up the merits of cancer treatment and hip replacements, say, against more and longer psychological therapies. Some counsellors in their well-intentioned, perhaps romantic and utopian way, do sometimes imagine that infinite resources are available. It might be nice for everyone who wants it to have as much therapy as she or he desires, and it would be nice to resource a much greater number of counsellors and therapists. But this isn't going to happen.

Some of the disadvantages of time-limited therapy are already implicit in the above discussion. Sometimes the removal of one symptom does lead to the

emergence of another; indeed it may sometimes take months before someone can establish sufficient trust and contact or disclose repressed traumatic memories. It may sometimes be wasteful – a false economy – to fund short-term interventions when the likelihood of relapse can be predicted. We can certainly observe the machinations of the promoters of Increasing Access to Psychological Therapies (IAPT) with its 'stepped care' aims, alongside the call-centred style of CBT delivery, compared with much more intense, careful, face to face and long-term therapies. Years from now we may be ruing the investment in such false economy, quick-fix shortcuts and their (predicted by some) high failure rates over time.

The best compromise is perhaps to offer and evaluate therapy of varied lengths and time spans and in general to reconsider the temporal factor altogether – one-offs, short-term, longer sessions, intermittent therapy across the lifespan, very long-term and so on. Where some practitioners are vehemently opposed to time constraints, let them at least demonstrate a thought-out argument on the matter.

Further reading

Feltham, C. (1997) *Time-Limited Counselling*. London: Sage.

6 What's Wrong with Counsellor Self-disclosure?

Most approaches to counselling recommend that counsellor self-disclosure is either absent or minimal. A counsellor who shares too much personal

information is likely to take attention away from the client, perhaps even encourage the client to 'counsel' or feel sorry for or protective towards the counsellor. (This is to overlook those few humanistic and existentialist therapists who have espoused as much openness as possible.) Too much counsellor self-disclosure is taken by most practitioners as a sign that the counsellor has unresolved personal problems. However, purposeful, skilful and timely 'countertransference disclosure' or congruent disclosures on the part of the counsellor are thought to be sometimes helpful. For some clients, hearing that the practitioner has experienced sexual abuse, a drink problem or bereavement, for example, and has lived through and perhaps overcome its distressing effects, can be reassuring. A relative minority of therapists eschew such reassurance altogether, wanting clients to be able to be wholly themselves with all their fears and fantasies. And some regard the counsellor as being in a parental role, or at least in a position of perceived strength so that the client can feel safe and if necessary regress. But an absolute refusal to disclose anything about oneself is sometimes thought too rigid and dehumanizing. So counsellors tread a fine line.

In general most of us like to be listened to. Attentive and asymmetrical listening is unusual in our society. But there are some little considered aspects of counsellor 'abstinence' that it may be useful to examine here. The attentive, unconditional acceptance offered by a counsellor can give a client the impression that everything he or she has to say is fascinating. Perhaps that is the case in the view of some counsellors, but I have heard enough supervisees expressing their exasperation at client small-talk to doubt it. Granted that some clients find such unusual attention initially disquieting, most come to value it. Rarely is it a counsellor's intention that a client should relate everything that comes to mind, no matter how trivial (the psychoanalyst may appear to encourage this but does so for interpretative purposes). Counsellors tend to disdain too much small talk or chit-chat, often regarding it as defensive. Indeed most counselling skills subtly shape clients' talk in the direction of problem identification, emotionally meaningful material and goal-setting. But the asocial, asymmetrical nature of counselling, much of it based on an unnatural withholding of the counsellor's talk about self, creates something of a void that a client comes to fill. Aristotle suggested that nature abhors a vacuum and it is often noted that human beings tend to be restless pattern-seekers, perhaps especially in situations with a deprivation of normal stimuli.

Another interesting aspect of counsellor abstinence from self-disclosure (and from expressing personal opinions) is that the client's fantasies (or phantasies) about the counsellor are thereby fuelled. Anyone with a mysterious vocation

like a counsellor, with a corresponding job title and perhaps an associated private setting to match, is likely to come across as having expertise, even if this is inwardly eschewed by many counsellors. If you come in distress and confusion to a job-titled counsellor or psychotherapist, you are almost sure to imagine that she or he has some mastery of life that you do not have. You would not knowingly go to see a counsellor who had significant unresolved distress and confusion of their own. But, in spite of counsellors' and psychotherapists' training, including personal therapy, personal development work and ongoing supervision, we have no effective way of knowing whether any practitioner at any one time carries distress and confusion. Practitioners themselves may be unaware of it, or aware of it but inclined to deny or conceal it. And in my view it is almost certainly true that none of us is immune from the everyday ravages of the human condition. In any case, usually the person in the client role (talking about herself, paying the money, and so on) is in the spotlight, vulnerable. Most of us would probably not pour our hearts out to a stranger if we believed that they were as distressed or confused as we were (or perhaps even more distressed). Most of us are sensitised to a right to privacy and personal discretion for all citizens, and this certainly includes therapists – but many therapists deliberately practise a paradoxical withholding of self, alongside an expectation that the client will freely disclose.

Let's consider if this ever were indeed the case, if it necessarily matters. It's possible that just at the time you (the client) started seeing a counsellor (Karen) she had recently begun going through a divorce. In principle (according to professional, ethical guidelines), if this were sufficiently distressing to her, she would temporarily cease practising; but this is unrealistic if Karen depends, as most of us do, on her everyday work for economic survival. She may well try to offload some of her distress on to a supervisor or therapist but this would be no guarantee that she won't still be distressed. Now, the asymmetrical nature of counselling (the client discloses, the counsellor doesn't) means that the client is very unlikely to know about Karen's divorce and its upsetting effects. In general the practice of counsellor non-self-disclosure unintentionally feeds the fantasy that counsellors don't have personal problems – because, after all, their selection and rigorous training would have minimised these.

We sometimes forget too that we cannot *not* disclose certain things about ourselves – by the way we speak and dress, our appearance and demeanour in general, even by where we live and at what level of comfort, if we are in private practice. The real choice may be, then, between minimal non-verbal self-disclosure, occasional therapeutically purposeful disclosures, and at the other (rare) extreme, a willingness to be highly transparent.

Further reading

Farber, B.A. (2006) *Self-Disclosure in Psychotherapy.* New York: Guilford.
Jourard, S. (1964) *The Transparent Self.* Princeton, NJ: Van Nostrand.

7

How Crucial are Counselling Ethics?

It is sometimes said that 'ethics is the cornerstone of counselling' and this seems such a weighty and indisputable statement that few would contest or question it. There does, of course, have to be some sort of agreed safety net and set of norms for something that aspires to become a profession. The *BACP Ethical Framework for Good Practice in Counselling and Psychotherapy* replaced former codes of ethics and practice that had come to be regarded as too complicated and prescriptive. Hence, this framework sets out the basic guiding principles. These begin with core values which include respect and fairness, they mention desirable personal qualities such as empathy, sincerity and wisdom, and they spell out applications in practice, teaching, supervision and research. They are also linked with complaints procedures. The *Framework* is a key document in addressing problems and complaints. Key areas within it concern confidentiality, personal and sexual contact and compromised effectiveness. Something that most courses are not equipped to do is to present and debate the origins of the moral philosophy underpinning professional ethics, as well as examining individuals' areas of uncertainty, weakness and temptation.

Unable to agree on counselling theory though many counsellors are (recall the 400+ models), all seem agreed on confidentiality and the taboo on sexual contact. It's hard to find anything to say against confidentiality, except that it is stretched by the exemptions for supervision and possible harm to self and others. No-one can guarantee absolute confidentiality when there may be several members of a supervision group, for example, and when supervisors themselves are required sometimes to discuss their work with others, in an indeterminate chain. Confidentiality in practice has to be taken on trust while any detected and serious breach of it should be met with appropriate measures. What we do not seem to have developed is a systematic means of making links between transgressions and the psychological causes of these in individuals so that we can learn to avoid such harm. We might however agree that it is probably fantasy to imagine that we could ever wholly eradicate ethical transgressions.

While almost every practitioner agrees on the taboo against sexual contact – since it violates trust, abuses power and changes the nature of the relationship – not all would agree on the limits involved. For example, some insist on an absolute, lifelong ban, while others suggest the ban can be lifted at the termination of therapy or after some agreed period, say a few months. This is complicated since some therapeutic relationships are lengthy and intense while others are brief and not intense. There is also the objection that it is against our human rights to dictate who can or cannot have sex with whom. In some other professions this is also a grey area. Greyer still, perhaps, are questions about flirting, kissing, innuendo and sexual suggestiveness. Therapists are not shy about admitting that erotic transferential and countertransferential dynamics are potentially ever-present. But again, there are different views on these matters; most agree transgressions should not happen but some would want to distinguish between degrees of transgression and effects on the client involved. It is often assumed that the perpetrators are mainly the practitioners and also mainly men but this is not necessarily the case. Clients and women (whether clients or practitioners) are also quite capable of making sexual advances and counsellors however principled are capable of making mistakes. Obviously by its nature this is an area that is very difficult to research. Sexual contact in counselling is regarded as the 'big taboo', second to other kinds of dual relationship, but these overlook the question of forgiveness (should a practitioner lose his or her livelihood over a forgivable mistake?) and other, possibly more common and neglected areas of ethics.

Counsellors are required to monitor their effectiveness and not to exploit their clients. There is arguably less chance of ineffectiveness and exploitation incurring financial and health costs in short-term and 'free' therapy than in private practice. Counsellors in the NHS do not take money from clients, do not generally see them for very long, and are connected with other health professionals and familiar with NICE guidelines. Counsellors in private practice tend to see clients for longer (in some cases for years), they do take money directly and they may or may not have close links with health professionals and a familiarity with NICE guidelines. Indeed as far as I am aware they are not obliged to be so aware and may have philosophical and clinical objections to such criteria. Some counsellors and psychotherapists do not regard their work as a health profession at all.

This combination of circumstances leads to the situation where private practitioners (particularly in psychoanalytic and humanistic approaches) are arguably the ones most likely to be complained against. Whatever their 'ethics', their practice can be compromised by the above factors, as well as a possible temptation to skimp on continuing professional development due to its costs. I have little idea how common the situation is wherein a private practitioner sees a client for many years with little to show in the way of an effective outcome. But publications by dissatisfied clients have tended to attribute blame to practitioners in private psychoanalytic practice more than to others.

Given the headlight attention that abuses of confidentiality and sexual contact have had, it seems strange that relatively little attention is given to, and complaints made about, counsellor ineffectiveness. Serious delays can be implicated in a client not getting the right help, as well as a serious loss of money. Compared with these, problems of sexual contact and confidentiality may be seen as not necessarily the worst abuses or instances of disservice. Professional ethics in counselling are obviously important but we should not overlook the possibility that for all their positive public relations reassurance impact, ethical statements generally fail to give due importance to effectiveness. The reason for this, I suspect, is that we cannot agree on best methods among the 400 or so approaches and their internal techniques; we do not have an agreement about psychodiagnostic validity; we can always 'blame the client' for not complying or for being resistant (and some clients may fit these descriptions); and indeed we have no consensus as to whether counselling and psychotherapy are health-oriented professions or even professions at all.

Behind ethical statements about 'best practice' is the overlooked domain of definitions and aims. Ethics are crucial but they are lame if a significant number of clients are not getting effective help. Since much research suggests that counselling is 80 per cent effective (and even this can be disputed), it is still possible that one in five clients receives unsatisfactory therapeutic attention. It would not be ethical to dispense with or play down our ethics but it is possible that for our own convenience we will unethically and tacitly avoid at the highest levels contentious areas like effectiveness.

It can also be said that ethics underpin everything that therapy, and everything in this book, is about. When any of us becomes aware of levels of psychological suffering and thinks that we might like to try to do something about it, our choice is an ethical one. I could give money to a mental health charity. I could, like the Buddha, give profound attention to the movement of suffering inside myself. I could decide that suffering arises or worsens in unequal, 'selfish capitalist' societies and do something actively political about this. The choice to become a psychotherapist or counsellor is an ethical decision about resources and perceived causes and remedies, as well as being about personal preferences. The choice to research the micro-ethics of, say, minor ethical infringements rather than to research more substantive topics is an ethical choice. This isn't to say that we must choose between ethics and therapeutics but to call for an awareness of proportions. Of course there are abusive professionals in all walks of life, and any of us could in a moment of weakness or misjudgement fall foul of ethical standards. But there are also systemic weaknesses and misjudgements in our professional bodies and training courses that cause unhappiness and stress (because fallible human beings drive systems). For some reason we do not refer to these as unethical.

Further reading

Bond, T. (2009) *Standards and Ethics for Counselling in Action* (3rd edn). London: Sage.

Bates, Y. & House, R. (eds) (2003) *Ethically Challenged Professions*. Ross-on-Wye: PCCS.

Gabriel, L. (2005) *Speaking the Unspeakable: The Ethics of Dual Relationships in Counselling and Psychotherapy*. London: Routledge.

8

Can You Counsel Effectively When Affected by Illness or Personal Troubles?

It is recognized by professional bodies that practitioners should monitor their own physical and mental health, that problems should be discussed in supervision, and that in certain circumstances they should consider withdrawing from practice until they are healthier and more fully available for clients. It is also very common for counsellors and psychotherapists to engage in their own therapy before or during their practice and part of the rationale for this is preventative. However, it is not clear whether these principles can always be realistically operationalized.

Take some examples of the kinds of events that might significantly compromise the mental or emotional health of counsellors: separation and divorce; bereavement, post-traumatic stress; work stress (e.g. high caseloads); accidents and illnesses; being a crime victim; financial problems; family conflicts and problems; caring responsibilities; the effects of ageing. In addition, anyone can experience transient depression and anxiety. In principle, employed counsellors can take any necessary sick leave and the self-employed should have sickness insurance. But in practice employers are not always understanding and too much sick leave may not practicable, and sickness insurance is expensive.

Most of us will experience times of relatively brief influenza or infection, for example, and have to (and can) bear a week or two off work without too much disruption. But protracted or frequent periods of illness – including post-viral fatigue – are another matter because client appointments have to

be cancelled, waiting lists may build, colleagues may have to take on the extra work, and the uncertainty for and vulnerability of some clients will have to be considered. The practical and clinical impact of longer absences is, then, one major consideration. I have not considered here the 'equal opportunities' implications for those with disabilities or limitations that either periodically or continuously impact on their ability to work consistently.

When it comes to personal troubles that are not primarily about physical illness, there are complications. For the most part people are not given extensive paid leave to address the problems of divorce, which can drag on for many months or even years, creating emotional and financial problems along the way. If you experience a combination of problems such as divorce, illness and ageing (say, in your fifties or sixties), yet need to hang on to your counselling practice as your sole source of income, what should be your ethical action?

I have sometimes heard the claim, and indeed have experienced this myself, that in periods of crisis one may actually find 'refuge' in counselling practice, in the discipline of listening intently to another and suspending one's own preoccupations. Some have even commented that personal turmoil can helpfully re-immerse you in the raw pain that many clients are feeling, while a practitioner whose life is 'too good' may become unintentionally distant from clients' suffering. The publicised personal breakdowns of Jung and some other therapists attest to the value of such experiences for wounded healers.

My contention is that the professional ethics of counselling, while completely well-meaning, create a fantasy that all practitioners are or should be extremely mentally fit, relatively untroubled and able to deal effectively with any difficulties that do occur. This fantasy is likely to discourage practitioners from being open about their problems. Idealistic ethics are also likely to make some practitioners hide their troubles.

There is probably also a hidden class dimension. If you are the sole breadwinner in your family and also on a very modest and tight income, you could not afford to withdraw nobly from your work for a period while you sort things out. On the other hand, if you have a fairly privileged lifestyle and an affluent partner, you may well be able to take time out or at least to reduce your workload. I don't think anyone would explicitly argue that counselling should be practised only by the affluent but the call for a temporary withdrawal from work implicitly overlooks the real situation of the majority on modest or low incomes. This is a point that professional body policy makers need to consider carefully – exactly how are practitioners who are temporarily compromised to address such matters *realistically*?

Perhaps there is a thorny conceptual issue here too: I have spoken above of people *suffering* and this term is used relatively rarely, and indeed disliked, by some counselling writers who prefer to emphasize personal strength and agency. Suffering may connote helpless victimhood. I do not develop this topic much here but it is pertinent to ask whether we do not all suffer, and sometimes suffer for prolonged periods. This view is at odds with being portrayed as heroically addressing and resolving all our problems promptly. Should therapists be such prompt and effective all-round problem-solvers in their own lives that few psychosomatic, emotional or financial problems ever occur for them?

Further reading

Dryden, W. (1992) *The Dryden Interviews* (Chapter 9: The counsellor and ME: An interview with Pat Milner). London: Whurr.

Orlans, V. (1993) The counsellor's life crisis. In W. Dryden (ed.), *Questions and Answers on Counselling in Action.* London: Sage.

9

Does Is It Matter If Empathy Is Not Matched by Personal Experience?

The personal experience I refer to here is the counsellor's and I have in mind those times when clients bring experiences and stories that the

counsellor may have no experience of herself. For example, the client may be bereaved, divorcing, elderly, bisexual, disabled, anxiously facing an imminent promotion or redundancy, or battling addiction. If the counsellor has no such similar experience, she can still of course closely track the client's feelings and meanings, experience some degree of accurate understanding and convey this to the client. Indeed this is one of the most key skills of any counsellor. Now, it's clear that none of us as counsellors can have experienced the full range of possible traits and states, events, dilemmas and struggles that we may meet in clients. Perhaps it's ridiculous to imagine we could ever come close.

But to what extent can a man know what menstruation, pregnancy, miscarriage, birth and menopause feel like, for example? How accurately and emotionally can a heterosexual man understand a gay man's sexuality and experiences of homophobia? In many addiction counselling agencies it has been traditional to employ staff who are themselves 'in recovery' and therefore able fully to understand their clients' experiences. Many years ago I counselled a woman in her sixties who, recently retired and single, was agonising over whether to move house to another part of the country to be near relatives. At the time I thought I had understood her well but years later, as I faced similar issues for the first time, the anxiety, loneliness and practical difficulties involved hit me much more personally and made me wonder in retrospect if she had sensed the limitations of my understanding.

Of course, the capacity for emotional and imaginative empathy probably varies considerably from person to person and from time to time. Many counsellors report being viscerally affected by clients' stories during sessions. Many find it helpful to read up on subjects outside their own experience, including relevant fiction. We probably all know that it's possible to call on our most similar emotional experiences in order to understand another's. For example, you may never have experienced an acute bereavement but memory of the impact of once losing your job, house or marriage may go some way towards appreciating another's experience of the loss of a partner by death.

The really important question here is what effect our limitations have on clients. When we engage in disciplined empathy, might it come across to some clients as *pretending* to understand? If so, it might well undermine the congruence of the relationship. If the client feels unconvinced by the counsellor's demeanour, he or she may drop out of counselling: 'How can she help me? She's too privileged to understand my poverty/too young to appreciate the struggles of old age'. Counsellors will of course often congruently convey such mismatches or lacunae: for example, 'I can't pretend to understand how

hard that must be for you'. But even such a deployment of interpersonal skills won't always convince clients that they're really being heard or that effective help will be found.

Another dimension to this matter is that you may have had a similar experience but many years ago. For example, you may have been very poor and struggled to make ends meet in your youth but have since done well by one means and another. Although you can dimly remember your own experiences of poverty they are now faint, they may be a little painful for you to recall and you may even have some sense that if you transcended your own poverty, your client should be able to do likewise. It does happen sometimes that we put the past behind us in this way and may even change our personal and political views across the decades. An older person with varied life experiences will not necessarily be able to use these in helping another. The client might well, in any case, feel inadequate at discussing her financial struggles if she is being counselled in private practice in your affluent home, the non-verbal, visual message being that she should be able to pull herself out of poverty just as the counsellor presumably has done. Conversely the younger counsellor might struggle to fully understand and convey her understanding of her much older client's disillusionment with wealth if she herself is in the early stages of aspiring to material wealth.

Ideally, we can clear our minds of our own memories, values and wishes within sessions in order to fully attend to the client and empathize with his or her particular issues. In a sense counselling demands both this kind of emptiness or receptivity at the same time as fellow-feeling (often drawn from a similar experience) is needed. All these factors matter – none of us can be the perfect counsellor, but neither should we be weighed down by awareness of the gaps between our own and our clients' experiences. On the other hand, the question of client-counsellor matching won't simply go away: are clients helped better by therapists with similar life experiences?

Further reading

Freire, E.S. (2007) Empathy. In M. Cooper, M. O'Hara, P.F. Schmid & G. Wyatt (eds), *The Handbook of Person-Centred Psychotherapy and Counselling.* Houndmills: Palgrave.

Rowan, J. & Jacobs, M. (2002) *The Therapist's Use of Self.* Maidenhead: Open University Press.

Everyday Counselling Practice:

Challenge

Provide a robust defence for conventional views on the topics in this group. In other words, argue with the author's views where these go against the prevailing norms or your own views. Weigh up what is called 'good practice' or 'received wisdom' against the right to a responsible challenge. Consider what the author says in the light of your experience and developing practice, and find ways to articulate any disagreement. You might also identify any areas where the author isn't critical enough for your liking.

Case Study

Martin is a mature and confident person with a naturally enquiring disposition. His practice seems to thrive and clients respond well to his authentic, compassionate and flexible style. Feeling that accreditation is probably necessary to progress his career, he reluctantly goes through the application process. Although a very skilled writer, he baulks at the requirement to name his approach and to make it look more coherent than he believes any counselling really is. In practice, he doesn't always observe time boundaries, he freely self-discloses (his life is sometimes chaotic), and he admits to working eclectically. He applies for accreditation but his application is not accepted. Should he modify his practice? Should he re-apply and disingenuously modify the way he describes his practice? Might it be said that his professional body fails to appreciate the effectiveness of his actual counselling and to extend unconditional positive professional regard to him? (See Lomas, 1993.)

Critical thinking perspectives

Martin might find that he cannot compromise his own values, in which case he could (a) continue in practice but remain unaccredited; (b) reapply with some small changes but also give a full statement of his values and reasons for differing from the evaluators, and then accept the consequences; (c) terminate his membership and join another organization such as the Independent Practitioners Network; (d) publicize his own views and create his own network or organization. These options all, however, contain some risks and further compromises, and require further energy: Martin is only human and he might succumb to depression, in which case we could infer that professional requirements as stressors can sometimes be responsible for causing or exacerbating mental health problems. Many sociological and philosophical issues can be found here.