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# Response to the HPC Draft Standards of Proficiency for Psychotherapists and Counsellors from the Adlerian Society of Wales

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There are a number of issues of concern which recur repeatedly throughout this document. These will be listed as a summary before proceeding to comment about the Draft Standards of Proficiency.

- 1) The language and structure of the HPC is focussed on the medical world – references to the use of equipment, to infection control, and to the wearing of protective clothing. This leads us to ask the question of how much knowledge and understanding the Council has acquired during the last three years or so when it has been in discussion. Most of what is written clearly does not apply to counselling and psychotherapy.
- 2) The view of therapy assumed by the HPC is seen as a procedure applied to a passive patient. This is evidenced by the language of the document which consistently describes a patient as passive in receiving help from a team of experts in their field. This view is not only at odds with Adlerian psychotherapy which involves a relationship between two equals (one of which is skilled in therapy), but also contradicts the main work of Humanistic therapy per se, which is carried out not by the therapist but by the patient. Hence the patient is the active agent in the whole process starting from the very first phone call they make to get help. And dynamic relations between patient and therapist are the central component of the work.
- 3) The draft standards rely on procedures such as audit, management and predetermined outcome which are the antithesis of counselling and psychotherapy. If applied in the way suggested by the HPC, the private space afforded by therapy would become more like an examination room. The consequences of this on therapeutic practice would be destructive. The irony is clear in some schools of Adlerian and Humanistic psychotherapy, where we define the counselling process as the effort to free oneself from the internalised critical judge that may be the initial cause of the patient's unhappiness.
- 4) Finally, the Standards rely on a view of the self which is discarded by Adlerian psychologists world-wide. The assumptions behind the HPC include seeing human beings as faulty, somehow needing repair, and

then needing to be continually upgraded. Whereas in reality human beings are very creative, and from infancy create beliefs about self, others and the world which influence their childhood behaviour and eventually lead them to habitually act and behave the way they do in adult life. When someone presents the Adlerian therapist with bipolar disorder or OCD they are not viewed as “ill” or “mentally dysfunctional” as though they had a symptom to be removed. They are viewed as creative individuals who have (mostly) unconsciously put problematic behaviour in place to make sure life does not get worse. This means we ask, “What is the purpose of this behaviour?”, not what is wrong with this person, or what condition does this person have. Not a psychology of “possession” but a psychology of “use”.

### **Commentary on the Draft Standards**

**NB:** Although we occasionally use the term ‘patient’ rather than ‘client’ which is the term used in counselling, we do not intend to convey a passive or medicalised position, but rather that of an active person in the therapeutic process.

We have not addressed every point but have prioritised those that most concern us.

**Point 1A.1** The point that psychotherapists and counsellors must ‘*understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing*’.

We do not see ourselves as doctors or health professionals. Counselling and therapy provide a respectful space for a conversation with and about the patient, rather than delivery of healthcare. Similarly, we would see it on occasion, as a central part of our work, to respectfully confront the value systems of the patient. The clash of values can be a crucial instrument of change within therapeutic practice.

**1A.6** The requirement that psychotherapists and counsellors must be able ‘*to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem*’ is not acceptable. This is a medicalised view of psychotherapy where there is a problem to be defined and a procedure put in place to deal with it. The care of the patient may or may not include problem solving. For example the devoted 84 year old whose partner dies cannot solve “the problem” – the “cure” is in the process and the long-term tasks of mourning and grief.

The danger here is that the HPC approach of problem-solving and solution focussed work are used as definitive of good standards and then used to either exclude or sanction alternative therapeutic approaches. Adlerian psychotherapists do not see their job as solving problems.

**1A.8** The requirement that psychotherapists and counsellors '*understand both the need to keep skills and knowledge up to date and the importance of career long learning*' needs to be unpacked and understood in relation to psychotherapy. The kind of knowledge operative in psychotherapy is often unconscious knowledge rather than academic knowledge which is easy in transmission. Training in psychotherapy involves profound inner psychological awareness and change, and it is this change that will allow the person to work with other people as a therapist without confusion or neglect of important psychological boundaries. The focus here is on personal development in order to open oneself up to another human being. The fact that this perspective is central to a large number of established traditions of psychotherapy, and a requirement on diploma training courses, must be recognised in any consideration of proposed standards of proficiency.

The requirement that psychotherapists and counsellors must be able to recognise '*their own distress and disturbance and be able to develop self care strategies*': Self- Knowledge and Self Awareness are at the heart of the our approach. However, the danger with this requirement as stated is that the therapist is seen as a kind of manager whose job involves risk management of the patient whilst managing and auditing the self. Perhaps there are some practitioners who hold this view but Adlerians do not.

**1B.1** The requirement that psychotherapists and counsellors '*understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team*' may apply to those working in the NHS but will not apply to many of us who work in private practice and who are clear about the importance of independence. Some patients will prefer this setting rather than a group or corporate setting. This does not discount the need for professional accountability, but rather respects the value of independence and choice for both the therapist and for the client.

The requirement that psychotherapists and counsellors '*understand the need to engage service users and carers in planning and evaluating the diagnostics, treatment and interventions to meet their needs and goals*' might be important to those therapies which focus on targeted interventions, but is not relevant to therapies which offer an open exploration of human life situations. Epistemologically, the HPC and Adlerian Psychology are at odds here. Evaluating diagnostics, treatments and interventions is a medical paradigm that *puts the patient in the position of an object, to whom a treatment is applied*, i.e. in the "one up" (practitioner) and "one down" patient position. The ethos

in our form of counselling is for negotiation where the client and the counsellor work together to form an hypothesis upon which therapy can take place. This hypothesis is then tested by the client as to how it resonates and fits with them. This puts the patient on an equal footing with the therapist. Any notion of inferiority or being “less than” is never acceptable.

Furthermore, Adlerian psychotherapy often aims specifically not to meet the needs and goals of the patient – to do so would tie in with their *Private Logic*, i.e. their beliefs about self, others and the world which underpin their socially useless behaviour. Any therapy which recognises that needs and goals may be unconscious phenomena, formulated in the conscious world as demands and behaviour, means that the therapist has an ethical obligation to listen to the client at an unconscious level. This is central in all psychoanalytic therapies, where the idea of meeting the patient’s needs and goals would be unthinkable. In fact, therapy would mean the refusal of the analyst to meet the patient’s demand.

**1B.2** The requirement that psychotherapists and counsellors ‘*be able to contribute effectively to work undertaken as part of a multidisciplinary team*’ may be applicable to certain therapists working in the NHS but has no application to those of us in private practice therapy or counselling.

**1B.3** The requirement that psychotherapists and counsellors must ‘*be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relative and carers*’ may be applicable to health professionals, but the confidentiality of client material, not advice or instruction to “*colleagues ... relatives and carers*”, is paramount in Adlerian Counselling.

The next requirement, that *therapists and counsellors be able to communicate in English to Level 7 of the international English language testing system* does not sit easily with psychotherapy. This is because language itself could form part of the transference process a client needs in order to do the personal work on themselves. For example, if a client had a mother who was unable to speak clearly the language of the country in which they lived, they may unconsciously identify with a therapist who does not have “*appropriate communication skills*”. To require proficiency in the English language undermines the client’s freedom of choice and their opportunity to work on their relationship with their mother via the therapist.

The requirement that psychotherapists and counsellors be ‘*able to communicate appropriately and effectively with other professionals about the client and propose therapeutic work*’ reiterates what can be found all through the HPC document, that a patient is someone about whom other professionals may discuss. This shows just how central to the HPC draft is the medical model where

professional others discuss a patient as the recipient of interventions done to them. In contrast, for Adlerians, the patient is an active person and the main work of therapy is undertaken not by the therapist but by the patient.

**1B.4** The requirement that psychotherapists and counsellors '*understand the need for effective communication throughout the care of the service user*' needs clarification. For example – what notion of communication are we talking about and what theory of efficacy is assumed? If a therapist was silent for a whole session – this might be seen as effective communication by one client but as non communication by another. Silence can be a space in which the patient can hear themselves in a new way. Some therapists would see the idea of communicating information to the client as non-professional in that it can be seen as the therapist making suggestions to the client which then places the therapist in a superior role as expert, a situation which Adlerians would wish to avoid.

The requirement that psychotherapists and counsellors '*be able to build, maintain and end therapeutic relationships with clients*' seems rather straightforward but it again points to something applied to the patient, rather than seeing therapy as the work done by the patient. It is really the work of the client to build, maintain and end the therapeutic relationship, albeit the therapist facilitates this to the best of their ability. This practice of negotiation is something that is consistently unrepresented in HPC's standards of proficiency.

**2A.2** The requirement that psychotherapists and counsellors '*be able to select and use appropriate assessment techniques*' may apply to some therapists who work diagnostically, but we aim to avoid objectifying a patient through 'assessing' them. This also applies to the following requirement, *that psychotherapists and counsellors 'be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment'*.

The following requirement obliges psychotherapists and counsellors to '*be able to devise a strategy and conduct and record the assessment process that is consistent with the theoretical approach, setting and client group*'. We do not accept, *a priori*, that there is such a thing as a 'client group': we work with each unique individual who presents themselves. The objection to making client groups out of individuals is that it imposes classification structures rather attending to the uniqueness of each individual.

The section entitled '*Formulation and delivery of plans and strategies for meeting health and social care needs*': We would not necessarily recognise that as counsellors we are there to meet the health and social care needs of their patients. Often what we have to offer in the counselling room is a process which contrasts with the health and social care model of care.

**2B.1** The requirement that psychotherapists and counsellors *'be able to use research, reasoning and problem solving skills to determine appropriate action'* may be appropriate at times in Adlerian therapy, as it is here that we co-incide with other cognitive-based therapies. However, the next requirement that psychotherapists and counsellors *'be able to engage in evidence based practice, evaluate practice systematically, and participate in audit procedures'* is symptomatic of a growing therapeutic culture which is flawed in its very premises. "Evidence-based research" is marketed as 'best practice' for different particular symptoms, and when accepted as "truth" drives the funding process, thus financing no-cost counselling (e.g. IAPT) which in turn affects experienced therapists in the field in that their client base diminishes. As choice of counsellors diminishes, so does patient choice. The Adlerian Society of Wales would not accept the notion of audit procedures which is linked to the world of business or managed health care rather than to the individual and creative work that is the process of psychotherapy.

The following requirement that psychotherapists and counsellors *'be able to demonstrate a level of skill in the use of information technology appropriate to their practice'* has nothing to do with psychotherapy and counselling. The recording of client information on computers is highly controversial as confidentiality can often not be ensured. A client above all needs to feel emotionally and psychologically safe with the counsellor to enable therapeutic discussion and interventions of change which are often difficult and challenging to emerge.

The requirement that psychotherapists and counsellors *'be able to make informed judgements on complex issues in the absence of complete information'* is clearly misplaced in the draft document. Here is the medical model again, where information may be necessary about health issues prior to the prescription of medication or surgery. Even to assume that complete information is tenable is a fallacy.

**2B.3** The requirement that psychotherapists and counsellors *'be able to formulate specific and appropriate management plans including the setting of timescales'* will probably suit counsellors working in NHS settings where funding is released for time-limited work, but this has little to do with the open-ended work of psychotherapy where often counsellor and client contract together for as long as the work might take, and where both parties negotiate that time together. In fact the very idea of a 'management plan' is nigh on impossible because of the fallacy of trying to predict in advance what will happen in the therapy. More and more as the HPC document is read and assimilated, it feels like a neurosis of mega-control trying to destroy what is a creative, holistic and benevolent profession which is already regulated by reputable professional organisations like BACP who understand the conceptual and experiential world in which therapists work.

**2B.4** The requirement that psychotherapists and counsellors *'be able to conduct appropriate diagnostic or monitoring procedures, treatments, therapy or other actions carefully and skilfully'*: As we have already mentioned, different forms of therapy would not accept the notion of diagnostic or 'monitoring procedures'.

The requirement that psychotherapists and counsellors *'understand the need to maintain the safety of both service users and those involved in their care'* needs explanation. What notion of safety is this? Ethical psychotherapists would wish to work in an environment which is safety conscious, but the maintaining of safety in terms of health is the responsibility of the patient, not the duty of the therapist.

On a more subtle level, there is a danger of therapists colluding with the fantasy (conscious or unconscious) that it is possible to attempt to control the therapeutic process, and render it safe. The paradox is that the illusion of safety can end up being *more* dangerous for clients than the status quo. For example, those institutions which surround themselves with "Mission Statements" may discover they are examples of false illusion – the wording is therapeutic, but the neglect and ineffectual treatment given to patients can be masked by words, and codes of behaviour have a different and often hidden tale to tell.

The requirement that psychotherapists and counsellors *'be able to establish an effective, collaborative working relationship with a client'*: Psychotherapy is not something that the counsellor gives to the client, but is rather a dynamic relationship between two people. It is unacceptable to require the psychotherapist to establish an effective collaborative relationship because the relationship will also be the responsibility of the client.

The requirement that psychotherapists and counsellors *'be able to enable and work with expression of client emotion'* is not acceptable because there are very different schools of thought about the role and function of emotion in the counselling process. Some schools of psychotherapy see no great value on the expression of emotion, rather what matters are the unconscious thought processes within. On this view, emotions may be misleading. Other therapies emphasise the expression and release of emotion as part of the therapy but there is no agreed view.

The requirement that psychotherapists and counsellors *'be able to communicate empathic understanding to clients'*: Whereas Adlerian therapists would agree with this statement, it would not be accepted by other schools of psychotherapy who believe there should be emotional distance between therapist and client. This means that listening could well be attentive but not empathic, for empathy implies that the internal states of the patient are accessible and can be wholly or partly shared by the therapist. There is no consensus on this issue.

The requirement that psychotherapists and counsellors *'be able to respect and take into account the client's capacity for self-determination'* does not hold if self-determination is to have no self-determination. This is what so often happens to long-term cannabis (skunk) users who are patients. Their self-determination is to have no motivation for anything socially useful and they feel trapped in their own self-determination. The issue of self-determination gets even more complex when, for some schools of therapy, autonomy and self-determination are fictions.

The requirement that psychotherapists and counsellors *'be able to work with both the explicit and implicit aspects of the therapeutic relationship'* is difficult to understand.

**2B.5** The requirement that psychotherapists and counsellors *'be able to keep accurate, legible records and recognise the need to handle these records and all other information with applicable legislation, protocol and guidelines'* is not problematic to most Adlerians who record the Early Memories of the client and details of family constellation etc., and keep them carefully confidential. But many psychoanalysts are against record keeping because they believe it blocks the spontaneity of unconscious communication between patient and analyst.

The requirement that psychotherapists and counsellors *'understand the need to use only accepted terminology in making records'* is either madness or badness and we are not sure which.

A) If it is madness it implies that there is such a thing as accepted terminology in psychotherapy. What would terminology include? "collective unconscious?", "super-ego?", "gemeinschaftesgefühl", "biased apperception?".

B) If it is badness then therapists, in using acceptable terminology, will allow themselves to be shaped and moulded and eventually influenced to think about their work through the eyes of some unseen bureaucrat – either a benevolent bureaucrat or a psychotic dictator. When this happens, and the minds and practice of psychotherapist are influenced by a third party, then the practice of psychotherapy is dead, and freedom of thought and practice is dead.

**2C.1** The requirement that psychotherapists and counsellors *'be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly'* is not acceptable in therapies where the counsellor does not plan activity. Where therapy seeks to address the needs of the client in the here and now, where it recognises that there are ongoing unfolding conversations of depth where interventions may or may seem appropriate, then applying specific procedures of monitoring and checking are seen as relevant only when summary or synopsis would help the client, not as a requirement.

The requirement that psychotherapists and counsellors *'be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user'*: This kind of language comes directly from the NHS and has little or no application to Adlerian psychotherapy. Our world does not involve intervention plans that are then applied to the patient as the recipient of a procedure, and there is no notion of 'recognised outcome measures'. In psychotherapy, the psychotherapist listens to what the client has to say.

The requirement that psychotherapists and counsellors *'recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes'* is acceptable if by that it means that clients can anonymously (to avoid lack of objectivity) give feedback to the counsellor or therapist and that feedback then informs future practice. But if it implies the task of a therapist managing the patient, then the task undermines the mutual process of therapy and the sense of equality of client and counsellor in the process. In addition, 'quality assurance' is unacceptable to schools of psychotherapy that are not based on a business model of service provision.

The requirement that psychotherapists and counsellors *'be able to make reasoned decisions to initiate, continue, modify or cease treatment for the use of techniques or procedures, and record the decision and reasoning appropriately'* raises the question of why every clinical decision would need to be recorded and explained. This means taking on board an approach to counselling in which what the therapist does would only be valid given a designated other person affirming their practice. This feels more like a police state, and is about as far from the ethos of psychotherapy as you can get. Good supervisors often ask counsellors about techniques and procedures and their efficacy, sometimes suggesting further methods or monitoring the rationale for their usage. The proposed requirement is already partly adhered to in a formative and normative way in the supervision process.

**2C.2 T** The requirement that psychotherapists and counsellors *'understand the principles of quality control and quality assurance'* is problematic in that it is the language of the consumer-led market place. At the heart of Adlerian psychotherapy is to provide a space outside our consumer-led culture. In this space human beings are not seen as 'resources'. We would never use business vocabulary to describe the process we undertake with clients.

The requirement that psychotherapists and counsellors *'be able to maintain an effective audit trail and work towards continued improvement'*: This business language is getting worse – now we have metaphors of accountancy and audit. Adlerians do not even believe in the idea of 'continual improvement'. So much therapy for human suffering and dysfunction is all about integrating

or accepting or reframing experiences of trauma, loss or fragmentation at the heart of human experience. In contrast it is the “well-being” industry which focuses on ‘continual improvement’, so that they can sell more and more products to people. We do not sell therapy or make promises to the public about results.

**3A.1** The requirement that psychotherapists and counsellors ‘*understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction*’: Adlerian therapists, like Alfred Adler (1870-1937) their mentor, focus on the body, but not in the way assumed by mainstream medicine. We adhere to the belief of Holism, that is, the indivisible connection between mind and body. To see a physical condition is also to see a mental condition and vice versa.

The requirement that psychotherapists and counsellors ‘*be aware of the principles and application of scientific enquiry, including the evaluation of treatment efficacy and the research process*’ is not unreasonable to us, but not if that means a biased conception of scientific enquiry, efficacy and research, for example, scientific enquiry *à la* primary model of CBT which is then used as a protocol to evaluate therapeutic practice.

The requirement that psychotherapists and counsellors ‘*understand the typical presentations of severe mental disorder*’: We are critical of how psychiatric models of mental disorder are used as a benchmark in the evaluation of therapeutic practices.

Adlerian Psychology generally acquaints its students and practitioners with the DSM IV not as a diagnostic measure but as an important tool in recognising different behaviours as an aid to observation, and to enable appropriate conversation with both clients and the medical profession. For us, a client uses behaviour, even ‘mentally disordered behaviour’, either to avoid feeling grossly inferior or to elevate themselves to perceived superiority as in the grandiose behaviours. Thus the client is a creator of their universe, not a victim of a condition or disease.

**3A.2** The requirement that psychotherapists and counsellors ‘*select or modify approaches to meet the needs of an individual, group or community*’ might apply to some, but not for example to psychoanalysts, where it is only ethical if the analyst is skilled in refusal to meet the needs of the patient.

**3A.3** The requirement that psychotherapists and counsellors ‘*be aware of applicable health and safety legislation and any relevant safety policies and procedures in force in the workplace, such as incident reporting, and be able to act in accordance with these*’ is obviously valid if you are working in NHS contexts, less so in private practice. Of course, having said this, there are basic measures taken to ensure that the consulting room does not contain unsafe conditions.

The requirement regarding '*hazard control and particularly infection control*': It is startling that such a requirement has been applied to this draft document on counselling and psychotherapy, especially since the HPC has taken some three years to think about it.

Adlerian Society of Wales

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