



9

Ethical considerations

◆ Introduction

In this last chapter we consider a range of ethical considerations, which can be grouped under the heading of 'Fitness to Practice' as set out by the BACP (2013, page 7). These include the importance of adequate training for counsellors, the requirement for ongoing supervision and personal development, and issues relating to the therapeutic relationship between counsellor and client.

The word 'ethics' refers to the study of right and wrong behaviour, and in the counselling context this has special relevance. This is because of the close nature of the therapeutic relationship and the possibility of abuse that exists within it. Indeed, the actual counsellor–client relationship is perhaps the most important topic in this section, and many of the other issues, such as confidentiality, are impossible to separate from it. The subject of confidentiality will be discussed in this chapter, its limitations identified, and some examples will be given to highlight the difficulties it could present. Client–counsellor good practice, counsellor limitations and knowing when to refer will also be discussed. Finally, in this chapter we shall also discuss two very important dimensions of counselling: diversity of client groups and feminist counselling.

KEY TERM

Confidentiality: In the context of counselling, the word 'confidentiality' means ensuring that what is told in 'confidence' by a client is not repeated to anyone else, apart from certain exceptional circumstances.

Confidentiality

Confidentiality is one of the most important aspects of the counselling relationship. It is also a subject that generates a great deal of interest and discussion when it is raised in training groups. This is because it is a topic about which most people have very firm views. It is often seen as an absolute right for clients who, after all, trust counsellors with some of their most intimate thoughts, feelings and desires. The information clients disclose in counselling may never have been spoken to anyone before and, indeed, it often takes clients a very long time to summon up the courage to approach helpers in the first place. For this reason, clients need to have confidence in the professional integrity of helpers and in their ability to keep private anything they discuss.

Clients may take some time to arrive at a state of complete trust in counselling. One indication of this initial reticence and caution is the way in which clients often focus quite extensively on secondary issues before they feel secure enough to reveal themselves fully. This could be seen as a way of testing

the counsellor, in order to ascertain just how unshockable, non-judgmental and discreet he or she is likely to be. Clients who do not get these assurances may retreat from counselling, but once trust has been established, they should feel sufficiently confident to disclose more about themselves. The following are some general guidelines relating to confidentiality.

- 1 Confidentiality is a subject that needs to be addressed as early as possible in counselling, although in crisis situations this may not be immediately feasible.
- 2 Even in crisis situations the issue of confidentiality should be addressed at some stage.
- 3 An atmosphere of trust is just as important as an explicit statement of confidentiality.

Some limitations

Some clients address the issue of confidentiality straight away; when this happens, the counsellor has an ideal opportunity to discuss the concept and clarify any limitations that may have to be stated. Those clients who do not address the subject of confidentiality may be reluctant to do so for fear of questioning the counsellor's professionalism. When this is the case, it is important not to assume that such clients are disinterested, or unaware of the issue. They may simply be waiting for the counsellor to provide the necessary information; if it is not provided, they may lose faith very quickly. Sometimes absolute confidentiality cannot be guaranteed in counselling, and when this is the case, clients should be aware of the limitations to it. The current BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* addresses the subject of confidentiality and stresses that client information should be protected, except in 'exceptional circumstances' (BACP, 2013: 6). Exceptional circumstances include urgent and serious situations, such as threats of harm to self, or others, by a client. In addition, confidential information about clients may be pooled in situations where helpers work closely together, but even here clients must be informed about (and agree to) this practice. There are certain situations where clients reveal information which, because of the guidelines stated by a particular counselling agency or organisation, cannot remain confidential. These usually include some of the following situations in which a client:

- threatens to injure another person or group of people
- discloses information about abuse of children
- expresses suicidal tendencies
- develops severe mental illness.

In describing the provision of good standards of care and practice, the BACP (2013) also highlights the importance of supervision when counsellors are faced with conflicting responsibilities. These conflicting responsibilities sometimes concern clients and other people, or society in general, who might be affected by them. Consultation through supervision is a mandatory part of good counselling practice, but it is especially important in situations where client confidentiality is questioned.

Perhaps the most important point to make about limitations to absolute confidentiality is that counsellors should be fully aware of guidelines pertaining to it within their organisations. Counsellors who are thus informed are in a better position to deal with emergencies as they arise. Occasionally aspects of confidentiality are far from clear cut, even where guidelines have been stated; in these instances, supervision can help the counsellor to get a clearer picture of what needs to be done. Later in this chapter, we shall look at supervision in more detail. It should be added here, though, that clients should be told about supervision, too, and given an assurance that their identity will not be revealed through it. When absolute confidentiality cannot be guaranteed to clients, they should be told this as soon as possible in the counselling process. The following case study highlights this point.

CASE STUDY

Confidentiality

Andrea, who was 24, received counselling over a period of six weeks because she was depressed. The counsellor who helped her was a trained psychiatric nurse, who had also completed a counselling skills course. Andrea had been referred by her doctor, who had prescribed antidepressants for her. However, he felt that she would benefit more from psychological support and Andrea agreed with this. During the first session, the counsellor talked about confidentiality and added that she could not guarantee this absolutely if Andrea became severely depressed, or suicidal. If either of these two situations arose then, as her counsellor, she would need to speak to Andrea's doctor about it. Andrea seemed to be reassured by this and, in fact, during a later session with the counsellor she admitted to having suicidal thoughts.

ANDREA: I think I began to feel worse after the recent rows with my boyfriend. There have been times when I wished it was just all over.

COUNSELLOR: These feelings of wishing it was all over . . . tell me about them.

ANDREA: Well, . . . I have felt like killing myself at times . . .

COUNSELLOR: Strongly enough to make a plan?

ANDREA: Yes I had a plan. I thought of driving my car along the motorway and crashing it.

COUNSELLOR: And that feeling . . . is it still with you?

ANDREA: Not so much . . . but yes, sometimes.

COUNSELLOR: You remember how we talked about confidentiality . . . about how I would need to speak to your doctor . . . it might be that your medication needs changing, or adjusting.

ANDREA: Yes, I do remember. That's all right. I don't know if these tablets are the right ones for me, anyway. I don't know if they have done me any good.

You can see from this example that clients can experience great relief when they know their problems are monitored and taken seriously in the way the counsellor demonstrated. The issue of confidentiality had been openly discussed at the outset, which meant that further discussion flowed naturally from there. In situations where ‘absolute’ confidentiality is guaranteed to clients, counsellors must be prepared to respect such assurances. Whatever the arrangement between client and counsellor, however, discussion is essential if misunderstanding and confusion are to be avoided.

EXERCISE

Confidentiality

Working in groups of three to four, discuss your individual areas of work, highlighting any special rules regarding confidentiality. Ask one person in the group to write these down under individual headings, for example:

- ◆ social work
- ◆ nursing
- ◆ teaching
- ◆ Citizens Advice Bureau (CAB)
- ◆ Samaritans
- ◆ Childline
- ◆ Cruse
- ◆ Women’s Aid
- ◆ Alcohol Concern
- ◆ care of the elderly
- ◆ HIV and AIDS counselling
- ◆ drugs counselling.

Some of you will probably be involved in other areas of work apart from those listed above. The aim of the exercise is to generate a discussion about the issue of confidentiality generally, and to consider the ways in which guidelines differ among professions and organisations.

Talking about clients

In student training groups, there are frequent discussions about problems encountered in professional work. The usual practice is to refer to clients indirectly and never by name. It is difficult to see how ideas and issues can be shared without these discussions, but there is a case for saying that every casual reference to clients, however indirect, is bound to devalue the integrity of the counsellor–client relationship to some extent, at least. There is the added possibility that a member of the group will identify some of the details under discussion and, in doing so, recognise the person discussed. This may be a remote

possibility, but nevertheless it does exist. This is not to suggest that clients are damaged by indirect discussion about problems and issues that could, after all, belong to anyone. However, we all need to be circumspect when talking about work, because even though clients have no knowledge of these discussions, the effects of the way the counsellors treat them behind their backs do become manifest during counselling. Weinberg (1996: 68) highlights this phenomenon and points to the possibility of the therapeutic ‘alliance’ being weakened as a result of this indirect loss of confidence. In other words, clients do pick up unconsciously transmitted messages during counselling, and when these attitudes convey casual attitudes about confidentiality, real trust will never develop.

The client's responsibility

Another aspect of confidentiality concerns the client's obligation (if any) towards maintaining it. Some therapists, including Weinberg (1996), take the view that clients do have responsibilities in this regard. As far as Weinberg is concerned, the issues should be discussed early in the first session with the client. When clients find the request for confidentiality difficult in some respect, then the difficulties are explored and discussed too. There are probably quite a few clients who would, in fact, experience anxiety if requested to make a pledge of confidentiality in counselling. These include people who have been traumatised in childhood, as a result of keeping ‘secrets’ relating to sexual or other forms of abuse. Clients in this position would certainly need to be given the opportunity to voice their anxieties about any request for confidentiality; if such a request is made, the reasons for it should be comprehensively explained. In spite of potential difficulties, however, confidentiality on the client's part could be considered important for the following reasons:

- 1 When clients discuss their sessions freely with other people, the beneficial effects of counselling are often negated. This is because others tend to offer conflicting opinions and even advice, which may prove confusing for the client.
- 2 Facts are very often distorted when they are discussed outside counselling.
- 3 Other people may feel the need to tell the client what to say in counselling. Clients who lack basic confidence may well lose sight of their thoughts, feelings and opinions, as a result of such pressure. This goes against the whole ethos of counselling, since a basic aim of therapy is to help clients identify their own needs and to become more autonomous generally.
- 4 Discussions which take place outside counselling tend to weaken the client–counsellor relationship. This is an important point to consider, since the quality of the relationship is, as Rogers points out, central to effective counselling (Rogers, 2003).
- 5 A client may choose a confidant, or confidantes, who will support his or her reluctance to change. When this happens, counselling may prove to be a waste of time.
- 6 If a client knows that he will talk to relatives or friends about counselling, he may become more inhibited about what he actually says in sessions.

Moreover, once other people are included, however indirectly, in the client's therapy, they are given the right to monitor progress and comment accordingly (Weinberg, 1996).

All the above points do not, of course, mean that clients should be encouraged to be totally silent about receiving counselling. Clients need to feel free to be open about this, just as they need to feel free to be honest about any other aspects of their lives. Counselling should not be something clients have to hide, but detailed accounts of what is discussed in sessions are probably best avoided. Clients often know this instinctively anyway, but when outside discussions do become an issue in counselling, helpers need to address this as they would address other significant aspects of the client's behaviour. The following is an example:

CASE STUDY

- CLIENT:** I talked to my friend Angie about some of the things I said last week. She said I should never have mentioned the abortion . . . that it's better to keep some things quiet . . . now I don't know.
- COUNSELLOR:** You don't know what to think now that your friend has given her opinion . . . ?
- CLIENT:** I suppose it's made me worried about anyone else finding out . . .
- COUNSELLOR:** Perhaps you are worried about confidentiality . . .
- CLIENT:** I don't know . . . yes maybe.
- COUNSELLOR:** What you say to me here is confidential . . . what you told me last week is confidential.
- CLIENT:** Yes, I know. It's just that Angie made me feel I shouldn't have said it.
- COUNSELLOR:** This is something which obviously worries you. And Angie . . . her views matter to you a lot?
- CLIENT:** Well sometimes . . . though she does irritate me . . . I just wish she would keep her opinions to herself at times.
- COUNSELLOR:** And your own view . . . about what you said last week . . . are you regretful that you mentioned it?
- CLIENT:** No [slowly] No I'm not. I've never told anyone before . . . it was a great relief, even though Angie doesn't approve [laughs].
- COUNSELLOR:** Maybe we could look at why you ask for her approval . . . why you don't trust your own judgment more.

The example just given illustrates another point, which is that clients sometimes seek further assurances of confidentiality, apart from the one given early in counselling. In instances like this, clients should be given the assurances they need, though the underlying reasons for repeated pledges of confidentiality need to be discussed. This is because clients who lack trust in this important area may well lack trust in any relationship. For these clients, the development of trust is crucial, and over a period of time they need to learn to express trust, in order to foster and promote it.

EXERCISE

Developing trust

Working individually, think of a time in your life when you confided in another person. What were your feelings beforehand about revealing personal information? What were your feelings afterwards, when you realised you had given another person important information about yourself? Write down the feelings you experienced, and then discuss these with other members of the training group. It is not necessary to discuss the nature of the problem you disclosed, but you should focus on your reactions to the disclosure itself.

The counselling relationship

People are usually affected by some degree of emotional stress when they first seek counselling. This fact alone makes it imperative that they receive the best possible help, with the lowest possible risk of exacerbating any of the problems they already have. The difficulties clients experience may have been with them for a very long time. These include problems of depression, faulty relationships, marital problems, anxiety, phobias, difficulties at school or university – to name just a few. One of the factors that prompt people to seek help through counselling is the realisation that it might be impossible to continue to cope alone. When people feel helpless, they frequently look for someone who is ‘expert’ in a particular field. Though trained counsellors do not regard themselves as experts in this way, they nevertheless need to be aware that vulnerable people may have such a perception of them.

The majority of clients have a basic trust in a counsellor’s ability to help them deal with the problems they experience. In fact, it is probably true that many clients overestimate any helper’s prowess, and may actually ascribe to a counsellor exaggerated or magical powers which are, of course, unrealistic. It is important that clients do, in fact, trust the counsellors who help them, but excessive expectations can work against clients unless counsellors are aware that they do exist. When there is this awareness on the counsellor’s part, then it becomes possible to help clients become

more autonomous and self-directed over a period of time. Such a position of autonomy cannot, of course, be achieved until clients are given the opportunity to explore their problems and to consider what it is they need to do in order to effect change. The following example illustrates some of these points.

CASE STUDY

Mr Black

Mr Black was aged 68 when his wife died. Apart from the grief he suffered, he was also distressed by the many new and unfamiliar tasks he now had to perform. Mr Black's wife had been his best friend, as well as a loving partner; and their relationship was a traditional one, in the sense that both had clearly defined roles throughout their marriage. Mrs Black had taken care of the home and children, while Mr Black had gone out to work, earned the money and generally looked after all the financial aspects of their lives together. When Mr Black retired this pattern continued, and after his wife's death he found himself unable to cope with the basic tasks of shopping for food and cooking. The tasks his wife once fulfilled now seemed incredibly daunting to him. In a fairly short space of time he became depressed and neglected to care for himself generally.

Through his GP, Mr Black was persuaded to attend a day centre one day a week, where he received counselling help from a carer who was trained to give this kind of support. Mr Black's initial response was to abdicate personal responsibility for his diet and other practical aspects of his care. Over a period of time, however, he was encouraged to discuss the problem he now experienced and to consider ways in which he might become more independent and self-reliant generally. Mr Black confided that he always liked the idea of cooking, but his wife had opposed this ambition and always seemed to be threatened by it. With the help and encouragement of the carer who worked with him, Mr Black attended basic cookery classes, and after a while became proficient in many of the skills he had previously lacked. This gave him the confidence to tackle other practical problems. His depression lessened as he acquired new skills and became more independent.

Comment: Mr Black's case study highlights the point made earlier concerning the vulnerability of clients, and the tendency they often have to place all their expectations and trust in the person who is designated to help them. The carer who helped Mr Black did not encourage him to become dependent on her, although she accepted some measure of dependence in the initial stage of their relationship, since this is what he needed at the time. Having reviewed his life, however, and the current problems affecting him, Mr Black was then encouraged to identify his personal resources and to develop these in ways which would enable him to become more independent and confident about his own ability to cope. If the carer had encouraged his dependence (in many ways, an easier option for her) she would have acted unfairly towards the client, even though this is probably what he would have liked her to do initially.

Transference and the counselling relationship

The subject of transference is one we considered in some detail in Chapters 3 and 4, in the context of psychodynamic counselling. However, transference and its twin concept countertransference are not unique to psychodynamic theory, and the concepts have also been discussed in connection with other theoretical approaches described in this book. Because of their significance within the counselling relationship, transference and countertransference also deserve extended consideration in this section, dealing specifically with the subject of the counselling relationship. We know that transference refers to the client's emotional response to the counsellor (or to any other helper) and that it is based on much earlier relationships, especially those formed in childhood with parents and other important people in the client's life. Transference, therefore, is by definition unrealistic, since it stems from outdated information that people carry with them and apply to others who help them (as parents might have done) in times of emotional upheaval or distress. When people are distressed they are, of course, vulnerable and this vulnerability makes them open to abuse, however unintended.

Unconscious feelings

Unconscious transference feelings can be positive or negative, distrustful, idealising, loving, erotic, envious or antagonistic. Though these (and many other possible responses) may not be obvious at the beginning of counselling, they tend to emerge once the client–counsellor relationship is established. In other words, clients may respond to helpers in totally realistic ways to start with, but later on they may respond in ways that are inappropriate or out of date. When Freud first wrote about psychoanalysis, he described it as 'the true vehicle of therapeutic influence' (Freud, 1909: 84). He also added that the less transference is suspected by a therapist, the more likely it is to operate in a powerful way (Freud, 1909).

The counsellor's response

One reason for highlighting these unconscious transference feelings is to show how important it is to be aware of their emergence in counselling. It is also important to realise that transference feelings are, as we have already indicated, unrealistic and inappropriate. This may be easier said than done, however, and it often takes another person to help us see this more clearly. Regular supervision is essential as an aid to monitoring both transference and countertransference feelings; without this facility, counsellors are quite likely

to make serious mistakes in respect of their own feelings and those of their clients. The word ‘countertransference’ describes the counsellor’s emotional response to the client’s transference. A counsellor who is, for example, cast in the role of critical parent, may well be drawn into responding in the way that a critical parent would respond. This type of unconscious role play situation may continue unproductively and indefinitely, unless and until it is identified and changed either through spontaneous insight, or with the aid of supervision.

Lack of objectivity

The point to make here is that clients do not benefit when a counsellor’s judgment is clouded because of countertransference feelings and residual complexes, stemming from unresolved problems of his or her own past. Any distorted view of the client–counsellor relationship will inevitably get in the way of objectivity when working with clients and their problems. When counsellors experience countertransference feelings towards clients, they need to be able to ‘contain’ these, rather than acting on them in a way that clients act on their transference feelings.

Apart from regular supervision, counsellors also need to develop habits of self-scrutiny if they are to identify those roles which are often unconsciously forced on them by clients. In addition, counsellor awareness of both transference and countertransference feelings can prove to be an invaluable asset to therapy, especially when it provides information about the client’s emotional problems. However, it is important to remember that not all responses to clients come under the heading of countertransference. Counsellors frequently perceive their clients as they really are, and often the responses elicited by clients in counselling are similar to those elicited in any other situation or relationship. On the other hand, it is often difficult to differentiate between what is real in our responses to clients, and what is countertransferential. The following are some indications of countertransference reactions that may be experienced by counsellors:

- strong sexual or loving feelings towards the client
- inexplicable feelings of anxiety or depression
- feelings of over-protectiveness towards the client
- feelings of guilt in relation to the client
- extreme tiredness or drowsiness
- feelings of anger towards the client
- loss of interest in the client
- inability to make proper interventions when necessary
- dreaming about clients, or thinking about them outside sessions.

Unit 3 contained a more detailed account of countertransference and its related phenomenon, projective identification, with several examples of the way in which every imaginable feeling may present itself in these forms.

One way in which counsellors can monitor their own countertransference feelings is to ask the following questions in relation to clients:

- 1 Do I experience any strong feelings at the moment which seem inappropriate or out of place?
- 2 Are my interventions geared to the client's needs, or do they stem from my own needs?

It is not, of course, always possible to answer these questions, which is why regular supervision is needed for all counselling practitioners. Later in this chapter, we shall look at supervision in more detail.

EXERCISE

Countertransference responses

This is an extension of an exercise on countertransference (entitled 'Student self-assessment') given in Chapter 3. In this current exercise, however, you are asked to be more specific about personal responses. The list of possible responses given in this section should encourage you to approach the exercise at a deeper level of honesty and self-awareness.

Spend about 15 minutes thinking about your experience of working with clients in counselling. Are there any personal responses that you can identify from the list outlined here? If you do identify personal responses, are you aware of what prompted them? Discuss common countertransference with other members of your group.

The possibility of exploitation

Any discussion about exploitation in counselling tends to focus on the more obvious forms, including those relating to the sexual and financial abuse of clients. It is unfortunately true that these do occasionally occur, but there are other less obvious forms, which counsellors can, either knowingly or unknowingly, inflict on clients. It is fairly easy to see how sexual involvement with clients can arise, especially when we consider the heightened emotions clients often experience in relation to counsellors, as well as the imbalance of power that exists within the relationship. Such responses may be seductive and irresistible to helpers who currently experience problems in their own lives, especially if they are relationship problems, or problems of loneliness. Once again, this emphasises the point that counsellors need to know how to take care of their own needs without involving vulnerable clients. In Chapter 1 we looked at the subject of personal therapy, and discussed its inclusion or non-inclusion within counsellor training programmes. Whether or not it is

part of training, however, it should certainly be undertaken later on when, and if, personal problems arise. Some of the other possible areas of abuse within counselling and therapy include the following:

- failure on the counsellor's part to undertake adequate supervision
- arriving late for sessions, or leaving early
- encouraging clients to become dependent
- being unclear or inconsistent about financial arrangements if these apply
- premature termination of counselling, and lack of consultation with clients
- failure to maintain confidentiality, or failure to inform clients if there is a conflict of interest in relation to confidentiality.

Contracts

In order to provide explicit and clear guidelines for clients, it is necessary to establish contracts with them. Establishment of a contract, preferably in writing, ensures that both client and counsellor understand the nature of the commitment between them and what it entails. In Chapter 3 we considered the subject of contracts, with special reference to their significance in a psychodynamic framework. However, contracts are an essential component of all approaches to counselling and should be made at an early stage. In the first instance, it is useful to clarify certain points with clients, especially those relating to the nature of counselling itself. Many clients believe that counselling includes advice, for example, while others may expect to receive friendship or a more intimate relationship. Clients need to know the exact nature of the counselling relationship, and they also need to know that the person to whom they have come for help is, in fact, a qualified counsellor. When contracts are made confusion is less likely to arise, especially when objectives and desired outcomes are also clarified and priorities discussed. The following are important aspects of counselling, which clients should be informed about from the outset:

- confidentiality and its limitations
- details regarding frequency and length of sessions and where these will take place
- financial terms if these apply, and how payments should be made
- arrangements concerning missed appointments
- details about holidays
- information about the counsellor's qualifications, accreditation, supervision and training
- information about the counsellor's approach and any specific procedures likely to be used
- details about regular reviews of progress between client and counsellor

- discussion about ending counselling and how this will be managed
- details about record-keeping by the counsellor and the client's right to see these
- information about making a complaint, and procedures for clients to follow if they wish to do this.

This may seem like a daunting and lengthy list of requirements for a counselling contract, but the more clients are informed about the process the more they are likely to 'own' it and to participate fully in a way that will empower them. When contracts are written, clients need time to study them and to ask any questions they may have about content. Clients are often baffled about the differences between counselling and psychotherapy, for example, and some may be concerned about the nature of the counselling process (especially if a specific model is being offered) and what to expect. Another important point to clarify for clients is that counselling is a joint commitment between client and counsellor, based on talking and listening, and not something that is 'done' to clients. A surprising number of people suspect counsellors of seeking to change (largely passive) clients who remain inactive throughout the process. Counsellors are aware of how inaccurate this is, but people with no prior experience of therapy may not be. This is why it merits some discussion with new clients so that they are motivated to joint participation and personal change.

KEY TERM

Contract: In counselling a contract is an agreement made between two people, the counsellor and the client. It may be verbal or written and is made before counselling starts. A contract encompasses all aspects of therapy, including confidentiality, times, dates, fees and commitment of both counsellor and client to the process.

EXERCISE

Making contracts

Working in pairs, look at the list of contract details included in this section and discuss any concerns you think clients may have about them. Are there any other details you would add to the list? Members of a training group may have differing views about contracts, depending on their experience or individual areas of work. What are the factors which emerge as the most important in relation to client-counsellor contracts?

Ending counselling

We have noted that the main objective in counselling is to help clients become more independent, self-reliant and capable of dealing with any present or future problems. This means, in effect, that the counselling relationship, unlike many other relationships, is meant to end. Termination of therapy is, therefore, always implicitly present. Endings can be difficult for all of us, however, and clients in counselling are no exception in this respect. Many people experience a variety of conflicts about endings in general, and this is especially true of those people who have been traumatised by separations in the past. The ending of any relationship is obviously much more difficult for someone who has lost a parent in early life, for example, or indeed for anyone who has been bereaved in later life too. Each new ending in an individual's life tends to reactivate memories of previous separations, endings or losses. Clients need to be able to talk about these experiences and what they mean to them; counsellors can help by encouraging expression of all these feelings.

Looking ahead

When contracts are established at the beginning of counselling, clients should be aware of the number of sessions they will attend. When the number of sessions is limited to a very few, and in many organisations and agencies this is currently the case, clients may also be very motivated to make whatever changes are necessary to help them deal more effectively with any difficulties they have experienced. A good beginning is often the key to a satisfactory ending in counselling, which is further reason for explicit contracting and clear goals from the outset.

Often a client's newly acquired confidence becomes obvious towards the last stage of counselling, and this may show itself in different ways. One way in which this new confidence is visible is in the client's attitude to counselling itself. What was once an important focus in the client's life is now placed in perspective and becomes secondary to other relationships and interests. Clients may also find it more difficult to think of subject matter during sessions. For those clients with a history of very specific problems, such as phobias or addictions, for example, there should be clear identifiable gains, which indicate a readiness to cope independently of counselling. Feelings about ending counselling may also surface in dreams. The following case study describes one client's experience of this.

CASE STUDY

Endings

A client called Terry received counselling over a period of eight sessions. Terry, who was 25, had been accused of assault by a colleague at work. Although he was acquitted of the charge, he suffered panic attacks and agoraphobia as a result of his ordeal. During counselling he was able to explore all the angry feelings he felt about the accusation, and he was later able to discuss the development of his other symptoms. The exploration of his feelings was a great relief to Terry, because the nature of the accusation made against him meant that he was extremely reluctant initially to acknowledge his anger to anyone. He felt that if he admitted to feelings of anger, this would be taken as proof of his guilt in relation to the incident with his colleague.

Over a period of time, Terry came to see that his feelings were a part of the ordeal he had been through; once he had acknowledged and expressed them, his panic attacks diminished in frequency and his reluctance to go out decreased too. Terry had formed a good relationship with the counsellor (a man), who worked as a volunteer helper at his local health centre. He had specifically asked to see a man, because he felt inhibited about relating the incident to a woman. A contact had been agreed between client and counsellor when they first met, so Terry was aware of the number of sessions there would be.

Towards the end of his counselling, Terry had a dream in which he was leaving school, but was unable to tell the teacher that he wanted to go. He related this dream to the counsellor and together they discussed it. Terry felt that the teacher in the dream would be hurt if he stated his intention to go. As a result of discussing the dream, the issue of endings and what they meant, Terry was able to place the dream in context, and to identify the counsellor as the teacher in it.

Other indications

The end of counselling, like the end of any close relationship, involves some degree of mourning. However, it should also involve internalisation of the process itself by the client so that the experience of counselling becomes a useful guide for more productive ways of dealing with any difficulties that may arise later on. Following a successful experience of counselling, clients may continue their own internal dialogue, similar to that conducted with the counsellor. In addition to the factors mentioned earlier, readiness to end counselling may also be indicated in other significant ways. The client is likely to feel more independent, for example, and as a result of this independence will see the counsellor as a 'real' person, rather than an object or a transference figure. Increased understanding of 'self' is another aspect of client development, and often clients will demonstrate more assertive attitudes as a result of this.

From the counsellor's point of view, this change is often 'felt' in the sense that the client's transference is no longer experienced and the counsellor becomes more relaxed. When client and counsellor actually do separate, they do so as equals who have worked together towards a goal (Solomon, 1992).

Additionally, they may both have a sense of sadness that the relationship has ended, although clients are sometimes offered the opportunity to attend another session in the future, in order to discuss progress.

EXERCISE

Looking at endings

Working individually, make a list of all significant endings you have experienced in your life. These might include the end of some of the following:

- ◆ school holidays
- ◆ summer
- ◆ childhood
- ◆ college or university
- ◆ friendship
- ◆ working life
- ◆ single life
- ◆ childbearing years
- ◆ an intimate relationship.

Can you identify the range of feelings you had on any of these occasions? Discuss these, and any other thoughts you have about endings, with other members of the group.

Referral

Clients receive counselling in a wide variety of contexts, some of which have been discussed in this book. In addition, clients may be helped by people who work in a variety of helping occupations, many of whom would not describe themselves as counsellors. On the other hand, there is an increasing tendency for helpers and carers to undertake counselling skills training, and this trend (though welcome) can cause some confusion for those people seeking assistance with personal or psychological problems. One of the difficulties that helpers may have, as a result of these trends, is to determine the limits of their own capabilities in providing the right support for clients. An important aspect of training, therefore, is identification of specific problem areas that might require other forms of help or support. Obviously, helpers differ in terms of professional training and background, and it is these differences which necessitate discussion of the subject so that proper guidelines for referring clients can be defined. Some helpers may not, for example, have the specific skills needed to deal with clients in crisis, or those with severe depression, or other forms of psychological illness. We all need to know what our own limitations are; the first step is to look for these and then acknowledge them. The next step is to know 'how' to refer clients so that they receive the appropriate help when they need it.

In its *Ethical Framework*, BACP stresses that routine referrals to other services or agencies 'should be discussed with the client in advance' (BACP, 2013). It adds that the client's consent should be obtained before making the referral; in addition, client consent should be obtained in relation to any information that will be disclosed in the process of referral. It is also important to ensure, as far as possible, that the referral is appropriate for the particular client, and that it is likely to be of benefit to that client.

Referral may be difficult for clients for a number of reasons: some may have experienced rejection in the past, while others may come to believe that they (or their problems) are just too formidable for anyone to cope with. On the other hand, if referral is left too late, clients will not receive the kind of support or specialised help they need. This last point emphasises the importance of good communication with clients from the outset, so that the possibility of referral is identified early on. Clients should be given the opportunity to discuss their feelings about the prospect of referral too. If they are not given this chance to express feelings, they may experience resentment or anger in relation to the whole process.

Reasons for referral

At every stage of the counselling process, however, helpers need to ask themselves what is the best course of action for specific clients. The reasons for referral are obviously very varied. A counsellor or client may, for example, be in the process of moving away from the area, in which case referral might be necessary if the client is to receive ongoing help. Certain clients may require psychiatric support, or other specialised health services. There are clients whose problems are specific to certain areas, for example, adoption, recovery after surgery, disability or language difficulties, and they may well benefit from contact with a helper, specially trained in one of those areas. Whatever the circumstances, and regardless of the problem, it is essential that clients are given the opportunity to participate in any decisions made about them. The counsellor's task is to inform clients about any specialised services that are available to them; it is then up to the client to accept or decline.

Occasionally, clients may ask to see either a male or female counsellor. This request is usually made for very good reasons and counsellors should respect them. A woman who has been physically abused, for example, may feel more comfortable with a female counsellor, while a man who has sexual problems may well feel more at ease with a male counsellor. Sometimes clients who receive individual counselling are given the chance to participate in group work too. This necessitates referral of a different kind, since the client is not being asked to forfeit one kind of support for another. Another reason for referral is indicated when the particular theoretical approach another counsellor uses is considered more appropriate for an individual client's needs. Financial constraints may also have a bearing on the kind of help available to a client; someone who cannot afford the

services of a particular helper may benefit from referral to a voluntary agency, for example.

The following is a list of factors that could impinge on your ability to help certain clients:

- lack of experience in specific areas; for example, severe mental illness such as psychosis or dementia
- insufficient time to offer the client
- your theoretical orientation and training may not be right for the client
- lack of the kind of information the client needs
- your relationship with the client is difficult or compromised
- client may receive appropriate help nearer their home.

EXERCISE

Referral

Working in groups of two to three, make a list of the reasons for referring clients to other people, or agencies. Do these reasons vary for different members of the group? Discuss the counselling skills necessary for successful referral, and indicate how early or late in the counselling process you would do it.

Resources for referral

Preparation is probably one of the most important aspects of referral. All helpers, including those whose work is part of other occupational responsibilities, need to be well informed about all the resources available to them within the community and, indeed, beyond. The names, addresses and telephone numbers of other professional workers who might be in a position to help clients with specific needs should be kept on record. Good liaison and consultation with other professionals is essential too. However, ongoing personal development and training is also needed for counsellors who wish to remain in touch with new developments in all the helping and allied professions. Continuing education has the added advantage of keeping counsellors in contact with as many people as possible, either locally or nationally, who may be able to help clients. Subscribing to professional journals and periodicals is also helpful and informative, since they can provide vital information about changes and trends in the helping professions generally.

Clients in crisis

In Chapter 1 we noted that clients often seek help when they experience a crisis. We also noted that each person's interpretation of crisis is quite subjective, which makes it difficult to list the experiences that may fall into

that category. However, it is not just the client's response to a perceived crisis that we are concerned with here. The counsellor's response to the person in crisis is important in this context, and there are certainly a number of grave situations that are familiar to most experienced practitioners. These include those circumstances in which clients threaten suicide or violence towards other people. We have already considered the issue of confidentiality in relation to such expressed intentions, and the point has been made that many agencies have very specific guidelines about them. Apart from the practical steps counsellors can initiate, however, the emotional impact on them needs to be considered too. In this respect, discussion and preparation are vitally important, since issues discussed openly in this way tend to be less threatening when they are actually encountered. Suicide and violence are not subjects people readily talk about, but we need to address them in order to identify our own feelings in relation to them. We could start by looking at the following points:

- 1 Some people take the view that as far as suicide is concerned, there is no ultimate preventative
- 2 Others take the view that clients who say they feel suicidal are, in fact, asking for positive intervention from helpers.

Helping clients in crisis

The above two points are likely to generate a great deal of discussion in any training group, and you need to be clear about your own responses in relation to them. The view taken here is that clients should be offered whatever support and help we can possibly give. Clients who reveal themselves in this way are, in fact, seeking the reassurance that someone else cares sufficiently to intervene. It should be added that intervention does not necessarily mean dramatic action; what is usually needed is identification of all the client's feelings and plans so that a realistic assessment of risk can be made. When this is done, clients are frequently relieved to be taken seriously. Afterwards, practical steps can be implemented to lessen the suicide risk. These steps may include consultation with the client's doctor so that medication can be prescribed or adjusted, though none of this can be done without the client's permission. Helpers are sometimes reluctant to address the subject of suicide openly, on the grounds that to do so would encourage the client's action. This is an entirely mistaken belief and one with immense potential for causing harm to clients. More often than not, people are very relieved to articulate their worst fears and impulses in the presence (or hearing, as in telephone counselling) of someone who is supportive and calm. In order to determine the extent to which a person is serious about suicide, it is useful to establish the following:

- 1 Has the person made a plan?
- 2 Is the plan specific?

- 3 Does the person have the means to follow through a plan?
- 4 Is there a past history of deliberate self-harm?

Without looking closely at these factors, it is difficult to establish the level of risk to those clients who may refer to suicide in oblique terms only. Counsellors and other helpers should be aware of other factors that may accentuate the risk of suicide. These factors include:

- feelings of depression or hopelessness
- alcohol or drug abuse
- recent trouble with the law
- family history of alcohol or drug abuse
- mental illness (e.g. schizophrenia) or family history of mental illness
- suicide of another family member
- conflict about sexual orientation
- violence or sexual abuse
- being bullied
- loneliness, isolation or loss of an intimate relationship
- terminal illness or chronic pain.

One of the most effective ways of helping clients in crisis situations is to prepare through participation in suicide prevention courses. These courses, which are usually of short duration, are becoming more readily available and are meant for anyone (including counsellors) who work in a helping capacity. Their strength lies in that they inspire confidence in anyone facing a potential suicide crisis, and this is especially relevant for those people who were previously apprehensive about coping.

When helping clients in crisis, counsellors need to be prepared to look at the underlying causes. Suicidal feelings are often precipitated by a number of accumulating factors and these factors need to be identified and discussed with clients. Once this is done, clients tend to experience relief of pressure, and with ongoing support and therapy they may be able to deal with their problems. Counselling can be continued with those clients who are referred for specialist help, and often it is this combined approach which proves most beneficial for them.

Threats of violence

Sometimes clients express violent feelings or impulses towards other people. In these circumstances, helpers need to assess the degree of actual danger involved and act accordingly. This is much easier said than done, since all of us have probably experienced antagonistic and negative emotions occasionally, as a result of conflict with others. Most people hide these feelings, for fear they will cause unnecessary alarm or upset. However, clients in counselling may express their negative feelings more readily, especially when they know they will not be judged for doing so. On rare

occasions, though, clients may be serious in the threats they make, and, in these instances, helpers need to adhere to the guidelines set down by the agencies in which they work. Clients who threaten violence to others, like those who threaten violence to themselves, may in fact wish to be stopped. It is unlikely that they would verbalise their impulses if they did not expect some intervention. However, counsellors, in common with other responsible citizens, have a duty to safeguard vulnerable people who might be at risk of violence. Support through supervision is probably the most effective way for helpers to deal with problematic issues of this kind. The guidelines for confidentiality and its limitations (described earlier in this chapter) are important in relation to any threats of harm to self or others expressed by clients in counselling.

Other crisis situations

Suicide and threats of violence are not the only forms of crisis which counsellors and other helpers may hear about from clients. Others include:

- sudden death
- rape and assault
- accident and injury
- discovery of child abuse
- acute illness
- diagnosis of terminal illness
- unexpected break-up of a relationship
- burglary or loss of belongings
- sudden financial problems
- loss of a job.

EXERCISE

Responses to crisis

Working in groups of three or four, discuss how people in crisis might respond to their new and unfamiliar situation. Make a list of the feelings that the crisis may generate, and then suggest ways in which clients can best be supported in counselling. Afterwards, consider how counsellors who work with clients in crisis can themselves be supported in their work.

Supervision

Throughout this book we have emphasised the central place of supervision for counsellors. In Chapter 1 we discussed the role of supervised counselling practice in training, and quoted the BACP *Ethical Framework* in relation to this. Some of the issues just discussed, especially those relating to crisis and its management, should highlight even further the need for regular support

of this kind. Many professional agencies make their own arrangements for supervision, and helpers who work in these settings are aware of the benefits of professional assistance and backing. Here are some further considerations in relation to supervision.

What supervision means

The word ‘supervision’ refers to the practice of giving support, guidance and feedback to counsellors who work with clients. It is, in fact, mandatory for anyone who works with clients in psychotherapy or counselling context, including trainees. The British Association for Counselling and Psychotherapy (BACP) is clear on the subject of supervision, and it is important that you read its *Ethical Framework* (2013), which specifies the requirements for trained practitioners and for students.

Supervision is not, of course, an entirely new idea for it has been in existence for a very long time. Freud and his followers supported each other in a similar way. Supervision has been used ever since, though not just by therapists and counsellors. Helpers in a variety of other roles, including nursing and social work, recognise the place of supervision in maintaining good practice with patients and clients. Supervision is essential for counsellors and helpers, because it affords the opportunity to discuss all aspects of work with someone who has received specialist training in this area.

Support for counsellors

Supervision benefits counsellors for a number of reasons. It:

- provides a more objective view of the counsellor’s work
- makes loss of confidence and ‘burnout’ less likely when it is regular
- gives the counsellor a clearer picture of transference–countertransference issues
- allows the counsellor to appraise the skills and approaches used with individual clients
- provides support, guidance, encouragement and differing perspectives
- affords time for reflection and thought
- can provide important information about the counsellor’s work, since aspects of the relationship between client and counsellor are often mirrored in the supervisory relationship
- is rewarding for counsellors, both intellectually and emotionally
- can help counsellors to clarify and modify any negative emotions they may experience in relation to certain clients
- enables personal problems that counsellors have to be identified through supervision, although these are not directly dealt with by supervisors
- serves to identify the counsellor’s own need for personal therapy
- enables counsellors to increase and develop their range of therapeutic techniques.

What supervision is not

Supervision is not the same as counselling, and the supervisor–counsellor relationship is quite different also. In the first place supervision is not therapy, although it can have therapeutic benefits. The supervisor’s principal task is to improve the counsellor’s relationship with his or her clients. This means that a supervisor is never directly involved in helping a counsellor to deal with personal problems, although evidence of these sometimes appears in the course of supervisory sessions. It may even be difficult to distinguish between the counsellor’s personal problems and those of the client. One of the supervisor’s duties is to help the counsellor differentiate between the two, and to recommend therapeutic support for the counsellor when necessary. Although supervisors do not give counselling, therefore, they nonetheless encourage counsellors to consider personal issues and to look at the way these impinge on their relationships with clients.

CASE STUDY

Jenny

Jenny worked as a student counsellor in a university. One of her clients, an 18-year-old student called Tamsin, had been dieting over a long period of time and had requested counselling when she realised that she had developed problems in relation to this. Jenny had also been overweight as a teenager, and this had caused her a great deal of anxiety and stress at the time. Because of her experience, Jenny felt deep empathy with her client, but sometimes this identification threatened to cloud the true nature of the counselling relationship.

On several occasions, Jenny was tempted to offer advice and to steer Tamsin towards certain courses of action. She also found herself worrying a great deal about her client outside counselling sessions. In supervision, Jenny was able to identify her countertransference feelings, and to separate her own memories and experience from the client’s experience. Afterwards her relationship with Tamsin was much improved, and certainly less controlling than it had previously been.

Confidentiality and supervision

One point of similarity between the supervisory and counselling relationships is that both are confidential in nature. This means that supervision should be independent of other relationships that may be in conflict. One example of such a conflicting relationship is that between manager and employer. Employees are obviously accountable to managers for a variety of work-related reasons, and the nature of the manager–employee relationship may mean that true confidentiality cannot be guaranteed when supervision is also taking place. Another example of a relationship that could compromise the supervisory function is that of trainer and student. Teachers and trainers are required to assess their students, and this might inhibit those students who are concerned about receiving satisfactory

grades. Some elements of teaching are certainly contained in supervision but it encompasses many skills; though its primary function is to protect clients through the provision of a safe and proficient counselling service.

Finding a supervisor

In Unit 1 we noted that students in placement need supervision as part of their overall training programme. Supervision in this context is known as training supervision, and is now an essential requirement of every training programme. Training establishments have, therefore, a duty to ensure that students have access to supervision. We know that supervision is not the same as counselling and that it requires a separate and specialist form of training. For students of counselling, the answer to finding a trained and competent supervisor lies in cooperating with trainers. Any suggestions you make for supervisory arrangements should be discussed and agreed with you.

How much and how often?

In its *Ethical Framework* (2013), the BACP states its supervision requirements for accredited courses; however, other courses may provide their own details in relation to frequency and number of supervisory sessions. These details should be worked out between the training establishment, the supervisor and the student or supervisee. When formalising a contract, it is also necessary to clarify any other relevant details, including those relating to student assessment and the degree of responsibility and accountability the supervisor has to the student's training establishment.

Forms of supervision

There are different forms of supervision, including the following:

- 1 Individual supervision, where there is one supervisee and one supervisor. This allows more time for the counsellor to present and discuss his or her work in a safe environment.
- 2 Group supervision, where a number of counsellors meet with one designated supervisor. This approach is more cost-effective than individual supervision, but a possible drawback is that less time is available for feedback to individual members of the group.
- 3 Peer group supervision, where a number of counsellors provide supervision for each other. This form is often used by trained and experienced counsellors; it is not recommended for student counsellors.
- 4 Co-supervision or peer supervision, where two counsellors provide supervision for one another, taking turns to do so and alternating the roles of supervisor and supervisee. This model is not suitable on its own for inexperienced or student counsellors, who may not feel confident enough to participate.
- 5 A combination of individual and group supervision is best for students and provides the right balance of support needed.

The relationship between supervisor and supervisee

It is obvious that the relationship between counsellor and supervisor needs to be based on trust and mutual respect if it is to work effectively. This means that supervisors should be prepared to discuss their qualifications, training and theoretical approach with their supervisees before work begins. As we have already indicated, all administrative and practical details of the supervisory contract should be openly discussed and agreed upon by both counsellor and supervisor.

EXERCISE

Experiences of supervision

Working in groups of three to four, discuss the benefits and disadvantages of the different methods of supervision described in this section. What experience of supervision do individual members of your group have?

Education and training

In Chapter 1 we discussed a range of issues relating to counsellor training, and most of these are common to many programmes, though individual programmes do still vary to some degree nationwide. The British Association for Counselling and Psychotherapy and other professional organisations are committed to continuing research and development in relation to both training and standards within the profession. This means that key elements in counsellor training programmes are quite likely to be deemed essential, or even mandatory, in the near future. These key elements, including supervision (which is already a requirement) and personal therapy, have been highlighted throughout this text. In addition, there is now greater emphasis on continuing professional development (CPD) for trained and accredited counsellors.

Continuing professional development

There is widespread recognition that counsellors must offer the best quality service to clients, and to do this they need to improve and update their knowledge and skills at regular intervals. Counsellors benefit personally from a commitment to training and development, because such a commitment keeps them in touch with the rapidly expanding discipline of counselling and with other practitioners, whose support and knowledge is invaluable. In its guidelines for maintaining competence practice, BACP (2013) states that counsellors should be involved in education if they are to keep in touch with

the latest knowledge and developments in the profession. The following are examples of activities which support or enhance CPD:

- personal therapy
- courses on professional or related issues
- academic study and research
- seminars and conferences
- facilitating courses and workshops for others
- research and publication
- counselling-related committee work.

Research

Student counsellors are often less than enthusiastic when the subject of research is mentioned in group discussion. This response is understandable when we consider the many elements already included in counsellor training. As we have seen in Unit 1, these elements encompass theory, written work and assignments, skills training, supervised practice, supervision, personal therapy and ongoing self-development. This is a demanding (and increasingly expensive) commitment and, for this reason, students tend to regard research as a daunting extra, which can be deferred until later on when training is complete. It is easy to see why the introduction of another area of study into an already crowded syllabus is seen by many student counsellors as a demand too far.

And yet, the extensive list of training requirements is not the only reason for lack of student enthusiasm when the subject of research comes up in discussion. Another, and perhaps the core reason, is that students often fail to see the relevance of research to counselling. Research is viewed as an 'intellectual' activity, whereas counselling is categorised in the 'affective' or feeling domain. Students, as well as many qualified counsellors, sometimes say that they do not believe it is possible to measure the complex individual experiences of clients with the research tools currently used in other areas of science.

Consequently, one of the challenges for teachers and trainers is to convince students of the value of research, and to place it at the very heart of training so that it becomes normalised, less intimidating and better understood. As we have seen, evidence-based therapies, in particular CBT, are currently favoured in the Improving Access to Psychological Therapies (IAPT) initiative, and it is likely that this demand for evidence in counselling and psychotherapy will continue.

Research, therefore, should be an integral part of education and training, so that when students graduate they are predisposed to engage with it. The most effective way of inculcating an interest in research from the outset is through extensive and varied reading. When students see that research findings (many of them health and psychology related) dominate newspaper and magazine headlines, they can start to make the connection with their own discipline, and develop an interest in finding out more about it. At a very basic level, we need to know what works and what doesn't work, and this is as true in counselling

and psychotherapy as it is in any other field. It is not just articles in newspapers and magazines that stimulate an interest in gaining new knowledge about therapy, however; books are essential too. There are numerous books available on the subject of research, a selection of which is included for further reading at the end of this chapter. But students should also be encouraged to read eclectically across a range of subject areas, including literature and philosophy, so that habits of reflection and enquiry are inculcated. This may seem like a tall order, and students are often reluctant to invest in extra books because of the expense involved. Libraries, however, are free, and the internet is an endless, though not always infallible, source of information. Journals and newspapers can be accessed in this way as well, and professional bodies such as the BACP regularly publish articles and research findings on a range of diverse subjects. When research is viewed as something that we can read about and is accessible, then it loses some of its off-putting esoteric status and becomes interesting and relevant to all of us. Once interest is in place, a desire to find out more is nurtured and this forms the basis for future research projects in areas of specific interest to individual counsellors and psychotherapists.

There are some obvious areas of mental and physical health that all students (and trained practitioners) should understand if they are to offer optimal support to clients. Keeping abreast of developments in these areas requires ongoing reading and research and, preferably, attendance at forums where they are discussed. The following areas should be relevant to counsellors and generate interest in study and research:

- mental health and illness
- physical illness and its psychological effects
- theories about the links between physical and mental illness
- environmental factors which impinge on health and wellbeing
- neuroscience and counselling.

Neuroscience, which is described in Medical News Today (2012) as the study of the brain and spinal cord and is included here because findings increasingly suggest that counselling engenders positive and lasting changes in the brain. Williams and Penman (2011) refer to this effect too and suggest that these changes in the brain include the regeneration and building of new neurons, a process called **neurogenesis**.

These effects have been detected through the procedure of **neuroimaging**, a medical procedure normally used for diagnostic purposes. Another term often used in relation to brain function is **neuroplasticity**, which describes the brain's ability to change in response to the environment and throughout a person's lifespan. In relation to counselling, this is a relatively new and exciting area of study, so it is important that student counsellors and trained practitioners keep in touch with its developments.

Undertaking an actual research project while in training is a substantial commitment and may not be feasible within a busy schedule. However, it is important to be aware of how it is done and to take an interest in it for future reference. In *Doing a Successful Research Project*, Brett Davies suggests

that many students are inhibited about research, because they wrongly believe it ‘involves complex methodological theories’ when in fact it does not. He encourages students to have patience, plan carefully, aim for simplicity and to be realistic about what can actually be achieved (Davies, 2007: 9)

Cultural diversity and counselling

Though we live in a multicultural society, counselling and psychotherapy are still predominantly white, middle class, heterosexual and largely affluent professions. This situation may reflect the fact that the traditional client base for counselling and therapy has tended (historically) to be drawn from these groups as well. This situation has obtained, not because people of different races or ethnic minority groups do not have the same rights and needs for therapy. On the contrary, it is because, until recently, most training courses failed to address cross-cultural issues in their programmes for students. Often, as Sue Marshall suggests in her book *Difference and Discrimination in Psychotherapy and Counselling*, intercultural and cross-cultural therapy is still regarded as a ‘specialist’ or ‘marginal area of interest’ outside mainstream counselling or psychotherapy (Marshall, 2004: 64). In addition, the theories underlying counselling and psychotherapy fail to take account of the experiences of black people or those from diverse ethnic groups. Freudian theory and its derivative psychodynamic theory are, for example, formulated on the experiences of a particularly narrow group of people living in Europe in the nineteenth century. This is a criticism that counsellors working from a feminist perspective would also level against traditional psychodynamic theory, though as Marshall (2004) notes, the situation has been redressed to some extent by the feminist movement itself, and by later theorists.

One interesting and disturbing factor that Marshall notes is that people of different races (if they do have access to it) tend to leave counselling early. Furthermore, they are less likely to benefit from therapy, even when they are committed to it. An explanation proposed by Marshall is the fact that all models of psychotherapy and counselling are ‘rooted in white Western values’ (Marshall, 2004: 59). It is not surprising, therefore, that theories derived from a white middle-class context do not address the values and ideals of other groups outside that narrow band. This white Western bias stems, of course, from the wider society, so it is no surprise that its insidious influence has permeated therapy as well. Because it fails to take into account the validity of equally important and diverse views, it becomes accepted as the norm and, unless challenged, will continue to do so. However, within recent years there has been a decided focus on race as a factor in counselling and psychotherapy, and the BACP is committed to research and the implementation of good practice in the context of intercultural and cross-cultural counselling.

In addition, BACP is dedicated to equality of treatment in all areas and, along with The British Psychological Society, opposes any treatments or interventions (referred to as conversion or reparative) designed to change same-sex orientation. Included in this group are gay, lesbian, bisexual and all other 'non heterosexual orientations', which have in the past been subjected to prejudice and regarded as illnesses (British Psychological Society, 2013:1). This is an important step forward in terms of addressing a hitherto neglected area of counselling and psychotherapy. What is needed, though, is more emphasis on cultural competency and diversity training for all student (and qualified) practitioners within the helping professions to address the deficit that still exists. Without this level of training, counsellors are liable to fall into the trap of trying to reframe clients' views and behaviours so that they fit those of mainstream values and perspectives. Such an approach is not only stultifying for clients (who will probably abandon counselling because of it), but it is also limiting for practitioners who will learn nothing of the varied and culturally rich lives of other people.

It is not within the scope of this chapter to discuss all the important issues that need to be addressed in relation to cultural diversity and counselling. However, it is an ethical issue, which means that students and practitioners need to ensure adequate training in order to meet the needs of all clients. Increasingly, specialist courses are available, but diversity awareness is so fundamental to good practice that it should form a substantial part of all counsellor training programmes. It is important that counsellors of the future are culturally competent and able to offer the best possible help to meet the needs of all communities.

EXERCISE

Terms and what they mean

Working in small groups, look at the following list of terms and discuss their meanings and the relevance they may have in the counselling context:

- ◆ discrimination
- ◆ culture
- ◆ ethnicity
- ◆ heterosexism
- ◆ multiculturalism
- ◆ dominant group
- ◆ empowerment
- ◆ diversity
- ◆ stereotypes
- ◆ prejudice.

Feminism and counselling

It is interesting to note that almost all the psychotherapeutic approaches described in this chapter have originated from a male perspective and, from Freud onwards, have demonstrated an almost exclusively masculine viewpoint about women and their experiences. The writer Nancy Chodorow, commenting in 1989 on the history of feminist discourse, suggests that ‘dominant ideologies’ have shaped opinion, so that women’s own voices have been ‘ignored or silenced’ (Chodorow, 1989:199). It is true that Melanie Klein addressed some aspects of female experience, though she did not focus on women’s experiences of oppression, but instead wrote extensively about the early mother–child relationship, with little or no reference to the father. Adler, too, was interested in the experiences of women; in *Understanding Human Nature* (1927), he wrote about the problem of ‘male dominance’ and the difficulties it meant for women who were disadvantaged because of it (Adler, 1927: 106). Adler, though obviously not a female voice, was writing about discrimination in the early part of the twentieth century, which makes his prescient approach all the more remarkable.

It was not until the early 1960s and 1970s (when the feminist movement began) that those aspects of ordinary women’s lives became a sustained focus of discussion and debate. During this time feminists provided conditions, mainly through their writing and facilitation of consciousness-raising groups, for women to tell their own stories in their own words. It would be wrong to suggest, however, that few people protested about women’s relative lack of power, or about their social and sexual subordination, before the second half of the twentieth century. As far back as 1792, Mary Wollstonecraft had written her treatise, entitled *A Vindication of the Rights of Women*, which argued for (among other things) women’s right to education. That women have a right to education is a fundamental aim of feminism today, but education here is defined in the widest possible sense and includes empowerment and the awareness of women’s assigned roles in society and the social control traditionally used to enforce them.

In contrast to all other approaches, feminist counselling was not founded by one particular person but encompasses many strands and is derived from feminist philosophy, in general, and the women’s movement of the 1960s, in particular. Those women, who collectively contributed to the movement, realised that the social, cultural and political context of their lives had to be recognised as factors in the cause of many of their problems. Before the emergence of feminism and feminist therapy, most women’s problems were believed to stem from personal or innate inadequacies, usually located in the female psyche, or in women’s refusal to conform to a predetermined and male view of how they should behave. Feminist counselling takes a different view and, instead of blaming women for their emotional or psychological distress, suggests that oppression and environmental causes

are the basis of their concerns. In order to address these concerns, feminist counselling has developed its own unique approach to clients, which is based on a historical awareness of women's difficulties. It is also linked to specific values and attitudes, including respect for individual client experience and awareness of the environment in which they live. Clients are not expected to adjust to a particular situation (often toxic or abusive) but are supported in their efforts to identify personal strengths and to change the environment that has a negative impact on them. Feminist counsellors also acknowledge the power balance between themselves and their clients and endeavour to encourage equality with them. One way of achieving this is through counsellor self-disclosure and through educating clients about the therapy process itself. Although there are no specific techniques used, feminist counselling can be incorporated into a variety of other therapeutic approaches, with the proviso that the origins of the client's problems are reframed in the context of environmental causation, rather than personal ineptitude or weakness. Assertiveness training is often offered to clients to help them develop confidence in interpersonal relationships and social situations. Reading (or bibliotherapy) is also often recommended to address issues, including power imbalance between men and women, gender role stereotyping and societal pressure on women to look or dress a certain way.

A basic tenet of feminist theory is that the 'personal is political', a phrase that is not attributable to any one person, but encapsulates and describes the relationship between individual experience and the devaluation of women as a group within society generally. It emphasises, too, that individual change is most likely within the context of social change. This realisation helps women to see that they are not alone, but part of a larger community of others with similar experiences. In addition, it stresses the wider issues affecting women of different races as well as lesbian feminists, and upholds certain fundamental values including equality, respect and dignity. Sharing of personal experience is an important aspect of group counselling, in particular, and is especially pertinent in the context of women's groups, which also provide peer support, information sharing, role modelling, and opportunities for 'identifying commonalities' (Israeli and Santor, 2010:236). Other features of feminist counselling include the fact that it is a person-centred approach, whose goal is to help clients identify and acknowledge their own strengths. When clients are enabled to do this, they can then mobilise their own resources and support systems. Ideally, they may also be prompted to work towards social change, not just for themselves but for women, in general, and other disadvantaged groups within society. Finally, feminists understand that counsellors should be drawn from a diversity of backgrounds, classes, races, abilities and sexual orientations, if they are to provide the broad spectrum of support their clients deserve.

SUMMARY

In this chapter we considered a range of ethical issues in counselling. These include the subject of confidentiality and its central place in the therapeutic relationship. The limits of absolute confidentiality were discussed and examples given of situations in which it might not be guaranteed. Contracts in counselling were discussed, and the subject of 'endings' and its attendant difficulties were considered. Aspects of the counselling relationship were discussed, including the twin concepts of transference and countertransference. The subject of referral and reasons for it were detailed. Crisis situations and their effects on both client and counsellor were addressed in this section, and the need for regular supervision highlighted.

Although this chapter did not attempt to deal with the subject of research in detail, it does emphasise the increasing importance of developing an interest in it. We looked at ways in which students can be encouraged to view research as a fascinating and relevant component of training, as well as a prerequisite of future exploration.

A section on diversity in counselling and another on feminist counselling were included within this chapter entitled 'Ethical considerations'. This is because the word 'ethical' refers to that which is right or fair, and because counselling should, rightly and in fairness, be available to all members of society who wish to access it.

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Resources

Websites

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British Association for Counselling and Psychotherapy.
- www.eac.eu.com

European Association for Counselling.
www.irish-counselling.ie
Irish Association for Counselling and Psychotherapy.
www.bps.org.uk
British Psychological Society.
www.psychotherapy.org.uk
United Kingdom Council for Psychotherapy.
www.tandfonline.com
Taylor & Francis online journal of Feminist Family Therapy.
www.researdgate.net
Website of feminist family therapy.
www.ingentaconnect.com
This is a supervision research and practice network funded by the BACP.
www.counsellingsupervisiontraining.co.uk
Dedicated to counsellor training and supervision
<http://ec.europa.eu/justice/discrimination>.
The European Commission for justice and tackling discrimination. Outlines
legislation and lists events, networks and courses.
www.uktrauma.org.uk
UK Trauma Group (services relating to trauma).
www.therapytoday.net
The online magazine for counsellors.

Journals

European Journal of Psychotherapy and Counselling
The Counselling Psychologist
Counselling and Psychotherapy Research
Cognitive Behaviour Therapy (Research)
Journal of Counselling and Development
Journal of Counselling Psychology
Journal of LGBT Issues in Counselling
Women and Therapy: A Feminist Quarterly
Journal of Gay and Lesbian Mental Health
Journal of Social Action in Counselling and Psychotherapy
Journal of Refugee Studies