

Professional Practice in Counselling and Psychotherapy

Ethics and the Law Peter Jenkins



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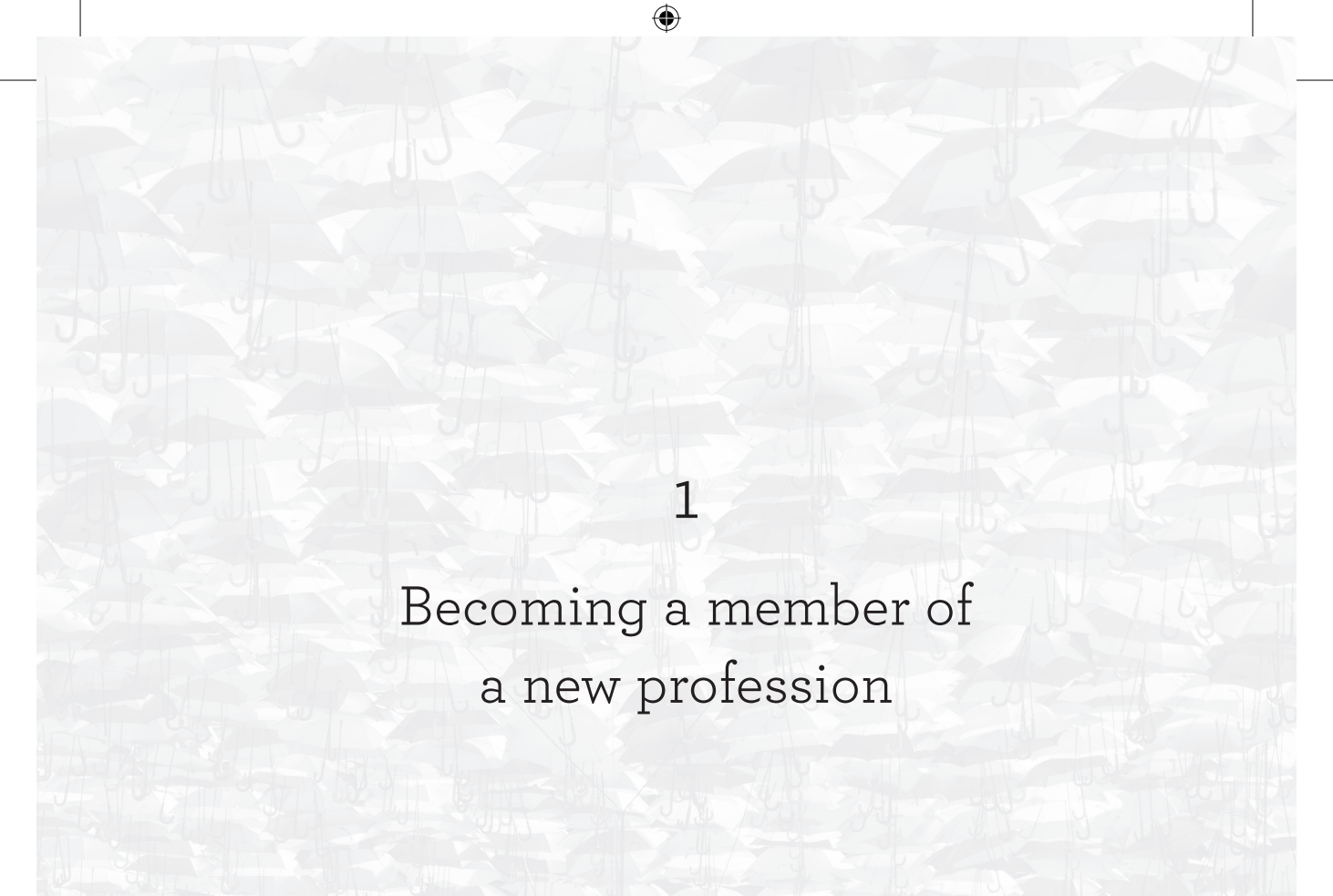
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Becoming a member of a new profession

Introduction

This chapter looks at what it means to join counselling and psychotherapy as a profession and what is involved in the process of becoming a 'professional' counsellor. It covers the following topics:

- understanding counselling and psychotherapy as a new profession;
- exploring the statutory regulation of counselling and psychotherapy;
- developing critical perspectives on the role of counselling in society;
- exploring the relationship of counselling and psychotherapy to other professions;
- becoming a professional counsellor and psychotherapist.

Learning context

The BACP *Core Curriculum* (2009) briefly sets out the requirement for students to develop knowledge and understanding of the history and culture of counselling in order to join and fully become a part of the wider community of therapists. The BACP *Ethical Framework for the Counselling Professions* (2016) provides a core part of what is required from students and practitioners in becoming a professional, by working to meet the appropriate standards of practice and behaviour. Extracts from both documents are included below for reference.

BACP Core Curriculum (2009)

9.1.A The professional role and responsibility of the therapist.

7. Understanding the values underpinning the profession, as exemplified in the Ethical Framework. (2009: 17)

9.1.D. The social, professional and organisational context for therapy:

The practitioner will have relevant knowledge to inform his or her ability to:

1. Take an active role as a member of a professional community.
2. Show a critical awareness of the history of ideas, the cultural context and social and political theories that inform and influence the practice of counselling and psychotherapy. (2009: 18)

BACP Ethical Framework for the Counselling Professions (2016)

Working to professional standards:

13. We must be competent to deliver the services being offered to at least fundamental professional standards or better.

14. We will keep skills and knowledge up to date by:

- a. reading professional journals, books and/or reliable electronic resources
- b. keeping ourselves informed of any relevant research and evidence-based guidance
- c. discussions with colleagues working on similar issues
- d. reviewing our knowledge and skills in supervision or discussion with experienced practitioners
- e. regular continuing professional development to update knowledge and skills
- f. keeping up to date with the law, regulations and any other requirements, including guidance from this Association, relevant to our work

15. We will keep accurate records that are appropriate to the service being provided.

16. We will collaborate with colleagues over our work with specific clients where this is consistent with client consent and will enhance services to the client.

17. We will work collaboratively with colleagues to improve services and offer mutual support.

18. We will maintain our own physical and psychological health at a level that enables us to work effectively with clients.

19. We will be covered by adequate insurance when providing services directly or indirectly to the public.

20. We will fulfil the ethical principles and values set out in this Ethical Framework regardless of whether working online, face to face or using any other methods of communication. The technical and practical knowledge may vary according to how services are delivered but all our services will be delivered to at least fundamental professional standards or better. (2016: 6)

Understanding counselling and psychotherapy as a new profession

So, what exactly is this new profession that you have decided to join, or which you are in the process of joining? Counselling and psychotherapy are hugely worthwhile occupations, with great job satisfaction and a strongly developing evidence base for their effectiveness in relieving human distress. However, whether they can confidently be called 'professions' in the more widely accepted sense of the word is still subject to dispute, at least in some circles. This chapter will look at some of the main features of what it is to be a member of a profession, or to act in a professional manner, which may not hold quite the same meaning.

Definition of a profession

The notion of a checklist, or list of key characteristics required of recognised professions, is a well-established format for guiding discussion on this topic. This is known as the *trait* model of professionalisation, which has been hugely influential in framing discussions on this topic. However, it has also been subject to increasing criticism for neglecting significant issues, such as power and gender. The checklist approach is, in part, a *developmental* model, holding out the possibility that different occupational groups, such as teachers and social workers, can work towards achieving full status as a profession by gradually achieving each of the required criteria. Becoming a profession involves a degree of legal recognition, when either the *title* (e.g. as a psychotherapist) or the *activity* of a particular group (e.g. counselling) becomes protected by law. This has important implications. A legally protected title (e.g. as a chartered psychologist) means that anyone claiming this status *without* being properly registered with a professional body (e.g. the British Psychological Society) or with a regulating body, such as the Health and Care Professions Council (HCPC), can be prevented from doing so. In addition, if a practitioner is subject to a successful complaint or a disciplinary procedure against them by their professional association (such as the British Psychological Society), or by their regulatory body (such

as the Health and Care Professions Council), they can be removed from the register. They are thus legally prevented from practising in that role.

The trait model has been a standard feature of sociological discussions of the process of professionalisation over the last century. It still retains influence as a working approach to deciding whether occupational groups, such as art therapists, dance therapists and social workers, fully qualify as professions. The Health and Care Professions Council used this approach in deciding applications from new and emerging professions up to 2011. It has had, therefore, real application in the recent past in deciding on the value of competing claims to professional status, even if it is no longer used for this purpose. The list of criteria follows a classic trait or a 'checklist' model, despite the growing academic criticism of this approach. Aspiring professions needed to demonstrate the criteria set out in Box 1.1.

Box 1.1 HCPC criteria for considering applications by new professions for regulation

- Cover a discrete area of activity displaying some homogeneity
- Apply a defined body of knowledge
- Practice based on evidence of efficacy
- Have at least one established professional body which accounts for a significant proportion of that occupational group
- Operate a voluntary register
- Have defined routes of entry to the profession
- Have independently assessed entry qualifications
- Have standards in relation to conduct, performance and ethics
- Have Fitness to Practise procedures to enforce those standards
- Be committed to continuous professional development (CPD)

Health and Care Professions Council (HCPC) (2001) New professions process, www.hpc-uk.org/aboutregistration/aspirantgroups/newprofessionsprocess/

Exercise Exploring HCPC criteria for a new profession

Consider the HCPC list of criteria in Box 1.1 and tick those you feel are met for counselling. Discuss and compare your answers with those of someone else, and then compare with the answers below in Table 1.1 (examples

(Continued)

(Continued)

relate primarily to the BACP as the leading body for counselling in the field, but similar responses could be supplied for the British Psychological Society (BPS,) United Kingdom Council for Psychotherapy (UKCP), British Association for Behavioural and Cognitive Psychotherapy (BABCP), etc.).

Table 1.1 Evidence of BACP meeting HCPC criteria for regulation of new professions

HCPC criteria	Commentary on evidence of BACP meeting HCPC criteria
Discrete area of activity	Continuing discussion over similarities and differences between counselling and psychotherapy. BAC added 'and Psychotherapy' to its title, becoming BACP in 2002.
Applied body of knowledge	BACP Research Panel set up in 1986; BACP peer-reviewed research journal (<i>Counselling and Psychotherapy Research</i>) published from 2001.
Evidence of efficacy	Increasing evidence of efficacy (see Cooper, 2008); however, relatively limited use of randomised controlled trials (RCTs) in this respect.
At least one established professional body	BACP is established in 1977 with current membership of around 44,000.
Voluntary register	Voluntary UK Register of Counsellors set up in 1997; introduction of Accreditation of Voluntary Registers scheme, operated by Professional Standards Authority for Health and Social Care, under Health and Social Care Act 2012.
Defined routes of entry to profession	From 2016, counsellor registration via either relevant training plus online assessment process or completion of BACP-accredited training course (the latter first set up in 1987).
Independently assessed entry qualifications	Blind online assessment process (90% pass rate) or completion of accredited training course.
Standards for conduct, ethics and performance	BACP <i>Code of Ethics</i> established 1982; BACP <i>Ethical Framework for Good Practice in Counselling and Psychotherapy</i> in 2002; <i>Ethical Framework for the Counselling Professions</i> in 2016.
Fitness to Practise procedures	BACP Complaints Procedure set up in 1983.
Commitment to CPD	CPD requirement for accreditation of individual counsellors first set up in 1983 and for all registrants from 2016.

The evidence outlined in Table 1.1 seems to suggest that BACP has already met, or is in the process of meeting, all of the criteria required by the HCPC for professional status and regulation. So, why is it still not subject to statutory regulation? This is a crucial question which will be discussed below.

Exploring the statutory regulation of counselling and psychotherapy

Counselling began to emerge as a distinct occupational group during the 1960s and 1970s, with the British Association for Counselling being established in 1977. This took a 'broad church' approach to membership, including as members those who used counselling *skills* as part of another profession, such as teachers. The issue of statutory regulation was first raised in 1971, with the publication of the Foster Report into the Church of Scientology (Foster, 1971), which was highly critical of the quasi-psychological methods used by Scientology to recruit, retain and control its members. It also raised the wider issue of regulating counselling and psychotherapy. However, it is telling that the Report struggled, then as now, to distinguish between the various different types of psychological practice. Hence "psychiatry" was seen as dealing with emotional or mental problems, "psychology" mainly with problems of the intellect. "Counselling" was widely practised, as was "psychotherapy without a fee" (Foster, 1971: 176). The Report concluded that 'It is high time that the practice of psychotherapy for reward should be restricted to members of a profession properly qualified in its techniques and trained...' (1971: 179).

The mantle was then taken up in the form of the Seighart Report (Seighart, 1978). This similarly struggled with resolving problems of definition:

we have serious doubts about whether psychotherapy as a function could be defined precisely enough by statutory language to prevent evasion, without at the same time casting the net so wide as to catch many people who are outside the mischief which the statute is designed to meet. We have in mind here professions as diverse as general medical practitioners, applied psychologists, clergymen, counsellors and educators who do not present themselves as specialised psychotherapists, but many of whom use interpersonal techniques in the course of their ordinary work... (Seighart, 1978: 6)

The strategy proposed was to regulate the use of the title of 'psychotherapist', given that it was not feasible to regulate a broad social grouping, with such loosely defined boundaries to its practice and

membership. Yet this first major attempt to introduce statutory regulation ultimately failed because of the continuing high levels of disagreement within the wider profession. In particular, concerns were raised by the behavioural psychotherapists. This group insisted on evidence of *therapeutic effectiveness* – and not simply of completion of a *period of training* – as a crucial precondition for the regulation of the profession (Jenkins, 2007a: 189).

Barriers to achieving statutory regulation

Disunity between the various therapists' organisations effectively ended this first attempt at achieving statutory regulation. The second major attempt developed after the failure of a Private Member's Bill in Parliament to regulate psychotherapy (but explicitly *not* counselling) in 1981. This led to a sustained round of lobbying by all the main therapists' organisations, the BACP, UKCP and others, during the 1980s, 1990s and beyond the turn of the century. Once again, this ran into substantial difficulties in trying to distinguish between counselling and psychotherapy for regulatory and legislative purposes. Another major cause of dissent among therapists was that the proposed regulatory body was to be the Health Professions Council (now the Health and Care Professions Council). This seemed to offer statutory regulation, but on a very medicalised model. Critics argued that this model was not suitable for the psychological or 'talking' therapies. Movement towards even this relatively unsatisfactory form of regulation ended with the change of government in 2010. The new Coalition government announced that the way forward would now be via the implementation of *voluntary* registers of therapists, rather than through statutory regulation. This decision ended the second attempt to achieve statutory regulation for counselling and psychotherapy. Almost 40 years of slow progress towards achieving the goal of statutory regulation was thus halted overnight.

This account suggests that the reasons why counselling and psychotherapy still do not have statutory regulation are quite complex. Progress towards regulation has been hampered by major disagreements between the different therapist bodies, over professional status and over their proven level of effectiveness in working with clients. Attempts to regulate have foundered, time and time again, on the difficulties involved in defining 'counselling' and 'counsellor' in a precise and binding manner. The situation now is that there is *partial* statutory regulation, in that psychologists are regulated in terms of title, via the HCPC. Art therapists, play therapists and child psychotherapists are also regulated by HCPC registers. Adoption counselling (although

somewhat ill-defined) is regulated via the Adoption and Children Act 2002. Infertility counselling is regulated via the Human Fertilisation and Embryology Act 1990. The overall result is something of a patchwork quilt, with different outposts of title, or practice, which are regulated. There are large parts of counselling and psychotherapy which are still not regulated, and are now unlikely to achieve regulation in the foreseeable future:

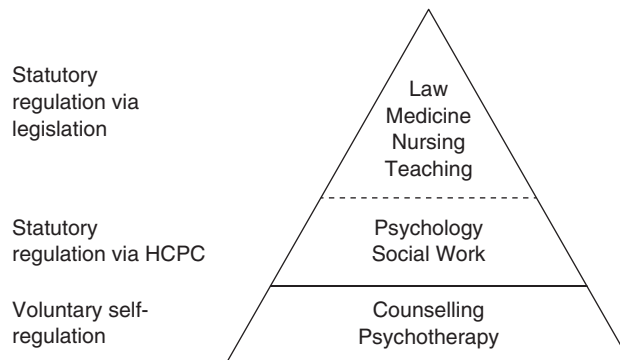


Figure 1.1 Schematic representation of different formats for statutory regulation and voluntary self-regulation for different professions and occupational groups

Exploring counselling, social work and nursing as semi-professions

There are a number of further potential answers to this crucial question of why counselling and psychotherapy are not fully recognised as professions. The following factors are important here:

- the problem of defining counselling and psychotherapy in an *exclusive manner*, i.e. which would *not* include other occupational groups that may use counselling as part of their role;
- the view that counselling and psychotherapy can only ever achieve *partial* recognition, given their limited and fixed status as a semi-profession;
- the argument that counselling adopted an *overly collaborative approach* to the process of seeking statutory regulation, which diluted its arguments and effectiveness in achieving regulation;
- the view that counselling and psychotherapy, rather than being a profession, really constitute a quite different kind of animal – namely '*a community of practice*'.

Problems with defining counselling

One view is that counselling and psychotherapy provide therapeutic interventions to individuals, couples and groups. However, the knowledge and skill base for these interventions and responses are not unique to those defining themselves as counsellors and psychotherapists. There is a real problem in defining counselling and psychotherapy in such a way that will effectively rule out competing claims for such expertise by other occupational or professional groups, such as psychologists. This difficulty is illustrated above in the account given of the history of progress towards statutory regulation. One possible answer is that counselling is an activity that can be carried out only by trained counsellors. This runs the risk of becoming rather a circular and unconvincing argument for those outside the profession. Sally Aldridge, a key player in the process of seeking statutory regulation, recounts the example of 'a senior civil servant in the IAPT programme asking me, as the BACP representative, to answer the question "What is *counselling*?"' (2010: 368, emphasis added). Perhaps, for us as counsellors, the answer to the question 'What is counselling?' may seem fairly self-evident, or a question that can be easily answered by referring to the current BACP definition. However, the lack of clarity about counselling's definition by a powerful government representative suggests a relative lack of understanding in the wider society, about what counselling consists of and how it can be distinguished from other, similar forms of psychological support (see Box 1.2).

Box 1.2 BACP definition of counselling and psychotherapy (2012a)

Counselling and psychotherapy are 'umbrella terms for a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.'

British Association for Counselling and Psychotherapy (2012a) *What are Counselling and Psychotherapy?* Lutterworth: BACP, www.bacp.co.uk/crs/Training/whatiscounselling.php

Exercise Defining counselling and psychotherapy

Devise your own working definition of either counselling or psychotherapy. Check it over. What is missing and needs to be added?

The problems inherent in trying to define counselling and psychotherapy are presented and discussed very thoroughly by Reeves (2013: 7–13) and Aldridge (2014: 2–6).

Professions, from one perspective, are essentially about the exercise of *power*. For example, the legal profession has legitimate power with regard to providing legal advice and representation. The medical profession exercises legitimate power over who can carry out specific medical activities, such as the diagnosis and treatment of illness and disease. The view advanced by Etzioni (1969) is that certain occupational groups, such as teaching, nursing and social work, are fixed and unable to progress beyond their current status as *semi-professions*. This is partly due to the fact that their core activities are hard to define in a way that would exclude other occupational groups. There is also the additional factor of *gender*, in that these are occupational groups largely consisting of women, who may find it harder to exercise power effectively within a male-dominated society (see Box 1.3). Counselling and psychotherapy share many of the features of teaching, nursing and social work, as semi-professions. However, each of these occupational groups (teaching, nursing and social work) has achieved statutory regulation, unlike counselling and psychotherapy.

Box 1.3 Characteristics of a semi-profession (Etzioni, 1969)

Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge, and they have less autonomy from supervision or societal control than the 'professions'. (1969: v)

...while the semi-professionals are more supervised than the professionals, supervision is more often conducted by their own kind. (1969: xv)

Etzioni is referring here to *line management* supervision, rather than to the type of *therapeutic or consultative* supervision, which is integrally associated with counselling and psychotherapy practice (for further discussion, see Chapter 7). Nonetheless, there is a well-recognised tension for many therapists in the prospect of being line-managed by people who are non-therapists and who do not necessarily subscribe to therapeutic values, e.g. relating to client confidentiality and information-sharing. 'Privileged communication' refers here to legal powers, which protect client or patient confidentiality from access by the courts.

Sally Aldridge was a representative of BACP during the most recent attempt to secure statutory regulation for counselling and psychotherapy.

She presents an interesting argument that these are 'insecure professions' with weak occupational boundaries. At critical moments, BACP has decisively opted for an *inclusive* approach to membership (hence the earlier title referring to the 'British Association *for* Counselling and Psychotherapy', rather than '*of* Counsellors and Psychotherapists'). Until comparatively recently, BACP has been reluctant to define membership criteria in a strict and exclusive manner. It could, for example, have opted to restrict entry *only* to applicants completing BACP-accredited courses, or *only* to those achieving individual accreditation. The process of negotiating statutory regulation with sceptical government figures was perhaps hampered by BACP's adoption of a relatively self-effacing (rather than a more assertive) lobbying approach. BACP failed, therefore, to push through its own agenda with sufficient forcefulness. This collaborative approach may have been perceived as reflecting weakness, on the part of the largely female-dominated occupational group of counsellors and psychotherapists, by the largely male gatekeepers, who held the power to award or withhold institutional recognition. This is a persuasive insider view. Nevertheless, it perhaps understates the more objective barriers to statutory regulation for new professions in the post-Thatcher era. In neo-liberal market economies, the emphasis is now firmly on de-professionalisation, rather than the creation of yet more new emerging professions (Aldridge, 2010).

Counselling as 'a community of practice'

An alternative view to the concept of counselling and psychotherapy as a semi-profession, or even as an *insecure* profession, is to reframe the discussion, away from the fruitless pursuit of professional status. Wenger (1998) suggests that it may be useful to look at groups of professionals, working together in a shared culture, with common values and understandings, as constituting 'a community of practice'. This is a difficult concept to define with any degree of precision, but it embraces groups of people coming together to work on and resolve particular problems or projects. Wenger uses the term to describe something that is broader than just a team, or a department within an organisation. It may be stretching his concept somewhat, but exploring counselling and psychotherapy as just such a 'community of practice' has the merit of shifting discussion away from a relentless focus on the quest for professional recognition, in the form of statutory regulation. So what is a community of practice? Essentially, this consists of 'a community of mutual engagement, a negotiated enterprise, and a repertoire of negotiable resources accumulated over time' (Wenger, 1998: 126).

Translating from this somewhat abstract, academic language, such a community requires a shared approach towards group membership and roles, a shared understanding of task and process, and a shared experience and a means of communicating with others of like mind. This awareness of belonging to a community makes a lot of sense at an *experiential and relational* level, in that counsellors will often quickly establish good working relationships with each other. They will routinely share their knowledge and skills with other practitioners, in the service of working with the client, rather than immediately retreating behind specialisms of therapeutic modality. Of course, there will always be some exceptions to this rather optimistic scenario, but differences of modality and professional label may often be submerged by a common interest in providing effective therapy for a given client or set of clients. This approach stresses the role of *shared values*, rather than focusing on *power* as such (see Box 1.4).

Box 1.4 The key characteristics of a community of practice

Such a concept of practice includes both the explicit and the tacit. ... It includes the language, tools, documents, images, symbols, well-defined roles, specified criteria, codified procedures, regulations and contract that various practices make explicit for a variety of purposes. But it also includes all the implicit relations, tacit conventions, subtle cues, untold rules of thumb, recognizable intuitions, specific perceptions, well-tuned sensitivities, embodied understandings, underlying assumptions, and shared world views. Many of these may never be articulated, yet they are unmistakable signs of membership in communities of practice and are crucial to the success of their enterprises. (Wenger, 1998: 47)

A community of practice is a unique combination of three fundamental elements: a *domain* of knowledge, which defines a set of issues; a *community* of people who care about this domain; and the shared *practice* that they are developing to be effective in their domain. (Wenger et al., 2002: 27)

This approach to exploring counselling as a community of practice places an emphasis on the shared, but largely informal, *culture* of counselling and psychotherapy. It focuses on shared meanings and expectations, rather than on formal roles, rules and qualifications. You may find that the idea of a community of practice quickly becomes real at an experiential level, when joining a discussion, a group, workshop, or conference which is composed of counsellors, rather than activities which include a broad mix of professionals from very different working backgrounds.

Developing critical perspectives of counselling as a new profession

Clearly, the drive for recognition as a fully qualified new profession is not a straightforward or easy process. Other powerful groups and interests in society may challenge, or even ridicule, the arguments put forward by newly emerging occupational groups. Classically, other more powerful groups have criticised counselling on the grounds that counselling is 'just talking' or that 'anyone can do it'. Other established professions, such as medicine and law, may actively oppose newer groups achieving a degree of professional control, given that a profession can be defined as 'a monopoly in the public interest' (Gross, 1967: 47). Established professions, which have already achieved a degree of this type of monopoly power over specialised services, may be reluctant to admit newer occupational groups to full professional status, particularly if this step involves a reduction in their own power. The issue of how counselling and psychotherapy relate to medicine and the law therefore becomes another factor to consider in exploring the process of achieving professional status, which will be briefly touched on later.

Exercise Exploring approaches to professionalisation

Consider one of these four approaches to the professionalisation of counselling and psychotherapy, as outlined above. Make brief notes of the positive and negative aspects of one of these for future reference.

Developing critical perspectives on the role of counselling in society

Other perspectives may be critical, either of counselling's claim to hold specific expertise, or of the ways in which this expertise may be put to use in society. Some of the main critiques and arguments about the role of counselling in this regard include the following:

- counselling and psychotherapy is a *social project*, promoting unhealthy levels of emotional vulnerability in society, based on its own vested interest in offering 'solutions' to largely invented problems of low self-esteem and trauma;

- counselling is a valuable form of *social engineering*, geared to reducing the distress of mental illness, via state-funded provision on a medical model;
- counselling is a by-product of affluence, *narrowly focused on individual change* and ignoring wider social issues of poverty and austerity.

These critiques and perspectives are briefly outlined and explored below.

Counselling as promoting social and individual vulnerability

One recent critique is by Furedi (2004), who argues that counselling seeks to exaggerate normal problems of transition and manageable anxiety in order to create a role for itself in apparently providing 'solutions' to these problems. His critique covers a wide range of applications of counselling, or 'therapy culture', to encompass trauma counselling, workplace counselling and counselling in schools and universities (see Box 1.5).

Box 1.5 Counselling and self-reliance: A project promoting a moral panic about vulnerability

I was meeting a friend in the lobby of the University of London Union. While killing time, my attention was drawn to a large poster displayed prominently on the wall. The poster was advertising one of the innumerable helplines that cater for university students. In bold black letters it proclaimed: 'The stiff upper lip went out in the 1940s'. Almost immediately, I understood that this in-your-face celebration of counselling contained an important statement about our times. The stiff upper lip was out and a new culture of helplines, support groups, counselling services, mentors, facilitators and emotional conformism was in. (Furedi, 2003: 22)

Therapeutic culture has helped construct a diminished sense of self that characteristically suffers from an emotional deficit and possesses a permanent sense of vulnerability. (Furedi, 2004: 21)

Furedi argues that therapy culture perceives people's emotions as 'objects to be managed', rather than experiences to be endured and learned from (2004: 34). In terms of his philosophical stance, Furedi is writing from a classically liberal position, in resisting pressures from

the wider society, or from the state itself, which encroach on the individual's autonomy and liberty. This has much in common with a Stoic position within classical Greek philosophy, namely of developing cheerful acceptance of life's adversities (see Howard, 2000: 62–79; Vesey and Foulkes, 1999: 275–276).

In a curious way, Furedi, a critical sociologist, is echoing the views of Victorian advocates of *self-reliance and self-help*. However, his views are increasingly out of step with changing perceptions of counselling and its role in contemporary society. Market research, commissioned by BACP, has indicated a sea-change in the wider public's perceptions of counselling. By 2004, 83% of British adults have had, or would consider having, counselling or psychotherapy (Future Foundation Projects, 2004: 17). Only 18% would 'never consider having counselling or psychotherapy'. Of course, on its own this does not demonstrate that Furedi's arguments are without some justification. Simply, he is arguing a minority case, given that the public acceptance of counselling has significantly increased over time.

Furedi's approach also tallies with that held by Epictetus, another Greek philosopher, who is credited with the saying: 'Men are troubled not so much by circumstances, as by their reactions to circumstances' (Howard, 2000: 68). This view correlates closely with the crucial role of *cognition*, or *thinking*, within cognitive behaviour therapy. The link with cognitive behaviour therapy is taken up in a different way by the next writer, who claims that CBT and counselling can play a major role in addressing society's current pressing mental health problems.

Counselling as producing a happier society

Lord Layard (2006) has taken a very positive view of the role of CBT and, to a lesser extent of counselling and other therapies, as a means of addressing and reducing the current high levels of depression and anxiety within society. This approach has provided the rationale for the influential Improving Access to Psychological Therapy (IAPT) programme. This has radically transformed the entire landscape of counselling and psychotherapy in England (see Box 1.6).

Box 1.6 Counselling and social engineering: Aiming to produce a happier society

We should look for the state in which people are happiest; the guide for public policy being how we can enable people to lead the happiest possible lives. (Layard, 2006: 6)

If you focus on the least happy people and ask how they differ from other people, you will find that the single most important factor is their record of mental illness. We know that while one in six people at any one time would be diagnosed as having mental health problems, only a quarter of these people are in treatment. Therefore, it must be a major objective of our society to get treatment available and used by the great majority of those people. It means a total change in the treatment we offer people, not only for those with psychotic disorders but also for those who have clinical depression or chronic anxiety conditions. They should be offered what NICE guidelines say they should be offered: not only medication but also psychological therapies, especially CBT [cognitive behaviour therapy], but also other therapies where relevant. (Layard, 2006: 7)

From a philosophical perspective, Layard is proposing a classical *utilitarian* rationale for the IAPT policy. This is consistent with the position adopted by Bentham, who favoured social legislation geared to achieving 'the greatest happiness of the greatest number' (Bentham, in Howard, 2000: 210).

Layard's goal is, effectively, one of *social engineering*, in order to reduce levels of distress in the population. His method is to use only psychological therapies of proven value. This requires therapies to have been rigorously evaluated, usually in the form of randomised controlled trials, according to 'best evidence' standards, as applied by the medical profession in devising the NICE guidelines. In terms of counselling and professional status, this needs the former to apply standards of evidence which are derived from medicine, using a quantitative methodology, firmly set within a positivist standpoint. Counselling and psychotherapy research is thus put under the wing of medical science, rather than being able to rely on its own independently developed research criteria. It has also placed counselling and psychotherapy at a significant disadvantage to other occupational groupings, such as clinical and counselling psychology. The latter have contributed to a much more extensive evidence base, which is now available for CBT. The evidence for CBT today is substantial, as compared with an often ill-defined 'counselling', as an alternative therapeutic intervention in scientific trials for depression and anxiety.

Counselling as an alternative to social reform

Layard takes the high levels of mental illness and distress as his starting point in arguing a case for making CBT and other therapies available on a much wider scale. Nevertheless, Wilkinson and Pickett (2010) are concerned to pose the question *why* these levels are so high

in the first place, given the rise of post-war affluence in many Western societies. They identify that, as societies have experienced a rising standard of living, for much of the post-war period, a real paradox has emerged. Levels of self-esteem have risen in society, but so have levels of anxiety and depression. This is a curious finding for counsellors, as our received wisdom might suggest instead that high self-esteem is an *antidote* to anxiety and depression. However, Wilkinson and Pickett claim that this self-esteem is insecure in its foundations, resting on high levels of what individuals perceive as a 'social evaluative threat'. This, in turn, produces growing levels of stress, measurable via increased levels of the hormone cortisol. From a counselling perspective, this highly insecure but increased self-esteem might be framed in terms of an *external locus of evaluation*, using a person-centred language. Self-esteem is thus high *only* if one can be sure that others constantly approve of one's behaviour, achievements and possessions. Some supporting evidence for this view is suggested by one study in Denmark, which found that taking a break from using Facebook was associated with feeling happier, for both children and adults (Happiness Research Institute, 2015).

For Wilkinson and Pickett (2010), the ultimate cause of these high levels of social anxiety and depression in many Western societies is the high level of social inequality, which increases a sense of social evaluative threat. More equal societies report lower levels of mental health problems, according to the authors (see Box 1.7).

Box 1.7 Counselling and social reform: The problems of anxiety and depression linked to 'social evaluative threat'

Politics was once seen as a way of improving people's social and emotional wellbeing by changing their economic circumstances. But over the last few decades the bigger picture has been lost. People are now much more likely to see psychosocial wellbeing as dependent on what can be done at the individual level, using cognitive behavioural therapy – one person at a time – or on providing support in early childhood, or on the reassertion of religious or 'family' values. (Wilkinson and Pickett, 2010: 238)

The solution to the problems caused by social inequality is not mass psychotherapy aimed at making everyone less vulnerable. (Wilkinson and Pickett, 2010: 32–33)

It follows from this view that social policies, such as IAPT, do not address the real underlying causes of mental distress and will therefore not be successful in resolving them. However, many counsellors will already be aware of the impact of inequality within society on mental health. They may also be aware that they can see the positive effects of their own therapeutic work in individual clients over time. They will be aware too of the growing evidence base for the effectiveness of counselling and psychotherapy in helping clients to overcome these concerns.

Exercise Evaluating critiques of counselling

Decide which of these three social critiques and perspectives in relation to counselling is closest to your own personal views. Now, take the critique or perspective you disagree with most. What arguments can you make *against* the case you agree with *most*?

Exploring the relationship of counselling and psychotherapy to other professions

One of the ways of exploring the relationship of counselling and psychotherapy as a profession, or semi-profession, or even as a 'community of practice', is to compare them with other professional groups. Counsellors will inevitably come into contact through their work with other more established professional groups, such as doctors, psychologists and lawyers. It is important to develop a good working understanding of the roles and contributions of these other professional groups in order to build better working relationships with them.

- **Medicine:** Counsellors will often work alongside members of the medical profession in multi-disciplinary teams, for example in occupational health, or in primary care within the NHS. Counsellors may also come into professional contact with psychiatrists, when working in more specialised medical settings, such as mental health services, either in the community or in hospital settings. The medical profession is much more hierarchical and structured than counselling, with a longer period of training. Issues of diagnosis and treatment are considered to be central to medical practice. Until recently, doctors had a monopoly of prescribing drugs and medication, but it has now become possible for advanced nurse practitioners to carry

out this activity, after taking the relevant training. Within psychiatry, doctors will usually refer to diagnostic manuals, such as ICD-10 (World Health Organization, 2010) or DSM-5 (American Psychiatric Association, 2013), which identify specific symptoms associated with particular mental health conditions; e.g. auditory hallucinations may be indicative of schizophrenia. Appropriately qualified doctors have the legal authority to admit patients suffering from a mental disorder to hospital for treatment, under the Mental Health Act 1983. Some psychiatrists will have completed at least some level of psychotherapy as part of their specialist training. Doctors are represented by the British Medical Association and are regulated by the General Medical Council.

- **Psychology:** Within the field of psychology, there is huge variation in terms of levels of qualification, expertise and employment. In IAPT, many counsellors may work alongside, or be employed as PWPs (Psychological Wellbeing Practitioners), providing initial support to patients or clients, regarding low-level anxiety or depression, on a stepped care model (see Chapter 4 for more detailed discussion of this model of care). PWPs will have an initial training in CBT, and provide guidance by phone or in person to clients, perhaps by guiding them towards computerised self-help programmes, through referral for exercise, or for purposeful reading of self-help guides. Other psychologists with postgraduate training may work as clinical psychologists, or as counselling psychologists, offering a range of therapeutic interventions to clients. They may provide 'high intensity' therapeutic work with clients who show more complex presentations, such as obsessive compulsive disorder or chronic depression. Psychologists, as a profession, are represented by the British Psychological Society (BPS) and are regulated by the Health and Care Professions Council. Some forms of psychological intervention are restricted to appropriately trained members of the BPS, such as the use of formalised assessments for dyslexia or autism. Increasingly, psychologists act as supervisors of counsellors, or of teams of counsellors, within the NHS and are often seen to have a stronger research base than counsellors, as active 'practitioner researchers'.
- **Law:** Counsellors may be somewhat less likely to come into professional contact with members of the legal profession, at least on a regular basis. When they do, it is often in the context of a requirement to respond to a legal request, or order, which can become quite challenging as an experience. Lawyers, like doctors, belong to a hierarchical and quite structured profession. Until recently, lawyers tended to be divided between solicitors, who provided legal

advice, and barristers, who represented clients in court. This division has been eroded, as solicitors have gained the right to act as advocates in court. Barristers are represented by the Bar Council and are regulated by the Bar Standards Board. Solicitors are represented by the Law Society and regulated by the Solicitors Regulatory Authority.

Counsellors may be contacted by lawyers for access to their client records, for use as evidence in either civil or criminal proceedings. One difficulty is that counselling training rarely provides much coverage of the legal system relating to counselling, other than at a very basic level, e.g. regarding confidentiality. Counselling training, therefore, does not properly equip counsellors to write court reports on their clients, nor to appear as professional witnesses, in contrast with other professional groups, such as social workers. However, much of counselling practice is set firmly within a legal context, such as the crucial role of contracts in private practice or supervision. It is important, therefore, for counsellors to build up their knowledge and confidence in dealing with legal matters and with the legal profession as a whole (see Chapter 5).

Becoming a professional counsellor and psychotherapist

It can be helpful, in undergoing the process of counsellor training, to have a model of professional development in mind. Often these are 'stages' models of development, involving progression from lower levels of skill, to more advanced and more independent forms of practice. One such model is proposed by Dreyfus and Dreyfus (1986), who distinguish between the following levels of practitioner development:

- **Novice:** This involves a process of learning which relies heavily on the *rules* of the activity in question. A common example in early counselling skills training is the internalised injunction about 'not asking the client questions'. This is thought to take the counsellor away from the client's *own* frame of reference. Rules can take on the quality of being absolute and, at this stage, rather like the client, are not 'open to question'. This approach is rather rigid, but perhaps understandable, in that assessment of competence at this early stage may well be based on observable compliance with basic 'rules' of how best to communicate empathically with clients.
- **Advanced beginner:** This is where the developing practitioner can begin to discern aspects of the client's behaviour, which then

inform the counsellor's decision-making, both inside and outside the session. An example of this might be recognising that a client hearing voices may signal the onset of psychotic symptoms, which should be taken back to supervision. The counsellor, although still a beginner, can recognise limits to their own competence and seek advice and support from more experienced colleagues.

- **Competent:** Here, the therapist can apply learned 'rules' from their earlier and ongoing training, but in a more relaxed and creative manner. Hence, the practitioner can begin to *anticipate* events, *before* they unfold, without this necessarily driving the therapeutic process. An example might be where the therapist has a sense that the client is on the cusp of experiencing anger, in the context of a recent major bereavement, or that a client may be likely to experience (even an agreed) ending of therapy as abandonment by the counsellor, based on the client's description of experiences in undergoing painful losses in the past.
- **Proficient:** Here, the practitioner has an awareness of nuances, such as perhaps subtle shifts in voice tone, eye contact and appearance, which are part of an underlying, but still easily missed, pattern of meaning for the client. These nuances probably would be missed by a novice, lacking both the proficient practitioner's experience and the latter's growing ability to recognise subtle patterns of client expression and meaning, such as shame or disappointment.
- **Expert:** At this level, the therapist works in a largely intuitive (but highly effective) manner, based on their experience and their own learning. The therapist has a strong and usually accurate sense of how to work best with the client, but may find it hard 'in the moment' to identify exactly *why* a certain emotional response was given. Therapist responses at this level may be governed more by immediate context and the sensed relationship with the client, rather than by reference to rules learned back in the early stages of training. An example might be where an experienced practitioner decides to vary the agreed length of sessions to two hours, after quick consultation with the client concerned, or to offer a video session in place of the usual face-to-face meeting.

The following example gives a flavour of how this process of learning can become internalised:

I learned all the rules and so I came to a point – after a lot of effort – where I knew the rules very well. Gradually, I modified the rules. Then I began to use the rules to let me go where I wanted to go. Lately I haven't been talking so much in terms of rules. (Dreyfus and Dreyfus, 1986: 66–67)

Exercise Evaluating your own professional development

What stage are you currently at in terms of your own professional development? What do you need to achieve in order to be confident about moving on from, or at least remaining at, your current stage as a practitioner? Select one aspect of the criteria from the BACP *Ethical Framework for the Counselling Professions* (2016) to work on, and set a specific goal to achieve over the next month.

Becoming a professional

The chapter so far has suggested that counselling and psychotherapy may not have reached full recognition in terms of their achieving full status as a profession. There is, however, an important distinction between being a member of a profession and being a *professional*. This is not simply in terms of being paid – counsellors are required to act and behave in a professional manner, even when giving their services for free, perhaps as a student or as a volunteer working towards accreditation. So what does being (or becoming) a professional counsellor involve?

Some standards of professionalism can be set out fairly easily. Counsellors need to be competent to provide therapy. This is easily said, but working to develop skills may often involve practising at the very edge of your own level of confidence and skill. Every counsellor will have worked with a potentially suicidal client for the first time at some point in their career. A crucial point here is the need to appreciate the need for ongoing support and consultation with other more experienced colleagues and to recognise your own limitations. One paradox is that counselling (apart from with couples and in groups) may largely be delivered on a one-to-one basis, but is, in many ways, a very *collegiate and collaborative* process, based on *sharing knowledge*, whether through continuous professional development (CPD) or through taking part in group supervision, hence the emphasis in the *Ethical Framework for the Counselling Professions* (BACP, 2016) on collaborative work with colleagues. Accurate record-keeping may be another aspect of this, because colleagues and service managers may need access to client records to maintain continuity of care to a given client. The counselling relationship is primarily a relationship between the client and the counsellor. However, it is also, at least in part, a relationship between the client and the *agency* that the counsellor represents and is a volunteer for, or is employed by. Records are one aspect of collaborative

practice in that another counsellor may need access to records to provide counselling in your absence or once you have left the agency.

Counsellors are increasingly expected to keep up to date with the fast-developing evidence base for their work. This can be done by reading professional journals from BACP, and from the more specialist divisions, such as for workplace counselling, or counselling children and young people. Many counsellors are resistant to research, perhaps seeing it as an academic exercise and unrelated to their ongoing practice. It is worth making a habit of reading at least one research article from journals such as *Counselling and Psychotherapy Research* to keep up to date with practice with your own client group, or to begin to develop new specialist interests.

The concept of becoming a professional has been open to some criticism in the past, in almost implying a rigid separation between the person and the professional role, as a kind of 'mask' that professionals sometimes wear. Counselling training makes it very clear that therapy is about *being* as well as *doing*. Being role-bound, as a therapist, is likely to come at the cost of being congruent, empathic and authentic in client work, and more generally in all our personal relationships. The BACP *Ethical Framework for the Counselling Professions* (2016) stresses the importance of self-care, both physical and psychological, in managing the stresses as well as the pleasures of therapeutic work.

In the main, these are probably quite conventional and well-established standards of being a professional. Others may be more subtle, being based on interpersonal communication with clients and colleagues. Time-keeping is critical for counsellors, through being in place and 'prepped' by reading notes from a previous session, with the counselling room already set out in its usual way, before client work begins. Emails need to be responded to quickly and courteously. How we dress as counsellors is also significant, in terms of the messages we may give off to potential clients, colleagues, or members of other professions. What is seen as appropriate dress, or appearance, may vary according to context and audience, with probably a higher incidence of suits being worn among workplace counsellors, perhaps, than among counsellors working with young people. As counsellors, we may not be a formally recognised profession, but we still need to impress clients, colleagues and members of other occupational groups and professions, as being fully and recognisably *professional* in what we do.

Summary

This chapter set out the key features of what it is to be a profession and discussed some of the problems experienced by counselling and psychotherapy in their bid to achieve statutory regulation. Different

models of professionalisation were considered, such as counselling as a semi-profession, and as a community of practice. Social critiques and perspectives of counselling were outlined, in terms of counselling undermining self-reliance, ignoring social inequality, or making a major contribution to reducing mental health problems in society. The relationship of counselling to other professions, such as medicine, psychology and the law, was briefly noted. Finally, a model of the stages of professional development was suggested, together with some of the main features of what it means to be a 'professional', as an aid to understanding the differing demands and opportunities available at different points of our overall development as therapists.

Resources

Research

Aldridge, S. (2010) 'Counselling – an insecure profession? A sociological and historical analysis'. Thesis submitted for the degree of Doctor of Philosophy at the University of Leicester, November 2010.

A detailed case study of BACP's development as a professional grouping and its attempts to achieve statutory regulation, by a well-informed insider: <https://ira.le.ac.uk/bitstream/2381/10261/1/2011aldrigesphtd.pdf>. For a 30-minute video presentation by Sally Aldridge on this topic, go to: www2.le.ac.uk/offices/red/researcher-development/DIL-video-archive/css/Counselling-an%20Insecure%20Profession

Bondi, L. (2004) "A double-edged sword?" The professionalisation of counselling in the United Kingdom', *Health and Place*, 10, 319–328.

Discussion of perceived advantages and disadvantages of professionalisation of counselling, based on interviews with counsellors in Scottish voluntary sector counselling (n: 100).

Centre for Economic Performance Mental Health Policy Group (2006) *The Depression Report: A New Deal for Depression and Anxiety Disorders* (also known as 'the Layard Report'), <http://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf>

An influential report which laid the groundwork for the Improving Access to Psychological Therapies (IAPT) programme and the current dominance of CBT in secondary mental health care within the NHS, via the use of NICE evidence-based practice.

Future Foundation Projects (2004) *The Age of Therapy: Exploring Attitudes Towards and Acceptance of Counselling and Psychotherapy in Modern Britain*. London: Future Foundation, www.bacp.co.uk/media/index.php?newsId=309

A key piece of market research, based on telephone interviews (n: 1008), demonstrating significant shifts towards wider social acceptance of counselling in Britain.

Further reading

Aldridge, S. (2014) *A Short Introduction to Counselling*. London: Sage.

A brief, well-informed overview of counselling as a professional occupation and activity.

Cooper, M. (2008) *Essential Research Findings in Counselling and Psychotherapy*. London: Sage.

Useful summary of the evidence for counselling and psychotherapy's efficacy.

Daines, B., Gask, L. and Howe, A. (2007) *Medical and Psychiatric Issues for Counsellors*. London: Sage.

Introduction to the main roles and activities of doctors, psychiatrists and other staff working in medical settings such as the NHS.

Jenkins, P. (2007) *Counselling, Psychotherapy and the Law*. Second edition. London: Sage.

See Chapter 8, pp. 177–193, for a short account of the background and history of the movement towards achieving statutory regulation of therapists.

Reference section for supervisors

The BACP Professional Standards' *Counselling Supervision Training Curriculum* (2014) sets out relevant expectations for supervisors:

Competence 4: Applying Standards:

- knowledge of expected standards of professional conduct;
- knowledge of relevant professional and statutory codes of conduct that set out expected standards for pre- and post-qualification;
- knowledge of standards of clinical practice as defined by both relevant training organisations and local arrangements for clinical governance. (BACP Professional Standards, 2014: 10)