

# Ethics and professional conduct policy

## **Section 1: The foundations of the human givens ethical framework**

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An interest in dealing with the dilemmas of human behaviour is as old as history. (The word ‘ethics’ comes from the Greek word *ethikos*, which means ‘dealing with human nature’.) Currently our knowledge of how human nature works comes from the scientific study of Nature’s endowment to us all – the human givens – and direct experience.

The starting point for such a study should be, therefore, that Nature endows each healthy human conception with a wonderful array of living genetic ‘templates’ – that infinitely rich treasure house of pre-programmed patterns for which we instinctively seek completion in the environment throughout our lives. Babies, for instance, are capable of copying some of the non-verbal behaviours of their mothers, such as facial expressions or sticking out their tongues, within just an hour of birth. They also rehearse instinctive behaviours, such as breathing and swallowing, while in the womb, in readiness for being born.

Such patterns are largely expressed as emotional needs, so that we are driven to seek their fulfilment (babies need to create a connection with their main caregivers to ensure their survival). Nature is doubly generous in that she also brings us into the world with the means to help us get our needs met. It is precisely the way these needs are met, through the individual circumstances of our lives, that determines our individual nature, character and mental health. Throughout life this process is in a state of continuous ebb and flow, refinement and adaptation.

Only when the environment a child finds itself in healthily fulfils its innate needs can it mature into an independent, fulfilled and socially integrated adult. Recent discoveries about how the mind/body system works now give us greater insight into this process. The brain is a plastic, problem-solving organ that needs challenges in order to enable it to grow. Children therefore have to be stretched by their experiences of life if they are to develop well. Mastering any skill, whether riding a bike or learning the violin, takes time and effort – a combination of being drawn forward by the teacher and pushing oneself. There are also certain times when the brain is best equipped to learn – for instance, foreign languages are best absorbed before the age of 10. Taking advantage of such knowledge could powerfully improve the way we bring up and educate children. Indeed, we might need to question now whether it is ethical to leave language learning as largely the province of secondary school teaching, or to call the random imposition on children of ideologies, facts and procedures which do not whet their appetites for discovery and mastery ‘education’. Or, as Thom Hartmann challengingly asserts in his *Complete Guide to ADHD*, is it ethical to dismiss as troublesome no-hopers, a huge number of children whose talents and behaviours are different from those of the majority, but which have significant value nevertheless?

### **The importance of shared perceptions**

Of the many obstacles which stand in the way of ethical decision making, perhaps the most important, is the illusion that we share perceptions. This serves to hide ignorance, protect territory, deceive or manipulate, and is largely the result of the language we use. And nowhere is it more easy to see than in the abstract words used to discuss ethical behaviour.

Most people assume ethics is concerned with truth, aspirations, justice, equality, loyalty, fairness, values, principles, morals, etc. But all these words are abstractions. Philosophers call such words 'reifications' but they are now more commonly known as 'nominalisations': the term used in linguistics for an abstract noun usually produced by converting a verb into a noun. For instance, when the process of enlightening somebody about something is turned into 'enlightenment' it becomes an abstraction, a word that pretends to be something concrete. All such words lack specific, essential information; namely who is doing precisely what to whom.

The problem for ethics is that, because these words mean nothing in themselves, they are always going to mean different things to different people. We may think we understand the need, ethically speaking, to have principles, but it is dangerous to assume we hold principles in common. One person might believe, for instance, that seniority takes precedence over youth, while another holds that ability takes precedence over age.

Because nominalisations are abstractions, when we hear one, we have to fill in the missing gaps in the information ourselves. Our brain, as a pattern-matching organ, is forced to search its memories to identify from its own experiences what it believes to be the meaning that gives

reality to these words. If, for example, a politician says, 'I am going to put more resources into education', everyone will tend to applaud and support him. But putting resources into education will mean something quite different to every teacher, child or parent. They will each unconsciously go on an inner search to assign a personal meaning to these abstractions. One person might think the politician means that he is going to instigate research into the best way to educate children. Others might think he is going to pay teachers more; or build better schools; or reduce class sizes; or make schools safer; or have more exams; or have fewer exams; or improve the curriculum; or train teachers better, and so on. The politician tries to win support and credit by using these abstract terms to appeal to the different individual concerns of all those listening. He is creating an illusion and not promising anything specific at all. It is impossible to 'supply', 'give' or 'input' an abstract noun like education. What we actually do is educate. And what people are educated about, why, how, where and by whom, are the questions that must be addressed in detail.

To deal with nominalisations, the first requirement is to learn to spot them. We can tell if a word is an abstract noun by asking ourselves, 'Can I pick this up and carry it away?', or 'Can I touch it or feel it or see it?' or 'Can I buy this off the shelf?' In other words, does it have some kind of substance? If it doesn't, it is a nominalisation.

Secondly, we need to challenge them. This can be simply done by turning them back into the verbs they came from. For instance, if a boss says, 'My expectations must be met', we are more likely to be able to achieve this if we find out exactly what it is that he or she expects, rather than acting on our own assumptions of what the expectations might be. If someone tells us they are full of anger, we have no real idea of their experience at all unless we ask, 'What exactly is making you angry?' (People do not *have* anger. It is not a substance in them like blood. In the same way, people do not *have* depression or fear. They are depressed by something or afraid of something.)

Because there are no precise, commonly shared perceptions about the meaning of nominalised words, they readily confuse us and make us vulnerable to self-deception and manipulation. That is why they are beloved of politicians, preachers and anyone else with something to sell or an ideology to promote.

Although it is our nature to operate through metaphor and generalisations, and this can be a great advantage to us and increase our capacity for conceptualisation, it is also a vulnerability. This is because we are social creatures and, unless we have perceptions more or less in common with those around us, it is difficult for us to cooperate, and our interactions at all levels are necessarily more crude. Then it becomes harder to ensure our real needs are met and selfish behaviour becomes more likely.

Ethical decision-making within a society is only possible if its members share the majority of their perceptions. Perception is the act of understanding the world by whatever means. Our senses are the channels for information about the world and perception is what our brains do

with the information. But first the information is filtered and selected. The selection process involves matching up the sensory information to what we already know by passing it through the embedded patterns of innate and learned knowledge held mainly in the limbic system and the left and right neocortex.<sup>4,5</sup> The brain in effect compares all new information with its instinctive templates and learned memories of past experiences, and asks, 'Is this important survival information – do I need to react? Or is it just interesting, or can I ignore it?'

As the brain discriminates – excluding or accepting information through this filtering process – it is forever building and enriching its internal model of reality. But, inevitably, this model is based on heavily censored input because the discrimination process is influenced by emotion, appetites and conditioning. For instance, a young man walking down the street on a warm July day is more likely to be aware of the attractive young women in their summer clothes than of the unevenness of the cobblestones which preoccupy the unsteady old gentleman behind him. Or, when we applaud the words of a pundit or philosopher and proceed to repeat them to others, it may not be because of the clarity of the case presented but because we happen to agree!

All living creatures, even single-celled ones, that respond to sensations such as heat and cold, light and dark, hard and soft – moving forwards or away – are in effect practising discrimination: we require 'sensitivity' in order to discriminate. The same, in a wider sense, can be said of groups or cultures. Civilisation can only exist when enough people share similar perceptions about the nature of the world and their place within it. The more refined, or subtle, the level of generally shared perceptions within a particular culture, the more highly civilised it is. In other words, a society in which there is a high level of dissent about what constitutes acceptable behaviour in people's dealings with one another, or where there is an unwillingness to establish and abide by laws, operates at a cruder level than one where there is accord about such matters.

Thus civilised (moral) behaviour can never be a static achievement; it is a process involving the refinement of shared perceptions, the discrimination of countless shades of grey. We can see that whenever this process is halted or reversed, the organisation or culture concerned 'freezes' and becomes intolerant. It then degenerates and eventually collapses, as happened in many ancient empires and more recently, in spectacular fashion, in the Soviet Union.

To increase our understanding of the friction between cultures today, and the predicaments of being human in a crowded world, we need to work at refining our perceptions as far as we possibly can. That means enlarging our perspective with the aid of the knowledge available to us from history, anthropology and psychology, to enable us better to see the bigger picture – the view beyond our own individual outlook or take on events – and know how to discriminate between the abstract and the concrete.

## **Needs and wants**

Looking at life from different perspectives inevitably brings about a greater understanding of others' needs and wants and how they may conflict with our own. Ethical dilemmas mainly arise when circumstances are preventing someone's physical or emotional needs from being fairly met, perhaps because they are in apparent conflict with those of another individual or organisation. The woman in her sixties who wants to bear a child, because technology now makes it possible for her to be helped to do so, may want a child because she has been unable to conceive before, or because she has lost a child, or because her children are grown up and she feels her life lacks purpose without a caretaking role. Perhaps, however, it might be considered that her need to be needed could be better met in a different way. The medical authorities may feel that she has as much right as anyone else to an assisted pregnancy; or that her needs are secondary to those of younger women; or that the pregnancy would be dangerous; or that it is inappropriate for a post-menopausal woman to bear a child when that is plainly against Nature's intent. Others might argue that the menopause, which used to signal the decline of a woman's life, now commonly occurs less than two thirds of the way through it, when women are still very healthy and active.

Yet others may be concerned that the unborn child's needs conflict with those of the mother, if it is in the best interests of a child to have a parent who is able to take an active role in their life

throughout childhood or who has the ability to work to support them. Or might it be taken into account that a particular financially secure, physically and emotionally healthy 60-year-old woman, who has a younger husband and the support of her family, could be a more competent parent than a younger woman who is alone, mentally unstable, earns no income and often uses what money she has to buy drugs?

Taking the wider view, and establishing the different competing needs and interests involved, leads us to strive to understand each situation in which we find ourselves, rather than relying on belief systems for resolving them. Operating out of a belief system means blindly applying rules without questioning their applicability. Although beliefs 'live on', from generation to generation, they are, in themselves, dead things, preventing the pushing outwards of mental boundaries. Circumstances can alter cases.

## **Emotional arousal**

Issues such as the 'right' to have a child or the 'right' to a homeland generate an enormous amount of emotion. But taking the wider perspective requires objectivity – detachment. This is impossible when we are in a state of high emotional arousal. As is now well understood, the more emotional we are, the more the rational part of the brain is overwhelmed and we are forced back onto the binary responses of the emotional brain – fight or flight. Emotional arousal locks us into one-track responses, which although they have survival value in certain circumstances, in our complex world today, are rarely helpful for dealing with difficult interpersonal problems.

When emotional, we think in black-and-white, all-or-nothing, terms. Misunderstandings occur. Feelings of being out of control develop. We tend to misuse our imagination, becoming so anxious about change or so fearful of the unknown that we cannot meet challenges or take risks. We may worry constantly about loss of power or status; develop a morbid fear of failing, illness or death; begin to doubt our abilities and competence; become anxious and depressed. Because emotional arousal makes us inflexible, we suffer disappointment when things do not work out as we expect or as we feel they should.

In effect, being governed by emotion means being driven by the instinct to get our own needs met. In such a state, we cannot solve ethical dilemmas. Nor, when our emotions are strongly bound up in an ethical problem, are we capable of recognising that someone who does not share our view is not necessarily the 'enemy' or the 'opposition'; and that if, in fact, they are standing back and taking an objective view, they are better equipped than we are to come up with a fair solution. For instance, some pressure groups might clamour for an individual's right to die when suffering from a debilitating incurable illness, and refuse to hear any dissenting voice. Yet, someone with knowledge who is unemotionally involved might usefully point out that many incurably ill people are depressed and that, if they were helped out of their depressed mood, they might no longer wish to die.

Solving difficult dilemmas that have moral or ethical aspects takes time. We have to be calm enough to allow answers to arise in us. As neuroscientist John Ratey says in his book *A User's Guide to the Brain*, 'If one acts before allowing oneself time to think of the consequences, there is no willpower or self control. Values and goals are automatically ignored in the maelstrom of activity.'<sup>4</sup>

Two-and-a-half thousand years earlier, Aristotle and Plato also taught that moral development is achieved by educating children to modulate their emotions, saying (as Aristotle put it) 'The moral virtues are engendered in us neither by, nor contrary to, Nature; we are constituted by Nature to receive them, but their full development is due to habit. [...] So it is a matter of no little importance what sort of habits we form from the earliest age – education makes a vast difference, or rather all the difference in the world.'<sup>1</sup> We must remember that ethical dilemmas must be approached in a state of low emotional arousal.

## **Knowing where to go**

Knowledge is not found in our conscious intellect. It is through our intellect that we refine our perceptions and come to understandings. But when we do understand something our state of knowing is unconscious. For instance, it takes conscious effort to learn a new skill, such as driving a car. Whilst learning we consciously think about every step required – the gear changes, signalling, judging distances, trying to analyse comparative speeds and so on. But there comes a moment when that conscious effort falls away. We instinctively pattern match to the required actions. Driving becomes automatic – unconscious. At that point, driving has become part of our intelligence. ‘We know how to do it and might even be hard put consciously to describe all the elements involved. The knowledge only fully manifests itself when we get into a car and drive it.

This kind of unconscious knowledge enables us to act objectively, unencumbered by social conditioning or inappropriate emotional responses. It is perhaps what the philosopher Alfred North Whitehead was referring to when he said, ‘Civilisation advances by extending the number of operations we can perform without thinking about them.’<sup>6</sup>

It could be that consciousness evolved to help us focus more keenly on the world and question and analyse it, to help us get our needs met more efficiently and effectively. It is certainly a tool to solve problems with because it only wakes up when we realise we are ignorant about something and need an answer. If knowledge is found in the sum of the richness of the unconscious pattern-matching processes which go on in our brains, then the work of consciousness is to help the person look for more effective patterns to match to, to extend and enrich unconscious knowledge. The more successfully we do this, the more emotion serves consciousness and perception rather than controlling it. Don’t trust unconscious reactions.

## **Understanding human nature**

To have our best hope of acting ethically, as individuals, as members of a community or as members of a profession, we have to begin by gaining a better understanding of ourselves. We need to understand the processes of human conditioning; how ideologies restrict understanding; how the brain/mind/body system works; how to further refine perceptions; how emotional needs can be met without trespassing on the freedoms of others; and how best to use the resources given to us by Nature to do so. Quite simply, we need to study the science of human nature, and the advances in knowledge about behaviour, biology and the brain that have accumulated in the last few decades.

Facing up to this may be more urgent than we realise. In the heady optimism of the mid-1960s, Idries Shah struck a sober note quite at odds with the naïve but then fashionable notion that, to resolve any conflict, ‘all you need is love’. He said, ‘Tolerance and trying to understand others, until recently a luxury, has today become a necessity. This is because, unless we can realise that we and others are generally behaving as we do because of inculcated biases over which we have no control, while we imagine that they are our own opinions, we might do something which will bring about the destruction of all of us.’<sup>7</sup> His words are just as apposite now. Therefore, study the conditioning process.

## **Developing an internal monitor**

As a complex society, we will always find ourselves struggling with major ethical dilemmas, as there are multiple variables to everything. There are, however, three ethical safeguards in working from the human givens approach. First, professionalism and practice are based on the requirements of individual circumstances, rather than dogma and theory. It cannot be said too often that circumstances alter cases, and that what is appropriate in one instance may be inappropriate in another apparently similar one. Second, it focuses attention on looking largely at patterns and processes rather than content – the needs that have to be met in a situation to improve it, rather than the minute details of what maintains it. This is a mental posture which usefully helps keep us detached, vigilant, and focusing outwards, so that our own emotions do not become muddled up with those of patients, pupils, clients, colleagues or whomever we are concerned with.

Thirdly, it is understood that uncertainties or vulnerabilities within us can easily be triggered, through pattern matching, by an event or emotional story we read or hear. When this happens, inevitably we are no longer impartial or objective in our responses. For instance, a counsellor who is fearful of breast cancer, because of a raised family risk, may find herself being overly reassuring or, conversely, unwilling to address the concerns of a client in a similar position. If people are unaware of this unconscious pattern-matching process, they may misinterpret the reason for their own reactions – perhaps assuming it is a legitimate response to the situation being considered, rather than the result of their own aroused emotions – and thus make avoidable errors of judgement.

We have to behave ethically towards ourselves if we are to behave ethically towards others, and we are behaving unethically towards ourselves if we allow any single need to dominate at the expense of the others. For example, the development of any addictive behaviour (whether workaholism, substance abuse, gambling, shopaholism, sex, or lust after money, information, gossip, power, attention or status), cannot but interfere with our personal and professional relationships. If our own needs are out of balance, or we have so many emotional demands on us that we have little spare capacity left, we cannot reliably behave ethically towards other people or be effective therapists, managers, teachers or family members.

Over the last 50 years there has been a partial breakdown in the ethical and moral systems (legal, educational and religious) that society once relied upon to maintain stability. Paradoxically, that breakdown process had to happen because reliance on rigid belief systems was making us too inflexible – and therefore too vulnerable – for survival in a more rapidly changing world. New ideas and information can only permeate a society if it does not rigidly exclude such inputs.

While many people grow and flourish today, others are not adapting well to the way the world is changing. Some appear unable to take responsibility for their actions and become fodder for the cult of passive consumerism. Consequences of this include the development of the ‘victim culture’, where people becoming obsessed with ‘targets’, ‘rights’ and ‘blame’; and a massive increase in the numbers of people suffering mental disorders and addictions. Until we reorientate ourselves away from wants to needs, starting with a sincere examination of what Nature made us, we will continue to do more harm than good to this planet and its inhabitants.

## References

1. Aristotle, Tr. Thompson, J A K (2004) *Nicomachean Ethics* (4th edn.), Penguin Books.
2. Smith, D M (2000) *Moral Geographies: ethics in a world of difference*, Edinburgh University Press.
3. Hartmann, T (2002) *Complete guide to ADHD: help for your family at home, school and work*, Underwood Books.
4. Ratey, J (2001) *A User's Guide to the Brain*, Little, Brown.
5. Robertson, I (1999) *Mind Sculpture: unleashing your brain's potential*, Bantam Books
6. Cialdini, R B (2001) *Influence: science & practice* (4th edn) Allyn & Bacon.
7. Shah, I (1968) *Reflections*, Octagon Press.

*This is an amended version of the article by Ivan Tyrrell, Director of Human Givens College, which first appeared in Volume 9, No. 2 of the Human Givens Journal (2002)*

## **Section 2: The needs of clients**

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- 2.1 The lawful needs of clients are the foundation of ethical practice. Clients need to define the changes needed in their experience and capacities that will enable them to meet their needs more effectively. The efforts of therapists are guided by this founding consideration;
- 2.2 A fundamental principle underlying good practice is that therapists do not confuse their own needs with those of clients. The human givens approach therefore emphasises the relationship of trust between therapist or counsellor and patient, in which the focus should be on the patient's needs and resources, not on the desires, any selfish personal aims or ideological beliefs of the therapist;
- 2.3 In addition to this, therapists need to take account of the fact that human beings are social creatures, and that our lives take much of their meaning from interaction with other people. It follows that therapists will take account of the social networks within which they and the patient are operating and within which their needs must be met in a balanced way;
- 2.4 Starting from the human givens inclines us to avoid rules for good practice based on patients 'rights'. We arrive in the world with needs to be met and the resources to meet them, but not rights. Rights are not 'givens' but are arrived at by negotiation between people and enshrined in laws;
- 2.5 Clients require therapeutic services based on best available psychological, physiological and neuro-physiological scientific knowledge relating to healthy human functioning and the rapid relief of distress. Specifically, practitioners should understand the basic emotional and physical needs common to every human being and implications of these for emotionally healthy, well adjusted living;
- 2.6 For them to recover from whatever is troubling them, clients need the practitioners from whom they seek help to have a sound psychological and physiological understanding of all the common mental health conditions – namely stress and depression, fear and anxiety, anger, trauma and addictions. Practitioners should be able wherever possible to offer immediate help to relieve the symptoms associated with these disorders and discuss ways of maintaining change. Such understanding and skills should be based on up to date scientific knowledge relating to these conditions;
- 2.7 Clients need practitioners to be clear and straightforward in their verbal and, where necessary, written communication. They should therefore avoid vague, ambiguous or vacuous concepts and assertions: communications should be free of "psychobabble".

### **Section 3: The basis for good practice – needs of therapists**

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- 3.2** A necessary condition for being a good therapist is the need for ‘spare capacity’, i.e. sufficient time and extra energy to devote to clients. Therapists need this in order to see clearly what is going on with their patients, to understand them and influence events in a positive direction, wherever possible;
- 3.3** If the therapist is too pleased, too anxious or too depressed themselves, they have no possibility of developing the capacity to do therapy well. Excessive emotion of any kind is exhausting and uses up the energy needed to be held in reserve in order to observe objectively. If a therapist’s emotional life is too strong, they are not in control and therefore unable to work effectively with clients. So doing therapy should not use up everything the therapist has got, nor should there be so many draining demands that they have insufficient resources for doing good therapy;
- 3.4** Therapists should aim to enjoy doing something else with ease and confidence as a way to develop spare capacity. As people develop competence and confidence in a sport, craft, skill or hobby they take for granted that they can do it well, but do not become vain about achievements. This sense of inner confidence nurtures spare capacity for doing therapy;
- 3.5** Therapists should continually examine their motives and update their skills;
- 3.6** Therapists should be conscious of their own beliefs and the effects these may have in the context of their work with patients. This will include taking into account any differences between their own cultural background, gender, race, sexual orientation, beliefs, etc and those of the patient.

## **Section 4: The basis for good practice – essential knowledge and skills**

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### **An effective counsellor or therapist should:**

- 4.1 Have up-to-date knowledge about the spectrum of mental health disorders;
- 4.2 Help immediately with anxiety (fear-related) problems including trauma (or Post-Traumatic Stress Disorder), phobias, panic attacks and obsessional behaviour (OCD);
- 4.3 Understand depression and how to lift people out of it;
- 4.4 Be prepared to give advice if needed or asked for;
- 4.5 Avoid using jargon or ‘psychobabble’;
- 4.6 Do not dwell unduly on the patient’s past;
- 4.7 Be supportive when difficult feelings emerge, but not encourage clients to remain in an emotionally aroused state;
- 4.8 Know how to assist individuals to develop social skills, so that their needs for affection, friendship, pleasure, intimacy, connection to the wider community, etc. can be better fulfilled;
- 4.9 Know how to help people to draw on their own resources;
- 4.10 Induce and teach deep relaxation (to unlock patients’ attention from whatever strong emotions may have become focussed upon);
- 4.11 Be aware of the importance of the ‘observing self’, or state of being aware of awareness itself, when there is the potential to look in many directions and choose to focus attention in a variety of ways (see Appendix 1);
- 4.12 Help people to think about their problems in a new and more empowering way;
- 4.13 Set tasks to be done between sessions where the goals of therapy require this;
- 4.14 Learn how to recognise nominalisations and avoid being emotionally influenced by them;
- 4.15 Always encourage patients to be specific and to make concrete their beliefs and feelings so that there is something real to work with;
- 4.16 Look for patterns in what the patient brings to therapy, in addition to content;
- 4.17 Increase the client’s self-confidence and independence, and make sure that they feel better after every consultation.

## **Section 5: The basis for good practice – working ethically**

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### **Therapists should:**

- 5.1 Work within the limits of their experience and training, remaining aware, in particular, of the limits of their knowledge about medical matters;
- 5.2 Negotiate clear and ethical contracts with patients and always operate on the basis of informed consent. This should be explicit consent on the part of the patient. Working with young people requires careful consideration of the extent to which they can give consent independently of a parent or legal guardian. If patients are to be recorded or observed, or their personal experiences are to be used for research or training purposes, their consent must be clearly sought and explicitly gained;
- 5.3 Be straightforward and accountable about the financial transactions involved in therapy, for example, by avoiding any possible confusion or false expectations about therapy being a “course of treatment” by not accepting payment in advance;
- 5.4 Have respect for patients and their autonomy. Be sensitive, courteous and straightforward in communicating with them;
- 5.5 Keep records of all treatments. Records should contain sufficient detail, including a description of the patient’s presenting situation, their expectations of therapy, the treatment provided and the outcome;
- 5.6 Respect and maintain patient confidentiality at all times, ensuring that case notes and records for each patient are kept in a secure place, and remaining cognizant of their responsibilities under the Data Protection Act, other legal requirements and the right of patients to see their records should they so wish;
- 5.7 Take out and maintain comprehensive professional liability insurance. Have the highest level of Criminal Records Bureau disclosure possible;
- 5.8 Beware of conflicts of interest arising between patients, particularly in couple therapy, where they may have to choose between patients if they break up during therapy. Think whether it would be best to stop seeing either party and advise that each gets another therapist. If a conflict of interest arises, notify those concerned in writing;
- 5.9 Remain vigilant about the possible consequences of multiple relationships, i.e. when the therapist has more than one relationship with the patient, e.g. client and friend, supervisor and trainee;
- 5.10 Consider the implications of therapeutic interventions on other people in the patient’s life: friends, family and colleagues;
- 5.11 Take as few sessions as possible and develop sensitivity about when to refer on and when to end therapy;
- 5.12 Remember that in therapy, patients are highly suggestible and so avoid the labelling that can reinforce the pathology of their problem. Furthermore, care should be taken not to inadvertently create illusory memories about events in the past;
- 5.13 If the need arises, advise the patient that you are obliged to inform the appropriate authority should they divulge to you any illegal or potentially harmful act;
- 5.14 Seek good relationships with their fellow practitioners and other health-care professionals, co-operating with them where appropriate;
- 5.15 Be accountable to the patient and to the Human Givens Institute for the quality of their practice.

**Therapists should never:**

- 5.16 Make any kind of sexual advance towards, or sleep with, a patient;
- 5.17 Steal money or time from a patient, either directly or indirectly; for example, by keeping the individual in treatment for longer than is necessary;
- 5.18 Barter treatment, because it creates a confusion of roles. Do not accept upfront payment for a 'series' of treatments, either at discounted rates or for full price;
- 5.19 Impose their own world-view on their client, e.g. by implanting ideas of an ideological, religious or behavioural nature that fall outside the consciously agreed therapeutic goals. This includes, by definition, ideas about childhood sexual abuse, implanted by the therapist, to be 'recovered' later by the client;
- 5.20 Abuse, manipulate, or otherwise indulge in any kind of cult behaviour or practices which bind client or patient to the therapist;
- 5.21 Take advantage in any other way of the inevitable power invested in the role of 'therapist'.

## **Section 6: Training, governance and the conditions for maintaining good practice**

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- 6.1 Practitioners should seek professional training that teaches knowledge of the common mental health conditions and the methods and skills that give the best outcomes for relieving such conditions;
- 6.2 Because knowledge in these fields continues to expand as further research and insights reach the public domain, so will the professional training sought by practitioners need to take account of such advances wherever they are relevant to therapeutic endeavour;
- 6.3 Assessment of trainee therapists should include a thorough testing of relevant knowledge and the assessment of audio-visual recordings of their work with clients, so demonstrating, as far as is practicable, that minimum standards of competence have been achieved and demonstrated;
- 6.4 Practitioners should seek registration with professional associations whose objectives include the commitment to effectiveness in relieving mental distress and based on proper knowledge about the basis of healthy human functioning;
- 6.4 Therapists should publicly promote themselves as competent only when they have successfully completed all stages of professional training and successfully registered with the HGI/a suitable professional association;
- 6.5 Continued professional registration should be subject to the minimum standards for professional development and supervision required by the HGI/a suitable professional association;
- 6.6 Practitioners should seek and record feedback from clients at each therapy session in order to assess the outcomes and therefore the effectiveness of therapy as it progresses;
- 6.7 Records of outcomes of work with clients should be retained for no less than five years and, where necessary and appropriate, used as a tool for self evaluation, professional supervision and, where appropriate, certain complaints about practitioners by clients;
- 6.8 The Human Givens Institute shall have the power to remove any name from its register of members for professional misconduct, as determined by due procedure;
- 6.9 Practitioners are expected to make arrangements for the professional supervision of their work with clients by a suitably accredited person. This is to ensure that sufficiently high standards of professional practice are developed and maintained. The specific requirements of individual therapists will depend on levels of experience and competence;
- 6.10 Supervisors of therapists should complete an accredited course of learning that tests their ability to provide the oversight and consultation required by practitioners;
- 6.11 Practitioners should ensure that their professional training is continuously updated and refined, so that core therapeutic skills continue to be polished and, wherever necessary, updated. Records of such continuing professional development should be kept and submitted in due form to the relevant professional association/s;
- 6.12 Wherever competency to practice as a human givens therapist is in doubt and cannot be resolved by the use of informal channels for providing feedback, a complaints procedure is provided below. An upheld complaint against a therapist will be kept on file for two years.

## Appendix 1: The observing self

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The observing self is the transparent centre, that which is aware. It is the most personal self of all because it supersedes thought, feeling and action, for it experiences these functions. No matter what takes place, no matter what we experience, nothing is as central as the self that observes. In the face of this phenomenon, Descartes' starting point, 'I think; therefore I am', must yield to the more basic position, 'I am aware, therefore I am'.

The most important fact about the observing self is that it is incapable of being objectified. When you try to locate it to establish its boundaries, the task is impossible; whatever you can notice or conceptualise is already an object of awareness, not awareness itself, which seems to jump a step back when we experience an object. Unlike every other object of experience – thoughts, emotions, desires and functions – the observing self can be known but not located, not 'seen'.

There is a Yogic discipline that prescribes the exercise of 'Who am I?' to demonstrate that the observing self is not an object: it does not belong to the domains of thinking, feeling or action: 'If I lost my arm, I would still exist, therefore I am not my arm. If I could not hear, I would still exist. Therefore I am not my hearing.' And so on, until finally 'I am not this thought', which leads to a radically different experience of the self.

Western psychotherapy has yet to confront this paradox. The infinite regression of awareness, like two mirrors placed face to face, has largely been a subject for philosophers rather than scientists. The psychiatric and psychological literature refers to the observing self as 'the observing ego', but does not explore the special nature of that 'ego' and its implications for our understanding of the self.

The observing self is not part of the object world formed by our thoughts and sensory perception because, literally, it has no limits; everything else does. Thus, everyday consciousness contains a transcendent element that we seldom notice because that element is the very ground of our experience. The word transcendent is justified because if subjective consciousness – the observing self – cannot itself be observed but remains forever apart from the contents of consciousness, it is likely to be of a different order from everything else. Its fundamentally different nature becomes evident when we realize that the observing self is featureless; it cannot be affected by the world any more than a mirror can be affected by the images it reflects.

In the midst of the finite world is the 'I', and it doesn't belong in that world. It is obviously different from the world, but the difference is ignored. All else can be objectified, has limits and boundaries that can be described. All else is a segment of the world of fixed or relative dimensions. The observing self, however, is not like anything else we know.

Adapted from *The Observing Self: Mysticism and Psychotherapy*, by Arthur J Deikman (1982), Boston, Massachusetts, Beacon Press

## Guidelines on the writing and use of case studies

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### 1. Introduction

In recent years, in some areas of psychotherapeutic/psychiatric practice, such have been the constraints placed on the publication of case studies that, on the grounds of protecting client identity, their use has all but died out. One commentator recently described those case studies that continue to be produced in the above climate as “bland and anaemic”<sup>(1)</sup>. It is argued by some opponents of case studies that it is preferable to focus on reporting the findings of scientific research rather than on the results of individual cases. However, as one advocate of case studies has pointed out, it is the case histories of 100 years ago that we remember today — “Anna O” being a case in point — rather than the science of the day, which is now seen to be at least partly spurious.<sup>(2)</sup> The Human Givens Institute believes that, given the value of the case study, its use should continue, providing that in each case properly informed consent is obtained and effective steps are taken to preserve client confidentiality/privacy, as set out in these guidelines. Therapists should also note that it is possible to illustrate an aspect of therapy and its underlying principles and application without direct reference to an actual therapeutic episode (which is what a case study does). This approach avoids the issue of privacy and consent.

(1). *All in the Mind*, BBC Radio 4, April 2007. (2). *Ibid*.

In general, human givens practitioners produce case studies (i.e. accounts of particular therapeutic episodes) to reflect successful treatments and publish these to illustrate the approach used and the outcome for the benefit of colleagues. Alternatively and equally valuable are accounts of therapy which have not succeeded. (These latter cases, continuing or concluded, are most likely to be posted on the HGI Professional Forum, accessible only to accredited HGI members.)

These guidelines are mainly concerned with the kinds of case studies that can be defined as **narrative** case studies (or case histories) where the content is presented as events in an unfolding plot with participants (patient, therapist, significant others) and actions (presenting situation, treatment, outcome, etc).

Case studies are seen by the Human Givens Institute as valuable **teaching tools** in the context of courses of study, etc. Their purpose is to illustrate the successful application, or otherwise, of a therapeutic technique or approach.

A distinction is to be made between narrative case studies, as described above, and brief case illustrations/examples used in the context of verbal interaction during training, supervision and indeed therapy (e.g. ‘My friend John’ stories). The latter should be sufficiently condensed and generalised that they neither reveal confidential material nor require permission from anyone involved. Longer and more detailed case studies, however, need to be carefully anonymised and also require the consent of the client (see below).

In practice, case studies should include:

- A description of the client’s presenting problem and the initial context/circumstances of their case. NB: The focus should be on that which is essential to foster the reader’s understanding; incidental details which do not contribute directly to the reader’s understanding should be omitted;
- A description of the ‘trigger’ incident, for example a traumatic event, if applicable;
- The client’s symptoms and the resulting consequences/sequelae, for example detrimental effect on the client’s relationships and constraints on their mobility as a consequence of, for instance, trauma;
- In short, case studies should focus on a description of the problem and the relevant circumstances, the consequences for the client and/or others, the treatment provided and the outcome.

## **2. The Ethical Dimension**

### **a) Informed Consent to Case Study**

- If, at the end of therapy with a particular client, a therapist decides that it will be useful to produce a case study (i.e. an anonymised description of the therapeutic episode in question), they must seek the client's written permission, taking care to explain that their identity will be protected by the means outlined in these guidelines (see below);
- A case study consent form is available on the professional members' area of the HGI's website and should be used for the purpose of obtaining the written permission of clients. Completed consent forms should be retained with client records;
- If permission is given, the therapist should produce the case study, suitably altered to eliminate any possibility of identification, and submit for publication. NB See notes on the protection of client identity and publication of case studies below;
- As part of the above process, it should be made clear to clients that they can, if they wish, see a copy of the proposed case study before it is submitted for publication. Where a client requests sight of a completed case study prior to giving permission, the therapist must provide them with a copy together with a copy of the case study consent form. Under no circumstances must a case study be published without the client's written consent.

### **b) The Protection of Patient Identity**

It is of paramount importance that the identity of clients who are the subject of case study reports is protected. The following guidelines and examples are to be observed by those writing and publishing case studies. Whilst some of these will be familiar precautions, others may be less obvious.

- To minimise the risk of identification, clients' names and the names of other participants in the case must be changed;
- Incidental information, such as the occupations of clients, their relatives or other key characters must be changed or, if they do not lend meaning to the narrative, omitted;
- Reference to locations or organisations that might assist identification must be changed or, where not essential to the narrative, omitted altogether. Examples here could be towns, other countries which the patient might have come from or visited, organisations used by the patient, etc.;
- It is good practice for therapists to consult their supervisor as to whether any proposed case study conforms to these guidelines, particularly the sections relating to informed consent and the protection of client identity.

In addition, where it is considered appropriate for the further protection of identity:

- The gender of patients and other participants in the case can be changed;
- The content of several similar cases can be combined to form a single case study, provided that the above guidelines are followed.

### **c) Publication of Case Studies**

It is likely that the great majority of case studies produced by human givens therapists will be intended for inclusion in a human givens publication, for example a newsletter, journal, book or the HGI website. Consequently, the case studies concerned will be subject to the scrutiny of the relevant editor(s). However, where a case study is intended for a non-human givens publication such as a newspaper, newsletter magazine, journal, book, website, etc, the therapist concerned must consult with their supervisor in order to confirm that properly informed consent has been obtained and that the client's identity has been protected in accordance with the guidelines set out in this document. If in doubt, the supervisor and/or the therapist must consult with the HGI Ethics and Complaints Committee.

The guidelines concerning informed consent and the preservation of client identity also apply to audio or video recordings of treatment provided by human givens therapists intended for publication on websites such as YouTube, or in any other format.

#### **d) The Responsibility of Editors and Publishers**

Those responsible for editing and publishing the *Human Givens* journal, newsletters, books, website content etc., must satisfy themselves as far as possible through communication with therapists submitting case studies for publication, that informed consent has been properly obtained and that the possibility of a patient being identified has been eliminated through adherence to the above guidelines.

#### **e) Clean Intentions**

The Human Givens Institute suggests that therapists carefully examine their motives and intentions before producing case studies for publication. For example they should ask themselves the following question as it relates to their own needs:

- *Am I seeking to gain attention, raise my status or gain “payment” in any other way through the process, or am I on balance, seeking to extend human knowledge?*

Also apply the ‘Can you look them in the face?’ test:

- *‘Would I be able to show the case study to my patient in the knowledge that the account is fair and accurate and that their identity is adequately protected?’*

#### **f) Example of a Suitably Adapted Case Study**

**Scenario (necessarily fictitious for these purposes, but intended to represent an actual case):**

Rob, a 32 year old retail manager is mugged whilst using his debit card to withdraw cash from the ATM at his local bank in Wigan last June. As a result he suffers severe PTSD symptoms (avoidance of banks, intrusive feelings and thoughts, angry outbursts, etc) and time off work which is leading to problems with his employer. In addition, his relationship with his 30 year old wife, Sylvia, a dental hygienist at a local practice, is being put under considerable strain. Rob's relationship with his six-year-old twin sons Alan and David is being adversely affected. Description of treatment and successful outcome along the same lines.

**Case Study (derived from the above scenario and designed to protect client identity):**

Alison, in her thirties and a mother of two, is mugged in broad daylight on her way to the post office. As a result she suffers severe PTSD symptoms (avoidance of the local shops, including the post office, intrusive feelings and thoughts, angry outbursts, etc.) and time off work which is leading to problems with her employers. In addition, her relationship with her husband, John is being put under considerable strain and she is finding it difficult to deal with her daughters because of the angry outbursts. Description of treatment and successful outcome along the same lines.

#### **g) The Health Professions Council’s View on Client Confidentiality**

The following extract summarises the position of the Health Professions Council (HPC) with regard to the confidentiality of clients. The HGI endorses the principles contained in this statement, both in relation to case studies and with regard to wider issues of client confidentiality.

**“Standards of conduct, performance and ethics – duties of HPC’s registrants**

**“2. You must respect the confidentiality of service users**

You must treat information about service users as confidential and use it only for the

purposes they have provided it for. You must not knowingly release any personal or confidential information to anyone who is not entitled to it, and you should check that people who ask for information are entitled to it. You must only use information about a service user:

- to continue to care for that person; or
- for purposes where that person has given you specific permission to use the information.

You must also keep to the conditions of any relevant data protection laws and always follow best practice for handling confidential information. Best practice is likely to change over time, and you must stay up to date.”

This statement explains how to identify and manage risk. While for the majority of therapy clients, there is minimal risk of anything untoward occurring, risk can never be totally eliminated. In most cases, having reflected on the information available, it is likely that there will be little or no evidence of risk posed by the client to self or others. The level of significant risk should be identified and mitigated by following a simple risk assessment procedure, so that therapists can show if necessary that they had made an informed judgment about the client's level of risk.

Risk assessment should be an ongoing activity, used as a preventative rather than reactive tool.

### **Risk Assessment Steps – Identify, Evaluate, Mitigate**

#### ***Identify***

In reaching an overall judgment about risk, a client's history should be explicitly taken into account. It is well demonstrated that statistically, the best predictor of future suicide or violence is a past history of attempted suicide or violent behaviour.

The following questions and scores are taken from the CORE outcome measures and may be used as a basis for identification and evaluation:

- Physically violent to others?
- Thoughts of hurting self?
- Planned to end life?
- Threatened or intimidated another person?
- Thought it would be better if dead?
- Hurt self physically or taken dangerous risks with health?

#### ***Evaluate***

Each question can be scored as follows:

- 0 — Not at all
- 1 — Only occasionally
- 2 — Sometimes
- 3 — Often
- 4 — Most or all of the time

Add the scores and divide by 6 to give an average. A score of 0.5 or higher is of concern.

#### ***Mitigate***

Depending on level of risk identified consider:

- Discussion with client about any concerns – usually appropriate;
- Discussion with one or more members of your peer supervision group;
- Referral to GP/significant others – and in the case of children, ring your local authority main switchboard (not the GP) and say “I want to talk to someone about making a child protection referral”. They should put you through to a customer service specialist who passes on the information to Children's Services;
- Review whether therapy remains appropriate. Terminate therapy if identified risk indicates it is no longer appropriate [exceptional].

### **Recording the risk assessment**

The risk score should be recorded in the client's notes. This demonstrates that the therapist has reflected on the situation. Any mitigating action taken should also be recorded.

### **Risk and breach of client confidentiality**

The Data Protection Act allows for disclosure of confidential information:

- with client consent;
- for a valid reason, such as an order of court or written confirmation from a statutory agency;
- where in the therapist's judgment disclosure is necessary in the public interest (such as when you may have concerns about the safety of a child and/or vulnerable adult).

It would seem sensible, therefore, during initial consultations with clients, to obtain client agreement to disclosure if necessary.

# The HGI Ethics and Complaints Committee

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## 1. Statement of Practice

As the number of practicing HG counsellors increase so exponentially will the number of interactions with the public in counselling sessions. Experience and the discussions on the HG fora show that not every session will be successful every time.

Success is subjective – it is for the client to determine satisfaction. Sometimes the disappointment, frustration or anger of an unsuccessful session turns into a complaint to the HGI. These are passed to the committee to provide a response.

The committee's method is to obtain from the counsellor complained about an account of the therapy. It looks at what both the client and therapist say about the presenting problem and the course adopted by the counsellor. It is expected that the therapy be in line with the HG approach and the interactions to have been polite. Overall the committee examines that the welfare of the client was the therapist's main concern – which is the link with ethics. HG ethics is about acting to meet the legitimate and balanced needs of a person in a way consistent with the approach taught and published by the HGI.

The committee cannot offer the complainant an alternative therapeutic approach since its members were not in the session nor part of the course of therapy; it looks to the good judgement and conduct of the therapist based on the accounts provided by the complainant and the therapist.

Other matters considered are complaints made by HGI members against other members, and complaints from several sources – public professionals – against aspects of HG practice and policy. These are informed by developments in wider health care and public policy regarding patients, children and young people, duties of care.

## 2. Constitution

Committee members the committee are appointed by The HGI Board to whom they report and are accountable.

The Committee is drawn from members of the HGI though advice can be sought from any source on a particular issue.

## 3. Summary

The remit of the committee is:

- to consider complaints in line with the complaints procedure
- offer advice and disseminate learning from complaints or questions referred to it
- advise on aspects of the HGI's own working and organisation — its governance
- promote the development and dissemination of the HG Ethical Framework
- report to the HGI AGM.

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