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Ethical Dialogue

Edited by Andy Rogers

The dilemma

A new client tells you that she writes an online blog about her 'anxiety disorder' and her efforts to 'get well and be happy', including using therapy. She says she has 'had lots of counselling before', but hasn't found it very helpful. Are there dilemmas here?

The dialogue

S&S: *What are your first responses to this dilemma?*

Jay Watts: I think the dilemmas for me would be: whether to trouble her ideas of diagnosis or not; whether to be open about whether we can know if her goal of getting 'well' and 'happy' is feasible; whether to take her on at all if her blog might destabilize present, past or future clients; and whether – if previous therapy hasn't helped – we really can offer something alternative. If a client has had multiple unsuccessful therapies, I would wonder whether counselling is the best approach to go with, or if something else might be more effective. Lastly, I would be thinking how much to ask about the blog, and when.

My initial thoughts on these dilemmas? I wouldn't take anyone on without knowing about their history with previous therapies. I would first want to know what stopped previous therapies being useful, to consider if I could offer a space she could use in a different way. I would wonder about whether and how the blog might maintain things not changing – so if she 'got well' after all, would this way of gaining whatever the blog gives her fade? As part of this, I would be wondering what function the blog served – is it a way of protecting her from the intensity of a dyadic relationship, a way to attack, a form of surveillance on the surveilling other, a tease, a desperate attempt to get someone to think of her outside sessions?

I think it's very important to give clients room to love, hate, envy or attack us as part of the 'working through' process, and many nowadays will act out these feelings

first in cyberspace. We need to draw these dynamics into the therapy room, but not too quickly, and not too insistently, or it's a bit threatening. If we act like cyber-activity is a threat to our privileged therapy space, it's a bit paranoiac, I feel, a bit mad. My main anxiety on her blogging would be that she would use my name in the blog, and another patient in a fragile state might find that difficult to bear. I wouldn't be too worried about this, though, as most patients who blog seem to refer to their therapist using either initials or a nickname – in tacit recognition that the blog is about them rather than the therapy after all!

If there are big risk issues, I would usually let the patient know that I would never read any of her blog pages unless she wanted me to and printed them out and brought them to sessions, otherwise I could miss a direct communication that I might need to know. Whether to communicate the fact that I wouldn't look at the blog gets more blurry for me where risk is less of an issue. If there is an eroticized transference from the off, such a boundary might be important. Otherwise, not knowing whether someone is looking (or not) can be quite powerful for the work.

Is there some enticement, perhaps, in her mentioning the blog, some potential challenge to be special and outside the grouping of previous therapists, some desire for a safe place outside? I don't know, but these kinds of ideas might be around for me too. If she's really in bits, delusional, fragmented, what have you, I might actively encourage the blogging, even early on, as a way to give her an artificial third point; it might help her access me, it might be the only social contact outside sessions that she can bear.

S&S: *It's fascinating how cyber-activity might be seen as a 'threat to our privileged therapy space', as you say, because of course it has always been the case that any of our clients could 'go public' with their thoughts and feelings about us. That's their right, isn't it? But it's something about the effect of the internet – its 'democratization of publishing' and our culture's changing understanding of what is public and private – which kind of electrifies that potential, makes it more potent and perhaps more fearful?*

JW: Absolutely; but going public was a very different experience before Google! There has been so much debate about whether therapy works using technologies such as Skype, but far less on questions such as how the power dynamics between client and therapist have changed in recent years, not just through postmodern discourse but also by the increased visibility of data online. For example, if I have a new client and go into the waiting room, I won't know who they are, but they will often now recognize me before I utter any words (as most will have Googled me). This is relatively new – perhaps one of the many reasons for the rise of relational approaches, at least in psychoanalysis. The internet is forcing a fundamental change in the power relations between client and shrink in a way that decades of epistemological critique did not! A good thing, no?!

However, I think a shrink's reaction to our hypothetical client's blog will often be mediated by their experiences of being looked at and scrutinized and influenced by the rise in 'surveillance medicine' and monitoring in general, as well as things like how they construe practice. For example, I would not expect a client to find therapy easy and beneficial session by session, while someone practising Cognitive Behaviour Therapy (CBT) in Improving Access to Psychological Therapies (IAPT) would. If one is supposed to perform a certain way, it brings an anxiety.

I think that as psychotherapy is in a vulnerable place – knocked by the dominance of CBT and evidence-based discourse, and the humungous stress on organizations such as the National Health Service as just two examples – we can cling ever more desperately to the psychotherapeutic frame as a thing that defines us, a thing that makes us feel safe. This is perhaps what I was ever so slightly teasing in my use of the words 'privileged therapy space'. Yet if we get too obsessive about the borders of the psychotherapeutic frame, we are losing the opportunity for some fantastic, creative work at the borders of inner and outer, which cyber-activity about therapy can represent.

Perhaps that's why so many of us think of the digital realm as having, potentially, the qualities of a Winnicottian 'transitional space', as well as a space ripe for actings-out. I think we have to have a confidence that what we are doing can be powerful enough to draw in dynamics that are being acted out in cyberspace into the therapeutic space, and enjoy our clients' play around the borders of inner and outer, reality and dream worlds. But perhaps because a lot of my work is with people who hear voices and lose contact with reality, there are some situations where I am more explicit. So, for example, some psychotic clients can feel that I know what they write on a blog instantaneously – that it is a direct communication into my brain – as the area between fantasy and reality can be especially blurry. In such a case, I might say, 'If it's serious self-harm or suicide stuff, you phone, full-stop'. When I write that, it sounds kind of an anxious communication or a bit draconian, but I don't think of it like that. I think the anxiety of a communication is far more to do with cadence than words, implicit interpersonal cues. It's intended as a light but firm 'at this point here, we make a line', and that can be important for those on the edge. This is perhaps because some of my clients can really struggle with the 'as if' quality of cyberspace.

Linked with all this, I think that our capacity to model being able to bear whatever the other makes of us and will do with us is very important. I find therapist websites full of positive, glowing testimonials a bit troublesome accordingly, as that's all in the service of producing a glowing image, when reality is always a bit murkier. It will be interesting to see how new generations of trainees – so-called 'digital natives' who have never known a pre-internet world – come to influence what practice looks like in the cyber era. At the moment, we still have a culture in psychotherapy organizations which I feel is over-hierarchical, and this can stop younger generations challenging psychotherapy norms.

S&S: *As you mentioned in your first thoughts, Jay, there is another way power operates through therapy, both among 'professionals' and within the encounter itself, and that is via the discourse of medicine and health-care. In my experience, clients arriving with diagnoses, just as ours does here, are increasingly common. But the therapy world seems rather reticent about challenging this approach to distress.*

JW: I think it's really interesting what we choose to do if clients use medicalized discourse, like mentioning a disorder. I have a bit of a bugbear about theorists who practise or work from modalities distinct from the medical model, but whose websites basically list out all the diagnoses: 'I treat social anxiety, depression' etc. If a client thinks I can offer one thing, and I don't, is it really ethical not to say

something? Yet if we fill sessions with our own critical thinking, what space is there for the client's discourse?

At the moment, what I tend to do is send messages to new clients to suggest such knowledges (e.g. that 'anxiety disorder' can be questioned), which they can pick up or not. That of course depends on what a diagnosis means to a client, and what function it seems to serve. For example, when our client mentions her 'anxiety disorder', I might be wondering – is it her attempt to fit in to what she imagines my views to be? Is it a label that allowed her distress to be legitimized for the first time? Does it carry with it specific ideas for her about treatment and the possibilities or not of cure? I would probably use body language to suggest there is a potential question there, and her response to that would be part of my assessment information.

The same thing goes for the idea of 'getting well' and 'being happy'. I wonder where these norms have come from for this client. Are they ones she sees as the legitimate aim of counselling, are they being used as a barbed criticism of the counselling relationships she has had before? Or, or, or … When clients make communications like this early on, I question whether *not* commenting is ethical, at least for practitioners who hold a critical framework like me.

How I might work with this would depend on what had happened with her previous counselling. If they were 'well-being' approaches and had not worked, I would potentially be quite explicit about different views on therapy, to give her a choice. More likely I would say something like, 'To get well and be happy?' – repeating her words with an inflection of surprise to see what she would do with the implicit questioning of this as a possibility. I do often say explicitly that counselling can be life-changing for others but sometimes makes people feel worse or does nothing, and I have no way of knowing which it would be for her. Fortunately/unfortunately, this kind of comment seems actually to increase the positive transference, especially if they have had previous therapies that didn't work. But at least it's honest! And I think it can free up both parties, perhaps, to have no damn idea what will happen, and to create something from and through that.

S&S: *The potential for creativity through freedom – this is crucial, isn't it? Perhaps a therapist offering just the sort of open and questioning approach you describe – a critically informed not-knowing, if I can put it like that – might help break the pattern of unhelpful counselling relationships for our client? It's impossible to know. But whatever might emerge through working with her in this way, I can't help wondering whether creative potential is as likely to flourish amid the professional defensiveness and supposed certainties of 'evidence-based psychological treatment' in the health-care model.*

JW: That's a really nice way of putting it, Andy. Absolutely – I think that a practitioner here would need to get forensically interested in why counselling had not worked before, and not just assume their model or their personal skills would make the difference! There is that great study, isn't there, that most therapists of whatever modality rank themselves in the top percentiles! We need to get a bit humble and not presume that we will break the repetition automatically; very often there will have been something not put into words – a feeling, a presumption, an idea of how the client has to be in the therapy space. We need to search for that nugget of gold that we can use to direct our treatment to be something other.

But I also think we have to be careful not to assume there is a counselling that will work at this point in the client's life. Sometimes, there will be too much to lose to get things to change – the 'sick role', for example. Naming some ambivalence and giving a choice back to the potential client can be quite freeing then – it can reorient a client who has attended multiple counsellings to the fact there is a question: do they really want to change? Is it worth it in the wider context of their life? That is a core of my practice, really, questioning everything – including 'doing wanting to get better' – but, I hope, in a compassionate way such as to communicate that we are all complicated, multi-layered nutters who are in it together; that I am not better or here to judge, but rather to provide a space for us to get curious together.

I have worked with a lot of brilliant trainees – people who inspire me, challenge my ideas of what practice is – whose spark, whose creativity, has got squashed in the years after they qualify by the belittlement and soul-crushing imposition of certain ideas of good practice in the 'quality assurance' era. So how can we keep creativity alive, how can we understand professional defensiveness in a way that is safe enough to allow something more complicated to emerge?

I think one thing that courses *have* to do is teach trainees how to deconstruct ideas around the evidence base for themselves, so that they can stand tall in their justification for a relational practice and begin to collect their own practice-based evidence. We have to do that as individuals because we don't have as much ownership of deconstructionism if we just read an article someone else has written – or at least I don't! But I also think we have to discuss the ethics of our practice more, and how we combine the surveillance obsession of our age with Winnicott's task of 'keeping alive, keeping well, keeping awake' as a therapist.

My personal formula, as it is at the moment, is to explore for myself if I could justify daring moments of practice to a group of experienced therapists from multiple models who are vaguely benevolent. If I can do that, fine. Of course, I know enough about the dynamics of organizations to realize that were there ever a complaint, I might be in a situation where I was used as a scapegoat to make some greater point. But our work is always about dealing with the potential for loss, isn't it, so we can't let such realities affect what we do. Linked to this, I think it's really important that we start to collect an alternative evidence base of creativity – that practitioners write about 'moments of connection' in their practice and share these in journals and cyberspace, so that we can show these tend to be the moments of greatest transition. I know many of *Self & Society*'s readers are involved in such work, and I hope that more will be soon.

Notes on contributors

Andy Rogers trained at the University of East Anglia in the late 1990s and has worked in and written about the therapy field ever since. He now coordinates a counselling service in a large college of further and higher education, and is an active participant in the Alliance for Counselling & Psychotherapy. Andy is also a father, contemporary music obsessive, occasional blogger and a keen home cook.

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The new dilemma

A client has mentioned on several occasions that her community psychiatric nurse will be contacting you to suggest that you incorporate mindfulness into your work with her. No one has contacted you. What dilemmas might this situation provoke?

If you would like to participate in the next ethical dialogue, which is conducted via email, please get in touch. Also, please send suggested dilemmas for future dialogues and other correspondence to: andy.rogers@sparsholt.ac.uk