

CHAPTER 1

CONTEMPORARY THERAPEUTIC PRACTICE

Therapy and ethics

It is perhaps the intimately collaborative nature of the therapeutic process and relationship, whether in short- or long-term work, which our clients most value. Collaboration and negotiation are therefore at the heart of therapeutic ethics. Therapist and client, as partners in this project, share responsibility to engage with each other, to value each others' experience, and to persist through any difficulties that may arise on the way. The therapist makes a commitment to the client's well-being, using his or her professional expertise and personal learning in support of the client.

In this collaborative process there will be moments of absolute meeting between two human beings. There will also be times of difficulty: blocks and misunderstanding to be worked through. Such a journey can not be wholly encapsulated in our professional codes of practice or set down in procedural frameworks. Creativity, spontaneity, risk-taking are part of the therapeutic process. So is the consistent and constant 'holding function' on the part of the therapist who respects the client's need for security and containment (Winnicott, 1990: 240). Our efforts as therapists are directed towards support for the client's development, but we also recognise that the client is the expert on their own lived experience. No amount of professional knowledge and judgement should deter us from valuing this expertise in the client.

In collaborative therapeutic ethics the client's well-being is appropriately balanced with that of their therapist. From this perspective, ethical considerations respect the fundamental equality between two people, therapist and client. Such equality nevertheless sits alongside areas of difference in experience, expertise, personal development and responsibility within the therapeutic dyad. For example, the therapist will expect to take responsibility for their own well-being, as well as that of their client, but the reverse should not be the case. Therapists need to be aware of the sometimes subtle ways in which clients might try to take care of them, so that if necessary this can be given attention in the course of therapy.

The following vignette illustrates how care for a client, therapist self-care, and client autonomy may interact. It includes three different 'possible therapist responses' to the same set of circumstances.

VIGNETTE: 'HILARY AND MALCOLM'

Hilary is a psychotherapist in private practice who sometimes accepts referrals from psychiatric support services in her locality. She has been seeing Malcolm twice a week for six years, since he left hospital following a psychotic breakdown. Since then he has had no further hospitalisations, has found employment in a small furniture factory and has developed a relationship with a woman he met through work. Hilary and Malcolm have been discussing a move to once weekly therapeutic support. Whilst he is keen to do this on one level, he has said he is also afraid that with less support he might become unwell again. Hilary is reflecting on all this whilst waiting for him, and is also looking forward to a walk in the park with a friend, planned later that afternoon. Malcolm telephones to say that his bus has broken down so he will be late and maybe will not get to his session. He sounds very distressed and also reports that he and his girlfriend have had a row that morning.

FIRST POSSIBLE THERAPIST RESPONSE

Hilary tells Malcolm that she will be available until the time set for the end of his session and asks him to ring again if he decides to abandon the attempt to come. Putting down the phone, she is pleased that she held the therapeutic boundaries and did not just react to his obvious distress. When he rings again five minutes later to cancel the session she simply reminds him of the date and time of their next planned meeting. She makes a note of the interchange with Malcolm and goes off for her walk. At his session the following week, Malcolm is a bit subdued at first but soon becomes involved in talking about his relationship. Hilary is aware that neither of them has mentioned what had happened the week before. She assumes it has all 'blown over' and is relieved to get back to what she sees as the main business of Malcolm's therapy.

SECOND POSSIBLE THERAPIST RESPONSE

Without giving it too much thought, Hilary suggests that Malcolm should not worry about the time but come when he can and they can time the session from whenever he arrives. She knows that she has no more clients that day, though it will mean cancelling her walk in the park. He eventually arrives 40 minutes late, looking tense and flushed. He expresses his annoyance at being late and his gratitude for Hilary's flexibility. Late in the session Hilary thinks that he has calmed down enough to talk about the row with his partner and how he might try to re-connect with her following the row. Malcolm is effusive in his thanks when he leaves 50 minutes later.

THIRD POSSIBLE THERAPIST RESPONSE

When Malcolm rings, Hilary reminds him that there are still 45 minutes of his session left, so he may well arrive in time for at least a part of the session. She considers offering him a later time as he is obviously distressed, but decides against this as she

does not wish to cancel her planned walk. In the event, Malcolm arrives with 25 minutes to spare. He looks tense and flushed, loudly expressing his annoyance at being late and losing half his session 'even though he was paying for all of it'. He switches quickly to talk of the row with his partner but Hilary remains affected by his anger. She interrupts him, saying 'Malcolm, I can't hear you properly because I feel as if you are angry with me. I know you realise that it is not my fault that the bus broke down and made you late. But you seem annoyed about me not being able to offer you a full session, too?' Malcolm replies almost immediately 'I've never been angry with you before, have I?' They go on to talk about his fears that Hilary might not be able to tolerate him being angry with her. He knows his anger had destroyed other relationships. Hilary carries on this work, owning her wariness of his powerful anger but assuring him that she will not be destroyed by him being a bit annoyed with her, or disappointed in her; that was normal in any relationship.

● ● ● **Pause for thought: care, responsibility and autonomy** ● ● ●

- *Which of the three 'possible therapist responses' in this vignette best illustrates the ability to hold these ethical considerations alongside each other: care for the client; therapist self-care; and the client's autonomy and self-responsibility?*
- *What are the features of the therapist's response that lead you to say this?*
- *How would you characterise the ethical stance taken by the therapist in the remaining two possible responses?*

The third therapist response perhaps illustrates the most collaborative attitude. This therapist tries to hold the balance between the ethical considerations of care for the client, therapist self-care and the client's autonomy and self-responsibility. There are a number of features of her response that demonstrate this. For example, she keeps her focus on Malcolm's issues without losing sight of her own needs. She holds therapeutic boundaries around time and money without being defensive or rigid in her interactions with Malcolm. She considers Malcolm's therapeutic needs in the context of his development as a person, in particular his need to feel and express emotions in a contained way. She understands that he may be afraid of his own powerful anger because of the negative consequences he has experienced in the past. Nevertheless, we could imagine a supervision session following this episode in Malcolm's therapy where Hilary's supervisor might challenge her 'wariness' of Malcolm's anger. Perhaps she has her own work to attend to around her experience of 'angry men'? Hilary might also need to adjust to the fact that Malcolm has changed over his years of therapy and now has more self-support and maturity, as evidenced in the contactful way the two of them have now begun to work on these issues. This response, in summary, seems both ethical, in the sense of displaying Hilary's developing wisdom and commitment as a therapist, and creative, in the way she genuinely interacts with her client and recognises the changes he is undergoing as a person.

You will have identified ways in which the first two possible responses differed from the third one. In the first response, Hilary held the time boundary very firmly. Many therapists who emphasise the importance of the therapeutic process and relationship as a holding 'container' might do this. But they would also be likely to ensure that they explored the incident in depth with Malcolm at a subsequent session, unlike Hilary here. In a positive sense, she does no intentional harm and does observe recommended therapeutic boundaries. She keeps within the 'rules' she has absorbed from her professional training and made her own. This is a legitimate way of working, and can also be a perfectly adequate response when we are unsure what to do or feel that we need to discuss a situation further with a colleague or supervisor. Most of us – especially perhaps at the outset of our careers, or when working with a very new client – will have 'followed the rules' in order to make ourselves feel safer. The down side, of course, is that here Malcolm has little opportunity to further his development when Hilary responds so inflexibly. There is little space for his anger in this consulting room. You might say here that Hilary protects herself at Malcolm's expense. She does get her walk in the park, but in allowing the incident to 'blow over' she colludes with Malcolm's fear that his angry emotions must be destructive. He complies with her need to return to therapy as she wants it to be.

It also seems less likely that these issues will be taken to supervision, which of course makes the work less 'safe' in the end. As we will see later on, many complaints made by clients are in fact about relatively trivial-seeming incidents, which the therapist, for whatever reason, has consciously or unconsciously missed or glossed over. For the client seeking a relationship with a therapist who will engage with them as a person, such experiences are far from trivial.

The second possible therapist response seems to err in the opposite direction. A subsequent supervision session might see Hilary, in this case, sharing her reaction to Malcolm's distressed phone call. Perhaps she might see that her response had been over-protective and more related to the 'old Malcolm' than Malcolm as he now was; a much stronger person. Together, Hilary and her supervisor might examine this idea in relation to the fact that Malcolm had been 'panicky and tense', treating her on this occasion as the 'one who would make everything all right'.

Looked at in transference terms, Malcolm's feeling of 'panic' is generated not only by the actual anxiety of the current situation, but by previous experiences where he may have had to cope with similarly intolerable anxiety, but perhaps then without anybody present to 'make it all right' and help him handle those intense emotions. In this way he is 'transferring' intense need from unresolved past experiences into the current situation, which really just involves being delayed in getting to see his therapist. He is treating Hilary *as if*, in a sense, she is that longed for 'helping parent'. Hilary's counter transference – here meaning her spontaneous response to the way Malcolm brings his intense relational need

to her – is for her to be accommodating, soothing, and protective, *as if* she was indeed Malcolm's much needed 'helping parent'. She does not think enough about her own needs because she is caught up in the transference relationship, rather than the real one, here and now.

Of course, she has been his helper in many ways over the course of time, so it was not unnatural for her protective instincts to be triggered by his sense of fear and danger. But now she might ask whether this could have been explored more with Malcolm. It is possible, for instance, that the row with his girlfriend had reactivated Malcolm's need for an empathic, available figure in his therapist. They might also have identified Malcolm's 'gratitude' and Hilary's relief and pleasure. As therapists like Melanie Klein have argued, gratitude can be 'prompted mainly by feelings of guilt' about envious or angry feelings towards a caregiver (Klein, 1975: 189). Maybe Hilary was avoiding becoming the target of Malcolm's anger when she decided to be 'flexible'? At any rate, we think you will agree that Hilary here takes an over-caring stance, perhaps because she places caring for the client above her own self-care and an awareness of the client's self-responsibility. This nevertheless distorts her capacity to hold the whole picture in mind and appropriately sustain her professional awareness.

'Practical wisdom' in therapy

As we have seen, there is a balance to be struck between the demands of the therapist's care for the client, the client's self-responsibility and the therapist's self-care. This holding of potentially competing values and demands is part of 'practical wisdom', or what some classical Greek philosophers termed *phronesis* or ethical prudence (Aristotle, 1976: 209–16). With this approach, we do not use our mental capacities to create ethical 'rules' which we then subsequently apply to life situations, separating thinking and reflection from active living. Rather, ethical reasoning is embedded in the actual experiential and practical circumstances of life. Experience causes us to reflect – to take time to consider the meaning of events, experiences, feelings and ideas – and the fruits of our reflection in turn give us wisdom about how to live. The circumstances we encounter generate complex and often competing ethical considerations. Practical wisdom is the capacity to apply ourselves to this particularity and complexity, finding the ethical resolution that seems best in those circumstances. It is a 'resolution' rather than 'solution' because there is not usually a 'right answer' to a complex ethical situation, in the way that, for instance, 'codes of conduct' might suggest. Rather, there is a weighing up of all the ethical considerations in an attempt to act reflectively and wisely.

The concept of practical wisdom is important to us as therapists, because therapeutic ethics originate from our own experience as human beings in relationships. We understand persons to be both individually unique and autonomous *and* intimately interdependent with other people, with community or

society, and with the natural world. As we will see in Chapter 2, these ideas are often expressed in professional ethical codes and value frameworks. But by themselves these ideas and values do not guarantee wise action. There is a need for us to engage with the cycle of reflection and experience which can develop our own practical wisdom over time.

Theories of therapy have been generated in just this way. Ever since Freud's groundbreaking work in the 19th century, where he offered an explanation for the mental and emotional lives of his patients, therapy theory has grown out of real engagement with people. The theories can, of course, become quite powerful in themselves, to the point where they assume the status of 'truth' or clinical 'certainty'. This is arguably one factor leading to the rivalries between different therapeutic approaches. But ideally, perhaps, theory can inform therapeutic practice rather than dominate; and practice itself can generate new insights. Each unique situation, and each person's perception of the world, has the potential to contribute to the development of further theory.

Practical wisdom also entails the capacity to live and work with provisional knowledge: the ability to hold uncertainty and adopt a conscious position of 'not knowing'. This attitude complements the therapist's awareness of professional knowledge built up over time, informed by a variety of therapeutic practitioners each with different emphases and understandings about human beings. As therapists we try to hold the whole picture, not judging too soon or discarding whatever does not match some pre-conceived idea. We seek reflection and resolution, rather than solutions which leave out what does not fit. We live and work with uncertainty as therapists, in a world that often encourages us and our clients to split the whole, and to judge what is 'true' or 'right' or 'good' as if these were uncontested ideas, applicable to any circumstance or person.

Let us explore these ideas a little further, by considering this example.

VIGNETTE: 'ELIOT AND ANNE'

Eliot first came to Anne for counselling when his relationship had been disrupted by his partner's sexual infidelity. His partner had also gone to a counsellor on her own account as neither one wished to try couple counselling. Eliot was clear that he wanted to focus on dealing with his 'frightening rage' at what had happened, and needed 'objective input' to help make a decision about whether or not to stay in the relationship. Over the initial weeks, Anne noticed that it seemed to be her role to remind him that he had wanted this focus. Eliot seemed more interested in the exploration of links between his current rage and anger experienced earlier in his life. He also seemed to enjoy discursive conversations with Anne about their very different cultural backgrounds; his in a wealthy, extended Caribbean family and hers in a relatively poor Midland factory town. Drawing on the ideas of Stephen Johnson, Anne suggested that one way of looking at Eliot's early experience was to see himself as an 'owned child' (Johnson, 1994: 129–53). He had always done what his family expected of him as it was his job to make them proud and happy. This meant that Eliot often felt

his desires, hopes and achievements were 'appropriated' by others. He thought that this experience had affected his later life choices, including choices made in his central adult relationship which now made him resentful, driven and something of a martyr to his current family. Together he and Anne reflected on his relative lack of experience of respectful, intimate relationships, as contrasted with intrusive and controlling elements in his developmental relationships. This may have caused him to defend himself against 'invasion', as he saw it.

At the end of a session not long before a planned holiday Eliot surprised Anne by making a request to change from weekly to monthly sessions after the break. Anne suggested they talk more next week, and later took her concerns to supervision. She and her supervisor discussed the work on Eliot's 'owned child' and considered his request in the light of a possible need to control the pace and level of intimacy in the counselling relationship. Anne explored her own feelings of being a bit controlled by Eliot. She was aware of feeling 'on her toes' and 'being kept hard at work'. Was this her own need to 'work hard' in order to feel she was doing valuable work with Eliot? Or was it also, perhaps, a counter transference response – Eliot's 'angry child' who needed to be in control, in a sense making Anne 'work hard'? If so, this might help Anne understand better what it was like for Eliot to feel so driven and 'controlled' in order to feel worthy inside himself. It was important to hold all this in her awareness when deciding how to deal with Eliot's request, so that it did not become a battle for control.

When they met again they reviewed the work so far, recognising that although attention had been given to Eliot's original relationship problem, this remained unresolved. He was still unsure about it, if much calmer than he had been, but said he could live with that for the time being as he had become aware that he had his own questions to deal with. He said he was beginning to recognise that he had never really made choices for himself until recently. He did not want to become a 'resentful – and guilty – old man'. They also considered his need to slow down, wondering if this could be a theme for both of them. Anne shared a little of her experience of 'wanting to be a really good therapist for you' but feeling 'on her toes' sometimes. Eliot laughed and said he was very familiar with that striving in himself. They both agreed it would be good to lessen the pressure, whatever was decided about session regularity.

●●● *Pause for thought: practical wisdom in therapy* ●●●

- *Can you identify in this vignette any of the key features of therapeutic ethics, as discussed so far?*
- *How would you say it illustrates the therapist's practical wisdom in development?*
- *Can you bring to mind an experience of your own (with a client, if possible) which illustrates similar features – collaboration, balancing 'goods' or 'truths', holding not-knowing as well as knowing, and so on?*

This example does seem to illustrate some of the key features of therapeutic ethics. The process of therapy is characterised by the collaboration between

therapist and client and therapist and supervisor. Anne hears her client's account of himself and his needs in therapy. She engages with Eliot whilst also reflecting on what he says from her own perspective, informed by professional study and supervisory support. There is a process of negotiated meaning-making at the heart of this work (something we will discuss further in Chapter 2). The response to Eliot's request is not presented as a 'right way' or a 'good answer' but is more an acknowledgement of the need to consider the whole picture, as far as possible.

All this illustrates the therapist's developing practical wisdom. You could say that Anne arrives at a resolution to this issue with her client, rather than a solution. Some of the complex layers of meaning are suggested by her own professional understanding and in conversation with her supervisor. She learns, for example, that when she feels 'controlled' by a client this can often be a sign that the client feels, or has felt, controlled at some important point in their own development. But it is with Eliot that she finds a resolution that reflects his insights as well as her own. They both accept his uncertainty about his initial presenting problem; he remains unsure about his relationship with his partner. Eliot himself finds satisfaction in the recognition that his 'frightening rage' is perhaps a necessary process for him in challenging the power of past relationships, as well as being a response to current relational events. The practical 'answer' to Eliot's request – whether or not to change the regularity of his counselling sessions – remains to be decided but both parties are confident that it will be on the basis of this fuller, shared understanding of the issues.

Therapy and consumerism

We have seen so far that there are some key features of therapeutic ethics. These include the process of collaboration and negotiated meaning-making at the heart of therapy. The intention to hold the whole, rather than split off or polarise opinions, views and experiences seems integral to this enterprise. The therapist's reflective attitude to ethical issues in therapy supports the development of wisdom, rather than mere knowledge, for both client and therapist. Practical wisdom grows out of experience shared, mutually honoured and understood.

These are grounded ideals that inform our work as therapists. But in the UK and perhaps in the developed world more generally, we and our clients are living in a consumer society, which can generate practices that run counter to therapeutic ideals. Therapy is concerned with people as relational human beings, interconnected with each other and the wider world, whereas consumerism focuses on the individual as a 'user' or 'buyer' of things, experiences and people. Therapy, at its best, fosters negotiated, shared meanings and collaboration towards human growth. Consumerism, at its worst, breeds competition, rivalry and the envy of others. The uncertainty that therapists accept as an

appropriate response to life's complexity seems to be at odds with the search for 'happiness' or 'success' that is central to consumerism. Being a consumer is supposed to provide us with a sense of security, satisfaction, belonging and happiness. No one wants to be left out of the promise of this experience. As therapists, though, we understand 'the good life' to be one that is based on authentic choices made by the person who continues to discover what gives *their* life meaning. This person aims to lead a 'flourishing' life, rather than a narrowly 'happy' one (Macaro, 2006: 16). We also understand that the 'flourishing' life will usually be a mixed experience. Life will always have ups and downs; some aspects may feel resolved for now and others remain less settled.

Everywhere, it seems, the consumer ethic prevails. Professionals come to be seen as selling a service just as a shopkeeper sells goods to customers. Universities, hospitals, arts events increasingly use the term 'customer' rather than student, patient, audience, participant. Even 'client', our most commonly used term for the people we work with, is a word more redolent of a business arrangement. A glance at some of the current advertising for the variety of therapeutic services on offer highlights the extent to which therapy can be presented as a commodity, to be bought and sold. In plain terms, as therapists and clients we are often caught up in the tensions generated by the fact that we are practising therapy within a consumer context.

The following vignette is an imaginary example based on concerns expressed in many supervision group discussions. Mustapha is a counsellor in a workplace counselling service within a large organisation.

VIGNETTE: 'MUSTAPHA'S STORY'

Many of the clients I work with come to counselling feeling ill with stress or anxiety. They are often on sick leave so they can take the time to come to counselling to 'sort themselves out'. The corporation is paying for the counselling and they supply feedback forms to complete at the end of the series of sessions. They want to know if the client has made good use of the counselling, and in consultation with the client I give feedback about what issues have been covered. First of all, I can see that for most people I work with, the reasons for their stress and anxiety are absolutely plain. Maybe the corporation has made other staff redundant and this has had a direct impact on my client's workload. The anxiety they feel is often the result of pressure put on by managers or other colleagues to complete an impossible workload. The culture is very macho in this corporation. But usually, the client thinks there is something wrong with them for not being able to cope.

How do I respond? Well, I try to understand what the person is experiencing that makes them feel so worried and unable to cope with the work situation. As well as recognising the real, practical, external reasons for their stress and anxiety, we look at how the client reacts. Sometimes this means helping them develop practical coping strategies like finding support with other colleagues and friends. Sometimes we look at how stress can be a disempowering experience because it triggers a child-like memory

or behaviour, so the client does not feel or act like an adult. And we work together to give the client a clearer sense of what is their responsibility and what is the manager's, or the employer's, so they see the politics of the situation, if you like. Now and then, the best thing is to help the client to move towards getting out of a toxic situation and finding another job. Even so, I often feel compromised because I'm helping a client to adjust to a less than tolerable situation.

●●● **Pause for thought: practising therapy** ●●● **in a consumer culture**

- *Try to summarise the ways in which Mustapha attempts to hold and resolve the tensions between his therapeutic work and the demands of a consumer culture.*
- *Then, consider how you might have experienced such tensions in your own work. For example, have you ever felt, like Mustapha, 'compromised'?*
- *Finally, have a think about what these experiences suggest concerning tensions that may exist between the practice of therapy and the ideology of the consumer.*

Mustapha's account highlights at least one source of tension. The corporation expects Mustapha to 'fix' this client so he can return to work as a more effective employee. It is, supposedly, the client who has something wrong with him: he cannot cope with the demands of his job, which are deemed to be appropriate. Mustapha, on the other hand, sees the situation in a more complex light. If an aim of therapy is to support his client's well-being, Mustapha may want to help him keep his job and cope more happily with the demands, if possible. But he also feels 'compromised'. There is often, he seems to think, a tension between his clients' authentic personal awareness of distress and lack of fulfilment, and the emphasis on success and money-making which defines consumer culture, rather than meaning-making. Mustapha does employ practical wisdom in prioritising his clients' well-being within a context that arguably does not offer enough support. He finds a way, with his clients, of reaching a provisional resolution of their immediate concerns. And even so he feels 'compromised'.

We wonder what experiences of this kind you might have had. Maybe you will have identified with the tension Mustapha feels between the aim of supporting his client to develop awareness, responsibility and choice as a person and the pragmatic need to help him adjust to a less than life-enhancing workplace situation. You might also have identified other tensions which arise when your core therapeutic values are challenged. Like Mustapha, you and your client may sometimes be asked to report to a third party who in a sense 'owns' the therapy because they are paying for it. This can set up a tension between your basic confidentiality boundaries and the knowledge that this is the only way your client is going to get any therapeutic support at all. What do you do? Our

guess is that like Mustapha, you try to find a way to resolve the tensions in a necessarily imperfect manner, trying to support your clients in the best possible way in those circumstances.

Practising therapy ethically, creatively – and ‘safely’

Complaints made to their professional organisations against therapists have been increasing in recent years. For example, in the ten-year period from 1996 to 2006, the British Association for Counselling and Psychotherapy (BACP) received a total of 142 complaints against members, of which 77 went to a full complaints hearing (Khele et al., 2008: 131). Figures provided to the authors of the present book in May 2011 by the BACP’s Professional Conduct Manager reveal that in the ensuing four-year period, from 2007 to 2010, there were 52 complaints hearings. This represents a rise from an average of seven or eight complaints hearings a year, to 13 – quite an increase.

It is important to keep this in perspective. These numbers represent only a tiny fraction of the numbers practising as counsellors, psychotherapists, or in related fields. Even so, the impact of a complaint on individual therapists – and their clients, and the professional organisation involved – is potentially extremely damaging. A lot of therapists find it hard to resume practice following the completion of a professional complaint process (Casemore, 2001: 9–17). Increasingly, it seems, many therapists, and clients, know of someone who has been caught up in a complaint procedure. Working within an atmosphere of potential complaint can have an adverse effect on our professional attitudes unless we open them up to scrutiny.

There are various possible reasons for the rise in the number of complaints against therapists. First of all, there are many more therapists in practice in the UK than there were 20 years ago, and a much larger percentage of the UK population is now having some experience of psychological therapy. This increase is partly due to health initiatives such as the Improving Access to Psychological Therapies programme (IAPT) which has trained over 3,000 new cognitive behavioural therapists to deal with the 491,000 new clients offered treatment by Primary Care Trusts (www.iapt.nhs.uk/). Given the greater numbers of people engaging in therapy, it is not in itself surprising that the overall number of complaints against therapists has risen.

We might also consider a second factor in this apparent rise in complaints: the consumer culture that we looked at in the last section. The consumer, or ‘customer’, expects to be able to buy a guaranteed product. People are also less likely to put up with poor standards or service; expectations are rising. There is a whole vocabulary of complaint handling which emphasises and often polarises two concepts. On the one hand, there is the responsibility of the service provider to deliver a good service to customers or clients. On the other hand, if the client or customer does not receive the service they expect they can make a

complaint, usually to a person or body deemed to be a 'higher authority'. There is now a society-wide apparatus of law and institution set up with the purpose of investigating and adjudicating complaints. Every organisation, small and large, has its complaints procedures, officers and departments. This is mirrored in the many different complaints procedures found among the wide variety of UK therapy's individual professional organisations.

Whatever the societal reasons for the rise in complaints, it is perhaps more important to consider in some detail the nature of the complaints, and factors that are specific to our profession. In a study carried out in 2008 by John Monk-Steel, Chair of the United Kingdom Council for Psychotherapy (UKCP) Registration Board, he concluded that though the most serious complaints concern sexual or physical abuse, the vast majority of cases are concerned with relatively minor 'relational' issues between client and therapist. He summarised these issues as arising from:

- misunderstandings between client and therapist;
 - lack of a shared perspective;
 - mistakes on the part of the therapist that have gone unacknowledged;
 - projections not owned, but acted out by client or therapist;
 - unconscious or unaware feelings, especially envy, hostility or erotic attraction.
- (Monk-Steel, 2009: 3)

As we will explore in Chapter 5, these relational issues, though in one sense 'minor' because they do not lead to serious physical harm or sexual abuse, are nevertheless highly significant when things go wrong in therapy. A misunderstanding or mistake on the part of the therapist can be experienced very intensely by a client seeking a healing or reparative relationship. Real emotional harm can be done to a client by a therapist who remains unaware of the kind of unconscious feelings Monk-Steel identifies. These are often just the kinds of issues that emerge when a complaint is made. Unfortunately it is sometimes then too late to repair the damage caused, wittingly or unwittingly, within the therapeutic relationship.

Furthermore, other research has suggested that there may be a significant subset of clients whose psychological profile makes them more likely to complain against their therapists. These are clients whose 'fragile self-process' also exhibits characteristics of complex post-traumatic stress disorder (Kearns, 2007: 40–2). They may also have been involved in complaints against other professionals. Kearns argues that these clients are over-represented amongst therapy complainants. It seems that such clients may be particularly vulnerable to forming the impression that their therapist is deliberately doing them harm whenever they experience a violation of personal security boundaries in therapy.

One example, based on an actual complaint case examined in recent years, might suffice to illustrate Kearns's point. The complaint centred on the therapist's giving the client a parting gift at the end of a period of therapy. The therapist saw this as a mark of respect for the client and the value of work undertaken over several years in therapy. The complaining client, on the other hand, saw the gift as representative of a shift in the therapist's relational boundary from therapist to 'friend'. This made the client frightened: significant boundaries had been broken in the client's previous life with tragic consequences. At the time of the gift-giving the client had felt unable to tell their therapist of these fears as they did not wish to be thought 'ungrateful' at this sensitive ending time in therapy. Three years later, the client made a formal complaint to the therapist's professional organisation and the complaint was upheld.

Kearns would argue that therapists need to know the risks involved in working with clients with fragile self-process. We need the capacity to work with such clients' unconscious as well as conscious material, which requires effective supervision, personal development, professional knowledge and competent practice. But there is another possibility that we need to think about: that the 'fragile self-process' of therapists can also influence the situation. As Kearns remarks, 'effective psychotherapists need to accept and get to know their fragile parts', in the understanding that 'self-process *is* essentially fragile' (2005: 25–7). Robert Lee also points out that many of us have had experiences of loss, trauma, discrimination, hardship of various kinds, which may result in us projecting 'significant parts of our self – our affects, desires, ways of being in the world' onto our clients (Lee, 2004: 339). Is it possible that in our example the gift-giving therapist thought their client needed a gift as a final valuing gesture, when this was in fact the therapist's own need? Had the gift been given earlier, and not in the final session, there might have been an opportunity for this potential muddle to be resolved, and the therapist's own self-process acknowledged as contributing to the client's experience of being ill-recognised in their need for firm boundaries.

Daniel Stern's pioneering research (1985), based on detailed observation of infants with their primary carers and conversations with those carers, did much to connect an interpersonal view of human development with the relational nature of reparative and healing psychotherapy. Lee takes a similarly relational perspective on human development and on therapy, arguing that we form our selves in interaction with others. My self-process affects yours, and vice versa. These writers take the view that human development happens in relationship. It is also 'layered', involving strands of development that emerge at different points in the therapy. With this view, development is not 'completed' when childhood issues are resolved. Rather, we go on developing throughout life. Therapy offers a primary arena for this relational life work, affecting both client and therapist (Philippson, 2001: 211). All this indicates a need for therapists to have awareness and responsibility for their own 'fragile

self-process', especially as differently experienced with each client. One therapist gives the following account of this:

I always ask myself, and my supervisor will often ask me as a reminder, just how I experience being with this client? What do I feel and think when I am with them – physically, in my body, as well as emotionally and mentally? What is my 'image' or 'snapshot' or 'headline' regarding this client and the way I feel with them?

Over time, I've learnt that when I find myself trying very hard to please or to impress, my own 'grandiose' self-process is being activated. I'm probably dealing with a client who may have had to impress significant people with their hard work in order to get approval or love. Alternatively, if I feel intensely drawn into a client's story, especially if I'm tempted to step over conventional therapeutic boundaries to help or accommodate the client, I'm probably with a person who needs to evoke my 'rescuer' because they don't know how else to deal with intense emotional experiences.

It is not that this therapist's interpretations of her counter-transference responses to clients are necessarily 'correct' or even capable of being generalised. The point is that the therapist knows something about how she typically reacts to different kinds of self-process in her clients. Arguably, this therapist is more likely to be able to use that knowledge to support a client to heal and change, rather than have them repeat a distressing relational experience from the past – either the client's past, or the therapist's.

In this section, to summarise, we have been exploring some of the possible reasons for an increase in complaints against therapists in recent years. There are more therapists practising and many more clients seeking therapy than 20 years ago. The complaints culture and consumer context of our work may also be a contributory factor. Added to this, we may need to develop more awareness of why some clients make formal complaints about relatively minor matters, rather than addressing conflicts more directly with their therapist. All this suggests that a greater priority be given to professional understanding of the relational field of therapy, and the self-process of both client and therapist as they affect the work.

A further factor underlying complaints is that we may not have a deep enough understanding of the ethical potential in our work with clients. We might be familiar with the words used in our various professional ethical codes, without us ever having fully developed and integrated a real appreciation of concepts like 'beneficence' or 'autonomy'. We might not have considered how these values need to be applied to ourselves as well as our clients. We might not have seen that these values sometimes conflict in a given situation. As the next chapter will indicate, such an understanding comes with reflection on therapeutic experience – a central argument of this book. Later chapters will ask you to think in detail about aspects of the ethical framework of therapy, and to note how your own values relate to those expressed in the code of ethics of your own professional organisations.

● ● ● **Pause for thought: possible responses to the** ● ● ●
'complaints culture'

- Take a moment to check how you have been feeling as you read the previous section about the possibility of complaints being made against therapists. Try to pinpoint your reactions without censoring them, if working alone. If you are in a group, discuss and compare your responses.
- Then look at the following responses from therapist participants in a workshop entitled 'Practising Safely in a Complaints Culture', and compare your responses with theirs.

Therapist 1

'I know the effect all this talk of complaints has on me. I try to stick to the rules of my professional organisation. I observe therapeutic boundaries quite tightly. I only keep minimal records. I don't see clients in my own home but work at a centre where I feel less vulnerable because it is more obviously an institutional setting.'

Therapist 2

'I know complaints happen. I've read about some of them in the professional journals and I actually knew someone in my supervision group who went through a complaint procedure. But I just can't think too much about it. I don't imagine any of my clients would complain. If they did, I don't know what I'd do, so I don't let myself get too preoccupied about it.'

Therapist 3

'I refuse to be intimidated by the possibility of complaint. Clients know when they come to work with me that they are responsible for themselves and must tell me if they don't like what I'm saying or doing. I don't like being tied down to some generalised professional code with its rules and regulations, though I do belong to a professional organisation. I'm responsible for my own practice.'

You may have noticed similar feelings of anxiety or rebellion, or confusion or concern as you were reading this chapter. In our experience these reactions are very common in continuing professional development situations, once the topic of possible complaints against therapists is raised.

The first response above illustrates the more compliant therapist who errs on the side of safety. This therapist has a tendency to stick to the 'rules' and not take chances, which is very understandable. The down side might be that their professional responsibility, creativity and flexibility are diminished. It might be less likely, too, that they would encourage clients to consider the broader options available to them, preferring instead to support their conformity and adjustment to a more limited sphere of life choices.

The therapist in the second response takes the 'ostrich position' and trusts to something more like 'luck' or chance. This therapist does not show much reflection or 'practical wisdom', and does not seem to involve clients creatively in

paying attention to potentially difficult issues. Their unwillingness to consider the possibility of complaint arguably makes them more likely to miss experiences that might in fact lead to the client complaining. In this respect, this therapist is less 'safe' than the first.

The third response is something of a maverick. This therapist does have a strong sense of equality between themselves and their client, but seems to pay little heed to the differences of power inherent in the therapeutic relationship. Clients who feel powerless sometimes wait for years after the event to bring a complaint. Such clients might appropriately feel that they have no other recourse but to take formal action, as there is little sense of dialogic space in the therapeutic relationship.

Most of us – and we the authors include ourselves in this – will recognise the fear, dismay, compromised compliance or rebellion expressed by these therapists. Yet as professionals committed to our own and our clients' well-being, we need to continue to maintain and develop our abilities to self-regulate our work. As therapists, we have a responsibility to introduce our clients to the therapeutic approach we take and convey our understanding of the way therapy works as a collaborative enterprise, using both therapist and client expertise and experience. The narrative and discussion in the rest of this book is designed to help you in this. In Chapter 2, reflection on the 'cornerstones' of therapy can support you in articulating more clearly to clients the process and possible outcomes of therapy; what boundaries are; what this means for the way you work together. Any therapeutic agreement or contract you make can then grow out of a shared understanding, as Chapter 3 makes clear. The therapeutic relationship, as Chapter 4 will suggest, can be warm, intimate, creative and supportive and still work within important 'frames' that bound the work of therapy. And in the event that misunderstandings or disputes do arise between therapist and client, these matters might then more often be resolved with respect for the therapeutic process of the client and less often by recourse to legalistic complaints procedures, as Chapter 5 illustrates.

Chapter summary

This chapter has highlighted some of the features of therapeutic ethics, looking at the relationship between reflection and action, thinking and doing. It has argued that therapists need to develop and exercise 'practical wisdom' in order to practice ethically, creatively, and therefore effectively. It has looked at some of the tensions existing between the values of therapy and our consumer culture, situating the rise in complaints in this context. Lastly, it has affirmed that practising 'safely' does not imply defensive or therapist-protective practice. Instead, it requires a steady appraisal of possible reasons why complaints occur and a willingness to engage with these issues from a professionally competent and creative position.

Further reading

- Anderson, S.K. and Handelsman, M.M. (2010) *Ethics for Psychotherapists and Counsellors: A Proactive Approach*. Chichester: Wiley-Blackwell. A lively, resource-filled exploration designed to support the reader in defining and developing their own ethical therapeutic framework.
- Nicholas, M.W. (1994) *The Mystery of Goodness (and the Positive Moral Consequences of Psychotherapy)*. New York and London: W. W. Norton. Nicholas argues that for a client – or therapist – ‘getting better’ necessarily involves them in becoming more ethically aware and self-responsible.
- Palmer-Barnes, F. (1998) *Complaints and Grievances in Psychotherapy*. London and New York: Routledge. This offers a succinct survey of the history and development of complaints handling in four major professional organisations, highlighting the issues raised for therapists and clients.
- Macaro, A. (2006) *Reason, Virtue and Psychotherapy*. Chichester: Whurr Publishers. This develops the ideas of Aristotle in the modern therapy context. The second chapter focuses on the idea of ‘Practical Wisdom: The Art of Making Good Decisions’.