Not in my name… State regulation and psychotherapy

by Matthew Henson

Introduction

When people first hear that I stand opposed to state regulation of psychotherapy and counselling, the responses usually range from surprised curiosity to shocked suspicion: 'Why would you not want to protect the public from bad practice? What have you got to hide?' My answer is that I am not opposed to any measures that will safeguard the public and I have nothing to hide. Respectfully, I stand opposed to state regulation precisely because I value public protection; I also value freedom, choice, inclusivity, diversity and transparency in our craft.

Regulation, in the proposed format, is a threat to those principles rather than a safeguard. That is a challenging statement to make, when state regulation perhaps feels inevitable, when so many good people have put so much well-intentioned effort into trying to ensure its effectiveness. Yet I feel compelled, as we stand as a profession on the brink of legislation that I believe would do untold harm, to hold that line.

Before moving to Ireland with my Irish partner in 2010, I was a psychotherapist in the UK, when state regulation under the *Health Professionals Council* (HPC) – the UK equivalent of the *Health and Social Care Professionals Council* (HSCPC) – appeared to be inevitable. I was a supporter of the *Alliance for Counselling and Psychotherapy Against State Regulation* (hereafter referred to as the *Alliance*) and one of well over 4,000 alarmed practitioners who signed petitions to that effect. Viable and better alternatives were proposed by the *Alliance* and there was strong talk of principled non-compliance in the event that harmful legislation was introduced. The *Alliance* was successful and plans for state regulation were abandoned in favour of a robust system of accredited voluntary registration. Today, as a practising psychotherapist in Ireland, I am equally alarmed by the proposals for state regulation under the Health and Social Care Act 2005. Notwithstanding some minor differences in the precise circumstances, the issues are directly comparable.

In making the case against regulation in Ireland, I will draw upon the arguments that were successfully made in the UK; compelling arguments which have been developed through discussion and debate over some 40 years (see, for example, Godet, 2009; Hogan, 1979; House & Totton, 1997; Mowbray, 1995; Parker & Revelli, 2007; Postle, 2007; Rose, 1989; Wampold, 2001). I will also be drawing upon my experience as a member of the *United Kingdom Council for Psychotherapy* (UKCP), as someone who has sat as an expert psychotherapist panel member at Fitness to Practise hearings for the *British Association for Counselling and Psychotherapy* (BACP), as a current lay member of the *Medical Practitioner's Tribunal Service* (MPTS) Fitness to Practise Panel, and a member of the superbly diverse international organisation, *Psychotherapists and Counsellors for Social Responsibility* (PCSR). For propriety, I must point out that the views expressed here are my own and not necessarily those of any of the organisations with which I am associated. That said, these views are shared by an overwhelming number of my colleagues within PCSR.

Public protection: The emperor's new clothes

The Department of Health (2016) online noticeboard sets out the ostensible need for regulation as follows:

> *Counsellors and psychotherapists assist with people with psychological, emotional and or mental health issues. There is concern that, in many cases, there is no statutory oversight of their competence and conduct and that some practitioners lack the qualifications and professional training needed to work with such vulnerable clients.*

This perceived need for public protection against bad practice and unscrupulous practitioners is almost exclusively cited as the reason why state regulation is necessary. If such widespread abuse were occurring, state regulation might be appropriate. However, the case *for* state regulation has never actually been made. It is simply assumed. 'Bad practice' is presented as synonymous with anything that does not conform to limiting criteria confirming it as 'evidenced-based' within the narrow tradition of empirical positivism. Similarly, it is assumed that anyone who practices any form of therapy outside of those narrow confines (regardless of effectiveness) must be a rogue, free from any personal or professional ethics.

This image is portrayed time and again within the media. In an article in the Irish Independent, for example, Lynch (2016) tells us that the IACP "*know*" that in the "*gap between the demise of the stigma and the beginning of real regulation, there has sprung up a whole cottage industry of quacks, and it's only a matter of time before there is a scandal*". Like every other article that peddles this type of scaremongering, absolutely no evidence is offered by the author to back up his claims. Instead, as is also so often the case, in place of the non-existent solid facts, Lynch offers only misrepresentations of the therapeutic frame: "*if time's up they will check their watch and kick you out*", and witticisms: "*I once saw a therapist who arrived wearing socks and sandals and I spent the hour wondering how sage his advice could really be if that was his choice of footware*" (ibid). Funny perhaps, but no substitute for actual evidence that state regulation is needed. Importantly, as Lynch acknowledges, we are in fact in the time "*before there is a scandal*" to the extent that regulation might be necessary, not *after* a series of scandals, which is the usual prerequisite for this type of public outcry. Such scandal has not yet happened (and might never). Of course, every profession must tolerate ill-informed journalism. That isn't the issue and Lynch's article needn't be taken seriously, save that it does highlight the real problem; that is, the extremely problematic basis upon which regulation is perceived as necessary.

The reality is that the majority of therapists subscribe to very high ethical standards. On this issue, *The Maresfield report on the regulation of psychotherapy in the UK* (2009) has the following to say:

> *Therapists accept that their clients need the highest possible form of protection from inadequate and unethical practitioners. No therapy organisation or individual has argued against this principle. Indeed, therapists have consistently been open and active to strengthen the effectiveness of their current systems by all reasonable means. However, there is no research-based evidence suggesting that the client-group here is in the degree of danger that would justify being forced into a type of regulation that, in many respects, is unsuitable and unworkable for current professional practices… [The focus is] on two central issues regarding protection of the public: that any unscrupulous individual may set up a brass plate advertising their services as a therapist, and that, once struck off by a professional body, a therapist can simply continue to practise independently. Yet neither of these concerns is addressed by HPC regulation. HPC regulate professional titles not functions, so as long as the individual does not use a title protected by HPC, they can set up shop through use of any unprotected title: life coach, mentor, lifestyle consultant etc. As the BACP pointed out*

> *to the Department of Health: "the protection of a title, which is the main means by which statutory regulation operates, is proven to be ineffective: practitioners are able to re-title and re-brand themselves and continue working".*
>
> (Arbours Association et al, 2009: 8-9)

Based upon figures from the UK, statistical analysis of actual complaints does not support regulation under state sponsored bodies like HPC. Voluntary bodies like UKCP compare much more favourably. In 2007, HPC spent £2.9m to protect the public in just 12 cases to answer. For 2008, £3.76m was the cost of protecting the public in 18 cases to answer. For 2009, £4.66m was the cost of protecting the public in 17 cases to answer. The complaints process of bodies like the UKCP are more cost effective and more appropriate for the profession. The UKCP also has a much higher rate of finding that complaints from members of the public have a case to answer than the HPC (UKCP 89.5% case to answer against only 29% HPC; ibid).

It is a fine irony, if not also hypocrisy, that the stated need for narrowly defined 'evidence-based' practice is itself not evidence-based within its own terms of reference; it is a fallacy. Moreover, in the small number of cases where bad practice and genuine abuse does occur, members of the public are already protected by the laws of the land. Civil and criminal proceedings can be brought against therapists who behave in ways which are harmful. This is acknowledged by the Government, who note that whilst:

> *counsellors and psychotherapists are not currently designated under the Health and Social Care Professionals Act 2005… they are, however, subject to legislation similar to other practitioners including consumer legislation, competition, contract and criminal law*.
>
> (Department of Health, 2016)

The idea that professional sanctions will be a greater deterrent than the prospect of a criminal conviction (and in serious cases a prison sentence) is at best questionable. But it is not simply a case of: *if it ain't broke don't fix it*. State regulation would not only be ineffective but actively harmful for both the profession and its clients.

One size fits one

The system of regulation for health and social care professionals, and its associated complaints and redress procedures, is based around a health consumer model. As the *Alliance* points out, this model is very problematic when applied to the therapeutic arena:

> *Although many counsellors and psychotherapists work in medical settings, their work is not a branch of medicine nor an activity ancillary to medicine. Most forms of therapy do not focus exclusively on the relief of symptoms, but emphasise creating and exploring a relationship. If there is a goal, it is a general improvement in the quality of life (so that client satisfaction, rather than the improvement of an isolated symptom, is the appropriate measure of effectiveness). Regulation [alongside medical professionals] implies medical values and criteria which are in many ways antithetical to psychotherapy and counselling.*
>
> (Atkinson et al, 2009)

Many forms of therapy do not fit the health consumer model and by necessity stand outside of that system. For example, many therapists regard the notion of selling 'an hour of therapy'

as nonsensical. What is offered is something that does not fit a consumerist conceptualisation of what is being 'bought' and 'sold'. Clients of these practitioners are buying a *therapeutic relationship*, which is something co-created; not – like medicine – something only supplied by one and only consumed by the other.

Within this relational context, effective therapy requires an exploration of everything that can and does happen within the therapeutic relationship, both *good* and *bad*. The conceptual framework and language employed differs between modalities, but most models regard rupture and repair as essential components of the *therapeutic alliance*. When things go 'wrong' in therapy, good therapists stick around and remain open to exploration. Healing occurs precisely through this process of rupture and repair, rather than despite it; this is one of the bases upon which some practitioners use *purposeful misattunment* as a deliberate intervention.

Relational healing of this nature requires courage, from both client and practitioner, and a willingness in both parties to take risks. This usually results in the long-term benefits that clients are seeking, but in the short term these risks can be scary and temporarily destabilising. It is essential that practitioners have the courage to trust and support the process, which in turn requires a system that is appropriately challenging in a supportive way. The psychotherapeutic community, across modalities, knows the truth of this from well over a hundred years of collective experience. Hence:

> *Psychotherapy and counselling cannot therefore be made to conform to safety-first culture. State regulation will only strengthen the existing trend towards defensive practice – that is, practice which is more concerned to protect the practitioner from complaint than to help the client's growth and self-understanding*.
>
> (Atkinson et al, 2009)

State regulation in the current proposed form does not take account of this essential difference between medicine and therapy. In its very nature, it promotes litigation based upon the consumer ethos, with the likely outcome that ruptures will be taken outside of the therapeutic relationship at an early stage, destroying the therapeutic alliance in the process and possibly perpetuating a relational dynamic that may well be the cause of the client's difficulties in the first place. This in turn perpetuates a fear-based system, with clients increasingly seen as potential complainants, leading inevitably to those presenting with complex and/or challenging therapeutic needs finding it increasingly difficult to locate a therapist willing to work with them.

Most therapeutic contracts are between adults, yet the suspicion that clients and therapists cannot be trusted to contract appropriately for themselves infantilises the process. This presents an unnecessary, unhelpful and potentially harmful barrier to all modalities of therapy where, for example, childhood attachment styles are explored. How can clients ever fully occupy their adult selves in therapy, if both clients and therapists can only operate in a system which implicitly regards them as children in need of parental oversight?

What is really being protected and what is really being excluded?

For the past 12 years, I have sat on various tribunal panels alongside judges, psychiatrists, clinical and forensic psychologists, chief police officers and senior social workers. In these circles, I tire of constantly feeling the need to justify my professional existence. This taps into the deepfelt longing I often experience within our profession, for us to be taken seriously and

valued as the skilled, competent, knowledgeable and clinically wise practitioners that we are. Within that context, state regulation looks attractive upon first impression. Acknowledgement by the state in line with Quality and Qualifications Ireland (QQI) competencies implies 'my qualification is as good as that of any other professional'. Who wouldn't want that? The problem is that whilst state regulation would bring us more firmly into the system, the system is both medical and hierarchical; it doesn't fit what we do and, in any event, we would remain close to the bottom of it. More importantly, the cost of whatever validation state regulation might bring is unacceptable.

The Department of Health noticeboard states that its intention for state regulation:

> *is primarily by way of the statutory protection of professional titles rather than restricting scopes of practice. The use of protected titles is restricted to practitioners… [who] must comply with a code of professional conduct and ethics and are subject to "fitness to practice" rules similar to those applying to nurses and doctors*.
>
> (Department of Health, 2016)

Proponents of regulation state that there is no interest in restricting scopes of practice, yet the current proposals will have precisely that effect; the only people who could practice as 'psychotherapists' and 'counsellors' would be those who adopt a frame of reference for their work based on empirical positivism (similar to nurses and doctors). This empirical positivism, which is only one definition of objectivity, is the basis of the QQI standards proposed as the baseline qualification for all psychotherapists and counsellors.

QQI standards are woefully inadequate as benchmarks for much therapeutic activity. As already noted, successful outcomes in counselling and psychotherapy are almost always dependent upon the practitioner's ability to establish and maintain effective therapeutic relationships with clients. Whilst this requires sufficient working theoretical knowledge, there is no correlation between academic prowess and the ability to work therapeutically with individuals in distress. QQI standards are weighted heavily in favour of academia and would serve as a significant barrier to many otherwise potentially excellent practitioners from training in the field. This would be an unacceptable development in terms of client welfare.

The view of the *Alliance* on this matter is that:

> *Many practitioners see their work as more an art than a science: a series of skilled improvisations in a relational context, where each client, and indeed each session, offers unique issues and demands unique responses. Such an activity cannot be captured by a list of 'competencies', however elaborate; at best, such a list can offer only a parody of therapeutic practice. Yet regulation by civil servants, who themselves know nothing of the field they are regulating, demands an 'objective' version of our practice, even if this falsifies its nature. The inconvenient reality is that the field consists of many groups and individuals doing some of the same things in some of the same ways, but with many small and significant differences and with constant invention and variation – which has always driven advances in practice… Any attempt to impose a quasi-objective framework of standards and competences not only stifles creativity in the field, it also damages the therapeutic work with the client. In trying to apply a predetermined set of external principles to a particular individual, the practitioner must override the client's individuality and sacrifice the therapeutic process to the demands of a fixed technique. This is ethically unacceptable for the practitioner as well as*

therapeutically ineffective for the client.

(Atkinson et al, 2009)

Rather than vulnerable members of the public, protected titles only really protect vested interests; that is only the interests of those therapists who align their practice along medical model lines and, by extension, only the interests of those clients who are able to benefit from that model. Everything and everyone else – regardless of actual effectiveness – is unacceptably excluded from this monoculture:

> *The HPC brings with it mechanisms that may be suitable for professions allied to medicine, but which threaten the survival of the very essence of psychotherapy. Therapy is forced into a one-size-fits-all model of healthcare intervention, with its focus on outcomes and protocol-based procedures. HPC's current Standards of Proficiency for psychotherapy effectively exclude many of the most widely practised forms of therapy, which cannot be made to fit its framework. By marginalising and even making illegal those forms of therapy which follow a different model, HPC regulation would deprive the public of their free choice of which therapists to consult.*
>
> (Arbours Association et al, 2009: 9)

This is also the risk of state regulation in Ireland under HSCPC.

Protected titles also need to be considered alongside the principles underpinning *Equal Opportunities, Anti-Discriminatory Practice, Inclusivity*, *Diversity* and valuing *Individual Difference*. Therapists should be leaders in championing these principles, perhaps more so now than ever before, when we consider the current global trend towards self-interest and intolerance of difference that underpins recent events in America, Britain and across Europe. Serious barriers already exist which inhibit people from disadvantaged and marginalised communities from accessing counselling and psychotherapy. This problem is exacerbated by relatively small numbers of people from minority and/or marginalised groups being able to train as therapists.

Notwithstanding that reality, the counselling profession – in particular – in Ireland, perhaps more so than any other European country, has a rich heritage of being a genuine community-based activity. In Ireland, counselling has developed within the humanistic integrative tradition of being *of* the people and *for* the people. It is this heritage, rather than any specific titles, that must be protected, promoted and widened to reach all sections of Ireland's marginalised communities. Protected titles are by their very definition *exclusive*, and would make it even harder for individuals from the more marginalised communities to have access to practitioners from those same communities.

Any system of restriction, particularly one based upon such narrow and arbitrary academic standards, would be a seriously harmful retrograde step – for me, my many diverse colleagues who practice as unique *and* ethical therapists, and, most importantly, the many, many clients who benefit from what we uniquely offer.

Conclusion

The constant allegations of quackery we endure are exhausting and they hurt. One, understandable, response is to try to contort what we offer professionally into a monoculture that does not fit. Another response is to resist; to truly value the rich diversity that underpins our profession; to occupy the ambiguous and challenging relational spaces with courage

rather than shame; to continue to develop the organisations (and their codes of ethics) to which we voluntarily subscribe; and to really protect our clients by insisting upon a working environment which does not systematically undermine therapeutic processes through the promotion of fear-based and infantilising practices.

Not only viable, but also better alternatives for public protection exist. That is why the *Alliance* was successful in the UK. I do not know whether there is appetite for a similar alliance in Ireland. I do know that it is not too late. I do hope that enough of us will say: "No, not in my name".

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