Keeping up with our clients

Jeanine Connor welcomes the emphasis in the new *Ethical Framework* on keeping pace with social trends

When was the last time you read the BACP *Ethical Framework*? In my experience, formal documents such as these are read on a need-to-know basis: something goes wrong, or has the potential to go wrong, and we turn to an official lodestone for succour. But the *Ethical Framework* also has a role in our learning and development within the wider social and political context. It helps ensure that things go less wrong in the future.

The section 'Our commitment to clients' in the new *Ethical Framework for the Counselling Professions* serves as a reminder that our overarching aim is to do good, not harm, and there are some interesting amendments here. Previously, the *Ethical Framework* was couched in terms of 'alleviating personal distress and suffering'; now we are committed to alleviating the 'symptoms of' personal distress and suffering. I facilitated a training day about mental health and asked participants to respond to the statement, 'I see it as my role to cure my client's symptoms'. The unanimous consensus among the 40 BACP-registered counsellors was discomfort with the words 'cure' and 'symptoms', both of which were initially perceived as pathologising. But as I encouraged further consideration of the statement in small groups, I witnessed a gradual shift in perspective. Most counsellors remained uncomfortable with 'cure', which developed into something more like 'alleviate'. As their explorations continued, I observed less abstract thinking and more reflection on tangible clinical experience.

One counsellor spoke about a client he'd been working with for many months who had presented for counselling with chronic anxiety and social phobia. The counsellor admitted an initial urge to make things better for his client – a desire to 'cure' him. With the support of the group, he was able to reflect on the work, which up until now had felt hopeless, and reframe the counselling objectives. As a result, he would return to the counselling room with an increased robustness that would feel enabling for his client. The exercise had achieved its aim of bringing alive our commitment to alleviate the symptoms of distress and suffering in an authentic and meaningful way. If time had allowed, it would have been pertinent to replicate this application for each of the commitments outlined in the new *Ethical Framework*. This would be valuable CPD.

The new framework states that well-founded ethical decisions should be strongly supported by one or more of six ethical principles: trustworthy, autonomous, beneficent, non-maleficent, just and self-respecting. In my experience, the most difficult dilemmas arise when there is an impasse between two or more of these principles. A common example from work with young people are requests for information. Parents and guardians are commonly asked to provide blanket consent for professionals to share information about their children's development, education, health and social care. What this means is that an adult with parental responsibility may have consented to this information being shared some considerable time ago, long before the current involvement, and/or may have given consent even though the child did not agree to it. Ethically, medical professionals, including counsellors and psychotherapists, should also seek consent from the young person themselves, according to the law of Gillick competence,[1] so valuing and respecting their right to be autonomous and self-governing.

A difficult ethical dilemma can also arise when consent has been given yet the counsellor believes that to share information would be detrimental to the client's wellbeing. When ethical dilemmas such as these arise, as they so often do, my foremost aim is to promote the client's wellbeing and protect them from harm. For me, these are the guiding principles of my work and for my clients that is good enough.

Where the previous *Ethical Framework* contained 10 personal moral qualities to which we were 'strongly encouraged to aspire', now there are 11. Some of the old ones have been cut and others have been added (care, diligence and identity). I think they are all worth considering, both individually and in supervision. They provide a solid framework for the consideration of clinical issues. For example, I have supported supervisees in considering how they can remain resilient in their practice without diminishing their own needs, how they can deal with colleagues honestly and how they can manage their fears and uncertainties in a profession where there is very little that is certain.

The 'Good practice' section of the new *Ethical Framework* has had a major overhaul and is clearer, more comprehensive and promotes greater inclusivity. We are no longer being instructed in what practitioners should do; instead the statements read like a pledge: 'We will work with our clients... We will do all that we reasonably can... We will collaborate with colleagues.' This engenders a sense of ownership that should promote useful self-reflection.

There were a couple of statements that stood out for me as particularly pertinent to my work with young people. For example: 'We will... recognise when our knowledge of key aspects of our client's background, identity or lifestyle is inadequate and take steps to inform ourselves from other sources where available and appropriate...' (22f). I am forever being reminded of my inadequate knowledge about social media, gaming, popular music, sexual practices and its accompanying terminology, and I do

my best to educate and inform myself. My Google search history makes fascinating reading. I continue to despair at colleagues' beliefs in the inherent dangers of 'new' apps such as Facebook and Snapchat: Snapchat has been around for five years and Facebook for 12. We have to accept they are here to stay and that we need to know about them.

Another area where I have had a lot to learn is in relation to physical illness. I have no formal medical training but have developed a decent understanding about some conditions because I've worked with clients who have had these diagnoses, and I needed to understand them. Similarly, I know about the effects and side effects of common drugs such as Risperidone, Sertraline, Quetiapine and Aripiprazole. And I can pronounce them. Being informed of the facts doesn't replace getting to know what the condition feels like for the individual; that's always a very idiosyncratic, personal thing that can be explored in therapy. But it does provide a shared language that helps us to connect.

My guess is that many people will interpret this clause of the 'Good practice' guidelines in a different way, perhaps focusing instead on culture, religion or sexuality. I recently attended a meeting of counselling practitioners where we discussed a young person who identified as transgender and pansexual. Most of my colleagues were unfamiliar with the terms. Some perceived them as 'fads'. There was a conversation about gender identity and bisexuality being 'all the rage'. I applaud the inclusion in the new *Ethical Framework* of the statement 'We will... inform ourselves'. My fear is that those colleagues with the most to learn do not know what they do not know. I suppose it's our collective responsibility to gently nudge them.

Another clause that stands out for me is: 'We will ensure that... reasonable care is taken to separate and maintain a distinction between our personal and professional presence on social media' (33c). In my experience, the worst offenders fall into one of two camps: they either use social media indiscriminately, blurring the boundaries between personal and professional, or they shy away from it completely. I was commended recently on my 'media presence' by a counselling training provider who had accessed my services via my professional website and who follows me on Twitter. She spoke about the widespread reluctance among counselling and psychotherapy professionals to make use of social media and her consequent difficulty in making contact with any of us.

I'm aware of this reluctance. At a training I attended, one prominent facilitator proudly announced that he has no internet presence whatsoever! How does he get work? I use Twitter to share pertinent reflections and links to my published work and newsworthy items from the world of counselling and psychotherapy. I follow professional organisations such as BACP, as well as psychotherapists I hold in high esteem. It's a way of keeping in contact, maintaining my professional profile and keeping my knowledge up to date. This is another of the professional standards outlined in the 'Good practice' section.

My website includes details about my qualifications, experience and private practice. I've outlined my therapeutic model and included a contract and referral form – all in line with the BACP *Ethical Framework*. Rather than merely telling potential clients that I abide by the Association's professional standards, I use my website to demonstrate how I do this. And I share nothing there or on Twitter that I wouldn't share in the therapy room. The social media forums I access for personal use are separate and I've learnt to check the privacy settings regularly to maintain this. If clients request to 'friend' me on Facebook, I remind them about the therapeutic boundaries and that they exist to protect us all, and that this applies to the virtual world as well.

If you haven't already read the new *Ethical Framework*, then you should do so now. I also urge you to have a notebook and pen to hand. Better still, review and discuss it with your supervisor or a colleague. Don't look at it as a dry, directive document. Instead, transform each clause into a question and reflect on how it applies to you and your clinical work. Really engage and be honest about your practice. Think about the times when something went wrong, or could have gone wrong, and use the framework to help you to consider how you would respond differently if a similar dilemma arose in your work tomorrow.

The new *Ethical Framework* won't tell you what to do or remove your clinical responsibility, but it will provide you with a robust scaffolding to support your decision-making, as any good framework should. ■

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References

1. Gillick v West Norfolk and Wisbech Area Health Authority [1985] (1985) 3 All ER 402 (HL).