

Mental health in the context of the counselling professions

Good Practice in Action 112
Clinical Reflections for Practice

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Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's *Ethical Framework for the Counselling Professions* in respect of mental health.

Purpose

The purpose of this resource is to stimulate ethical thinking in respect of mental health.

Using Clinical Reflections for Practice resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

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Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

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In this resource, the terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care. The terms 'therapist' or 'counsellor' are used to refer to those trained specifically as psychotherapists and counsellors.

Introduction

The World Health Organisation describes 'Mental health' as 'a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.'

Mental health is much more than not having a mental health condition. For more information see www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

The quality of mental health is important during childhood, through adolescence and into all stages of adulthood. See www.mentalhealth.gov/basics/what-is-mental-health. It is associated with a range of better outcomes for people of all ages and backgrounds, impacting upon physical health, life expectancy, educational achievement, risk behaviours, work productivity, antisocial behaviour/criminality and social interaction. However, when our mental health is compromised, 'mental illness' can occur. The types of mental health conditions we might see in our work depend on many factors. Whilst we could imagine the most prevalent conditions in society would be those most commonly seen in the therapy room, practitioners would be wise not to rule out the possibility of encountering any mental health condition in their work. Whether we are competent to work with any condition is an essential matter for consideration.

We can think of mental illness in general as characterised by some combination of abnormal thoughts, behaviour and relationships with others. Nevertheless, having a mental health condition is an experience unique to each person; one person's depression will differ from that of another person. Whilst having a mental health disorder or condition might feel 'all-consuming' for some people, it is important we remember that it is not the totality of that person's experience.

Mental health conditions can occur in isolation or alongside another mental or physical condition (co-morbidity) and when this happens, the clinical picture can seem more confusing.

Sometimes, a mental health condition accompanies, or follows, a physical illness or disease. For example, depression can arise in some people who experience chronic pain. Also, mental health conditions can be considered as disabilities if they have a substantial and long-term effect on normal day-to-day activity (as defined under the Equality Act 2010, see www.gov.uk/when-mental-health-condition-becomes-disability).

These may include permanent, fluctuating or recurring conditions. In such cases, service providers and practitioners are required to make 'reasonable adjustments' (Good Practice in Action 080 Fact Sheet: *Reasonable adjustment in the counselling professions*).

It is essential that we consider the place of culture when thinking about mental health. For example, Western models of therapy may be more oriented towards valuing individualism whereas collectivism is more valued by Eastern traditions. See Good Practice in Action 056 Research Overview: *Equality, diversity and inclusion in the counselling professions*. Aspects of a person's race, culture, gender and so on can heavily influence access to mental health services. Language and how words and terms are used (by both client and practitioner) will impact on how each understands (and talks about) mental health and how a client's distress/situation is interpreted.

Unless medically qualified, counsellors and psychotherapists are not qualified to diagnose a mental health condition. Whilst this is common to all modalities, how mental health conditions are seen by each varies and their classification is a hotly debated topic. It may be a useful experiment to consider how your core model sees 'mental health' and then to consider those of other modalities, to see if there is anything interesting or useful that you might take into your own practice.

One common tool for standardisation of mental health, used by many medical professionals is the *Diagnostic and Statistical Manual of Mental Disorders DSM-5-TR* (American Psychiatric Association 2022). See: www.psychiatry.org/psychiatrists/practice/dsm.

Another is ICD-11 *Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders* <https://icd.who.int/en>. The use of frameworks and diagnosis within the counselling professions is often controversial due to the conflict between medical and psychosocial models – the former viewing mental health conditions as biological in nature and the latter viewing the societal and relational aspects of people's lives as the major contributors to their mental health. In the last decade, however, there has been a helpful movement within mental health and medical health services towards biopsychosocial models that embrace both the physical and social aspects of mental and physical health.

Understanding classifications outlined within diagnostic guidelines should not replace psychosocial understanding, but their use can bring common understanding and language that help professional dialogue and so it is useful for counselling professionals to have knowledge of these frameworks.

For more on this debate, see *Therapy Today*, February 2019 and Johnstone et al. (2018). Furthermore, Emmy van Deurzen, Existential Therapist and Counselling Psychologist provides an additional perspective on the common classification systems at www.youtube.com/watch?v=8ZoTEwjETXo.

How we regard mental health and mental illness depends on many factors including our personal experiences, values, assumptions, prejudices, culture and age. Whilst much has been done to raise the profile of mental health awareness, we know that stigma, prejudice and discrimination still exist.

Encouragingly, a survey carried out in December 2016, with analysis by King's College London, revealed that since 2009 there has been: 15% increase in willingness to live with someone with a mental health problem; 11% increase in willingness to work with someone; 10% increase in willingness to live *nearby*, and 6% increase in willingness to continue a friendship with someone who had a mental health problem (www.time-to-change.org.uk).

Sometimes, their doctor is the first professional that a person talks to about their mental health and medication may or may not be prescribed as a consequence. We now know that the use of some of these medications has changed over time; in England, during 2018, 70.9 million prescriptions for antidepressants were given out (almost twice as many as 2008). (NHS Digital data quoted in *Therapy Today*, May 2019). Counselling professionals will have experience of clients who use such medications whilst other clients might be considering starting, reducing or stopping them (with or without consultation with their doctor). A number of clients may feel very strongly against taking medication altogether. It is important that we remember the limits of both our role and competence in the area of medication. (See the All-Party Parliamentary Group's guidance *A short guide to what every psychological therapist should know about working with psychiatric drugs* at: <https://prescribedrug.info/short-guidance>.)

The topic of mental health is the subject of legislation and members agree to keep 'up to date with the law' (Good Practice, point 14f). Barbara Mitchels informs us that 'Mental illness is not defined as a specific term in the Mental Health Act of 1983 because there has always been a general reliance on case law and medical and psychiatric practice for the definition of mental illness on a case-by-case basis' (Good Practice in Action 029 Legal Resource: *Mental health law within the counselling professions in England and Wales*). Some practitioners and members of the public find the term 'mental disorder' to be offensive.

However, it is important to be aware that this is a legal term defined under S.1 (2) of the Mental Health Act.

A 'mental disorder' means any 'disorder or disability of the mind.' See Good Practice in Action 048 Research Overview: *Mental health literature within the counselling professions*.

The Covid-19 pandemic impacted heavily not only on physical health but also mental health. The virus that caused the pandemic became a concern to the UK public early in 2020, bringing changes to how many people viewed their lives, relationships and ways of working. March 23 of that year saw the legal introduction of lockdown, an experience not known before in the living memory of most. Much of the population were not allowed out of their houses for purposes other than buying food, taking limited exercise and other essential reasons. Clients could no longer have sessions in the therapy rooms of their counsellors and psychotherapists, supervisees could not visit their supervisors, trainees could not attend college and many workplaces shut down.

BACP's Public Perceptions Survey (2022) found that one in four people thought their mental health was negatively impacted by the pandemic. Feeling isolated from family, friends and romantic partners, loomed large. Over half of respondents had anxiety or concern about friends or family members becoming infected with Covid-19. Large numbers of those surveyed said that the pandemic made them more conscious of not only their own mental health but also that of family and friends. Almost three out of four members of the public surveyed said they thought that people might be happier if they talked to a counsellor or psychotherapist.

www.bacp.co.uk/news/news-from-bacp/2021/10-may-three-quarters-of-people-say-their-mental-health-impacted-by-the-pandemic

But it was not only 'the public' whose mental wellbeing was impacted by the pandemic. Sometimes, we sit listening to a client's story and realise that what they are going through bears a marked similarity to our own lives. However, this does not happen with all clients day in day out (and indeed, month in month out) at least not until the pandemic took hold. BACP's Mindometer report (2021) surveyed almost 5,000 members, exploring the impact the pandemic had on practitioners themselves.

The survey found that almost half of members felt more stressed and overwhelmed since the pandemic began, with nearly one in five feeling more depressed or hopeless. As the UK began to emerge from the Covid-19 pandemic, a range of social, economic and global issues was having a compounding negative impact on the population's wellbeing, resulting in therapists reporting on demand for therapy increasing by over 10 per cent since the previous year (as detailed in the Mindometer report of 2022). The report also showed that three quarters of therapists considered that the public's mental health has declined compared to last year.

Due to the unprecedented nature of this worldwide crisis, the demand for therapy in the UK escalated. In response to this and wanting to honour commitments to existing and potential clients, many practitioners went online. Having found working online suited them (and their clients) some practitioners decided to remain online after lockdown was lifted. Some offered only online work whilst others adopted a hybrid approach.

Providing online services can itself impact a practitioner's mental wellbeing both in positive and negative ways. For example, if a practitioner working within an organisation can provide online therapy from home, this cuts down travelling thus freeing up time for activities that might otherwise have had to be squeezed in elsewhere. However, this must be balanced with a sense of isolation that some feel. Working at a computer or on the phone for extended period takes its physical toll, which in turn can easily impact mental wellbeing.

'Zoom fatigue', that is feeling anxious, socially isolated, or emotionally exhausted due to lack of social connection, was reported as having affected more than half of BACP members who responded to the Mindometer survey of 2021. This in addition to the various aches and pains that can arise from working online can all impact mental wellbeing. Initially, this may be in ways that might not seem obvious but as they accumulate, can start to restrict other activities and impact on the ability to sleep well.

'Online disinhibition' is a phenomenon which can arise during online therapy (and possibly supervision). This is where clients make rapid, uncensored disclosures of sensitive material about themselves or others although sometimes, it might be what Suler (2004) describes as 'harsh criticisms, anger, hatred, even threats'. Both manifestations can be very stressful for practitioners. However, practitioners are not immune to online disinhibition themselves and might become aware that they have 'let slip' something they'd rather not have done (and this might weigh heavy on their mind).

Working online can impact on workload (see GPiA 099 and 109) with working and non-working hours merging into one. The 24-hour society means that practitioners have to set realistic expectations with clients and stick to boundaries otherwise they can find themselves 'just checking' texts and emails at times when they have supposedly 'stopped work for the day' or even later in the evening, which could adversely affect ability to sleep well. More about boundaries can be found in Good Practice 110 and 111.

Working online competently places extra demands on practitioners, which if not managed well, can impact on both physical and mental wellbeing and has implications both for the 'wellbeing' element of fitness to practise (see GPiA 078 and 094) and practitioner self-care (see GPiA 088).

There are many differences between working in the same room as a client and providing online therapy. However, when working with psychological processes and in particular, those of people who have a mental health condition, this can take on extra significance. It can be harder to recognise and respond to existing mental health issues as well as those that become apparent as the therapy progresses.

The Online and phone therapy (OPT) competence framework can help counselling professionals identify knowledge, skills and abilities required to work online as well as identify gaps so that relevant CPD can be accessed.

NB: The ability to identify, assess, acknowledge and respond to existing and/or emerging risk is heavily impacted by the fact that the 'online client' is not sitting in the same room as the practitioner.

GPiA 125 reminds us 'Assessment processes in distance-based work require practitioners to make careful and more complex decisions about whether to engage with potential clients themselves or to refer on sometimes to more specialist or local services, and these will require considerable self-appraisal alongside client assessment'.

This resource can only touch the surface of the huge topic of mental health (particularly following the Covid pandemic). It does not aim to give specific advice about working with issues of mental health but has been written in the hope that members will think further about this complex, and often challenging, subject. We also recognise that many counselling professionals (or those close to them) have experienced (or live with) a mental health condition.

Questions for reflection and discussion are provided to stimulate personal reflection, ethical thinking and discussion with supervisor or colleagues. You may notice other ethical and practice issues that stand out and these might usefully form the basis of supplementary reflection or discussion. For those wishing to deepen their understanding, Further reading has a list of suggested publications.

1 Overview of vignettes

The four fictional vignettes describe therapeutic practice in which a client presents either with a mental health condition or one emerges during the course of the work. Contexts may vary from your own, but it is hoped that underlying issues, challenges, complexities and dilemmas form enough basis for reflection and discussion so as to be supportive to your practice.

As you read the vignettes and Observations on practice that follow, consider how well each counselling professional meets their ethical responsibilities, as described in the *Ethical Framework*.

Although Good Practice points are dotted throughout, you are invited to think how others might also apply. A suite of additional Good Practice in Action resources is available at www.bacp.co.uk/gpia.

Vignette one:

Lilia has been diagnosed with Bipolar Disorder. Padma, her psychotherapist must make an important decision regarding her care.

Vignette two:

Lydia, a newly qualified counsellor is surprised at the drastic change in the behaviour of her client, Derek.

Vignette three:

Xue's curiosity proves very demanding for Michael, his counsellor. Then the work goes online with unexpected consequences.

Vignette four:

Freddie is anxious about his health and Tom, his psychotherapist, finds the work and therapeutic relationship very challenging.

2 Vignettes

Vignette one

Lilia has been diagnosed by her psychiatrist with bipolar disorder. Her psychiatrist has recommended that in addition to the lithium medication prescribed, she has psychotherapy. Preferring to organise this herself, Lilia has arranged some sessions with Padma, a private practice psychotherapist.

Using Padma's standard 10-session contract, they agreed how they would work together. So far, they have had eight sessions and Lilia's mood seems to have stabilised. Last week she described her mood as 'more levelled out for now.'

Today, Lilia arrives, uncharacteristically 20 minutes early for her session. She rushes past Padma carrying what looks like a very expensive handbag. Padma wonders whether it is the genuine article or perhaps a fake from the local market as she knows that Lilia's employment is sporadic. Noticing Padma looking at her bag, Lilia says "I bought it on the spur of the moment ... if you must know!", her uncharacteristic bluntness surprising Padma.

Soon, Padma's curiosity is replaced with a sense of concern. Lilia is talking incessantly and seems unable to stick to one topic. Padma tries to break into the conversation Lilia is having with herself but can't. Lilia's voice has increased both in pitch and volume and what she says isn't making any sense to Padma. "I don't like radishes. It's the brown dog that went to work the other day. If I lose weight ... I might buy a house" shouts Lilia frantically.

Padma recognises this type of speech as a 'flight of ideas' (a pattern of speech sometimes heard during a manic episode) but also notices the 'word salad' (seemingly random mix of words or phrases). She wonders whether Lilia has been taking her medication and if her lithium level has been monitored recently.

Padma feels really concerned and considers Lilia's GP should be made aware of her state of mind.

She suggests Lilia call her surgery from the therapy room and ask to speak to a doctor. Lilia doesn't seem to pay attention to this suggestion so Padma asks whether she can have Lilia's permission to contact her GP. "Yes, GP call ... quack ... little duck ... muck ... puck ... luck!" replies Lilia in a loud sing-song voice as she spins round the room.

Padma isn't sure how much Lilia has understood or whether she has given permission for her GP to be contacted on her behalf. Feeling in the midst of a crisis, Padma realises she must do something quickly.

Observations on practice

Bipolar disorder, formerly called manic depression, is a mental health condition causing extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). During a 'high', a person may feel euphoric, be full of energy but perhaps more irritable. During a 'low' they can feel sad, hopeless and lose interest and pleasure in things.

We can think about the first session; Padma works with a 'standard' contract and applies this to her work with all clients. Is a 10-session model appropriate for Lilia? Should she perhaps have been referred to a more specialised practitioner offering longer-term contracts? (Good Practice, points 13, 14, 30, 31).

Thinking more about the contract, we do not know whether Padma and Lilia have agreed times when Padma might breach confidentiality in order to protect her (Commitment 3b, Good Practice, points 9, 10, 13, 26, 44, 55). See Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions*.

Padma asks Lilia if she can call the GP on her behalf but now wonders whether Lilia possesses mental capacity (Good Practice, point 28) and thus is capable of giving informed consent (Good Practice, point 26). Lilia might have responded by saying "Yes, GP call ..." but quickly followed this with 'clanging' (word-rhyming). Did Lilia have transient mental capacity?

Did Padma consider whether Lilia had mental capacity when they agreed their contract (and would that initially gained consent be valid now)? See Good Practice, point 26.

Regarding mental capacity – Barbara Mitchels tells us that:

'The Mental Capacity Act 2005 (MCA) empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including whether decision is about care and/or treatment' (Mental Health Act 1983 Code of Practice, Department of Health 5:97).

Does Lilia understand what Padma seeks consent for? Even if Padma were able to explain the potential benefits, risks and consequences of taking action, would Lilia comprehend? In her current mental state, can Lilia retain the information and explanation long enough to make a decision? Given how Lilia was speaking at the end of the session, would she be able to communicate her decision in a way that Padma could understand?

When considering mental capacity, five statutory principles apply:

1. Lilia must be assumed to have capacity unless it is established that she lacks it.
2. Lilia must not be treated as unable to make a decision unless all practicable steps to help her do so have been taken without success.
3. If in Padma's opinion, Lilia makes an unwise decision, this must not be taken to mean that she is unable to make that decision.
4. If Padma decides that Lilia lacks capacity, any decision she makes must be in Lilia's best interests (and not her own).
5. Before Padma makes a decision or takes action, regard must be had as to whether the purpose of the decision or the act can be as effectively achieved in a way that is less restrictive of Lilia's rights and freedom of action.

Capacity to give valid consent may depend upon several factors. See Good Practice in Action 029 Legal Resource: *Mental health law within the counselling professions in England and Wales*.

The United Kingdom General Data Protection Regulation (UKGDPR) comes into play here. In relation to processing personal information, data protection legislation sets a high standard for informed consent, see the *Ethical Framework* (Good Practice, points 13,14f., 15, 26, 46) and BACP (2018) Good Practice in Action 105 Legal Resource: The United

Kingdom General Data Protection Regulation (UKGDPR) *legal principles and practice notes for the counselling professions* and <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/consent>.

Padma doubts whether Lilia can give informed consent and she may feel in the midst of a dilemma (Good Practice, points 92, 94). Regarding her practice in general, there are a few other points to note. It may have helped Padma to have thought through what she might do in various emergency situations that could involve any client. It might also have been useful if Padma had picked up on Lilia's comment that her mood was 'more levelled out for now.' Lilia arrived early; the time a client arrives (be it late, early, 'just in the nick of time' or 'always on time') can yield interesting information for the work. Whilst for most clients this does not relate to their mental health, Lilia's early arrival may have been relevant as she has moved into a manic phase of her bipolar condition.

Increased risk is clearly an issue here (as it is when there is knowledge or suspicion of any mental health condition). Early in the final session described, Lilia's impulsivity was becoming clear (note her uncharacteristic bluntness and potentially expensive impulse buy).

There appears to have been no liaison between Padma and either Lilia's GP or psychiatrist.

She seems very much on her own here and it is important for her to consider not only her self-care but having professional back-up. See GPiA 088 Fact Sheet: *Self-care for the counselling professions*.

Access to consultation with health, pharmaceutical and mental health professionals would have been useful both in terms of consultation and referral (Good Practice, points 13, 16).

Finally, how much is Padma's supervisor aware of her work with Lilia? (Good Practice, points 53, 60, 73). Support here would have been invaluable.

Questions for reflection and discussion

1. Thinking about Lilia's mental state, if you were Padma, what would you do next? Could you justify any a) action or b) inaction, to Lilia (once she regained mental capacity)? Could you do the same with your colleagues within the counselling professions (and possibly in court)?
2. How much involvement do you think a practitioner should have in monitoring whether clients are taking their medication and having associated tests (such as measurement of lithium levels)?
3. How much do you consider a client's mental capacity when carrying out activities such as making any assessment, explaining the service to them and agreeing a contract?

4. Clients in some contexts have transient mental capacity. How might this affect the therapeutic relationship and work?
5. Padma worked with Lilia in the same room. What might she have had to consider if the work had moved online (such as during the Covid lockdown)?

Vignette two

Lydia, a recently qualified counsellor, has three clients who she sees at her home.

One of these is Derek, 45, who sought help for depression and what he describes as feeling 'out of it sometimes'. He says he is 'lost' but seems to habitually lose his possessions too. He keeps losing his mobile phone and keys and even claims that a year ago, for a few minutes, he forgot where he lived.

Derek is 'keen to get started with the counselling' so in response to this, Lydia quickly describes her contract, they agree terms and the counselling begins.

Lydia considers Derek's dress style 'interesting'. Sometimes he comes wearing a suit, tie and looking very well groomed. Other times his clothes appear tattered, his hair uncombed and greasy, and he looks like he's not washed in days. Although Lydia does not know what job Derek does, she thinks by the quality of his suit, he might be some sort of senior executive. 'He's an enigma' she thinks and wonders whether the days when he comes less well dressed, are when he just wants to chill out. Lydia was going to raise his dress-sense at supervision but was worried her supervisor might say she was bringing trivial things to discuss.

So far, Derek has attended eight sessions, forgotten two and been late for two. When asked about forgetting he replied "I just lost track of time – alright!

"I was probably doing something else ... We didn't feel like coming, that's all". Usually very polite, on this occasion, Derek seems not to be. However, Lydia is pleased that he has been honest about his ambivalence.

When thinking about Derek, Lydia sometimes likens him to her teenage son; 'Joe's always losing things, forgetting things and he can be a bit rude too! Maybe, Derek's stuck in his teenage years' Lydia thinks.

Derek pays for some of his sessions by cheque and others in cash. Recently, as he handed over cash, Lydia asked whether he had forgotten his chequebook but felt confused when he said he'd finished it quite a while ago and never got a new one.

Today, Lydia opens a letter from her bank. Some of Derek's cheques have been returned to her. There is a concern that the handwriting and signatures between them is inconsistent, and some cheques not dated. At first, Lydia feels irritated with the bank but looking more closely, she appreciates the concern. She'll raise the matter with Derek at this afternoon's session.

Later that day, whilst waiting for Derek to arrive, Lydia hears two small children chattering on her doorstep. She feels annoyed because she doesn't want them there when a client is due. The doorbell rings and she is relieved to see the children have gone and Derek has arrived. Showing him into her counselling room, she goes into another room to fetch the cheques.

Approaching her counselling room door, she feels frustrated to hear the noise of the children. Now they seem to be playing right underneath the open window of her counselling room! Walking across the room to shut the window, she almost falls over Derek sitting on the floor.

"Let's play with this doll ... I found her over there" says Derek in a high-pitched voice. "I'm plaiting her hair, so it looks like mine."

Lydia is speechless as Derek asks "What's your name? ... mine's Katya."

In disbelief, Lydia stares down at her 45-year-old client who sits cross-legged on the floor carefully plaiting a doll's hair.

Observations on practice

Derek seems to be showing signs of dissociation. Dissociative disorders can sometimes arise from trauma and help keep difficult memories out of awareness. As a newly qualified counsellor, we can only imagine how shocked Lydia might feel to meet 'Katya'.

She is building her experience, but we can query whether she is yet competent to work with clients who have severe and complex mental health conditions (Commitment 2a and b, Good Practice, points 13, 14).

The awarding body, CPCAB uses 'service levels' to indicate levels of training which, in their opinion, practitioners should attain in order to provide the best possible service to a client <https://counsellingtutor.com/cpcab-service-levels-explained>. Service Level C would apply here.

Keen to build up her practice, how willing might Lydia have been to 'lose' Derek to another counsellor by referring him on to a more appropriate service (that is if she had realised a mental health condition could be involved)?

Deciding to go into private practice early in her career, might Lydia have benefited from working within an organisation first? However, it is acknowledged that finding paid employment within an organisation may not be easy at this stage (although volunteer work might be available).

Whilst we can imagine Lydia didn't want to lose a potential client, initially proceeding at her own pace (rather than being 'hurried' into starting 'the work') might have allowed her to gain more information about Derek and to think more about the process of the therapy as it was happening.

Access to consultation with health, pharmaceutical and mental health professionals would also have been useful here both in terms of consultation and referral (Good Practice, points 13, 16).

Lydia works from home, and this is a potentially high-risk situation. Not all clients with a mental health condition pose a risk to practitioners (whilst some do who have no mental health conditions). We can be concerned about her safety as there is no indication that anyone knows she is alone with clients.

We have seen a very dramatic demonstration of Derek living through one of his 'alters'. These alternative identities (or dissociated personality parts) can appear, disappear and change very rapidly with very little warning. For more information see <https://patient.info/doctor/a-brief-guide-to-working-with-dissociative-identity-disorder> and Gill Frost's account of working with clients who have dissociative identity disorder in *Therapy Today* November 2020.

Worryingly, we don't know what other (perhaps distressed or dangerous) characters he may identify with at any time.

A network of colleagues who could set up a 'buddy system' for lone workers could help Lydia be safer in her practice in general. See Good Practice in Action 029 Legal Resource: *Mental health law within the counselling professions in England and Wales* and Good Practice in Action 106 Clinical Reflections for Practice: *Safe working in the context of the counselling professions* and 004 Commonly Asked Questions: *Working in private practice within the counselling professions*. More information on lone working can be found at: www.bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-guide.

This newly qualified practitioner has missed several potential clues regarding Derek's mental state. Whilst not all counselling professionals agree with the idea of carrying out formal assessments on their clients, did Lydia do enough here? So much seems to have confused Lydia about Derek but what has she done with that sense of confusion? It doesn't sound like it has been discussed at supervision (see Good Practice, points 53, 60, 73).

Lydia did not seem to reflect much on Derek's lateness (or the forgotten sessions). Whilst clients are not obliged to give reasons for these events, it does seem part of the clinical picture.

It did not strike Lydia as odd that the normally polite Derek became quite dismissive and abrupt (and put this down to him being truthful). Nor did she note his use of language when he referred to himself in the plural – "We didn't feel like coming."

What about Derek's change in dress style? What could that have told Lydia? She seemed worried that her supervisor might think she was bringing 'trivial' things to supervision. Derek's dress-sense seems quite relevant here so we might wonder why Lydia thought she should not raise it with her supervisor. Is she being open and honest with her supervisor (Good Practice, point 72) and what is the quality of their working relationship? See Good Practice in Action 010 Fact Sheet: *Monitoring the supervisory relationship from the supervisor's perspective* and 011 CAQ: *Monitoring the supervisory relationship from the supervisee's perspective*.

The theme of 'lost' items, time and even home address does not seem to have registered with Lydia as a possible indicator of a mental health condition. There seems to be some confusion over whether he owns a chequebook, and we have the return of cheques by the bank (irritating Lydia rather than ringing alarm bells about what might be happening).

Occasionally, counselling professionals struggle with the idea of accepting money for their services.

This can mean that when a cheque (and particularly cash) is handed to the practitioner, it can quickly be 'put away' without much attention to either the process of the 'giving' or to what exactly has been given. Lydia accepted several cheques without really looking at them too closely (even after Derek had gone). Much can be learnt from how financial transactions are carried out. This applies to all clients but has been particularly so in the case of Derek. See Good Practice in Action 118 Fact Sheet: *Charging for services in the counselling professions*.

Thinking about the contracting process (Good Practice, point 31); Lydia 'quickly describes her contract' – might this assessment not have been as detailed as it could have been? Did Derek have capacity to give consent during the contracting process (Good Practice, points 26, 28)? Whilst we can be reasonably confident that he wasn't identifying with his alter, 'Katya', could it have been another alter? Was consent valid for each session and what part might GDPR play here? See Good Practice, points 13, 15, BACP (2018), Good Practice in Action 105 Legal Resource: *The United Kingdom General Data Protection Regulation (UKGDPR) legal principles and practice notes for the counselling professions* and <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/consent>.

Thinking more about the contract, we know that the agreement process was rushed.

We can wonder what was agreed or discussed regarding times when Lydia might wish (or be statutorily obliged by law) to breach confidentiality (Commitment 3b, Good Practice, points 9, 10, 13, 14f, 26, 44, 46, 55). See Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions*.

Finally, Lydia compares Derek's behaviour to that of Joe, her teenage son. Is she able to separate her personal life from that of her clients? What might help here?

Questions for reflection and discussion

1. Derek appears to be in a dissociated state. How might you feel if you had just met 'Katya' in your therapy room?
2. If you were Lydia, what would you do next?
3. With Derek, there were several signs that he may have been capable of dissociation, but with other clients, there may be very little indication. If you have limited or no experience of client dissociation, how best could you prepare for work with a client whose 'alter' one day suddenly emerges?
4. Thinking about clients who sometimes dissociate, how might working online have impacted on Lydia's work? What might she have had to do differently to work competently? How might her assessment process have differed?

Vignette three

Twenty-year-old Xue has been diagnosed with panic disorder, and his GP has prescribed a Selective Serotonin Reuptake Inhibitor (SSRI).

He has come to a counselling service run by a local mental health charity and been assigned to Michael, an experienced volunteer counsellor. They have eight sessions available.

Michael is interested in his new client's name and Xue proudly tells him it means 'studying person' - appropriate as he says he has 'a very enquiring mind'. Currently, Xue works as a laboratory assistant but would like to study chemistry at university one day.

Xue engages well with the counselling process and initially, Michael enjoys his client's sense of curiosity and apparent thirst for knowledge.

But soon, this starts to become a problem - Xue just won't stop asking questions and seeking Michael's opinion about various topics connected to counselling and mental health. Xue wants to know whether talking therapy works better than medication, how ('exactly') his medication works, what impact it might have on the counselling process and whether anxiety is genetically inherited. He also feels confused by the different terms he has heard such as mental health 'condition/illness/disorder/ problem' and asks Michael which he thinks is the best term to use. Michael is beginning to feel overwhelmed and exhausted. Not feeling overly confident in his answers, he makes a mental note to find some mental health CPD.

The following day, Michael receives some terrible news. The charity where he volunteers (and sees Xue) has lost its major source of funding. Recently, the rent for the premises had sky-rocketed and now the landlord has evicted the organisation. In an effort to continue supporting existing clients, volunteers have been given the choice to either refer their clients to other practitioners and organisations, have sessions with them via video or on the phone. There is no option to see clients at a volunteer's home. Michael is not very 'up with technology' so he's not keen on 'going online'. He's unhappy that he can't see clients at his home because he has a very suitable room and lives alone so would have no interruptions.

Michael certainly does not want to refer his clients to another practitioner because the work has been going very well. Opting for the phone option, he tells his clients that "The therapy will be the same, just on the phone that's all. I'll call you at your session time". Michael's work with Xue commences on the phone and whilst it is going well enough, Michael has noticed recently that Xue's questions have begun to feel more personal. He asks Michael whether he has ever had panic attacks ('or any other mental health thing?'). When thinking how best to respond, Michael remembers how isolated he felt when, at Xue's age, he went through a period of major depression and was almost hospitalised. Distracted by these memories, Michael finds himself telling Xue about his own traumatic experiences. After a couple of minutes, he realises he has made an unintended (but very personal and long disclosure) to his client. He promises himself he won't do it again.

Today, at session five, Xue seems preoccupied. He says that at first, having a diagnosis of 'a disorder' explained a lot but now it's really beginning to upset him. He asks "Why have I got this thing Michael? Do you think I'm crazy?" Michael isn't sure what to say.

Later that session, Xue says he has read online about people becoming addicted to certain medications and asks whether his could be addictive too.

Whilst Michael tries to remember, Xue announces he has 'made a big decision anyway'. He plans to stop taking his medication 'with immediate effect.'

Michael is not sure about any potential impact of this but suggests Xue make an appointment to see his GP. Xue says he forgot to mention that he had moved to a different location and so did not have a GP at the moment.

Xue tells Michael that he has told his mother about his plan to stop taking the medication. She is worried that he won't be able to sleep properly so has given him some of her 'very strong' sleeping tablets prescribed for her last year. She has told her son that working in a laboratory, he must get a good night's sleep! Xue says he always does what his mother says and plans to take her sleeping tablets. Michael thinks he remembers reading somewhere that this particular medication is a Class C Controlled drug (controlled under Misuse of Drugs Act 1971) but gives it no further thought.

Observations on practice

A panic attack is a sudden episode of intense fear that triggers, in the absence of any apparent cause, severe physical reactions. This can be very frightening, and a person may feel out of control, like they are 'going mad', having a heart attack or about to die.

Some people have just a few panic attacks then the problem goes away (perhaps when a period of stress ends). But if these attacks keep occurring or a person is terrified of further attacks, they may have panic disorder.

Michael feels 'overwhelmed' by Xue. We can imagine his constant questions may be a way of keeping material out of his awareness or is a defence against intimacy. We can also imagine a practitioner might get caught up with a client's 'enquiring mind' but also think that we have to produce answers to everything. Aware of his lack of knowledge, Michael plans to do some mental health CPD (Commitment 2a., b, Good Practice, points 11, 14).

Clients sometimes ask, 'Why me?' (be it following the development of a physical or mental health condition or a life event). In general, mental illness is thought to be caused by a variety of genetic and environmental factors. Personality type may also play a part. How might you have answered this question? Xue asked, "Do you think I'm crazy?" It is important that Michael does not get pulled into 'diagnosing' whether Xue is 'crazy' or 'sane' but rather explores what 'crazy' might mean to Xue.

Xue has raised some concerns regarding the diagnosis of mental health conditions. The classification and systematic way of viewing mental illness are controversial topics with the conflict between medical and psychosocial models coming into play (see Introduction).

Whilst counselling professionals are not required to have in-depth knowledge of medications, it can be useful to have some understanding of how they work, potential side effects, symptoms of withdrawal and whether addiction or dependency could arise (Good Practice, point 14). Michael has advised Xue to visit his GP but there is a lengthy wait, and he may be at risk of quite distressing withdrawal symptoms if he stops his medication suddenly.

Whilst it is not within the remit of a counselling professional to advise that medication be tailed off or withdrawn, we have an important role to play in supporting clients who choose to do so (see the All-Party Parliamentary Group's guidance *A short guide to what every psychological therapist should know about working with psychiatric drugs* at <https://prescribedrug.info/short-guidance>).

Practitioners will be aware of the power differential that can exist in a relationship between client and counselling professional. This may be especially true when that client has a mental health condition. As well as a 'well/sick person' or 'sane/insane person' dynamic, a 'doer/being done to' relationship can arise. Xue certainly put Michael in the role of 'expert', and it may have been useful for him to have explored this with Xue, his supervisor or both (Good Practice, point 53).

Xue asked what initially, might have felt quite an intrusive question regarding his practitioner's mental health. It would seem that Michael encountered the 'online disinhibition' effect making a rather major personal disclosure about his own mental health, which was unlikely to be helpful to Xue (and may have adversely affected the therapy). Michael 'promises himself' he won't do it again but is he aware of this very powerful phenomenon and what will he put in place so as not to repeat what happened? We can only hope that he would talk to his supervisor about it (although he does seem to have minimised it). For more information on practitioner self-disclosure, see Good Practice in Action 117 (2021) Fact Sheet: *Practitioner self-disclosure in the counselling professions*.

Xue now plans to take his mother's 'very strong' sleeping tablets. Michael does not know the effect that taking this drug will have on Xue and without having him in the same room as him, may not be able to accurately assess the situation whilst working online.

We should also be concerned that Xue has accepted his mother's sleeping tablets, a Class C controlled drug (controlled under Misuse of Drugs Act 1971). Apart from the dangers of taking another person's medication, is Xue aware that his mother is breaking the law by giving another person medication prescribed to her – even her son? See Good Practice, points 14f, 46 and www.release.org.uk/law/classes. Michael is vaguely aware of this but has not thought any further about it.

Whilst Michael does have the support of his supervisor, he also works in an agency setting. What responsibilities might the organisation and Counselling Services Manager have for Michael's work with Xue?

Access to consultation with health, pharmaceutical and mental health professionals would have been useful here both in terms of consultation and referral (Good Practice, points 13, 16).

Michael does not want to refer his clients but sometimes this is the best option.

He lives alone and sees this as an advantage if he were in future, to see clients at his home. We can only wonder what safety measures he would put in place, if any (see Good Practice 106 *Safe working in the context of the counselling professions*).

Michael thinks and indeed has told his clients, that working on the phone will be 'the same' as working with them in the same room. This assumption has huge implications for the therapy and the ethical commitments he has made to his clients, whichever method he uses to deliver services (see Good practice, point 20). Michael would be advised to discuss this thoroughly with his supervisor and revise the contract he has with clients. Michael says he will call his clients at the start of their session. Does he pay the phone bill? If so, might this place financial pressure on him which if it escalates, could affect his own mental wellbeing.

Michael's client has moved house and Michael was unaware of this. Had Michael contracted with Xue that he would inform him of any changes to his contact details, GP and so on? Also, if during a phone session, Xue told Michael he had decided to end his life and perhaps even, that he had taken an overdose of his mother's sleeping tablets, Michael would have no address for Xue to which he could send emergency help. Any GP details held would now be out of date. Michael might be left trying to persuade Xue to call help for himself.

Now that Michael has moved from 'same room' therapy to phone therapy, he would find the *Online and phone therapy (OPT) competence framework* very helpful. Using this, he could identify the knowledge, skills and abilities required to work online (including the phone) and identify gaps where CPD would be supportive.

Questions for reflection and discussion

1. How adequately prepared would you feel to answer the various questions Xue asked?
2. Xue felt confused by the various terms used to describe a generic mental health condition (disorder, condition, illness, problem?). What is your opinion about the various terms used? Do you have other ways of talking about mental health? Are there any alternative viewpoints that you would like to investigate further?
3. When working with clients who present with mental health concerns, do you see any advantages and/or disadvantages if the practitioner also has personal experience of mental health issues? How might you have responded had Xue asked you about your mental health? Have you ever been affected by the 'online disinhibition' effect?
4. Would familiarising yourself with the *OPT competence framework* be helpful to your work?

Vignette four

Freddie is very concerned about his health. At various times, he has worried about having pancreatic cancer, liver cirrhosis, diabetes, multiple sclerosis plus many other medical conditions besides.

His GP has examined him, run various diagnostic tests but found no evidence. Diagnosing health anxiety, she has recommended talking therapy.

Initially, Freddie was reluctant, but felt so worried about his health that he went along with his GP's suggestion. After all, he thought, the therapist might be able to intervene and convince her that he should have his health concerns taken more seriously.

For two months, Freddie has been having weekly psychotherapy with Tom. He says his health concerns began when at eight, his mother told him she had breast cancer and spent time away in hospital.

For what felt like a long while, the times she was at home, Freddie remembered that she seemed very distant from him, and he worried that she might not love him anymore. In an attempt to 'take away mum's cancer', Freddie took on the sick role. Thirty years later, his mother is well but because he still worries her cancer 'may come back any day', he says he will "never leave home".

He understands the possible cause of his health anxiety, but still it continues. For example, a month ago, he had a sore throat which was 'almost certainly glandular fever'. For several hours a day, Freddie has been surfing the internet looking for his next self-diagnosis.

Freddie's anxiety now seems to have switched to his appearance and his latest worry is that he is losing his hair. When Tom looks, he sees a full head of hair although Freddie insists "it is falling out at an alarming rate".

Freddie tells Tom that over the last few weeks, he has visited several hair loss clinics, paying large sums of money for shampoos, ointments and tablets. None of this has worked and, running out of money fast, he is unable to go to any more clinics. Freddie says he feels very alone, depressed and sometimes cries. He's not sleeping well, wakes at 4.30am most mornings and his appetite has decreased. He feels guilty that it is something he has done that is making him go bald and that "everyone'll hate me because of it".

Last week, Freddie brought his hairbrush to show Tom and more worryingly, has been emailing Tom photos of his head, asking him whether he thinks there has been any more hair loss since they last met.

Tom finds it quite a challenge working with Freddie. He doesn't seem to be getting very far and often feels 'stuck' and frustrated. At the end of sessions, Tom finds it hard to disengage from the work and feels Freddie is 'glued' to him. He has to shower after sessions to free himself from this feeling. However, things have got worse. Freddie's emails about his hair loss are now coming thick and fast into Tom's email inbox after work hours and even through the night!

Tom does briefly respond to his emails before he goes to bed but then silences his phone overnight. Freddie's latest message says he has not been able to sleep because he's 'devastated' that Tom did not reply immediately to his late-night message and accuses him of not caring enough! He says he would like 'more attention' and asks to increase his sessions to three times a week "in case the stress is all too much for me". Tom is determined not to 'give up' on Freddie and decides not to reply but to discuss the matter with him later that day during their scheduled session. However, for the first time ever, Freddie does not turn up. Nor does he respond to either a phone call or email from Tom.

Observations on practice

Freddie's GP originally diagnosed Freddie as having 'health anxiety'. Might Freddie also be showing signs that suggest body dysmorphic disorder (BDD) and an insecure attachment pattern?

Both can cause significant distress and impact on a person's ability to function well in daily life.

Freddie may also be showing signs of becoming depressed. Might there be an increased risk of self-harm and suicide? What about risk assessment? See GPiA 042, 057 and 120.

At the start of the work, it might have been wise for Tom to have suggested liaison with Freddie's GP. Access to consultation with health, pharmaceutical and mental health professionals would have been useful here both in terms of consultation and referral (Good Practice, points 13, 16).

Working with clients who have BDD can be very challenging. The CPCAB Service Level model would suggest that Service Level C applies here: <https://counsellingtutor.com/cpcab-service-levels-explained>.

Does Tom have sufficient levels of competence to do this work (Good Practice, points 13,14)?

He feels the need to free himself from Freddie by showering after sessions and feels 'exhausted' so what about his self-care? See Good Practice, points 18, 91 and Good Practice in Action 088 Fact Sheet: *Self-care for the counselling professions*. Freddie's issues seem very difficult to manage within the context that Tom works. Nevertheless, he is determined not to 'give up'! Whilst most practitioners do not like to easily 'give up' on their clients, perhaps in this case, personal reflection, supervision (and possibly personal therapy) might help Tom understand what seems a misplaced perseverance.

NICE guidelines suggest that the talking therapy treatment found to be most helpful for adults with BDD is cognitive behavioural therapy (including an element of exposure response prevention therapy). It may be appropriate therefore to refer Freddie to a specialist mental health professional (or preferably, team). However, referral to a practitioner with knowledge of attachment theories might also be useful.

Tom struggles with this work and may not like to admit what he might see as defeat or incompetence (Commitment 2a and b, Good Practice, points 13, 14).

Is Tom using his supervision sessions effectively? We can wonder about the quality of the supervisory relationship (see Good Practice in Action 010 Fact Sheet: Monitoring the supervisory relationship from the supervisor's perspective and 011 CAQ: *Monitoring the supervisory relationship from the supervisee's perspective*).

In an effort to gain reassurance, Freddie initially started emailing photos of his 'bald patch' to Tom but the frequency and the time of day these are sent has got out of hand.

We can imagine this might have been quite difficult for Tom and perhaps an intrusion. What was agreed in their contract regarding 'out of session contact' (Good Practice, point 31)? Freddie's final message is likely to have been very distressing to Tom as he had no option but to try and persuade his client to call help for himself.

Questions for reflection and discussion

1. If you were Tom's supervisor, what might you want to discuss with him regarding his work with Freddie so far?
2. Sometimes, clients make inappropriate or unagreed contact with their therapist between sessions. In your work, a) how do you reduce the chances of this happening (as much as is possible) and b) deal with it if it does? Does anything need to change in your way of working?
3. Sometimes clients email, phone or text their therapist after 'office hours' to discuss matters, such as re-arranging session times and so on. Do you ever find yourself picking these messages up and responding 'out of hours' too (and if so, how might clients interpret this)?
4. If this work had been carried out online, what considerations might Tom have usefully made regarding assessment, contracting, working remotely with psychological processes and risk?

3 Conclusion

Whilst at times challenging, supporting a client who has a mental health condition can be very rewarding.

No matter how in-depth our training and long our experience, during the course of our work we will encounter situations in which we find ourselves 'unprepared'. This may be particularly so when working with clients who have (or may have) a mental health condition. The Covid pandemic is a very dramatic example where practitioners had to adapt very quickly, with many taking their practice online. Clearly, this will have helped many clients with mental health conditions but its impact on the mental wellbeing of practitioners should not be underestimated.

The aim of this resource has been to depict some of the complexities of working with such clients and to help you increase your sense of 'preparedness'.

Throughout, you have been invited to reflect upon many different areas of practice. However, several overarching themes have emerged including competence, assessment, risk, referral, contracting, confidentiality, supervision and legal issues. It is essential that counselling professionals have an up-to-date knowledge of these issues in general, but also how they apply to working in the mental health field. Also important to hold in mind are self-care, fitness to practise, managing workloads, safety and working online (see www.bacp.co.uk/events-and-resources/ethics-and-standards/good-practice-in-action).

At times, a counselling professional's role might seem an isolated one, particularly when working alone and online. This can feel even more acute when working with clients with diagnosed mental health disorders. Having a network of colleagues, including healthcare, pharmaceutical and mental health professionals, with whom we can consult and refer, when necessary, is vital.

We must also remember that it is crucial to pay close attention to our own mental health and wellbeing.

Finally, there are many important issues around mental health currently being debated.

Whilst these are outside the scope and remit of this resource, we feel sure that members will continue to have respectful discussions within our professional community as well as further afield.

About the author

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Further reading

More information can be found at:

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