The HGI Ethics and Complaints Committee considers some of the ethical challenges that human givens practitioners may face. ***Ian Thomson*** *sets the scene.*

Practising ethically

MANAGEMENT consultants constantly exhort commercial and public-sector organisations to welcome consumer complaints. "When a customer complains, you should be grateful," says customer service guru John Tschohl, adding that companies should bend over backwards to apologise for mistakes and go out of their way to correct them. According to Tschohl, "Research shows that only about four per cent of customers will tell you when they have a problem. The other 96 per cent simply won't do business with you again. Instead, they quietly fume and take their business – and their money – elsewhere. They will also tell an average of 10 other people about the problem they have had with your organisation."[1]

While welcoming complaints can be made to sound like a great idea, at least in theory, how likely is it that human givens practitioners – or any health professionals – will be overjoyed when a complaint from a disgruntled client lands on the doorstep? Not very, I suggest. Here is how some GPs reacted when they received a complaint, according to a study published in the *British Medical Journal*. Negative experiences of a complaint followed three stages: initial impact – shock, panic, a sense of being out of control and indignation towards patients generally; conflict – depression, anger, thoughts of suicide, doubts about clinical competence and conflicts with family members; and resolution – practising defensively in future, deciding to leave general practice, or not coming to any resolution at all.[2]

Not all participants, however, reported such a negative experience. Some said they had become immune to complaints, and a small minority described the complaint as a learning experience.

A couple of things are worth noting here. First, human givens therapists have a support structure available to them, in the form of their peer supervision groups, one-to-one supervision and, on an informal level, through colleagues with whom they can communicate via various forums or individually. Second, it is perhaps to be hoped that human givens therapists, given their knowledge, training and experience of dealing effectively with high emotional arousal both in others and in themselves (self-calming techniques, taking a wider perspective, etc), are arguably better equipped than many to limit the negative effects experienced on receipt of a complaint. The HGI Ethics and Complaints Committee will seek to avoid, wherever possible, any conflicts arising from the management of complaints. It may then be possible to move more quickly and efficiently to a satisfactory resolution, avoiding pitfalls described by the GPs, such as defensive practice or a decision to quit practice. Ideally, seeing complaints as learning experiences would *not* be a minority response and could lead to better practice as a result.

Complaints, of course, come in all shapes and sizes, justified, unjustified or partly justified. They can arise for a variety of reasons, especially unrealistic expectations on the part of clients and the misunderstandings and conflicts that can occur, for example, when a parent arranges therapy for their child. (Iain Caldwell and Sue Cheshire explore such situations elsewhere in this article.)

Nowadays we live in what might be called a complaints culture, where many consumers are keenly aware of their 'rights' and know how to complain. As far as services provided by the public sector are concerned, this has its roots in the early 1990s, when government required publicly funded bodies, notably the NHS, to produce charters which set out clear standards of service – "what you can expect" – together with clearly laid out complaints procedures for use by those whose expectations had not been met. The government-sponsored Charter Mark award that many public bodies are required to hold is an extension of this philosophy.

These initiatives in the public sector were an attempt to mirror practices already operating in the commercial sector, initially in the USA. But progress has had an unintended consequence. As a result of increased expectations and awareness of rights, practitioners in the NHS or in private practice are more likely than ever before to be on the receiving end of complaints. Arguably, the mooted forthcoming regulation of psychotherapy and counselling will result in an increase in complaints by disappointed patients rather than a decrease. And, as the human givens approach becomes more widely known, so the risk of complaints resulting from faulty expectations and unmet attention needs is also likely to increase. In this climate, it is more important than ever that therapists understand the expectations of their clients and contract clearly with them at the outset, so that the potential for complaints is limited as far as is possible.

During the past year, the HGI Ethics and Complaints Committee has received and dealt with five complaints – two from dissatisfied clients; one from a member of the public con-

cerned about the safety implications of a human givens therapist practising locally (ie risk to others from potentially mentally unstable people coming for sessions); one about the risk of clients being recognised from details contained in case studies and one from a member of the HGI itself. In the two cases involving complaints by clients, the committee found that the therapists concerned had acted properly. Case study guidelines have been produced in response to the complaint about potential breaches of confidentiality. The committee was unable to adjudicate on the safety matter, as this was not an ethical issue, and advised the complainant to approach his local authority about public nuisance, if he wished to pursue the matter. The complaint made by a member of the HGI was partially upheld and an apology duly given.[3]

Where a patient complains, despite having failed to follow the advice of their therapist, the committee will not uphold the complaint, unless it is determined from the available evidence that the advice was not appropriate and realistic. The possible responses that the HGI can make to complaints range from "no further action" (the outcome, it is to be hoped, in the great majority of cases) to deregistration (we hope, a very rare occurrence indeed).

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Some questions to ponder

Harold Mozley *and* ***Julian Penton*** *consider some scenarios with particular relevance for human givens practitioners.*

Harold Mozley *has been a social worker for over 30 years and is currently a service manager in family court welfare.*

Julian Penton *is a human givens therapist who now works full time at a mental health charity as a therapist and trainer.*

Ian Thomson *practises privately as a human givens therapist and works part time as a quality manager with a careers guidance company.*

All members of the HGI Ethics and Complaints Committee hold the Human Givens Diploma.

The person who doesn't want to stop coming for therapy

Someone keeps coming to therapy over a growing number of months and doesn't seem to be 'getting better'. Yet he or she insists that the sessions are helpful and that they don't want to stop them. What is the ethical thing to do in such circumstances?

Clearly, circumstances will alter cases, but, for us, the alarm bells would be ringing if significant improvements are not being seen and maintained within half a dozen sessions. This does not mean that there might not be more work to do – we know that not all therapy is speedy. For instance, social skills, if lacking, may take some time to put in place; likewise, the many strands that may need to be addressed in complicated cases of abuse. However, the human givens approach prides itself, justly, on having a positive impact within a short period of time. So it makes sense that we need to have enough faith in our armoury of skills to expect a speedy shift in those attending with, for instance, anxiety, depression or post-traumatic stress symptoms. There is no place within our approach for the buying of friendship on the part of the client – if connection is a need, one would expect it to be identified as one of the goals of therapy and the client to be directed outwards and, if necessary, empowered with the skills to get it met.

We may need to be aware, however, of what it is that is impeding progress. Are certain clients lacking in motivation? This is usually evident if they regularly fail between sessions to carry out tasks that they have agreed to do. (If this is the case, it can be helpful to revisit the agreed goals and suggest that, when clients have carried out the tasks designed to help them start achieving these, they arrange a further session. This can have the effect of galvanising clients into action or helping them realise that their heart isn't in it and choose to cease therapy.) Or is motivation lacking because it is a parent or a partner who is footing the therapy bill and who is the one with a greater investment in change? Is a parent keen to keep paying, for instance, because recalcitrant teenage son is no longer on drugs, since coming for therapy, although he still isn't doing much of anything else? Such concerns may best be explored in peer groups or in supervision. (See also Sue Cheshire's account on page 20 of a conflict of interest between a mother and 17-year-old son.)

We realise that it is important not to rush to conclusions, however. One of us (JP) worked with a woman who seemed to lack motivation as, after eight or nine sessions, she hadn't moved forward very much and was still very anxious and sought excessive control in all social/interpersonal situations, yet insisted on making further appointments. Julian asked her to make an extra effort to learn the relaxation skills he had shown her, which she had consistently failed to do. She had subsequently contacted him to say that it made her "remember things she'd rather forget about". This pattern strongly reminded Julian of another client (all of whose needs appeared to be met) who showed no improvement yet continued to attend – who finally revealed a history of childhood sexual abuse and adolescent rape, which she had never previously shared with anybody, including her husband. This provided missing information and allowed progress.

So if people seem 'stuck', it may be helpful to ask them directly if anything is stopping them moving forward, or say, "Sometimes this happens to people with symptoms similar to yours because of something that happened in the past, which is still getting in the way. If that is the case for you, very often there is something we can do to stop that happening [rewind technique[4]], and I don't need to know any of the

details." If, however, nothing helps a person make the shift and goals are not reliably being worked towards, it might be most ethical to refer the client to another practitioner.

A couple breaks up during therapy

The committee received a complaint about a therapist from a client who resented the fact that, after breakdown of the relationship, the therapist continued to see the client's former partner only. Therapists who work with couples need to be clear about what they will do if one or both individuals wish to continue with the therapy after the break-up. It is highly unlikely to be a good idea to work with both, separately. (The need to avoid conflict of interest in couple therapy is written into the *Human Givens Ethical Framework* in the section on good practice.) It may or may not present difficulties for the couple, particularly if they become embroiled in a protracted legal case, if we continue to work with one. As always, circumstances alter cases – it is sometimes quite clear from the outset that one partner does not want to be present and is reluctantly going through the motions of trying to get a relationship they already see as failed back on track. (This will quickly become apparent, if not immediately obvious, if agreed goals are not worked towards by both parties.) In such a case, it might be a natural, and uncontested, development to continue to work with the remaining partner alone – clearly, with revised goals.

We would advise that therapists make clear before the therapy starts, either verbally or in a promotional leaflet, that their goal is to help clients work out the problems in their relationship in the way that is best for them both; that, in the event that the clients choose to separate or discontinue couple therapy, the therapist is willing/may be willing/is not willing, if requested, to consider offering therapy to one but not both; that couples may need to agree between themselves who will continue therapy with the

Whose needs must?

HUMAN givens therapist Karen agreed to see Matt, a 17-year-old student who had done badly in his AS Levels. He was gloomy, uncommunicative and spent a lot of time in his room, and his mother feared that he might have depression.

At the first session Karen soon learned that he was disappointed by his exam results, as his parents had been so keen that he become a vet. However, it quickly emerged that what most excited Matt was dinghy sailing, which he had taken up as a hobby through the college where he was studying. He was now in the regional team and there was talk of trials for international races. When Karen asked him what he would do for a career if he could wave a magic wand, he said at once, "Be a full-time racing sailor. But that's never going to happen, is it?" he added, sadly.

After a massive row during his exams, Matt had decided that he would do his best to please his parents by applying himself to his studies. But every time there was a choice between staying behind at the sailing club to repair boats and talk racing, or heading back home to revise his biology and chemistry, his whole being just seemed to make the decision for him, and so his studies continued to suffer.

Karen advised Matt to find out about sports-related degrees, and to look realistically into the possibilities of a career in sailing or something related to sport, before making any other decisions. She also helped him with strategies for speaking assertively to his parents without provoking them and for dealing with any angry responses he might encounter while keeping cool himself. Matt said that he felt much better at the end of the session, and Karen arranged to see him the following week.

It was a shock to Karen when she received an angry phone call from Matt's mother the next day. "What gives you the right to tell my son to change his career plans? You're not a careers adviser. You should stick to your own field. You have no idea of the sacrifices we've made to give Matt the best start in life, and now you come along and tell him he can just do whatever he wants! There's no way he's coming back to see you again. In fact, I've a good mind to ask for my money back!"

Happily, Karen managed to help Matt's mum to calm down and invited her in for a chat, focusing on the fact that they both wanted the best for Matt. It turned out that Matt's mother and her husband both came from families where professional careers were highly valued, and they themselves had felt constrained to pursue what was socially acceptable, rather than what they would most have wished to do. Karen helped her to see that, for Matt, there might be other, equally rewarding possibilities, and, although she still felt anxious, Matt's mother agreed to help him at least explore them.

How can human givens therapists avoid difficulties like those Karen encountered? If anyone other than the client is paying for therapy, it is probably best to hold an initial discussion with them to clarify their expectations. It can then be explained that the therapist's priority must be to identify the client's unmet needs and match them with their available resources – among which, of course, might be the support of the parent (or whoever is paying). This should help to prevent any conflicts arising and, of course, if they do not like this approach, they are free to go elsewhere.

Sue Cheshire

initial therapist – or whatever provisos you may wish to write into the contract. This should avoid escalating emotional arousal at an already tense and difficult time for the clients. However, we recommend keeping the wording as unrestrictive as possible, so as to leave room for personal judgement.

Someone who has read our material goes to a therapist saying that they want the rewind technique and nothing else

This scenario also reflects a real-life complaint: a client had visited a therapist specifically for the rewind technique and objected to the fact that the therapist wanted to do more. The downside of having available clear, simple, readable self-help books that illustrate our approach (for dealing with depression, addiction, anxiety and anger), as well as the definitive *Human Givens: a new approach to emotional health and clear thinking*, is that clients may arrive at our consulting rooms, having diagnosed 'exactly' what they think they need.

While clearly it is important to take this into account, we are, as therapists, obliged to adhere to our own codes of conduct, in line with our training in the human givens approach. This inevitably requires that we first build rapport and find out sufficient about our clients' lives to ascertain what needs are inadequately met, what, if any, symptoms are getting in the way of change, and what resources can be built on – while assuring clients that any details they do not feel comfortable about revealing do not have to be revealed. Whatever is uncovered, the task of agreed goal setting should ensure that the therapist focuses on the client's agenda, rather than their own. However, as we know, an understanding of clients' resources is important for effective therapy, whatever the goal. For instance, after carrying out the rewind treatment, having the client rehearse, while still deeply relaxed, how they will move forward with their life is at the core of the human givens approach.

It would be unreasonable, in our view, for any clients to feel that they can insist on therapy being delivered in the way they specify – nor would we be confident that it could be effective. It would be very hard, for instance, for a person to relax to the depth required for the rewind technique without their first having established trust in the practitioner. Counsellors have the right to say that they will not offer treatment other than in a way they are trained to provide it and consider effective; so, such a complaint would not be upheld.

Clients are disappointed if human givens therapists cannot cure all their ills extremely swiftly and surely

Case studies of speedy success, whether published in newspapers and magazines or in our own books, may give the impression to the needy and the desperate that *all* can be healed, quickly and reliably. Even Lourdes does not claim a healing for every pilgrim. Yet, very many therapists may have faced clients who, having read our literature, have an expectation that, this time, 'it' is going to 'work', just like a magic bullet. We have to tread the fine line between maintaining people's hope and expectation of positive change and not confirming them in unrealistic timeframes or expectations.

It is common, after first becoming fully fledged human givens therapists, to feel extremely confident of bringing about change within very short periods, and the risk is that we may have unrealistic expectations ourselves. We all need to be careful, perhaps, about what we may say, in a two-minute conversation in a social setting, about our work from the human givens approach, as this is often how the wrong ideas may be spread. Also, we are to some degree victims of the journalistic soundbite – so an article on human givens is commissioned and published in a national newspaper because of the attention-grabbing angle: how to cure depression in one session. Such an outcome is sometimes possible, we know, but we do ourselves and the approach itself a disservice if we foster that expectation. Misunderstandings are easily averted if we make it clear that people are *often* helped in a short time by our methods, so as not to imply instant success in every case. Conversely, because of our individualised approach, it is important not to accept payment in advance for a 'course of treatment', as no therapist will know how few sessions a client may need.

Is it realistic to expect that a therapist can overcome all prejudice or bias, when working with a client?

Although, in the human givens approach, we rightly emphasise working from the client's reality and helping them meet their *own* needs, thus making ethnic background, religious beliefs and sexual orientation irrelevant, we may still have some beliefs that are impossible to set aside. Someone who does not believe in abortion, for instance, may find it very hard to help a woman come to a decision about whether to have one or not. Because the human givens approach is concerned with human nature – how we *are*, rather than how we wish we could be – we would not expect that all firmly held beliefs can be put aside in order to help the client, and it may be best, where there is such conflict, to refer the client elsewhere. This would also be the case if a client's circumstances created a pattern match to one of our own that we know would affect our judgement and objectivity – although the emphasis in our approach on processes and patterns rather than on the minutiae of content may help to safeguard against this.

We believe we have a duty to become aware of our own prejudices, which may not be so overt

How not to create clients from hell

TERRY is a 34-year-old care assistant. He arrives with his partner for his first session with Paul, a human givens therapist – a session which the partner had rung to arrange. Paul reassures the partner that he is an experienced therapist and well able to deal with Terry's problems. The partner leaves. Terry then describes how he has suffered "clinical depression, with co-morbid anxiety" for over 10 years and that his "symptomatology began with an antecedent of meta-worrying". For eight of those years, he has seen a number of therapists, including a hypno-therapist, cognitive-behavioural therapist, and counsellors working from a variety of models of therapy. Nobody has been able to help him. Paul provides Terry with several therapy sessions but the depression and the anxiety do not recede. Terry begins to experience panic attacks. He keeps phoning the therapist in between appointments, turns up early for sessions and never leaves on time. When he sees the therapist with another client, he gets aggressive and storms out of the building.

Terry complains to his partner about his therapist's "lack of professionalism" and lack of effectiveness. In due course, Paul receives a written complaint from the partner. How could such a situation have been avoided? As a supervisor and manager of a therapy service dealing with thousands of clients each year, I have come across numerous cases of this kind and have recognised that they arise because of important unasked questions.

What did Terry expect from therapy (goals and expectations)? Paul assumed Terry's goal was to be helped with depression and anxiety. Did Terry actually have goals of his own or was he there only because of his partner's insistence – it was his partner who had arranged the therapy and who formally complained? Why did the partner attend – to support? Motivate? Or help to manage risk? (It later emerged that Terry had a history of violence against mental health professionals.)

What was Terry's expectation of being a client? He said that he had had numerous therapists, working from numerous models, and clearly knows some therapy jargon and what he thinks constitutes professional behaviour. He also had long experience of failing to be helped by mental health professionals. Was he simply expecting failure again?

Paul needed to know at the outset not only which previous services Terry had attended, but also the duration, frequency and outcomes of his involvement with each. This should be part of a comprehensive assessment. For instance, it eventually became known that Terry had spent his childhood unhappily in care and had an enduring problem with alcohol. It might also have been helpful if Paul had asked, "Is there anything else you think it might be helpful for me to know about you?"

As human givens therapists, we may feel tempted to prove that we can succeed where other therapists, working in different ways, have failed. If this is the lens we are looking through, what are we missing and do we stop asking the relevant questions? Carried away with an expectation of success, we may see only a short list of symptoms and believe we know enough to help the client. Quite often, I find, when a member of staff asks for help with a 'challenging' client, it is because they do not have sufficient information about who exactly is in front of them.

According to American psychotherapist Scott Miller therapists themselves may create 'impossible clients'[1] by:

- "labelling the client" – and then viewing all the client's behaviours accordingly
- "missing the client's needs" – by making assumptions as to what they are
- "doing more of the same" – if an intervention does not work, just repeating more of it.
- "theory counter transference" – explaining away clients' lack of change, instead of reflecting on what has gone wrong and why.

Iain Caldwell

1. *Duncan, B L, Hubble, M A and Miller, S D (1997).* Psychotherapy with 'Impossible' Cases. *W W Norton & Co, New York.*

as those relating to race or gender. Prejudice is about seeing the role rather than the person. For doctors, it may be the heartsink patient; for teachers the pushy parent; for therapists, it can be the experience of a 'certain kind' of client, who does not respond well to suggestions, carry out tasks, etc. We also have to be sure not to assume that certain behaviours or beliefs are negative or unhelpful for the client, just because they would be for us. (One client in a filmed therapy demonstration once described a method he used for trying to relax himself at night, which involved imagining his head disappearing into the pillow. Although this sounded rather disconcerting, the therapist did not assume so, but asked the client whether he found this helpful. "Very," replied the client.)

There is also the need to distinguish between true belief in others that needs respecting and the use of a belief system to justify behaviour – such as so-called 'honour' crimes or bullying.

Again, goal setting may be highly instrumental in helping us take the ethical course of action. Goals, to be agreed, must be acceptable within the society in which we live and, while leading to enhancement of the client's life, not lead to the harm of any other people's. For instance, if a con man wants to learn the skills to

be a better con man, that will not be an acceptable goal. But if a former paedophile, who has done his time in prison and claims no longer to be sexually active with young people, wishes to deal with his anxiety about being 'outed' or with his remorse about his past behaviour – it could be argued, ethically, that that is an acceptable goal, as long as the therapist feels confidence and trust in the client's words.

The term 'human givens' refers to the universals of human nature – the needs we all have – and these remain the same, even if expressed in different ways. It is our duty as ethical therapists to transcend the cultural and other differences between ourselves and our clients, so that the identification of unmet needs, and how they can most healthily be met, can keep us steering straight.

If we cannot work with an individual for whatever reason, we need to reflect on why – and this requires developing our 'observing selves' – but we may also need to be aware of the energy that is taken up by 'handling distaste' and how this may affect our motivation and spare capacity to do good therapy. Our first duty to the client is not to take their money if we cannot step outside our personal concerns sufficiently to put their needs first.

A client has expressed suicidal intent. What is the extent of therapist's responsibility?

This can be a particularly testing experience for human givens therapists, because we work to build hope. Can a therapist be sure that an individual who was suicidal on arrival but has left the consulting room full of new direction and determination will not revert to depressive thinking once out of sight and, with it, to suicidal hopelessness?

We ourselves would first ascertain degree of risk through the CORE forms which therapists are encouraged to use at the start of sessions.[5] Clients have to make responses, ranging from 'not at all' to 'all the time', to a variety of statements about their mood, and several of these concern risk of harm to self or others. But we would also probe this directly, if the subject has been raised. It is important not to lose rapport, we feel, by reacting instinctively and deciding that 'someone' must be told, whether that is a family member or GP. Scary though it may seem, maybe it is not appropriate to do so. A human givens practitioner raised this very concern on the HGI practitioners' forum, when a client with depression admitted to feeling suicidal but insisted she really would kill herself if anyone attempted to send her back into a psychiatric hospital, as had recently happened when someone, in alarm, contacted her GP.

A human givens therapist will, during the session, provide the client with plenty of reasons to live and to realise that the bad feelings will pass, by focusing on how to get unsatisfied needs met, reframing and building on the client's resources during guided imagery. One (atheist) therapist we know made much use, in guided imagery, of the fact that the client had a very strong faith and stressed that God had given him his many talents expecting them to be used positively for himself and others. Some clients may be willing to enter an agreement to contact the therapist first, if they decide to take their own lives. The fact that a person has come for help is, in itself, a good sign. However, if the person has been persuaded to attend by someone else, apparent calmness may be misleading. Sometimes people who have decided to kill themselves feel calmer because they can see an end to their inner turmoil, and thus their emotional arousal levels drop.

So, perhaps context is all. If a client declares they are suicidal but quite a few of their most important needs are being met, a shift out of depressive trance may be sufficient to ensure their safety. If their state of mind seems shaky, a number of actions might be helpful: first, to call or arrange to see them again the next day, and for a few days thereafter – making the time free to do so; to invite them to call, if they need to talk, and maybe to provide the numbers of other therapists willing to respond in the case of unavailability; and perhaps to offer to speak to the client's GP on their behalf, to explain how traumatising the client had found enforced hospital treatment, if this was the case.

Ethically, if we truly feel that we have done all that we could or should do, based on our judgement of the circumstances, this must be sufficient. (We have to take care of ourselves as therapists, too.) While we feel that maintaining patient confidentiality is absolutely *not* the priority here, passing the buck to someone in 'authority' is not the safe or most sensible solution either, if that might result in a very unhelpful response. So, while we may briefly feel swamped by our own need to act competently and raise the alarm, it may be far better to concentrate on the client's needs and work very hard to create realistic hopes of a better tomorrow – and then to discuss the situation with a respected colleague or two, or in peer-group or one-to-one supervision.

The yardstick of goal setting

The best ethics policy, we believe, is not one that has lots of rules for 'what-if' situations but one that engenders a way of thinking from which ethical behaviour naturally or intuitively flows – it just *is* the right thing to do. It is important to recognise the limitations of any policy in terms of encapsulating in words the multi-faceted situations that a therapist might encounter. As the HGI's ethics policy makes clear, and as we have reiterated in this article, circumstances alter cases. So, ensuring that clients' needs are met in balance and that goals set are not only achievable but also positively meaningful to achieve might be the simplest and most effective overall rule of thumb to work by. ■

REFERENCES

1 *Tschohl, J (2008). Quoted in "How to learn from complaints". www.newbusiness.co.uk (29 February).*

2 *Jain, A and Ogden, J (1999). General practitioners' experience of patients' complaints: qualitative study.* British Medical Journal, *318, 1566–9.*

3 *The ethics and professional conduct policy adopted by the Human Givens Institute can be accessed at www.hgi.org.uk/ethicspolicy.htm (information about the complaints committee and how to make complaints can be found at the same address).*

4 *See http://www.hgi.org.uk/archive/rewind-technique.htm*

5 *For an explanation of CORE, see Andrews, W (2007). Doing what counts.* Human Givens, *14, 1, 32–7.*