Counselling at the Crossroads: Preserving principles, autonomy and vocation

The National Counselling Society

This document is an adapted excerpt from our response to the Professional Standards Authority's 2020 strategic review. For further reading, please consult this response, which sets out our evidence base for this article and explores these issues in greater detail.

What problem is regulation or standardisation (e.g. SCoPEd) trying to fix?

Is it a problem? If so, can regulation or standardisation fix it?

If this problem is fixed, what else gets broken?

If something else is broken, is fixing the problem worth it?

Introduction

Counselling and psychotherapy face many pressures. On the one hand, the pressure for the profession to find meaningful and sustainable employment in the context of manualised therapies, the medical model, and the wider psychological professions workforce leads many to wish to consider further journeys into regulation and standardisation in the hope that these will lead to enhanced status and opportunity. Yet this very pressure to further 'professionalise' can place the profession at odds with the sense of vocation that many therapists express.

Especially (though not exclusively) in private practice, counsellors, psychotherapists and their clients seek an autonomous, creative, flexible and intuitive space, founded on a core relationship; a depth and breadth of approach that, while it can certainly incorporate issues of mental health, has far greater range and scope than the 'treatment of a condition'.

Counselling is at a crossroads. Increased standardisation and regulation, in order to achieve our professional goals, will inevitably threaten autonomy of both therapist and client – the very thing for which many of us entered the therapeutic world to begin with. Importantly, 'counselling' and 'psychotherapy' are not the only options by which we could define our practice. We exist within a much broader range of approaches, modalities, and definitions. Where then will we take our autonomy; what will we do in order to preserve it?

Perhaps the 'SCoPEd' style approach will lead us to the definition of 'psychotherapist' as more embedded in process, diagnosis, treatment, evidence - and 'counsellor' less so. In that sense then, calling ourselves 'counsellors' survives at the cost of hierarchy. Counsellors become, in essence, "less competent" and less "well-trained" psychotherapists. Essentially, such a model would be similar to doctors and nurses. Nurses can undertake additional training to upgrade their skills within the medical framework.

Are we comfortable with this? Is this where counsellors will 'sit', or will we seek new ways to define ourselves? Do we become coaches, therapists, NLP practitioners, or just use bespoke or proprietary definitions like 'Human Givens practitioners'? Do we retain the counsellor title but 'keep our heads down' and do what we need to do to remain in private practice? Are there more creative options available? At what cost to autonomy?

In responding to developments within the Professional Standards Authority, NCS responded to their strategic consultation. In our response, we talked a lot about standardisation and regulation. We developed a theoretical framework to point out the risks and issues of taking counselling and psychotherapy too far into standardisation and regulation.

Our framework recognises that counselling and psychotherapy combine two approaches: Autonomy Centred Practice (ACP) and Process Centred Practice (PCP). Both are important and vital to our profession; both should be fought for and retained. Let's explore this below.

Theoretical Framework

Public Assurance is a key and fundamental term used by the Professional Standards Authority to describe the over-arching purpose of the programme itself. We take public assurance to mean that the programme provides confidence and reassurance to a member of the public seeking to use the services of a registrant on an AR in a number of ways: for example, the registrant's training and qualifications have been checked; they are properly insured; their identity has been verified; a complaint against them could be heard in a professional, transparent and appropriate manner and therefore their practice is accountable.

A cursory analysis of the manner in which the AR programme provides said assurance would lead us to question how far any voluntary system of self-regulation can provide assurance, if ultimately:

- Anyone can practice without being on an Accredited Register and
- Anyone removed from a Register can continue to practice nonetheless.

These two fundamental questions are at the heart of the concerns of those who would point out the limits of the AR programme in its ability to deliver public assurance and are **questions of regulation.**

Alongside these two questions is the third question which, though related to regulation, is a distinct question in its own right:

- Any training seems sufficient to practice – should there not be *common standards*?

We will call this the **question of standardisation.**

On the surface, the solution to these questions seems obvious:

- Make the AR programme compulsory
- If you're removed from registration, make it illegal to practice; and,
- Set common compulsory standards for each profession.

These solutions, should, it would be imagined, lead to an increase in public assurance and therefore should be incorporated within the AR programme as part of the Authority's review.

Our evidence, however, informs us that there is a significant risk that, if these questions (two of regulation and one of standardisation) are not addressed very carefully, and in a right-touch manner, then there will be two unintended but avoidable consequences of any such changes which the Authority proposes for the programme:

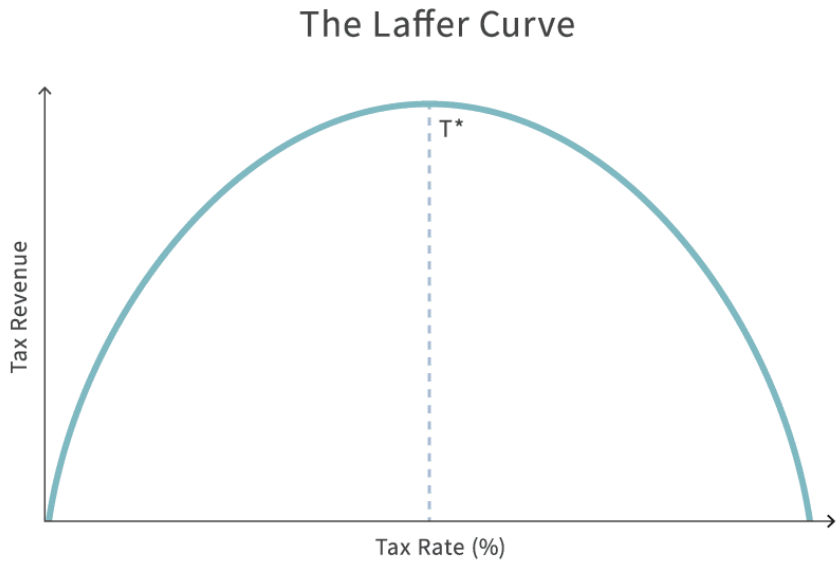
1. Public Assurance will decrease; and,
2. The provision of the services covered by the AR programme to the public will decline, placing additional avoidable strain on the NHS.

Why might our evidence suggest this, on first glance, counter-intuitive result? This is based upon two factors:

1. A 'Laffer Curve' of public assurance operates in counselling and psychotherapy; and this is based upon:
2. The nature of counselling and psychotherapy as being ***autonomy-centred*** which we will define below.

Let us look at each of these factors in turn.

1. The 'Laffer Curve Effect' in counselling and psychotherapy.



The Laffer Curve effect is an observed effect in economics as related to taxation. Simply put, the purpose of taxation is to increase revenues ('tax take') to the Treasury. Taking into account a number of factors, the Treasury wishes to maximise tax take and create a system of taxation which will do this.

Let's take a hypothetical example. The Treasury notices that, at a rate of 20%, the VAT tax take is £10 Billion per month. The Chancellor therefore proposes to raise the VAT rate to 40% in order to increase the tax take to £20 Billion per month.

In fact, what happens as a result of this hypothetical tax rise are three unintended consequences:

1. Economic Activity decreases overall. Faced with a 40% tax bill, many people simply stop buying products or services; such products become unaffordable, and so on.
2. Tax Compliance decreases overall. Faced with a 40% tax bill, in order to make a living, businesses decide to keep trading while avoiding what they perceive as an unfair and unjust tax. 'How much for cash?' becomes a

commonly heard refrain as both buyers and sellers of services seek to avoid what they perceive as a punitive situation.

3. Equality and Diversity issues are negatively impacted. Faced with a 40% tax bill, it is not only those with lower social capital who are more likely to find their economic activity negatively impacted, but also those who are more likely to feel forced to take the risks associated with non-compliance in order to financially survive.

In this scenario, the Treasury soon finds in its next quarterly figure that its anticipated £20 Billion revenue has, through the combination of decreased activity and non-compliance, fallen from £10 Billion to £8 Billion. In other words, increasing taxation had, in this example, counter-intuitively *decreased* tax take. The peak of the Laffer Curve had been passed as the unintended consequences began to manifest.

A clever Chancellor would wish to find the peak of the Laffer Curve. Maybe raising VAT from 20% to 25% would have seen tax take increase from £10 Billion to £12 Billion, but an experiment with a 30% VAT rate would have seen tax take decline to £9.5 Billion. The Chancellor in this example would have found the 'sweet spot' at the top of the Laffer Curve and set the rate at 25%. Any less, and they would have less tax take; any more, and the tax take would also decline. Such a Chancellor could even find that reducing VAT to 19% would see a greater tax take than at 20%. More tax revenue could be gained from reducing rather than raising taxation, as said reduction could increase economic activity and tax compliance.

The main lesson of the Laffer Curve in economics is that it is human behaviour, in terms of both activity and compliance, that will dictate the effectiveness of any tax regime, and that there can be unintended and counter-intuitive consequences to well-meaning attempts to impose taxation.

How is this relevant to counselling and psychotherapy?

Let us imagine that instead of 'tax take' we are talking about *public assurance*, and instead of taxes like VAT we are talking about *regulation and standardisation*.

Instead of the Chancellor, the Health Secretary wishes to maximise public assurance. Looking at the regulatory framework, they decide to do the equivalent of doubling VAT: substantively increasing regulation and standardisation in order to maximise public assurance.

We propose that an equivalent 'Laffer Curve Effect' will apply and that in such an eventuality both the provision of counselling and psychotherapy, and compliance with regulation, will counter-intuitively decrease.

Our data sets indicate that, if the answers to the questions of regulation and standardisation are handled badly, there would be three unintended 'Laffer Curve Effect' consequences:

1. The provision of counselling and psychotherapy would decline, as a significant proportion of registrants clearly indicate that they would not be prepared to remain in the profession if the burden of standardisation and regulation are unaffordable or contrary to their values and principles; and,
2. Public Assurance would decline, as a significant proportion of registrants clearly indicate they would not be willing to comply with standardisation and regulation if these were unaffordable or contrary to their beliefs and values.
3. Equality and Diversity would be disproportionately impacted, as the burdens of standardisation and regulation would disproportionately affect those with lower social capital.

Is non-compliance possible?

Previous legal advice taken over the 2009 statutory regulation approach mooted by HCPC, alongside current advice, indicates that non-compliance is, in fact, easily achievable for a number of reasons. For example, it is illegal to mis-represent yourself as a member of a statutorily regulated profession such as those regulated by HCPC. However, to guard against this eventuality a practitioner generally needs to:

- Not use the restricted title
- Explicitly state that 'I am not an HCPC (insert title of practice)' in their advertising
- Find a point of differentiation in the description of their practice in their advertising

There is precedent here where HCPC registrants removed from their statutory register continue to practice with very similar titles and so do not comply with their regulatory frameworks, but do so in an entirely legal manner.

Should we be worried about non-compliance though? Surely, for example, not being able to call yourself a 'counsellor' would significantly impact your private practice and make it unfeasible or untenable?

In fact, no. As our 2017 Unsafe Assumptions survey demonstrated, members of the public do not consider issues such as title or professional qualifications when choosing a therapist. Issues such as advertising, referrals, word of mouth, and the general feeling a potential client gets when first looking at a website are all more important determinants of client choice. It is, in short, perfectly feasible to continue your private practice successfully while not complying with regulation which is against your principles or values. This should be of primary concern for those keen to ensure public assurance is maximised within the AR programme.

In addition, it's clear that counselling and psychotherapy are umbrella terms but that these terms sit within a spectrum of talking therapies, modalities, and approaches in a territory which is ever-shifting and changing. Ranging from proprietary approaches such as Human Givens to approaches such as coaching, wellbeing therapy, shamanic therapies, pastoral care; there is a wide variety of titles and approaches under which practice can flourish. And our evidence shows that counsellors will indeed explore other options should they feel that the regulatory framework is no longer 'right-touch'.

Why though, might this Laffer Curve effect be present in counselling and psychotherapy? The answer lies in the second of the two factors we outlined above:

Counselling and psychotherapy can be both 'autonomy-centred' as well as 'process-centred'

Why is there such continued, principled, widespread opposition to decades of attempts at regulation and standardization within the profession?

A broad examination of objections raised by counsellors and psychotherapists to attempts to answer the questions of standardisation and regulation are very revealing. Historically significant objections were raised to the ENTO National Occupational Standards. In 2009 when it was mooted that the HCPC would regulate counselling and psychotherapy, all professional associations involved at the time raised significant objections to the impact on practice that the proposals would have. In addition, since 2018 the SCoPEd competency framework exercise, which can be best seen as a new approach to the question of standardisation within the profession, has drawn widespread objections from a significant number of organisations and from thousands of individual therapists.

Why are attempts to answer the questions of standardisation and regulation so bitterly opposed?

If we look for common threads here over decades, they seem to be **repeated expressions of the following key objections:**

- A medical model cannot be applied to counselling practise
- I do not recognise my practice in these proposals

- Something fundamental to my practice is under threat
- The 'evidence base' has significant flaws
- The framework you are proposing will harm diversity of practice
- I will be forced to practice in a way contrary to my principles or values
- You do not understand the way in which I work or my modality
- The frameworks seem only to understand one side of counselling – e.g. manualised therapy within a state run framework or closely related employment framework; hospital based psychotherapy, etc
- This is just not relevant to how I work
- These proposals will actually damage my clients
- An unaffordable and unachievable burden will be imposed which will significantly impact equality and diversity
- Counselling is not academic – this appears to be biased towards the academic.

Why are these kinds of objections so consistently raised over so many decades?

It was rightly discussed in the context of 2009 HCPC regulation that counselling and psychotherapy are 'non-homogenous' and that the then proposed regulatory framework was an attempt to fit many different shaped pegs into one round hole.

What is the best way to understand this heterogeneity (the depth and breadth of diversity) in counselling and psychotherapy?

We propose that 'counselling' and 'psychotherapy' are non-homogenous in that *they are umbrella terms describing a series of practices which exist at various points on what we will call a* ***spectrum of autonomy-centred practice on the one end and process-centred practice on the other end.***

Let us explain this.

By **autonomy** we intend to mean, in its simplest sense, that which is about a person's ability to act on his or her own values and principles. Taken from ancient Greek, the word means 'self-legislation' or 'self-governance'. In order to do these things, the autonomous person must have a sense of self-worth and self-respect.

Counsellors and psychotherapists are often, in looking to join the profession, first drawn themselves towards the vision of an autonomous, creative space in which their client also has full autonomy. The *mutuality of the autonomy of both counsellor and client* forms the framework for wellbeing, healing, self-discovery and helping that lies at the heart of the profession and underpins its vocational nature.

By **autonomy-centred practice (ACP)** we mean an approach which is focussed on things such as but not solely:

- The client as a whole person – their subjectivity
- The client relationship
- Autonomy for both the client and counsellor
- A holistic view rather than focus on symptoms
- Creativity to explore a variety of possible therapeutic directions
- An individualistic approach to evidence ('what works here and for you may not work elsewhere and for someone else')
- Not measurable in a way that would be amenable to Government
- Flexibility, including a flexible understanding of the therapeutic outcome
- No fixed definitive 'cure', 'diagnosis' etc
- Creating a space for wellbeing
- Understanding the impact of society on the individual
- Complementary to medical healthcare
- Private practice

- Equality and Diversity centred, both for client and for counsellor
- Vocation

Autonomy is seen as a fundamental ethical principle in both the NCS Code of Ethical Practice and the BACP Ethical Framework, and this way of practising has a long and well-regarded theoretical basis in both the Person-Centred and Jungian traditions. It is related to what many practitioners refer to as 'experiential engagement' or 'relational depth'.[1]

By contrast, and in addition to autonomy, counselling and psychotherapy can exist as a **process** where issues of definition, diagnosis, tools, treatment and evidence can come into play.

By **process-centred practice (PCP)** we mean an approach which is focussed on elements including but not solely:

- Diagnosing the client's problem
- Developing a treatment plan
- An empirical approach to evidence ('this works for many people so it should work for you')
- The application of the correct therapeutic process for the problem, and only that process
- Focus on symptoms
- Measurable in a way that would be amenable to Government
- Integratable with medical healthcare
- Attempting a specific 'cure' or measurable amelioration
- Profession

[1] https://nationalcounsellingsociety.org/about-us/code-of-ethics
https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/ethics/

E.g. in Purton, C. (1989) *The Person-Centered Jungian*; Person-Centered Review, 4 (4) pp. 403-419:

> *'CLIENT AUTHORITY*
>
> *One of the most characteristic features of the person-centered approach is the insistence that clients know best what their situation is, and what they need. It is not for the therapist to impose his or her conceptual scheme on the client. Jung shares this basic attitude. For example, he remarks (1984, p. 3):*
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> > *In analysis we must be very careful not to assume that we know all about the patient or that we know the way out of his difficulties. If the doctor tells him what he thinks the trouble may be, he follows the doctor's suggestion and does not experience himself. .. It is important that the doctor admits he does not know.*
>
> *Similarly Jung (1935, p. 5) remarks 'If I wish to treat another individual psychologically at all, I must for better or worse give up all pretensions to superior knowledge, all authority and desire to influence.''*

Jung, C. G. (1984) Dream Analysis: C. G. Jung Seminars, Vol. I (E. McGuire, Ed.). Princeton, NJ: Princeton University Press
Jung, C. G. (1935) Principles of practical psychotherapy. In Collected works: Vol. 16. The practice of psychotherapy. Princeton, NJ: Princeton University Press.

https://www.karnacbooks.com/product/the-trouble-with-psychotherapy-counselling-and-common-sense/36073/?MATCH=1

http://www.dwelling.me.uk/PCJUngian.htm

Both kinds of practice exist within counselling and psychotherapy, and often within the individuals who practice counselling and psychotherapy and their various roles; and furthermore, much of practice does mix these two approaches. Autonomy-centred practice and process-centred practice can thus co-exist in a wide variety of complex ways:

- Within a singular training programme
- Within the practice of a single counsellor or psychotherapist, who may use different practices in different roles or in combination
- Within a particular role or job
- Differently expressed in private practice than in an employment setting
- Differently over time as a professional grows in experience

This said, it is identifiable that much of private practice is likely to sit towards the autonomy-centred part of the spectrum. NHS IAPT therapy could be a good example of a role and practice which is anchored within process-centred work.

Why become a counsellor or psychotherapist?

An interesting fundamental to consider here is to ask the question 'why do people become counsellors or psychotherapists?' The data we have indicates that the autonomy, creativity, flexibility, and client focussed nature of our profession is **the primary initial attractor for those working in this field**. In addition, a review of marketing and advertising materials from potential training routes both within the public and private sector tend to emphasise autonomy-centred practice. This is important as, in short, it is generally **autonomy-centred practice** which is the primary motivator to join this profession.

This is important to understand, as attempts at regulation and standardisation that are perceived as undermining the core values and principles that were the primary determinants of joining the profession are very likely to be vociferously opposed.

Counsellors and Psychotherapists oppose regulation and standardisation insofar as it is a threat to autonomy-centred practice: such attempts must not force all practice to become process-centred.

Returning to our questions of standardisation and regulation, the reason behind the widespread objections to ENTO, HCPC, SCoPEd etc lie, we submit, in the tensions on the spectrum between ACP and PCP.

Simply put, standardisation and regulation will always encounter principled opposition from the perspective of ACP and, looking back at the key objections raised since the 1990s, these objections are *rooted in the ACP nature of counselling and psychotherapy,* especially - but not exclusively - that of private practice.

This is because it is likely that further standardisation and regulation, unless handled with (a) incredible sensitivity and understanding, (b) awareness of the autonomous nature of the profession, and (c) in a very conscious right touch manner, will simply alienate the ACP part of our practice spectrum and risks forcing counselling and psychotherapy to move, against its will, from ACP to PCP across the board. *This is at the heart of the profession's decades-long wrestling with standardisation and regulation and we should all make an effort to fully understand this.*

It is worth mentioning that the issues of how counselling and psychotherapy as part of NHS healthcare are provided is a fundamental issue here. There is plenty of anecdotal evidence to support the contention that when process-centred practice fails, the public seeks autonomy-centred approaches, but that these are not supported by the state frameworks. Both approaches surely should have a key role within the NHS.

Lastly, let us return to the **Laffer Curve.** As we posited, the data indicates that inappropriate or 'wrong-touch' answers to the questions of standardisation and regulation will have the following negative impacts:

- Decreasing the availability of counselling and psychotherapy
- Decreasing public assurance through non-compliance by practitioners
- Disproportionately impacting equality and diversity

It is the presence of Autonomy-Centred Practice (ACP) in counselling and psychotherapy which gives context to, and explains why, the data indicates this. Counsellors and psychotherapists will act to preserve their principles and the autonomy of both their clients and themselves.

Much Ado About Titles

As the counsellor and/vs psychotherapist debate continues, the important thing to understand is that the evidence shows (as covered fully in our strategic review response) that *titles don't matter to clients.*

In our 2017 Unsafe Assumptions report we conducted a social media survey of the public asking questions about the determinative reasons they would have for choosing a psychological therapist.

Our data demonstrates that the prime determinants for a member of the public choosing a therapist have little to do with title, regulatory framework, or qualifications level. Instead, the main factors are engagement with the therapist's website and marketing, recommendation from friend or family, and initial positive contact.

In other words, the decision to find a therapist does not begin with 'I must find someone regulated in a particular manner' or 'someone who matches particular standards' but with 'this person looks good/my friend saw them and recommends them/they treated me positively on first contact'.

There is, in short, an entirely human and relational aspect to choosing a therapist which is not being considered in public assurance modelling.

This demonstrates a primary and under-explored role for 'the market' in determining public assurance in that - as suggested by the evidence that the difference between a margin of success or failure in private practice can depend upon recommendations and referrals, and such referrals only logically occur after a positive client outcome - over time it is likely that safer and more effective therapists will gain more clients.

This evidence also suggests that, whether statutorily regulated or unregulated, the way in which members of the public seek healthcare and wellbeing assistance is unrelated to these frameworks. In statutorily regulated professions for example, you choose a dentist (if you are lucky enough to have such a choice, which is of course a matter of significant privilege) not because they are on the GDC; nor is your starting place for looking for one the central regulated register. You'll hear about them from a friend, or like the look of their website or testimonials, or feel valued and treated well on your first visit or even initial phone call.

In short, it is a viable option for counsellors and psychotherapists seeking to preserve autonomy to seek a range of approaches of self-description.

Autonomy, Equality, Diversity

We are concerned that the development of a 'common set of standards', if handled incorrectly, will privilege certain models and training routes within counselling and psychotherapy. This could disproportionately impact registrants on the basis of race, sexual orientation, social class, income, partnership status, disability and geographical location. Great care must be taken to ensure that common standards are achievable, proportionate, right-touch, and diversity-aware.

We are concerned that the proposal for a 'profession-specific register' will also privilege certain models and training routes with the same differential treatment of and impact upon individuals with protected characteristics in a way in which a *profession-neutral* register would not. We are concerned that such a proposal will have a negative impact across a range of diversity issues.

We are concerned that reducing the number of Accredited Registers over time effectively will prevent applications from smaller registers with specialities in representing individuals and groups with protected characteristics under the terms of the Act.

Our concerns are based in evidence. Our surveys show that, in the context of increased standardisation and regulation, around 18.5% of counsellors may choose to end practice. A significant proportion who remain will only comply with regulation and standardisation in a very minimal way. For example, many respondents to our surveys speak of being a 'counsellor' in the workplace and calling themselves something else in their private practice, to protect its autonomy.

All this has a profound impact on access to mental health treatment. An 18.5% drop in the counselling workforce would lead to huge pressures on the NHS and in turn the most vulnerable clients would find it harder to access treatment.

Are we about to become a complementary therapy?

If further standardisation and regulation progress, process-centred practice *could* be advantaged if there were increased opportunities within the wider psychological professions workforce. What then happens to autonomy centred practice? If standardisation and regulation adversely impact diversity, modalities, creativity, access, length of contract and many other factors; if increased links to evidence informed practice excludes core approaches such as person-centred counselling – at that point does ACP become, effectively, a complementary therapy? Should this be embraced or resisted?

An interesting case study in some US states where psychotherapy is closely regulated and standardised is that psychotherapy increasingly becomes, in effect, clinical psychology. Training becomes hospital focussed, outcomes become highly measured and linked to costings such as insurance provision; pharmacological interventions become more commonplace as psychological professionals begin to prescribe or monitor prescriptions alongside their medical colleagues – the lines become blurred.

In these contexts, creative and autonomous approaches occur in several spaces. Either exhaustively trained clinical psychologists buy themselves (literally) the space to explore other approaches within their ringfenced private practice; meanwhile, other practitioners not wishing to sacrifice autonomy redefine as coaches, therapists, or even use religious constitutional protections to offer pastoral approaches. What we call 'counselling' begins to occur in very differently defined spaces, because although process-centred practice can help many, it cannot help all.

Is the fix worth the cost?

Turning to issues such as regulation or standardisation projects such as SCoPEd, the key questions we should be asking ourselves are, at the end of the day, quite simple:

What problem is regulation or standardisation (e.g. SCoPEd) trying to fix?

Is it a problem? If so, can regulation or standardisation fix it?

If this problem is fixed, what else gets broken?

If something else is broken, is fixing the problem worth it?

These fundamental questions are those we encourage all our members to ask themselves.

Conclusion

We need to protect and preserve the principles of Autonomy-Centred Practice – the very thing which brought most of us into the profession in the first place. As well as our professional role of ensuring that the Society remains engaged with opportunity, high standards, and retaining and growing our recognition and parity, we will always champion autonomy, creativity and diversity no matter where regulation and standardisation lead us in the future.