# Counsellor, Ms B
# Counselling Service

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 19HDC02371)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report concerns the care provided to a woman by a counsellor. In particular, it concerns the importance of written therapeutic contracts and clear counselling models, communication with other providers involved in a consumer's care, and the provider ensuring that they have appropriate expertise to treat the client.

### Findings

2. The Deputy Commissioner was concerned about the lack of a written therapeutic contract, the lack of communication with the woman's psychologist regarding roles and care, and the lack of expertise and a clear counselling model in the counsellor's treatment of the woman. In addition, there were concerns regarding the standard of out-of-session communication via text message, the adjustment of the counsellor's scope and focus of counselling without consultation or discussion with the woman, and the provision of an inaccurate transcript of the therapy session that occurred on 10 September 2019. As such, the Deputy Commissioner found the counsellor in breach of Right 4(1) of the Code.

3. The Deputy Commissioner also made adverse comment about the counselling session on 10 September 2019, the counsellor's management of the woman's complaint, and her reflection on the care she provided to the woman.

### Recommendations

4. The Deputy Commissioner recommended that the counsellor provide an apology to the woman, consider membership with the New Zealand Association of Counsellors, engage in regular individual supervision, and undertake communication training. The Deputy Commissioner also recommended that the counselling service evaluate its complaints process and respond to complaints written by professionals who are assisting the complainant.

## Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by a counsellor, Ms B. The following issues were identified for investigation:

- *Whether Ms B provided Ms A with an appropriate standard of care from July 2019 to December 2019 (inclusive).*
- *Whether the counselling service provided Ms A with an appropriate standard of care from July 2019 to December 2019 (inclusive).*

6. This report is the opinion of Deputy Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

7. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms A | Consumer |
| Ms B | Provider/counsellor |
| Counselling service | Provider |

8. Further information was received from:

| | |
|---|---|
| Dr C | Clinical psychologist |
| Ms D | Registered psychotherapist |

9. Independent advice was obtained from a counsellor, Ms Irene Paton (Appendix A). Ms B obtained advice from Mr E, a clinical psychologist.

## Information gathered during investigation

### Introduction

10. Ms A (in her thirties at the time of the events) attended ten counselling sessions with Ms B. Ms A experienced changes in Ms B's demeanour and counselling style in the later sessions. This report examines Ms B's lack of a written therapeutic contract, expertise, and a clear counselling model. The report discusses Ms B's lack of communication with Ms A's existing psychologist regarding roles and care, the adjustment of the scope and focus of Ms A's counselling without consultation or discussion, and the standard of communication during a counselling session.

### Ms B and the counselling service

11. Ms B holds a Bachelor's degree in counselling, and is the owner and shareholder of the counselling service. Ms B is not a member of the New Zealand Association of Counsellors/Te Roopu Kaiwhiriwhiri o Aotearoa (NZAC),[1] but the counselling service told HDC that it adopts the standard procedures and policies of NZAC. Ms B is a member of the Association for Contextual Behavioural Science (ACBS), which describes itself as "a worldwide online learning and research community".[2]

12. Ms B stated[3] that she did not have specific expertise or experience in working with clients with borderline personality disorder (BPD).

13. Ms B told HDC that one of the many different therapies, theories, and therapeutic models that she uses is a model which she developed herself. She said that it is a mindfulness and acceptance-based model of counselling that focuses on kindness and compassion.

[1] A professional body that represents the majority of counsellors in New Zealand.
[2] ACBS is not a licensing agency and does not verify qualifications.
[3] Ms B stated this to Mr E, her advisor.

**Request for counselling sessions**

14. Ms A had had previous contact with the counselling service.[4] She requested individual counselling sessions with Ms B in April 2019, after attending a mindfulness course.[5]

15. Ms A saw clinical psychologist Dr C regularly, and Ms A told Ms B that he had agreed that she could talk to someone else about a particular issue she was having with him. Ms A told HDC that she worked with Dr C on her BPD.[6]

16. On 10 July 2019, Ms A sent Ms B an email that stated: "I talked to my therapist and all is well with me seeing you for a couple [of] sessions."

**Therapeutic contract**

17. Ms B did not have a written therapeutic contract with Ms A, and told HDC that the therapeutic contract was verbal and covered availability, fees, cancelled appointments, confidentiality, session notes, and goals for therapy.

18. The counselling service told HDC that contracts with clients were generally verbal, and included all the relevant information as per the NZAC guidelines.

*Text message arrangement*

19. Ms B told HDC that during treatment sessions, she agreed to one text and response per day with Ms A. Ms B said that whilst it was not her usual practice to have contact with patients outside of therapy, she agreed as this was the arrangement that Ms A had with Dr C. This arrangement was not in writing, and it is unclear when this arrangement was made.

20. HDC received text messages from Ms B and Ms A covering the period 12 April to 13 December 2019.[7]

**Counselling sessions**

21. Ms A attended ten counselling sessions with Ms B — on 9, 18, and 23 July, 3, 8, 14, 20, 27, and 29 August, and 10 September 2019.

*Counselling sessions 1–5 (9 July to 8 August 2019)*

22. Ms B and Ms A agree that there were no issues in the earlier counselling sessions. Ms A told HDC that she found the first three sessions excellent, and that Ms B was helpful with some of her "complexes".

[4] In 2006 to 2012 she had individual counselling with a different counsellor at the counselling service, and in 2017 and 2019 she attended therapeutic training/mindfulness courses held by the counselling service, run by Ms B and another counsellor who had counselled Ms A previously.
[5] Ms A followed up her request in June 2019.
[6] Personality disorders are recognised as serious mental health conditions of clinical concern. One of the most prevalent personality disorders is BPD. BPD is defined as a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity. Emotional dysregulation is a fundamental feature. Ms A told HDC that she does not have a formal diagnosis of BPD.
[7] The text messages from 12 April to 3 July 2019 (inclusive) primarily appear to be in relation to the mindfulness course and administrative matters such as fees and receipts.

23. During this time, Ms B responded to Ms A via text message up to once or twice in a day (although not daily). On 4 August 2019, Ms B stated: "… A t[e]xt a day keeps the blues away!", implying that the text message arrangement had been discussed. On more than one occasion, Ms B responded to Ms A more than once per day, and outside of work hours.[8]

24. The text messages from Ms B during this time were brief, but acknowledged Ms A's text messages, and contained emoticons. On 8 August, in response to Ms A's message about what is inferred as a memory from her childhood, Ms B replied: "… I would protect you in the days ahead …"

*Discussion regarding ending counselling sessions*

25. On 9 August 2019, Ms A sent an email to Ms B stating that she could not afford two counsellors but she would like to continue seeing Ms B once a week until October 2019, and then would likely need to stop.

26. Ms B replied the same day: "That's all okay with me. Do what you need to do to be safe and secure. I'm here if you need me …"

*Counselling sessions 6–7 (14–20 August 2019)*

Change in style

27. Ms A told HDC that after the exchange about money,[9] the subsequent counselling sessions she had with Ms B were completely different. Ms A said that Ms B was more clinical, distant, and argumentative, and she was silent for long periods of time. Ms A stated that the sessions moved from rebuilding "mother connections"[10] to concentrating on literature and on techniques such as breathing and identifying feelings. Ms A told HDC that Ms B did not discuss the change in style with her.

Session 6 — 14 August 2019

28. On 14 August 2019, Ms A attended her sixth counselling session with Ms B.

29. Ms A told HDC that during this session she felt the change in demeanour "incredibly strongly". She said that she tried to ask questions to clarify the method Ms B was using. Ms A said that Ms B was evasive in her answers and did not give clear replies, which resulted in her becoming increasingly uncertain and self-doubting, which is why she asked for clarification and reassurance.

30. Ms A told HDC that the more confused she became, the more clarification she asked for, which then caused more confusion. Ms A explained that she also felt as if she was in a

[8] On 4 August and 11 August 2019. On other dates where there is more than one reply, it appears to be in relation to administrative matters such as scheduling.
[9] The text and email exchange on 9 August 2019.
[10] A topic discussed in therapy — the definition is unclear but it is noted that in earlier sessions, Ms A's childhood and family were discussed.

"double bind",[11] and asked Ms B repeatedly what she could do to make it better, but did not receive an answer.

31. Ms B documented:

> "[Ms A] is convinced that I have changed in my demeanour towards her. I explained the experience of my day is more likely the reason. [Ms A] is unconvinced by my explanation and challenged me. The therapy session revolved around this [illegible] feeling like a double bind, a dialectic stand off."

32. Ms B told HDC that during this session, her mood may have been affected by an incident that took place in her personal life. Ms B told HDC that she explained to Ms A what had happened. Ms A seemed disinterested and had "continued to personalise" Ms B's mood. In response to the provisional opinion, Ms A told HDC that she was "absolutely not disinterested" and she remembers commenting on both matters in an interested and caring way.

33. Ms B said that Ms A told her that she (Ms A) felt that something had changed, and that Ms B was different. Ms B said that she reassured Ms A that it had not, but Ms A was convinced that the relationship had changed. Ms B told HDC: "I identify this session as the moment when Ms A's good/bad split moved from good to bad activating an edge of paranoid mistrust."

34. At 7.10pm on 14 August 2019, Ms A sent Ms B a text message asking: "[Are] we are okay?" Ms B responded stating: "Perfect [okay emoji]."

Session 7 — 20 August 2019

35. The counselling notes from this session appear to be a list of feelings and emotions in relation to a memory, but further than that, the contents of the session are unclear.

**Text messages — 20–22 August 2019**

36. On 20 August 2019, Ms A explained by text message that she wanted to continue with counselling sessions with Ms B for the near future and would pay until the end of September, then negotiate the payment. During a further text message exchange, it was confirmed that the arrangement about the text messages would remain unchanged (one per day).

37. On 21 August 2019, Ms A sent a text message to Ms B saying that she felt that Ms B had been different over the past two weeks, and this had kept her up the previous night. Ms B responded:

> "Hi [Ms A], what I actually thought was, in your bringing our sessions to an end in September that you had decided you didn't need/couldn't afford to have two long term

[11] A communication dilemma that comes from a conflict between two or more messages — no matter what you do, any choice you make will be wrong.

> therapist relationships. At that point my task changed to short term therapy and developing strategies to 'nail' the addiction/OCD longing."

38. Ms A responded and asked why Ms B had not told her about the change to the counselling. On 22 August 2019, Ms B responded: "[W]anting to nail it were your words from our first sessions together."

39. Ms A repeated her request about the change, and Ms B responded:

> "I'm sorry [Ms A] I don't accept your implied … perspective that I made an arbitrary decision without informing you. Terms of engagement automatically change when you decide to end therapy."

40. Ms A told HDC that things started to go downhill when she asked Ms B about the change in demeanour in the text messages. Ms A explained that this is when she started to feel confused and distressed.

**Counselling sessions 8–9 and text messages**

41. Between 24 August and 2 September 2019, Ms A and Ms B exchanged text messages in which Ms A asked Ms B for clarification that she was still there for her, and Ms B reiterated that she was.

42. Ms B replied to Ms A more than once on 25 August, 26 August, 28 August, 30 August, and on occasion outside of work hours.

*Session 8 — 27 August 2019*

43. The counselling notes from this session outline that the session was set into a "double bind dynamic", and the conversation became more and more complicated.

44. The notes state that the "intervention" involved "clean language — creating a feedback loop in an attempt to enhance meta-awareness[12] and refrain from being caught in the dynamic of the double bind", and the outcome was "the client seemed to be resistant to this process and preferred to stay in one part of the split or the other".

*Session 9 — 29 August 2019*

45. The counselling notes from this session state: "[Ms A] offering me the options from the previous session — is she correct in her belief that [Ms B] has changed. I don't feel changed. Ms A insists there is a change." The notes state that Ms A was "agitated" and raised issues from the previous session.

46. Ms B's notes state:

> "I feel I am caught in a catch 22. A mother projection. I am reluctant to engage with her words that would further aggravate the situation and potentially lead to acting out. I

[12] A state of deliberate attention towards the contents of thoughts, feelings, and sensations as they are happening.

lean towards reflective listening in the hope of gaining further awareness without the double bind dynamics.

Outcome

[Ms A] experienced me as disengaging, not engaging with her and believing that I don't like her because there is something wrong with her. She speaks of her sense of powerlessness, that I suspect she feels because she is unable to drag me into the transferential invitation to fight her. Personally I am rather swamped by her force of delivery. I feel powerless to take any meaningful therapeutic action."

47. Ms A told HDC that these two sessions had a lot in common with the recorded session (session 10, discussed below).

**Text messages — 3–7 September 2019**

48. On 3 September 2019, Ms A sent Ms B a text message stating:

> "And now I have to sit out here completely beside myself. And I am not blaming you. But it is a big problem for me. I am so distressed and there is nothing I can do except wait for next week. Now I do feel powerless, completely because there is nothing I can do."

49. Ms B replied: "I'm sorry you feel that way. Why are you feeling powerless?"

50. Ms A responded:

> "Because I am now in a situation where I am out here and there is nothing I can do to make this better. It doesn't matter what I say or do with you it is like I am wrong. And I will take that as something wrong with me … if it happens with three therapists it is obviously me. I have just written you an email saying I can't work with you anymore, even though I want to so much. But am sitting in it overnight. Till I am calmer. Even you asking why I feel powerless … I don't understand, it feels so obvious. All I want to do is go and get a bottle of rum and down it so I don't have to feel. You might think I am blaming you I am not I know this is me. But I can't sit in therapy having a stand-off with you every week, and I don't want to but it keeps happening, I feel powerless."

51. Ms B responded: "I think there are things you can do to improve your feeling state. I will wait to hear what you decide in the morning. Take care."

52. That evening and the following day, Ms A sent further text messages outlining that she was in "agony" and asking Ms B if she could call her. Ms B did not respond.

53. On 4 September 2019, Ms A requested an appointment, and Ms B explained that she was fully booked and suggested that Ms A discuss her issues with Dr C and distract herself with YouTube talks, music, exercise, contact with her friends, or the outdoors.

54. Ms A sent further texts outlining that she had spoken to Dr C, and wanted to continue to work with Ms B, but "can't take this constant stand off. Especially when I don't really

understand what is happening. Maybe if I could understand what you are trying to teach me through our way of interacting it would help …"

55. Later that day, Ms A sent a text message stating: "I have had a session with [Dr C]. Would you [be] prepared to have [a] conversation with him?" Ms B replied: "I would rather not. I think your therapy with [Dr C] should remain clean and clear."

56. Ms B told HDC that her feeling at that time was that such a meeting had the potential to "triangulate" the two therapists, and ultimately would not be beneficial to Ms A.

57. On 5 September 2019, Ms A sent Ms B a text message apologising for "abusing" their text message agreement, and saying that she needed a reassuring message from Ms B. Ms B responded:

> "Yes. I will only be answering one t[e]xt p[er] day as agreed from now. The need for reassurance is OCD. That means no matter how much you get you will want more. You need to try and use distracting skills. You can do this."

58. Ms A responded that with every bit of reassurance not given she needs more. She said that she felt no reassurance from Ms B's text message, and felt sick, highly stressed, and as if she could not breathe. Ms A messaged:

> "Because I don't know if we are ok. And for some reason you won't tell me. [Ms B] I feel so powerless and I am trying to tell you I just need some reassurance. And I don't understand why you won't give it to me. Please please I am begging you to explain it? Please don't leave me like this. All I need to do is repair with you, know that we are ok and I will be able to reset … Please [Ms B] just a bit of reassurance. I know this is a second message but I really need some reassurance from you, to be able to move from this. Please."

59. Ms B did not respond. Ms A sent a further message to Ms B saying that she had sent her an email, and that if Ms B did not want to see her again, that was fine, otherwise she would see her on Tuesday. Ms A stated: "You win [Ms B]. I am left in a completely powerless position that I cannot get out of." Ms B did not respond.

60. On 6 September, Ms A sent Ms B a text message saying, "tired". Ms B responded saying, "I can imagine". Ms A responded, "needs reassurance please". Ms B did not respond.

61. Ms A sent a further message to Ms B asking her to give her some reassurance that they were "ok[ay]". Ms B did not respond.

62. On 7 September 2019, Ms A sent a text message to Ms B saying that she was "in a bit of a state". Ms A explained that Ms B not responding to her did not cause an OCD reaction, it caused her deep distress. Ms B responded: "As I said before, if I changed my mind about working with you I would talk to you about it. I haven't changed my mind …"

63. Text messages were exchanged on 8 and 9 September 2019 (one sent and received on each day) in relation to Ms A's past experiences and Ms A enquiring whether Ms B had received her email and Ms B confirming that she had.

**Increase in text messages**

64. As outlined above, the text message arrangement was that Ms A would send one text message per day, and Ms B would send one reply per day. On multiple occasions, Ms B responded more than once per day, or did not reply.

65. Ms B told HDC that during the time she provided counselling to Ms A, the volume and frequency of text messages increased. Ms B said that Ms A would always apologise for overstepping the agreement, but would nevertheless continue to send messages.

66. Ms B told HDC that she believed she was consistent in her responses to text messages, and said that on occasion if Ms A seemed particularly stressed she would reply to two text messages. Ms B said that her strategy was to be polite and kind, and informative if necessary, but to keep the messages brief.

67. Ms B said that she formed the view that corresponding with Ms A by way of text message only encouraged the volume and increased the intensity of her need of reassurance from her, and therefore she reconfirmed the agreement of one text message and one reply per day, and continued to uphold the agreement "despite [Ms A's] repeated attempts" to make her reply. Ms B said that Ms A had "easy access" to Dr C, and therefore she considered that Ms A's safety issues were well covered.

68. Ms A told HDC that Ms B did not tell her that the increased text messages she was sending were a problem, and they did not talk about it in any of the sessions. Ms A said that Ms B did not explain that she was limiting her responses because she felt that she required containment. Ms A told HDC that she felt that Ms B could have addressed the issue with text messages directly and clearly with her in a session, but she did not.

**Session 10 — 10 September 2019 — recorded counselling session**

69. On 10 September 2019, Ms A attended a counselling session with Ms B and recorded the session. Ms B was unaware that the session was being recorded. Ms A provided a copy of the recording to HDC. During the session, Ms A chose (and Ms B agreed) to discuss the topic of power and powerlessness.

70. Ms A told HDC that during this session it did not feel like Ms B was following the therapy method that she developed so she asked what method was being used. Ms A said that she never understood why Ms B would not tell her what type of therapy she was providing.

71. Ms B told HDC that her belief was that the out-of-session communications "cultivated a disgruntled discontent" in Ms A that presented as an undercurrent in their final session. Ms B said that she found Ms A's persistence in asking her about her therapeutic method quite strange, as Ms A had participated in training in her method throughout 2019.

72. Ms B said that a clear goal had been established at the outset of the session (to discuss "power vs powerlessness"), and she considered that her mandate as a therapist was to focus and refocus on that intention. Ms B said that on reflection, she could have checked in with Ms A to see if power versus powerlessness was still her preference for the session.

73. Ms B accepted that the session that took place on 10 September 2019 was not accepted practice. Ms B told HDC that this session cannot be represented as her overall care. She said that something did not feel right, and that Ms A moved suddenly in and out of various topics, and she found the sudden changes and sudden questions disorientating and confusing. Ms B said that the session was unusual, but she does not consider that it was "power over", cruel or abusive. She stated that it is not uncommon to use strategies that challenge clients who feature with complex presentation.

**Cancellation of counselling and clarification session — September–October 2019**

74. After the session on 10 September 2019, Ms A cancelled all further bookings.

75. Ms B told HDC that Ms A subsequently requested a clarifying session, which took place on 29 October 2019. Ms B said that during that session they discussed the events as Ms A saw them. Ms B stated that she apologised that Ms A had not found the session very helpful, and offered to provide the clarifying session free of charge. Ms B said that she did not record notes during the session, as it was a "clearing session", not a therapeutic session.

76. Ms A told HDC that during the clarification session, Ms B offered her a transcript of the previous session (on 10 September).

77. On 1 November 2019, Ms B provided Ms A with a copy of a transcript that she had created. Ms B included statements in the transcript that did not occur in the session. For example, Ms B's transcript stated: "[O]kay, that sounds like a good topic, it's come up a few times in your texts lately." What she actually said was: "Hmmm." Ms B's transcript also stated that Ms A said, "[W]hat sort of therapy do you use?", whereas what was actually said was, "[T]he way we are working is there a name for it?"

78. Ms A sent an email to Ms B asking whether the transcript "was all of it" or whether she had written only some parts of what had been said.

79. Ms B responded: "I wrote the whole conversation down, bar one line that I didn't complete. The conversation is short because you walked out." In response to the provisional opinion, Ms A told HDC that she did not walk out of the session early. Ms A maintained that she has always felt that the transcript was not long enough considering how long the session was and the length of the recording.

**Complaint made directly to Ms B — November to December 2019**

*Correspondence from Dr C to Ms B*

80. On 14 November 2019, Dr C sent an email to Ms B and thanked her for providing a transcript of the session on 10 September, which he understood was a transcript of the notes she had made. He informed her that Ms A had recorded the counselling session on 10 September

2019, and that he had listened to the recording and had concerns about the content of the session. Dr C did not explicitly state that this was a complaint about Ms B's handling of Ms A's counselling sessions.

81. Ms B told HDC that when she received Dr C's email she sought professional supervision, and received legal advice that she should not respond and that the communication should come directly from Ms A.

82. Dr C sent a further email to Ms B on 2 December 2019 and stated that he believed an acknowledgement of problems in the conduct of the session and a simple apology would assist to heal the situation. Ms B told HDC that she did not reply to this email because of the advice she had received not to respond.

83. Ms B told HDC that at the time of events (when Dr C emailed her), she was unaware that a complaint had been lodged. Ms B stated that she could not respond in accordance with the counselling service's policy[13] until she received the HDC complaint.

*Correspondence between Ms A and Ms B*

84. Ms B sent a text message to Ms A on 3 December 2019 and asked for a copy of the audio recording, and Dr C sent it to Ms B.

85. On 11 December 2019, Ms A sent a text message to Ms B that stated: "I feel maybe you do not understand that I am making a complaint to you about the way in which the session I recorded was conducted by you."

86. On 12 December 2019, Ms B sent Ms A a text message that said that they had met on 29 October 2019 to try to understand what had occurred during the 10 September session, and that she was not sure what else there was for her to explain. Ms A replied that she was making a complaint to HDC about Ms B.

87. On 13 December 2019, Ms B replied that she had reviewed all the text messages and emails exchanged, and that she had already said she was sorry that the session had not been a useful one. Ms B also stated that she had sent a "write up" of session notes not a transcript of the whole session, and that she was not sure whether there was anything else she could do.

88. Ms A responded that what she would like was an apology for a session that had not been conducted well, and for Ms B having sent a transcript that she had said was a complete transcript but was not.

89. Ms B responded: "I believe I have apologised to you a number of times and I can do so again. I am very sorry that the session was not useful for you."

[13] Ms B provided a policy entitled "[The counselling service] Counselling Policies & Procedures 2020".

90. In response to the provisional report, Ms A told HDC that she had told Ms B that she was making a complaint, and that Ms B just wrote a text message that "basically shut [her] down". Ms A stated that she had nowhere else to go with her concerns except HDC.

91. Ms B told HDC that she was unable to write everything that was said during the session, and she had written the parts she considered were the main points. Ms B said that when she told Ms A that she had sent the "complete transcript", she was referring to the words she had written, i.e., it was a complete copy of all she had written during the session.

92. Ms A told HDC that she understands how notes work, for example she understands that doctors, counsellors, etc take notes of the important parts of a meeting. Ms A said that she is upset that Ms B wrote many notes during the session on 10 September 2019, and that the transcript that Ms B provided did not include the parts that reflected badly on her, and kept in all the parts that reflected badly on Ms A.

**Further information**

*Ms A*

93. Ms A told HDC that she thinks it would have been helpful if Ms B had provided an apology about how she conducted the session, and not an apology that Ms A did not find the session helpful. Ms A said that she made this complaint because she felt worried that someone else would have to go through this.

*Ms B*

94. Ms B told HDC that overall she considers that the care she and the counselling service provided to Ms A was helpful, supportive, informative, and kind.

95. Ms B said that the HDC's independent advisor draws from a client-centered approach (a form of psychotherapy and a non-directive approach to talk therapy, where the counsellor allows the client to direct the process), where any directing therapist "would be frowned upon". Ms B told HDC that the HDC advisor's perspective is not a universally accepted standard of practice.

96. Ms B said that her own model is not the only therapeutic model she draws from, and there are many models of therapy that she could, and frequently does, rely on.

97. Ms B stated that in hindsight she would not have had individual counselling sessions with Ms A if she had known of her BPD diagnosis earlier on.

98. Ms B said that this process has caused her to reflect deeply on all of the matters raised.

**Responses to provisional opinion**

99. Ms A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, her comments have been incorporated into the report.

100. Ms A said that Ms B contradicts herself, for example when Ms B stated that she uses many models of therapy and then stated that she found Ms A's "persistence in asking about her

therapeutic method quite strange". Ms A said that this is a strong contradiction that always upset her.

101. Ms A told HDC that in her experience, if used correctly, the therapy room is a sacred and invaluable place with opportunity for healing to take place or much damage to be done. She said that "nobody except the client and the therapist knows what goes on in this space", which is why she made the complaint. Ms A said that there is always a power differential in the room, and this will always be the case, so all the trust needs to be in the therapist to navigate the space safely, respectfully and honourably.

102. Ms B was given the opportunity to respond to the provisional opinion. Where appropriate, her comments have been incorporated into the report.

## Opinion: Ms B — breach

### Introduction

103. At present, the counselling profession in New Zealand is not regulated under the Health Practitioners Competence Assurance Act 2003, and there is no requirement for counsellors to register with any association for counsellors. Ms B was not a current member of any professional body throughout the time she provided services to Ms A.

104. As this Office has stated previously,[14] despite not being a member of a relevant association, Ms B is nonetheless bound by the Code of Health and Disability Services Consumers' Rights (the Code). In *Director of Proceedings v Mogridge*,[15] the Tribunal stated:

> "The obligations of the Code apply to those who provide health services, whether or not they belong to any professional association or similar body, and whether or not they are aware of the standards set out in the Code."

105. The counselling service, of which Ms B is the sole owner and shareholder, told HDC that it adopts the standard procedures and policies of the NZAC. In line with what I have stated previously,[16] I consider that by holding herself out as a counsellor and by providing counselling services for a fee, Ms B is required to meet the ethical standards of a professional counsellor, and that the ethical principles set out in the NZAC Code of Ethics provide a sound reference point in establishing the ethical standards that should apply in these circumstances. Accordingly, I consider the NZAC Code of Ethics to be an appropriate benchmark for the assessment of Ms B's practice.

[14] Opinion 12HDC01512, also cited in Opinion 20HDC01793, available at www.hdc.org.nz.
[15] *Director of Proceedings v Mogridge* [2007] NZHRRT 27.
[16] Opinion 20HDC01793 (27 June 2022).

106. Counsellors provide guidance in solving personal and psychological problems to people who often are very vulnerable. Clients put their trust and confidence in their counsellors, who must exercise an appropriate standard of care when providing counselling services.

107. In order to assist my assessment of this matter, I sought independent advice from Ms Irene Paton, a psychologist. I have also referred to advice that Ms B obtained from Mr E, a clinical psychologist who has, in large part, affirmed Ms Paton's opinion.

**Pre-care considerations**

108. Both Ms Paton and Mr E identified concerns about actions not taken by Ms B prior to commencing treatment for Ms A. In particular, they identified the lack of a written therapeutic contract, coordination of care with Ms A's current mental health provider, whether Ms B had relevant competence to treat Ms A, and the lack of a clear counselling method used.

109. Ms B did not have a written therapeutic contract with Ms A, and told HDC that there was a verbal contract that covered matters regarding availability, fees, cancelled appointments, confidentiality, session notes, and goals for therapy.

110. My independent advisor, Ms Paton, outlined that accepted care requires a written contract that establishes mutually agreed goals with clear understandings about sessions and outside session contact, recording sessions, writing notes, access to notes, and procedures if any difficulties arise in the work. The inclusion in the contract at the outset of an agreement about the expected number of sessions, with a review date to examine progress or re-negotiate the end point, would also be recommended in order to avoid a recurrence of these events.

111. Ms Paton explained that it is unclear whether the service delivered to Ms A was counselling or therapy. Ms Paton stated that as there are different parameters, it is important to discuss in the contracting stage whether therapy or counselling is being provided. Mr E agreed with Ms Paton's advice that there was a need for a written contract.

112. Whilst having counselling sessions with Ms B, Ms A also had regular therapy with clinical psychologist Dr C. Ms B did not coordinate with Dr C, and stated that she thought a meeting had the potential to triangulate the two therapists and ultimately would not be beneficial to Ms A.

113. Ms Paton advised that accepted practice is to establish a clear understanding about how clinicians would work together in ways that would enhance the potential for therapeutic growth and avoid the potential for splitting.[17] Mr E similarly stated that it is best practice to establish how therapists could work together or the roles they would each take in a client's care.

[17] "Splitting" is a psychological mechanism that allows the person to tolerate difficult and overwhelming emotions by seeing someone as either good or bad, idealised or devalued.

114. Ms Paton also stated that as multiple relationships existed (in Ms A's case, the prior relationship with another counsellor at the counselling service and attendance at mindfulness workshops), it was important that these were discussed thoroughly and any potential difficulties explored, before another therapeutic relationship was commenced.

115. Ms B told Mr E that she did not have specific expertise or experience (beyond that of a counsellor in general practice for a number of years) in working with clients with BPD. Ms B told HDC that her therapy model is one she developed herself that draws on several other recognised models, but is not a peer reviewed or recognised model itself. An explanation of this model is outlined at paragraph 13.

116. Mr E stated that in his opinion, Ms B did not have the necessary competence to work with a client with BPD, and, given her lack of experience with such clients, ultimately Ms B should not have worked with Ms A. He noted that best practice would have been for Ms B to screen for mental health history and diagnoses that were outside her competence.

117. Mr E also stated that some of the sessions Ms B had with Ms A, and certainly the recorded one (based on the transcript reviewed), were undertaken without application of a clear counselling model. Mr E said that in operating without a clear counselling model beyond mindfulness, Ms B was always at risk of not providing a satisfactory counselling service to a client such as Ms A, whose condition needed some structured therapy. In addition, Mr E stated that before any counselling model is applied with a client, it is best practice for the suitability of that model to the client to be assessed, and it appears that in this case this did not occur.

118. The New Zealand Counselling Aotearoa (NZCA) Code of Ethics outlines the following:

- "The terms on which counselling is provided shall be clear and reasonable … Counsellors shall establish with clients the aims or purposes of counselling and renegotiate them as necessary."[18]
- "Counsellors should endeavour to achieve good working relationships and communication with other professionals in order to enhance services to clients … Counsellors should negotiate to work collaboratively with other professionals working with the same client."[19]
- "Counsellors shall determine, in consultation with the client, whether they are appropriate to provide the counselling. Where necessary and feasible, counsellors shall refer clients to other counsellors who would be more appropriate by reason of their skills, gender or culture or for any other reason indicated by the clients' needs."[20]

119. I agree with the advice provided above. The lack of a written therapeutic contract led to Ms A becoming unclear on the services Ms B was providing, which caused confusion and Ms A's need to seek clarification frequently. I also agree that it would have been appropriate for

[18] Section 5.4 — Clear Contracts.
[19] Section 7.4 — Collaboration with Counselling Colleagues and Other Professionals.
[20] Section 5.3 — Appropriateness/Suitability of Counsellor.

Ms B to have contacted Dr C to establish a clear understanding of how they would work together and the focus of the additional therapy, and to have this explicitly agreed to by Ms A prior to any engagement. I also note the comment by Ms B that she did not have the required expertise or experience to provide counselling to someone with BPD or someone exhibiting some features of the condition, such as Ms A.

**Standard of care provided by Ms B to Ms A**

*Adjustment of scope and focus*

120. Ms A attended ten counselling sessions with Ms B. On 9 August 2019, Ms A told Ms B that she could not afford to continue with the sessions after October. After deciding that she could not continue counselling, Ms A had five further sessions (the last session took place on 10 September 2019). Around 14 August 2019 (during the sixth session), Ms A noticed a change in style and techniques during the counselling, and felt that Ms B's demeanour had changed and that she had become distant and argumentative, and was silent for long periods.

121. Ms A found it disconcerting that Ms B refused to explain why she had made changes to the counselling, and that she said that Ms A was imagining it. In a text message on 21 August, Ms B confirmed that she had changed the style of counselling. However, she did not provide Ms A with an opportunity to have any input into the change to her counselling, and did not consult Ms A for ideas.

122. Ms Paton advised that accepted practice is to discuss any changes with the client, preferably in person (rather than by text or email), and give them an opportunity to have input about adjusting the contract, and consultation about their ideas for going forward.

123. The NZAC Code of Ethics outlines that some of the core values of counselling are partnership[21] and autonomy,[22] and that counsellors should seek to increase the range of choices and opportunities for clients.[23]

124. The lack of clarity and communication about process resulted in a poor conclusion to the therapeutic relationship. Ms A had advised Ms B of her situation with sufficient time to allow for planning how this engagement would conclude successfully. Instead, Ms B independently changed the style and focus of therapy in response to Ms A's indication that she would need to cease therapy, which caused unnecessary confusion for Ms A.

*Text messages*

125. Ms B had a verbal agreement with Ms A that she could send one text message per day, and that Ms B would send one response. As outlined above, this agreement was not put in writing. Ms B said that this was not her usual practice, but as Ms A had this arrangement with Dr C, she agreed to it. Ms B later formed the view that corresponding with Ms A by text message encouraged the volume and increased the intensity of Ms A's need for reassurance

[21] Section 3.2.
[22] Section 3.3.
[23] Section 4.6.

from her. This is supported by the tone and number of the texts from Ms A when Ms B responded only once.

126. Ms B told HDC that she reconfirmed the agreement of one text message and one reply per day, and continued to uphold the agreement "despite [Ms A's] repeated attempts" to make her reply. Ms A disagrees that Ms B told her that her increase in text messages was a problem, and told HDC that they did not talk about it at all.

127. The text messages provided to HDC show that during the treatment period, on multiple occasions Ms B would reply more than once per day, and there was more than one reply outside of work hours. The only clear confirmation of the agreement in the text messages occurred on 5 September 2019, and then from that date until 9 September 2019, there was one reply per day. The next contact was after the counselling sessions had been cancelled.

128. Ms Paton advised that accepted practice is to establish clear boundaries of contact outside sessions. She noted that having a written contract with the client (discussed thoroughly), with these understandings outlined clearly, gives both parties a reference point to return to when the boundaries get blurred, and that revisiting the contract and modifying as required gives the client a sense of safety and security. Ms Paton advised that it is the counsellor's responsibility to be consistent and to revisit in sessions when clients are wanting more than has been agreed to, and that the counsellor needs to be consistent in applying the contractual understandings.

129. Ms Paton also stated that there was intimacy in some of Ms B's text messages, which could have the potential to cause confusion — for example, Ms B's text message, "I would protect you in the days ahead." There was also an occasion where Ms B asked Ms A why she felt powerless, which Ms Paton noted was inviting a therapeutic dialogue over text, which has the potential to be confusing, especially for someone with BPD. Ms Paton noted that later on, the text messages became more abrupt, compared to (in her opinion) the warm and friendly responses earlier. I note that this may have been an attempt by Ms B to re-establish the boundary of one text per day.

130. Ms Paton stated that it is advisable to keep communications to administrative matters rather than therapeutic content, and to monitor and contract carefully around both the frequency and content of out-of-session communication. Ms Paton advised that if therapeutic communication happens between sessions, there is a risk that it can blur the boundaries and become confusing for the client. She said that if a client wants to journal or make notes between sessions, it needs to be made clear how these are part of the therapy, and the purpose of sending these as emails or texts.

131. Ms Paton considered that the out-of-session communication amounted to a significant departure from accepted standards.

132. Whilst Ms B was clear with Ms A that she was willing to partake in one text message and one response per day, Ms B did not clearly outline the purpose of the text messages in the therapeutic contract, did not maintain this boundary, and was inconsistent in her text

messages. In my opinion, this would have led to confusion for Ms A. In addition, I consider that the content of some of Ms B's text messages was unprofessional.

*Request of transcript*

133. Ms A told HDC that at the clarification session on 29 October 2019, Ms B offered to provide her with a transcript of the session on 10 September 2019. On 1 November 2019, Ms B provided Ms A with a copy of a transcript that she had created. Ms B's transcript included statements that did not occur in the session. For example, Ms B's transcript stated, "[O]kay, that sounds like a good topic, it's come up a few times in your texts lately," when in fact she had said, "[H]mmm."

134. On 2 November 2019, Ms A asked Ms B whether she had written all of what was said, or whether it was only some parts of what was said. Ms B responded that she had written down the whole conversation bar one line, and told Ms A: "[T]he conversation is short because you walked out."

135. On 14 November 2019, Ms B was informed that Ms A had recorded the 10 September 2019 session, and on 3 December 2019 Ms B received a copy of the recording. On 13 December 2019, Ms B sent an email to Ms A and stated that she had sent a "write up" of the session notes, not a transcript of the whole session. Ms B told HDC that when she told Ms A that she had sent the "complete transcript", she was referring to the words she had written, i.e., it was a complete copy of all she had written during the session.

136. Ms Paton advised that accepted practice in relation to transcripts is that they are an accurate record of the sessions. Ms Paton stated that Ms B's transcript appeared to be from the notes she took in the session, and did not include all the words in the recording. Ms Paton said that telling Ms A that she was hard to deal with was blaming the client for the difficulties, and was disrespectful. Ms Paton advised that accepted practice would be to take responsibility for the differences in the transcript and the impact of this on the client.

137. The NZAC Code of Ethics outlines that a core value of counselling is personal Integrity[24] and being honest and trustworthy in all professional relationships.[25]

138. I acknowledge that Ms B may not have been able to write the entirety of what was said during the session on 10 September 2019. However, I am critical that Ms B provided a record of the session that she called a "transcript", which contained phrases that had not been said during the counselling session, and that Ms B told Ms A that she had written everything bar one line, and that when Ms B received the recording of the session, she then changed her position to say that it was a copy of her notes. It was unprofessional for Ms B to have blamed Ms A for the shortness of the transcript. It is understandable that Ms B's insistence that it was a full transcript of what was said caused upset to Ms A, as clearly this was not accurate.

[24] Section 3.5.
[25] Section 4.7.

**Conclusion**

139. This Office has stated previously:[26]

> "The relationship between a client and counsellor is often described in terms of there being a fiduciary relationship. It is framed in this manner, as the client puts his or her trust in the counsellor. This results in an inherent power imbalance between the counsellor and the client, as the client entrusts the counsellor with his or her fears, vulnerabilities, and emotions."

140. Ms Paton advised that the care provided by Ms B departed significantly from accepted practice.

141. I accept this advice. Ms A was a vulnerable consumer seeking mental health assistance from her counsellor, Ms B. Ms A placed her trust in Ms B. Many aspects of the care provided to Ms A by Ms B fell below accepted standards, including:

- The lack of a written therapeutic contract, including for out-of-session communications via text message.
- The lack of communication with Ms A's psychologist regarding roles and care.
- The lack of expertise (created by the lack of a written therapeutic contract and lack of communication with Ms A's psychologist regarding roles and care) and lack of a clear counselling model in Ms B's treatment of Ms A.
- The standard of out-of-session communication via text message, which was inconsistent in frequency of replies and content, and potentially was confusing for Ms A.
- The adjustment of Ms B's scope and focus of counselling without consultation or discussion with Ms A.
- The provision of an inaccurate transcript of the 10 September 2019 session.

142. Accordingly, I find that Ms B breached Right 4(1) of the Code.[27]

**10 September 2019 session — adverse comment**

143. Ms A recorded the counselling session on 10 September 2019, and I have assessed that recording.

144. Ms Paton advised that the care provided in this session would not be accepted practice and departed significantly from the standard of care. Ms B acknowledged that this session did not meet accepted practice.

145. I agree. During the session there were a number of opportunities for Ms B to engage differently to effect a different outcome, and her responses to Ms A during the session were not in line with a therapeutic process. However, I acknowledge that Ms B found herself out

[26] In opinion 09HDC01937.

[27] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

of her depth, particularly with the sudden questions, which she found disorienting and confusing. I also note that my advisor, Ms Paton, is a psychologist, and not Ms B's direct peer as a counsellor, and, whilst Ms Paton's advice is accurate against psychologist standards, I am mindful that Ms Paton would have different expectations of the session.

146. In my view, the sequence of events that took place on 10 September 2019 could have been avoided if Ms B had assessed correctly whether she was qualified to provide counselling services to Ms A. Ms B should have made this assessment by obtaining complete information from Ms A and by contacting Ms A's regular therapist, Dr C. I also acknowledge that Ms A was satisfied with the service provided in previous sessions.

**Complaints process — adverse comment**

147. The complaint made directly to Ms B is outlined above (see paragraph 80). While I acknowledge that Ms B received advice not to respond to Dr C, I consider that professionally it would have been courteous at least to acknowledge Dr C's correspondence and briefly advise Dr C of her intentions (for example, that she had received his correspondence but would not respond until she was aware of Ms A's involvement), or to make contact with Ms A shortly afterwards to confirm how she wanted to proceed.

148. Ms B subsequently corresponded with Ms A through text messages. I acknowledge that the HDC complaint was then made shortly afterwards. I encourage Ms B to reflect on her management of these communications, and her practice around complaints.

**Reflection on care provided — adverse comment**

149. Ms B told HDC that she considers that the overall care provided to Ms A was helpful, supportive, informative and kind, and that the session that took place on 10 September cannot be represented as her overall care.

150. Ms Paton advised that Ms B's observations from the recorded session appear to be about justifying what she did, rather than demonstrating an openness to considering how the client experienced the session, and what they could have done differently. Ms Paton said that the capacity to be self-aware and reflective is an important factor in being a "safe" counsellor.

151. Ms Paton advised that Ms B provided evidence of perspectives and theoretical understandings of working with a client who identified as BPD, which appeared to be used to defend and justify her behaviour, rather than commenting on how the choices she made affected Ms A and the work with her.

152. Mr E similarly outlined that Ms B made limited references to self-reflections and planned changes in the area of style or process, and she had sought to limit the complaint focus to the one session of particular concern, rather than the overall counselling process with Ms A. Mr E also stated that Ms B's changes to practice seemed to be more about protection from a similar future complaint or addressing some specific areas, rather than the broader matter of analysing self as a therapist and the methods and interpersonal approach one brings to counselling.

153. In response to the provisional opinion, Ms B stated that she takes responsibility for the negative outcome for Ms A based on the poor session she conducted and the negative outcome, which Ms B says arose from inconsistent boundaries around out-of-session communication.

154. I agree with the comments of Ms Paton and Mr E. Ms B has shown concerning lack of insight into the reasons for Ms A's complaint. I am concerned about Ms B's inability to reflect appropriately on the standard of the service she provided to Ms A, and the effect that her poor communication had on Ms A.

## Opinion: Counselling service

155. As a healthcare provider, the counselling service is responsible for providing services in accordance with the Code. Although Ms B is an employee of the counselling service, she enjoyed a high degree of independence in her practice, as she is also the sole director.

156. In my view, Ms B's failings identified in this report were matters of individual practice and were not directly the result of shortcomings in the counselling service's systems. I find that the counselling service did not depart from the appropriate standard of care.

## Changes made

157. Ms B told HDC that she will make the following changes to her practice:

a) Update the policy and procedure booklet, devise a new client/counsellor contract, and revise the written supervision contract.

b) Have written contracts with clients incorporating the time, cost, contact, method, limits of confidentiality, style of therapy, note taking, and HDC clients' rights, and will review the contract agreements regularly, including the goals.

c) Obtain supervision around multiple relationships and how to mitigate the issues that may arise.

d) Decline the option to be a second therapist.

158. Ms B told HDC that for future sessions she intends to undertake the following:

a) Provide clear rationale for techniques, actions, and/behaviour.

b) Accept that there will be ruptures in the therapeutic alliance, and recognise that they provide valuable opportunities for exploration and change, rather than obstacles to treatment.

c) Pay careful attention to the level of agreement between herself and her client concerning the overall goals of treatment and the tasks necessary to achieve those goals.

d) Work with the client collaboratively to explore alternative ways of proceeding.

## Recommendations

159. I recommend that the counselling service evaluate its complaints process and include a response to complaints written by professionals who are assisting the complainant.

160. I recommend that Ms B:

a) Provide a written apology to Ms A. The apology should follow "The Ombudsman's Guide to Making a Meaningful Apology".[28] The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Consider becoming a member of the New Zealand Association of Counsellors, and report back to HDC with the outcome of her consideration within three weeks of the date of this report.

c) Engage in regular individual supervision with a counsellor who is not employed by the counselling service.

d) Within three months of the date of this report, undertake training on communication, and report back to HDC once completed.

## Follow-up actions

161. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Association of Counsellors and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[28] https://www.ombudsman.ie/guidance-for-service-providers/the-ombudsmans-guide-to-m/#:~:text=This%20means%20identifying%20what%20went,who%20has%20made%20a%20complaint.

## Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Irene E.M. Paton dated 20 August 2020:

"Re: [Ms B], Counsellor at [the counselling service]; Reference 19HDC02371.

Thank you for the request to provide expert advice on this case, which I received on 21 July, 2020 from [the] Complaints Assessment Team Leader. I do not have a personal or professional conflict of interest in this case.

The particular request, to comment on the following:

1. Whether the care provided to [Ms A] by [Ms B] in the period from July 2019 to October 2019 was consistent with accepted standards.
2. In particular, please comment on the communication and therapeutic method(s) of the counselling session on 10 September 2019.
3. In your opinion, was the out of session communication by [Ms B] with [Ms A] appropriate?
4. Any other matters in this case that you consider warrant comment.

I have read the HDC's Guidelines for Independent Advisors and the following:

1. Copy of complaint form dated 13 December 2019.
2. [Ms B's] response dated 4 March 2020.
3. Clinical notes from [Ms B] covering the period 9 July 2019 to 10 September 2019 (some of which were difficult to read).
4. A copy of text communication between [Ms A] and [Ms B] covering the period 12 April 2019 to 13 December 2019.
5. A copy of email communication between [Ms A] and [Ms B] covering the period 12 April 2019 to 13 December 2019.
6. Transcript of counselling session on 10 September 2019, prepared by [Ms A].
7. Transcript of counselling session on 10 September 2019, prepared by [Ms B].
8. USB with audio recording of counselling session on 10 September 2019.

I have added the following Appendices to this report:

NZAC Code of Ethics (Relevant Sections)

Information from [Ms B's] website.

**Introduction**

I have commented on two scenarios:

Scenario A, on the basis of the information provided by the client [Ms A]; and

Scenario B on the information from [Ms B].

No information was provided about [Ms B's] membership to a Professional Body, so given she has described on her website (Appendix 2) what she does as 'counselling sessions', I have used the NZAC Code of Ethics as the standard of Care expected. I have indicated the clauses that have potentially been breached in brackets, with the full list of these in Appendix 1.

I have also used the term 'counselling' as the service being delivered, however the work with [Ms A] was more psychotherapeutic than counselling.

Two discrepancies between the two scenarios are that [Ms A] mentions having seven sessions ([Ms B] indicates ten) and identifies the recorded session as the sixth session on 14/8/2019 and [Ms B] indicates it is the 10th session on 10/9/2019. This does not change the particular request I have been asked to focus on.

**Scenario A: On the basis of the information provided by the client [Ms A]**

**Background**

[Ms A] went to some Mindful courses provided by [Ms B] at [the counselling service]. On 9 July 2019, [Ms A] began attending counselling sessions with [Ms B] at [the counselling service] and she had a total of seven sessions. The purpose of these sessions was to explore topics that [Ms A] felt she could not discuss with her regular therapist (who she continued to see during this time). [Ms A] acknowledges the first three sessions were good '*actually excellent, and I found her very helpful with some of my complexes*'.

In the last three sessions '*she was distant, argumentative, would leave long periods of silences*'. When [Ms A] brought it up with [Ms B], she said '*it was in my mind*'.

During the session on 14 August 2019 (session six), [Ms A] recorded the session in order to '*listen and figure out what I was doing wrong*' and she shared it with her therapist who confirmed that the session '*was very problematic, not professional*', and at times [Ms A] felt like [Ms B] was '*purposely frustrating me and messing with my mind a little bit'.*

In the last session (29 November 2019), [Ms A] tried to discuss what went wrong in the last session and she did not speak about the recording. She describes this session as '*ridiculously crazy making and I found her difficult to talk to and explain how I was feeling.*' In email exchanges [Ms B] offered [Ms A] a transcript of the last session. After a number of requests, [Ms B] eventually sent it, although [Ms A] said it was not accurate. '*Big parts were missing, parts were changed around and the whole session came across completely different than I was'.*

With the help of her other therapist, [Dr C], an email was sent to [Ms B], followed by another one three weeks later as no reply had been sent. Five days later [Ms B] [sent a] text asking for a copy of the recording.

[Ms A's] complaints:

1. [Ms B's] conduct in the 14 August and 29 [October] 2019 sessions.
2. The changes and omissions in [Ms B's] transcript.
3. [Ms B's] refusal to talk or answer emails.
4. [Ms B] not apologising.

The following comments are made in relation to the information provided by the client ([Ms A]). There are many examples where the evidence shows that [Ms B] did not provide a service that met the standard of care expected of a counsellor. I have identified the main examples of concern under each of the areas below. I have included in brackets the clauses of the NZAC Code of Ethics that are relevant.

**1. Whether the care provided to [Ms A] by [Ms B] in the period from July 2019 to October 2019 was consistent with accepted standards.**

**What is the standard of care/accepted practice?**

Information indicates that [Ms A] acknowledged that she had a diagnosis of Borderline Personality Disorder and had struggled in therapeutic relationships. I will outline acceptable practice for all clients, however it is even more important to attend to these matters very thoroughly, given the BPD diagnosis.

Accepted care would require a written contract which had been carefully contracted, establishing mutually agreed goals with clear understandings about sessions and outside session contact, recording sessions, writing notes, access to notes etc which was honoured by the therapist. Contracts with clients also need to include procedures if any difficulties arise in the work. It is unclear if [Ms B] had provided and negotiated a contract with [Ms A]. *(5.4 Clear Contracts)*

Where there are multiple relationships e.g. the mindfulness course with both [Ms B's colleague] and [Ms B] and a previous therapy relationship with [Ms B's colleague], it is important that these are thoroughly discussed and any potential difficulties are explored before beginning another therapeutic relationship. *(5.11 Multiple Relationships)*

[Ms A] was already working with [Dr C], and accepted practice would be to be establish a clear understanding about how the clinicians would work together in ways that would enhance the potential for therapeutic growth and avoid the potential for splitting. *(7.4 Collaboration with Counselling Colleagues and Other Professionals (a) Counsellors should endeavour to achieve good working relationships and communication with other*

*professionals in order to enhance services to clients. (b) Counsellors should negotiate to work collaboratively with other professionals working with the same client).*

Accepted practice with Transcripts would be that they are an accurate record of the sessions. Whilst the transcript [Ms A] made, matched the Recorded session, [Ms B's] 'transcript' appeared to be from the notes she took in the session and did not include all the words in the Recording. *(4.7 Be honest and trustworthy in all their professional relationships.)*

[Ms A's] comment that [Ms B] '*offered me a transcript of the last session (the one I had recorded) to look at with [Dr C] as she maybe thought this would help me see how hard I was to deal with*' (P3) was blaming the client for the difficulties and disrespectful to [Ms A]. *(4.2 Avoid doing harm in their professional work)*

Also [Ms B's] email of 2/11 commenting about the transcript, *'The conversation is short because you walked out',* implies the client was to blame for the transcripts being different, when the evidence shows that [Ms A's] transcript had matched the recording.

Accepted practice would be to take responsibility for the differences in the transcript and the impact on the client of this. *(3.5 Personal Integrity)*

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

The care provided is not what would be considered accepted practice and departed significantly from accepted practice.

**How would it be viewed by your peers?**

Peers would view this as unwise and unethical.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

See below in Section B. 1. (d)

**2. Comment on the communication and therapeutic method(s) of the counselling session on 10 September 2019.**

**What is the standard of care/accepted practice?**

(i) Content of Sessions:

[Ms A] indicated she wanted to focus on '*power versus powerlessness dynamic*'. [Ms B] used minimal encouragers, responded to questions with more questions, and there were periods of silence. [Ms B's] voice tone sounded harsh and cold.

Exploration of the topic raised by the client needed to be done more thoroughly, especially how it could manifest itself in their relationship.

[Ms A's] comment '*So you are about to set up one of those stand offs — is that what you want to do?* And [Ms B's] response '*Then let's not do it'* is another example of her using her power inappropriately. After another period of silence [Ms B] says '*I will just reiterate what I said, I did not not answer, I just said that focusing on p v p is probably more important.*'

[Ms A] saying '*So what is happening right now fits into p v p'* was another attempt to explore what was happening in the present moment.

Standard of practice would be to warmly invite the client to say more, rather than responding in a way that had the potential to shut the client down e.g. *P 'Because you want me to do what you want me to do, and I want to do what I want to do. That is equality.'*

It would appear that [Ms B] decided after emails from [Ms A] regarding frequency of sessions *'At that point my task changed to short term, and developing strategies to nail the addiction/ocd longing'.* It appears from [Ms A's] responses that she had not been consulted about this change.

Accepted practice would involve a conversation, preferably in person (rather than via text or email) about adjusting the contract, where the client would be consulted about their ideas for going forward, rather than the counsellor making decisions on the basis of assumptions without consultation with the client.

*(3.3 Value of Autonomy, 3.2 Partnership, 4.6 Seek to increase the range of choices and opportunities for clients.)*

(ii) Client's experience of the Therapist

[Ms A] experienced [Ms B] as '*distant, argumentative, would leave long periods of silence, and was completely different to the first three sessions. I found this disconcerting especially as when I brought it up, she would not tell me why there was a change, and at times said it was in my mind'* (p.2).

Accepted standard of care would require exploration of this more fully, rather than saying it was in the client's mind.

*[Ms A] It is like the first time I came to see you, you didn't do this, have I done something to piss you of[f] [Ms B]? [Ms B]? SILENCE [Ms B] You have done certain things to annoy me. [Ms A] Could you please tell me what they are. [Ms B] I already have. [Ms A] Could you tell me again please. [Ms A]* Why? *[Ms B] Because I don't want to!*

Accepted practice would be for a validation of this being the client's experience and to have explored this from the client's perspective.

Making the comment *'You have done certain things to annoy me'* and then refusing to discuss this has the potential to be very harmful for the client.

*(3.4 Responsible Caring, 3.5 Personal Integrity, 4.2 Avoid doing harm in all their professional work.)*

(iii) Request for modality being used

[Ms A] asked a legitimate question about '*the way we are working, is there a name for it.?*' [Ms B] responds with '*That is a bit of a deviation away from power and powerlessness. Maybe we should stay with the theme that is most important.'*

Standard practice would be to answer questions that are relevant to the therapy and to be respectful of the client's choice about what is discussed in the session. It is not for the therapist to decide what is the most important.

*(3.2 Partnership, 3.3 Autonomy)*

(iv) Note taking in Sessions

In the silences, [Ms A] appears to be endeavouring to connect with [Ms B]. [Ms B] writing notes is experienced by [Ms A] as a disconnection and she endeavours to ask more about the purpose of this and [Ms B] responds to [Ms A] saying '*Can you stop writing? (quite desperately)* with '*No I am not going to stop writing, I am going to keep writing, a relationship is equal remember, I am allowed to write.'* Also [Ms B] saying '*Because you want me to do what you want me to do, and I want to do what I want to do. That is equality.'*

Indicating that '*a relationship is equal'* demonstrated that [Ms B] was not aware of the inequality and abuse of power that was operating and the impact of this for [Ms A]. [Ms A] accurately identified the dynamics in the session and [Ms B's] responses indicated a denial of this reality, which left [Ms A] with a sense of this being '*crazy making'.*

When [Ms A] asks why the notes are being taken, [Ms B] responds with '*I am writing down what is being said so I am completely cognisant and conscious.'*

Accepted standard of care would be to be willing to pause, make eye contact (if appropriate) with the client and be open to exploring what was happening, rather than refusing and using her power as the therapist to deny the client's needs to have a conversation.

*(3.1 Respect for human dignity, 3.2 Partnership, 3.3 Autonomy, 3.4 Responsible caring, 3.5 Personal integrity)*

(v) Overall I did not see evidence of communication and therapeutic methods of counselling congruent with what [Ms B's] website indicates that clients can expect from her: … And from Document 2, the way she applies the [therapeutic] process …

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

The care provided is not what would be considered accepted practice and departed significantly from the standard of care.

**How would it be viewed by your peers?**

Peers could view [Ms B's] behaviour as cruel and harmful.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

See below in Section B. 2 (d).

**3. Was the out of session communication by [Ms B] with [Ms A] appropriate?**

a. What is the standard of care/accepted practice?

The initial texts from [Ms B], appeared to have warmth and care e.g. *'I would protect you in the days ahead.'* '*10/8 'Please tell little [Ms A] that I am here for her without paying (like right now) and, I will keep talking with her until she is happy enough to out and play'.*

[Ms A] could interpret these to indicate that [Ms B] was available for 'therapeutic texting' to meet [Ms A's] needs. The texts were sometimes replied after the usual work hours. 11/8 9.45pm, 14/8 9.24pm. which also gives the client information about the availability of the therapist.

After a series of texts, [Ms A] indicates she had an understanding about only one text a day and when there was a change to this, it became confusing for her. She attempted to clarify this in *Document 5 Email Communication: 4/8/19 [Ms A] asking about text communication YOU CAN SAY NO TO THIS, AND I WILL BE OK. ONCE AGAIN, FINE TO SAY NO.*

It would appear that [Ms B] chose not to be consistent with this, despite being given the opportunity by [Ms A].

The texts began to change to more abrupt responses. When [Ms A] attempted to speak about this with [Ms B], it was not permitted. As [Ms A] says in her email 23/9, this is *'Crazy making'.*

Accepted practice would be Contracting with clients' needs to clearly establish the boundaries of contact outside sessions. It is advisable to keep these communications to administrative matters e.g. appointment times etc, rather than therapeutic content. If a client wants to journal or make notes between sessions, it needs to be clear about how these are part of the therapy and the purpose of sending these as emails or texts. The risk being that if therapeutic communication happens between sessions, it can blur the boundaries and become confusing for the client.

*(4.1 Act with care and respect for individual and cultural differences and the diversity of human experience, 5.4 Clear Contracts)*

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

This is a serious departure from accepted practice.

**How would it be viewed by your peers?**

Peers would view this as unwise and unethical.

**Recommendations for improvement that may help to prevent a similar occurrence in future.** See below in Section B. 3. (d).

**Scenario B: On the information provided by [Ms B]**

1. **Whether the care provided to [Ms A] by [Ms B] in the period from July 2019 to October 2019 was consistent with accepted standards.**

**What is the standard of care/accepted practice?**

Confusion over the service being delivered. It is not clear whether the work was 'counselling' or 'therapy'. As there are different parameters, it is important that this is discussed in the contracting stage of the work. *(5.4 Clear Contracts)*

Information from [Ms B] indicates that [Ms A] acknowledged that she had a diagnosis of Borderline Personality Disorder and had difficulty with therapeutic relationships. One of those being [Ms B's colleague] (2012) where 'On one occasion I was called in to assist when [Ms A] refused to leave the counselling room.'

Accepted practice would be where there are multiple relationships e.g. the mindfulness course with both [Ms B's colleague] and [Ms B] and a previous therapy relationship with [Ms B's colleague]. It is important that these are thoroughly discussed and any potential difficulties are explored before beginning another professional relationship. *(5.11 Multiple Relationships)*

[Ms B's] observations from the recorded session appear to be about justifying what she did, rather than demonstrating an openness to considering how the client experienced the session and what they might have done differently. The capacity to be self-aware and reflective is an important factor in being a 'safe' counsellor. *(4.2 Avoid doing harm in all their professional work)*

[Ms B] changing the focus of the work. There are a number of examples of [Ms B] making decisions without evidence of having consulted with [Ms A], both within the recorded session and the notes from [Ms B] e.g. regarding introducing skills training, '*She felt that I had made a unilateral decision without consultation with her and that this was again a display of "power over"'.* The evidence shows that [Ms B] had made a unilateral decision which could be described as 'power over'.

Accepted practice would be to discuss any changes with the client, giving them an opportunity to have an input, rather than using the power of the counsellor to change the focus. *(3.2 Partnership, 3.3 Autonomy)*

Reference is made to comments from [Dr C] that appeared in the sessions at various times which [Ms B] describes as 'only seemed to broaden the distance between [Ms A] and me'.

The way [Ms B] handled these appears to have had a significant impact on the disconnection between herself and [Ms A]. (3.4 Responsible Caring)

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

The care provided is not what would be considered accepted practice and departed significantly from accepted practice.

**How would it be viewed by your peers?**

Peers would view this as unwise and unethical.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

Consider the impact of the previous relationships and the potential contamination of the current relationship. Explore this with the client before beginning the professional relationship.

The implications of framing the work as a 'double bind'. How did this lock [Ms B] into a 'power struggle' and ways of being with the client that were not congruent with the information on her website. (See below 2 (a) (i))

Being clear about the particular service being requested (i.e. counselling or therapy), the parameters and implications of this on the work.

Awareness of how the work and content of sessions need to be mutually agreed, not imposed by the counsellor.

Identifying how to work effectively with the client when they are concurrently working with another professional, especially where the other professional is being reported by the client as criticising.

Consider the impact of [Dr C] 'entering' sessions from 27/8. [Ms B's] clinical notes indicate her intervention was 'meta awareness, refrain from being caught in a double bind, psycho ed.' How else could she have responded?

Having a written contract with clients, which has been discussed and then if satisfactory agreed to and signed by both parties. This gives something tangible to refer back to if there are difficulties in the professional relationship.

Clarifying if a transcript is requested, exactly what the client is asking for.

**2. Comment on the communication and therapeutic method(s) of the counselling session on 10 September 2019**

**a. What is the standard of care/accepted practice?**

There are many things I could comment on where [Ms B] has behaved in ways that would not be the accepted standard of care, however I have chosen the main areas of concern.

There appears to be an incongruency between the model indicated on the website with what happened in the session.

[Ms B] describes the model she uses as '*mindful acceptance, kindness and compassion …'.*

This was not evident in the recorded session. *(3.5 Personal integrity).*

[Ms B] explains the dynamic operating in the sessions as being part of a '*Double bind*' which she indicates is part of the difficulty of working with clients who have BPD. It would appear that she became attached to this framework and let go of the basics of connecting with clients in the way described in (i) above.

She also indicates that '*The task of the therapist is to shift from the either/or options by creating a third option, an observer position from which the dynamics of the situation can be observed and discussed*.'

I did not hear/see evidence of this in the session or her response to the complaint. *(4.2 Avoid doing harm in all their professional work.)*

**Difference in Transcripts**. It would appear that [Ms B] regards the notes she took in the session with [Ms A] as the transcript, rather than a written document taken from the audio recording which [Ms A] sent to [Ms B].

**Use of power.** [Ms B] states: '*[Ms A] had come to believe something about me that was untrue; that I had changed in my demeanour towards her, that she had done something wrong to annoy me and that as a consequence, I was disengaging from her and using my position as "the powerful therapist" to control our interactions*.'

If it was as [Ms B] claims '*untrue'* that [Ms B] had changed her demeanor, does this imply that all her sessions were like the one that was recorded? If so that is very concerning and had the potential to be even more damaging. *(4.7 Be honest and trustworthy in all their professional relationships.)*

In terms of controlling the interactions, [Ms B's] choice to continue to write notes despite [Ms A] asking and then pleading her to stop is a clear example of [Ms B] '*controlling the interactions*'. Saying *'I'm allowed to write*' and *'I'm writing everything that's being said — I'm conversing with you — we're engaging'* (this is clearly very

different from the recorded session where [Ms B] was not engaging with [Ms A] in a respectful and safe way).

*'I'm just trying to write it all down because I need to understand*' and then repeatedly saying ([Ms A's] transcript) '*Because I need to …'* was not accepted practice.

In [Ms B's] written response she indicated that '*I opted for using the anchoring strategy of writing notes as a method for maintaining perspective and equilibrium.'*

Another example is [Ms B] saying '*power and powerlessness*' was more important to discuss when [Ms A] asks her a legitimate question about '*what sort of therapy you use?*'

[Ms A's] observation '*What is happening now is P vs p …*' and '*I'm left here feeling powerless*'. [Ms B's] response '*I'm sorry that you are confused*' misses an opportunity to be respectful and explore what might be behind the question and then answering the question.

[Ms A] saying '*You're angry*' and [Ms B] responding '*I'm not angry/You seem angry though*', is an example of [Ms B] engaging in the power struggle in an inappropriate way. Accepted practice would be to explore [Ms A's] observations and what was happening for her in the present moment.

In [Ms A's] transcript and the recorded session it indicates there were periods of **silence** which were mostly broken by [Ms A]. Accepted practice would be that there would be a discussion about silences and how these could be worked with in the service of the work of the client, rather than being another example of how silence was used in this case. [Ms A's] experience of this as another example of powerlessness would appear to be legitimate.

[Ms B] saying '*You have done some things that have annoyed me*' and the refusing to say what they were could be described as 'cruel' for a client. Accepted practice would be to have explored 'annoying things' in supervision and attended to those in a way that did not impact on the client. If a counsellor makes a statement like this, then there would need to be a willingness to unpack this statement with the client.

*(4.1 Act with care and respect for individual and cultural differences and the diversity of human experience, 4.2 Avoid doing harm in all their professional work, 4.5 Promote the safety and well-being of individuals, families, communities, whānau, hapū and iwi, 4.6 Seek to increase the range of choices and opportunities for clients.)*

**Use of supervision**.

[Ms B] indicates that after the '*first communication from [Dr C]. Upon receipt I immediately sought professional supervision and legal advice*' and then '*after listening to the recording, I made further contact with my supervisor, [Ms D], and sought her advice.'*

The outcome of these sessions could have been outlined more fully.

Accepted practice would be to demonstrate how supervision helped her to reflect on the choices she made and of the consequences of these for the client.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

The care provided departed significantly from what would be considered accepted practice. The examples above would be considered to be potentially disrespectful, harmful and an abuse of power.

**How would it be viewed by your peers?**

Peers could easily view this as cruel and damaging.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

For [Ms B] to explore:

1. the use of and impact of power in the counselling relationship.
2. the damage for the client when the counsellor abuses their power e.g. continuing to write notes and say they are staying connected when the recording and transcript shows something different.
3. the dynamics around silence in sessions.
4. what influenced her to let go of the things that she has on her website that clients can expect from her. How could she have incorporated the theoretical perspectives alongside of [her therapeutic] process?
5. Other ways of anchoring herself rather than needing to write notes.
6. what happened for her when the information from [Dr C] came into the session, how did it impact on her capacity to stay present with [Ms A]?
7. how she uses supervision and how the supervision she received helped or hindered her.

**3. Was the out of session communication by [Ms B] with [Ms A] appropriate?**

[Ms B] indicates: '*Ongoing out of session contact is not something I do in my practice, however, as [Ms A] had this arrangement with [Dr C] (her primary therapist) I decided I would follow the protocol, so I agreed to one txt and 1 reply per day*.'

Accepted practice would be to monitor and contract carefully around both the frequency and content of out of session communication. From the texts it would appear that [Ms B] had responded with more than one text and sometimes after work hours. The content of these texts changed from warm and friendly to shorter, colder responses. There is also an intimacy and potential for confusion in some of [Ms B's] responses e.g. *I would protect you in the days ahead ….* 8/8*.*

*[Ms A] texts 'And you lie beside me till I fall asleep'* [Ms B] replies *'Correct'* and [Ms A] texts *'Truely',* [Ms B] replies *'Certainly'.* (Page 13/37, with No 9 on it.)

Other texts From [Ms B] to [Ms A]:

3/8/19 11.41pm *'Hi [Ms A], can you tell me what you are working so hard for'*

14/8, 9.24 pm *'Nevertheless I am with you — honest and real'*

28/8/19 7.25 pm *'[Ms A] could stay at home or I could go on camp with her. That would be fun. (flower emoji)'*

It would appear that [Ms B] had established an understanding about texting and emailing, '*[Ms A] would always apologise for overstepping the agreement, but never-the-less would continue to send them.*' There is an implication that [Ms A] was at fault in this statement. Clients will push at the boundaries and test the counsellor's capacity to maintain these. It is the responsibility of the counsellor to be consistent and to revisit in sessions when clients are wanting more than has been agreed to. Often this can be an important part of the work, especially with people who have had difficult attachment to parental figures.

Clear Contracts (a) The terms on which counselling is provided shall be clear and reasonable. Contracts negotiated between counsellors and clients may include matters to do with availability, fees, cancelled appointments, the degree of confidentiality offered, handling of documentation, complaint procedures and other significant matters.)

**What is the standard of care/accepted practice?**

Contracting with clients needs to clearly establish the boundaries of contact outside sessions. It is advisable to keep these communications to administrative matters e.g. appointment times etc, rather than therapeutic content e.g. 3/9/19 6.56 pm *'I'm sorry you feel that way. Why are you feeling so powerless?'* This is inviting a therapeutic dialogue over text which has the potential to be confusing, especially for someone with BPD.

Having a written contract (thoroughly discussed) with the client with these understandings clearly outlined, e.g. how often and when the counsellor will respond to out of session contact, alternative contacts for clients when they are not feeling safe and are not able to contact their therapist, etc. The counsellor needs to be consistent in applying the contractual understandings. Having a written document gives a reference point for both parties to return to when the boundaries get blurred. Revisiting the contract and modifying as required gives a sense of safety and security for the client.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?**

On its own, I believe this is a less serious departure from accepted standard of care, however in the context of the other areas of concern, it supports the significant departure from standard of care.

**How would it be viewed by your peers?**

Peers would view this as unwise and unethical.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

I recommend [Ms B] consider:

- what left her vulnerable to not holding to her usual protocol, apart from following what [Dr C] was doing?
- what the impact would be for [Ms A] of the texts, other than the explanations [Ms B] gave in her response to this complaint?

**Conclusion**

[Ms A] acknowledges that some of the sessions with [Ms B] were helpful and it would appear that if the transcript had been an accurate reflection of the recording, [Ms A] may not have needed to make the complaint.

Whilst [Ms B] included her clinical notes (with client information, interventions and outcome for most sessions) as well as evidence of perspectives and theoretical understandings of working with a client who identified as BPD, it appeared from her response to the complaint that she used these to defend and justify her behaviour, rather than commenting on how the choices she made impacted on [Ms A] and the work with her.

It was very helpful to have the recording of the 10 September session with the transcript. If this is an example of how [Ms B] typically works with clients, I would have serious concerns about the service clients are receiving from her.

In the recorded session and in her transcript, [Ms A] indicates '*I am proud of myself right now*'. It would appear that [Ms A] expressed her feelings, whilst remaining calm and contained, endeavouring to have her needs met respectfully in the context of the difficult situation with [Ms B].

Thank you for the opportunity to provide this feedback.

Yours sincerely

Irene E.M. Paton"

**Further advice**

**"**7 January, 2021

Re: [Ms B], Counsellor at [the counselling service]

Reference: C19HDC02371

Thank you for the request (1/12/2020) to respond to the information provided.

Documents consulted

1. Letter from [Ms B's] lawyer with the following enclosures:
    a. Response from [Ms B] and [the counselling service]
    b. [The counselling service] Procedures and Policies
    c. [Therapeutic method] training notes (141 pages)
    d. Qualification of [Ms B] and [Ms B's colleague]
    e. [Ms D's] response
    f. Information from [Ms B's colleague]
    g. Email from [Ms A] on 27 November 2020 and its attachments
    h. The Association for Contextual Behavioral Science Website and Information in Appendix 1

I understand that expert advice has been requested on the following:

<u>Whether it causes you to amend the conclusion drawn in your initial advice or make additional comments.</u>

My Conclusion in the report of 19/8/2020 was:

*[Ms A] acknowledges that some of the sessions with [Ms B] were helpful and it would appear that if the transcript had been an accurate reflection of the recording, [Ms A] may not have needed to make the complaint.*

*Whilst [Ms B] included evidence of perspectives and theoretical understandings of working with a client who identified as BPD, it appeared from her response to the complaint that she used these to defend and justify her behaviour, rather than commenting on how the choices she made impacted on the work with [Ms A].*

*It was very helpful to have the recording of the 10 September session with the transcript. If this is an example of how [Ms B] typically works with clients, I would have serious concerns about the service clients are receiving from her.*

*In the recorded session and in her transcript, [Ms A] indicates 'I am proud of myself right now'. It would appear that [Ms A] expressed her feelings, whilst remaining calm and contained, endeavouring to have her needs met respectfully in the context of the difficult situation with [Ms B].*

After having read the material submitted with the letter (1/12/2020) from [the] Senior Investigator at HDC, I still hold to the conclusion above and now have more concerns about [Ms B's] ethical and professional practices.

Any further comments about the care provided by [Ms B].

Before commenting on the care provided by [Ms B], I am curious about why she has included 141 pages of her [therapeutic method] *training notes* in responding to this complaint?

Whilst [Ms B] indicates there have been some changes made as a result of the complaint, these were not in place at the time of the sessions with the client and it would have helped if in the process of responding to the complaint, if [Ms B] had been able to acknowledge the impact of the absence of these for the client.

On Page 3, No 7. Whether [the counselling service] has considered making any changes to the service provided following this incident and, if so, what. Policies and procedures reviewed/changed following the incident, include, but are not limited to: 1. Reviewed policy and procedure booklet, 2. New client/counsellor written contract, 3. Revised written supervision contract, 4. Specialist supervision PRN.

Having these policies and procedures available for clients will give written transparency for both clients and clinicians to refer to. I have some concerns that I have commented about below.

Whilst [Ms B] has indicated (P.8) that on reflection she intends to adopt the process of *Repairing Alliance Ruptures* (Safran, et al 2011) for future sessions, [Ms B's] response on P. 6 indicates that she does not believe and is not able to acknowledge the care she provided departed from accepted practice. On page 6 e. The overall care provided by you is not what would be considered accepted practice and departed significantly from accepted practice. 1. I consider that the overall care [the counselling service] and I provided to [Ms A] was helpful supportive, informative and kind. 2. The session in question cannot be represented as my overall care.

The concerns I have about the care provided by [Ms B] are supported by the following statements by [Dr C]: (Letter 23/3/2020)

On P. 178 *I have undertaken an analysis of the transcript of this recorded session. In summary I believe that [Ms B] conducted the session using a number of highly problematic processes. Several of these processes mesh with and amplify the issues that [Ms A] is struggling with and seeking to attend to in her counselling.*

On P 179, *However, I believe that any competent and knowledgeable counsellor or therapist would come to a similar conclusion that the session was, in various ways, problematically conducted by [Ms B].*

On P. 189 Commentary (on the light being on or not): At this point [Ms A] has gone from being clear and confident to uncertain and I believe that this was caused by [Ms B] using a double bind process on [Ms A], made worse by the fact that it is a process [Ms A] is actually trying to work on and resolve. The irony is that in the session which [Ms A] recorded [Ms B] herself initiates a double bind of her.

I wonder if [Ms B] may have decided that the way to treat [Ms A's] need for reassurance (which [Ms A] did seek in a 'compulsive' way — using the everyday sense of the word) was to try to not 'reward' it by responding to it. If this was what she was doing she did not tell [Ms A] that she was and this left her feeling confused and thinking that she had done something wrong. [Ms B] did not explain anything, she just took action and made statements. I think that this approach of hers is not sound practice.

On P.189 Likewise, as [Ms A] has said, no one has given her a diagnosis of Borderline Personality Disorder (BPD). It is true that she does have some features of this and it is true that she struggles with some of the things [Ms B] describes but I feel that she uses this diagnosis as a kind of defensive weapon.

Rather than holding to the view that the session was not represented by her overall care, if [Ms B] had been able to demonstrate a more open perspective and with the help of a regular supervisor, look at the session and demonstrate her understanding of how it could have been perceived to have departed from accepted practice, acknowledging the impact of her choices on the client, it might have influenced me to alter my original conclusion.

<u>A response to [Ms B's] statements:</u>

7. 'I note that on her website Ms Paton advertises that her services do not cover:

a. addictions (alcohol or drug or eating disorders)

b. Counselling for more severe psychiatrically disturbed people

c. counselling children.

I therefore question whether Ms Paton has the relevant and necessary experience to perceive the nuanced complexities of this case.'

Yes, [Ms B] is correct I do not 'cover' the things above because I choose not to work with clients where those are the main presenting issues. I have had training and attended workshops and conferences where I have an understanding about both a. and b. For the report I wrote in response to this complaint, I had extensive supervision with my regular supervisor who is a Clinical Psychologist and an expert in working with more

severe psychiatrically disturbed people. I believe she supported me to perceive and understand the nuanced complexities of this case.

In my work on the NZAC Ethics Committee, I am part of assessing complaints, conducting RETs (a process of meeting with the Complainant and the Respondent), and have also been on Hearing panels for more serious complaints. Whilst this requires a knowledge of the particular kind of work or client presentation, my role is to ascertain if the matters raised by the Complainant would be regarded as aligned to the Code of Ethics or where the behaviour of the Respondent has not fitted what is expected of an NZAC Member. Where necessary 'expert advice' is requested from suitable people to aid in the responding to complaints.

I understand HDC has asked me to give expert advice because they believe I am suitably qualified and experienced to provide this.

<u>The appropriateness of [the counselling service's] policies at time of these events.</u>

I understand that the information I received that the information on the policies at the time of the event were not supplied. *'2. Access to the original document has been lost on an old computer from 2001.'*

<u>5. Any other matters in this case that you consider warrant comment.</u>

Professional Membership

In response to the question 'Details of your membership of any College or professional association', [Ms B] states that she belongs to the Association for Contextual Behavioural Science (ACBS). Unlike NZAC or NZCCA who have a robust membership application process, Code of Ethics and Complaints process, the Association of Contextual Behavioural Science is according to their website '*a worldwide online learning and research community and a living resource for anyone interested in ACT, RET and Contextual Behavioural Science'*. From Appendix 1 it can be seen from the email from ACBS that they are not a licensing agency and they don't have a formal complaints policy for members.

[Ms B] refers to NZAC a number of times in the information provided.

e.g. On page 2 *conduct and professionalism 1. [The counselling service] adopts the standard procedures and policies of the NZAC.*

There is a risk that those reading this could assume that she is a Member of NZAC.

2. *'Supervision will be confidential however if there is a concern re the supervisees practice this will initially be discussed with the supervisee and if not resolved a discussion will be had re which body to seek advice and input from (NZAC or NZCCA).'*

I am wondering how [Ms B] intends to do that when I understand she is not a Member of either of these Professional Associations?

Interpretation of concerns raised by [Ms A].

d. She ([Ms A]) is upset by your management of her complaint.

1. *It is disappointing to hear that [Ms A] is upset by my management of her complaint. I have followed the HDC guidelines, answered HDC questions and kept within the required time frame.*

The comment about 'it being disappointing' appears to be more about the impact on [Ms B], than an acknowledgement of [Ms B's] actions that had the potential to contribute to the reasons [Ms A] was upset and needed to make the complaint.

I took the comment by [Ms A] to be about how [Ms B] managed the situation before HDC became involved.

(iii) [Ms B] not responding to [Dr C]

[Ms B] responds with 3. *I was confused regarding [Dr C's] role and unclear about my obligations as a colleague. I did not have a clear pathway regarding ethics and protocols. I needed to clarify my obligations and processes.*

If she had been consulting with the Ethics of NZAC as she indicated she does, she would have found the following:

The NZAC Code of Ethics states:

7.4 Collaboration with Counselling Colleagues and Other Professions

(a) Counsellors should endeavour to achieve good working relationships and communication with other professionals in order to enhance services to clients.

(b) Counsellors should be respectful and mindful of confidentiality in all communications with other professionals about clients.

(c) Counsellors should negotiate to work collaboratively with other professionals working with the same client.

The information from [Dr C] (Letter 23/3/2020) indicates he was endeavouring to work in the best interests of [Ms A].

On P. 179 'I cannot accept [Ms B's] rationale for not replying as she had already communicated with me by sending me her transcript. My intention had all along been to avoid a formal complaint. I never said that [Ms B] should "humble herself" instead I said (in a collegial and friendly way) "that a process of humble, honest and open communication by all would prove reparative and enable both of you to put this behind you".'

Supervision

It would appear that for [Ms B] there is some confusion about 'supervision' and 'consultation'.

On P.18 *I attended one session with [Ms D] to seek advice. In her statement [Ms D] refers to the session as a consultation with an expert. I consider this to be the same meaning as a session with a supervisor and for this reason I previously described [Ms D] as my supervisor*.

P.171 [Ms D]

*I request that the complaint documents be corrected; that my name be removed as a supervisor. I am not and have never been [Ms B's] supervisor and I had no involvement in supervising this case.*

Working in this field, clinicians are expected to attend to their responsibility and obligation to attend to supervision requirements.

NZAC Code of Ethics 9.1 Professional Supervision Arrangements (a) Counsellors shall arrange for regular and ongoing supervision with competent supervisors, who should be either NZAC members, or members of another professional body with a Code of Ethics acceptable to the NZAC National Executive.

Having one consultation/supervision session would not be considered to be adequate. [Ms D's] request above for her name to be removed as the supervisor would indicate that she did not regard the session as supervision. Had [Ms B] been able to identify clearly how she used regular supervision during the work with [Ms A] and in the process of responding to the complaint, this would have had the potential for me to change my original conclusion.

(v) Complaints Procedures for [the counselling service]

P. 24 [The counselling service] is committed to ensuring feedback. Complaints, about services are, welcomed, handled fairly, and acted on, appropriately. We understand that feedback is essential to ensuring a high quality.

I understand that [Ms B] is the Director of [the counselling service] and also works as a clinician. How safe is that for clients to express a complaint about her when she is also the person processing the complaint? As she indicates on Page 2 3. *A copy of any internal review or investigation in relation to this complaint, if not already provided. I would effectively be reviewing myself so there is no written internal review available although I did discuss the incident at the time and subsequently with [my colleague]*.

Having another impartial person (maybe the supervisor or a Professional Body with a Complaints process) who a Client could express their concerns to, would separate out the roles of the clinician providing the service and the person receiving and processing the complaint.

Agreeing to work with [Ms A]

As there had been some previous contact with [Ms A], e.g. the sessions with [Ms B's colleague] which had ended badly and the group sessions, I wonder if [Ms B] had taken into account the impact of these on the individual work with [Ms A]. There also appears to be some confusion about the work that had been verbally contracted.

On P. 170 [Ms D] states: *The complex presentation which is demonstrated here reflects Borderline Personality Disorder traits and behaviours. [Ms B] was not working with this presentation, she had contracted for short-term sessions to better understand the client's difficulties with female counsellors and endings. This is exactly what occurred; the difficulty the client has with female counsellors and endings was acted out. This would be better held in the long-term therapy with her ongoing therapist. To split it off and have it play out with a female counsellor who did not contract to work with such long-term difficulty and complexity would only risk it being set up to fail.*

I discussed Borderline Personality Disorder in some depth and provided information on this complex presentation and how to work with clients who present in this way. [Ms B] reported that that was not the focus of the short-term sessions and that this would have been outside her scope of practice.

Although according to [Ms B], the BPD was not the focus of the short-term work, if she believed as she states that it is important to take this into account [P. 188 [Ms A] notes that [Ms B] states 'At the outset, it is important to take into account the client's psychiatric diagnosis' (Borderline Personality Disorder, Addiction and OCD), how was she planning on separating this out from the short term work?

This is also mentioned by [Dr C] (P. 178): *Subsequent to hearing the recording my view did indeed change and I advised [Ms A] that in my view this session was highly problematic and she would be best advised to end her counselling with [Ms B]. I have undertaken an analysis of the transcript of this recorded session. In summary I believe that [Ms B] conducted the session using a number of highly problematic processes. Several of these processes mesh with and amplify the issues that [Ms A] is struggling with and seeking to attend to in her counselling.*

**Conclusion**

Whilst [Ms B] and [Ms B's colleague] indicate that the taped session is not reflective of [Ms B's] normal way of working, it is the evidence that has been presented to me to consider along with the written material.

Whilst there has been some acknowledgement of things [Ms B] would have done differently, there is also a strong element of defensiveness in the way [Ms B] has responded and as she acknowledges herself 'I did not have a clear pathway regarding ethics and protocols'.

If she had demonstrated more capacity for self-reflection and focused more closely on the concerns raised and how her responses could have potentially breached what is

accepted as the standard expected of a clinician delivering 'counselling' services, it would have had the potential to influence me to reconsider the original conclusion.

Thank you for the opportunity to respond.

Yours sincerely

Irene E.M. Paton"

## Appendix B: Advice obtained by Ms B

Ms B obtained the following advice from a registered clinical psychologist, Mr E:

> "The writer was engaged by you to provide an opinion about [the counselling service] [Ms B] provided to a client in the second half of 2019. In particular to advise in relation to the standard of care she provided to the client and subsequent issues raised by the HDC and the expert/peer counsellor who reviewed the services provided by [Ms B]. As part of this, the writer was specifically asked:
>
> 1. To provide an independent assessment of the issues raised in the complaint and by the HDC, and of [Ms B's] response to the HDC.
> 2. To provide an assessment/comment on the advice provided by the expert peer that HDC referred to, Ms Irene Paton, and report whether he agrees or differs in opinion and the reasons why.
>
> Firstly, the writer declares that he thinks he may have some prior knowledge of the complainant/client of concern, [Ms A]. … During that time the writer was a member of a … consult group. The writer recalls that one of the other psychologists on the consult group had a client who he recalls to be [Ms A], and that the psychologist shared some of her experiences working with [Ms A] during some consult sessions. The writer has never himself met or worked with [Ms A].
>
> This report is based on a telephone discussion with [Ms B] on 21st April 2021, and review of the following documents:
>
> - Letter from HDC and initial complaint to HDC by [Ms A], dated 10 January 2020, including transcript of counselling session from 10 September 2019.
> - [Ms B's] response to complaint, dated 4 March 2020
> - Letter from HDC to [Ms B], dated 9 October 2020
> - Irene Paton's advice to HDC, dated 20 August 2020, 7 January 2021 & 3 February 2021
> - [Ms B's] response to HDC, dated 20 November 2020
> - Information from colleague/business partner of [Ms B], dated 14 November 2020
> - Qualifications provided to HDC of [Ms B]
> - Response of [Ms D] to HDC, dated 13 November 2020
> - [Ms B's] draft response to Ms Paton's advice, prepared March 2021.
>
> *Credentials of Reviewing Psychologi*st
>
> …

**Personality Disorders: Presentation and Best-Practice Therapeutic Approach**

Personality Disorders are recognised as serious mental health conditions of clinical concern. In applied practice, Personality Disorders are assessed based on criteria in the DSM-5 — Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition). The defining feature of all Personality Disorders is *an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture*. The pattern is manifested by either (at least two must be present) abnormal cognition, affectivity, and/or interpersonal functioning, or difficulties with impulse control. The pattern needs to be found to be inflexible and pervasive across a broad range of personal and social situations, and to lead to clinically significant distress or impairment in social, occupational, or other important areas of functioning. Additionally, the pattern of problem emotion, cognition, or behaviour, is stable and of long duration, and its onset can be traced back to at least adolescence or early adulthood (DSM-5, American Psychiatric Association).

One of the most prevalent personality disorders is Borderline Personality Disorder, (BPD). BPD is defined a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity. Emotional dysregulation is a fundamental feature. The DSM-5 diagnostic criteria require five or more of the following nine criterion for the diagnosis: Frantic efforts to avoid real or imagined abandonment; A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; Identity disturbance: markedly and persistently unstable self-image or sense of self; Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating); Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour; Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days); Chronic feelings of emptiness; Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); Transient, stress-related paranoid ideation or severe dissociative symptoms.

It is indicated in documents reviewed that [Ms A] has had an established diagnosis of BPD, and that this is not in dispute, although [Ms A] may have had other conditions also.

There are various guidelines available for therapists working with persons diagnosed with a personality disorder (see American Psychiatric Association, British Psychological Society), a consideration of which is outside the scope of this report. Further, certain therapeutic models are considered to be more appropriate for BPD due to being evidenced-based, i.e., Dialectical Behavioural Therapy (DBT), or due to relevancy and depth, i.e., Psychodynamic therapies. Needless to say, because of the complex presentation and features of personality that can negatively impact on the therapeutic relationship, a certain level of specific expertise and experience is required to work with persons who have a diagnosis of BPD.

It would be expected by a suitably qualified peer that a professional engaging in any individual therapy sessions with a client with a BPD diagnosis would:

1. Have some training in a model appropriate for treatment or management of the condition, and be able to apply that model in a structured or coherent manner when working with the client including being well-versed enough in the model to do so when under pressure or stress.
2. Be aware of the particular need to apply boundaries, manage expectations, and have clear goals, including using a written agreement or contract with the client even if not doing that as a standard with other clients.
3. Address the issue of multiple therapeutic relationships and be mindful of the risk of splitting — where the client emphasises differences between therapists to therapists in relation to their case formulation and care.
4. Be aware of the potential for the client to attack the therapist (or quickly switch from therapist admiration to devaluation) including through projection and transference, and react in a professional rather than personal or defensive manner.
5. Assume that there is a possibility of 'deception' or 'manipulative' behaviour occurring, such as sessions being covertly recorded or the client not directly revealing when they are upset about something that was said; and always act in line with that assumption, including being transparent even if the client is not always so, consider all you say 'on the record', and being validating even when the client's behaviour is of concern and seems against the therapist.

It seems that none of these five things were demonstrated or consistently displayed in [Ms B's] contact with [Ms A]. [Ms B] stated to the writer that she was not initially aware that [Ms A] had a diagnosis of BPD. [Ms B] also stated that in her individual sessions with [Ms A] that she was not particularly using the therapy that she herself 'developed' … but rather was working in an eclectic way that drew upon her twenty plus years of counselling experience and knowledge from the various areas of professional development she advised she had.

[Ms B] acknowledged to the writer that she did not have specific expertise or experience (beyond what a counsellor in general practice for a number of years would have) in working with clients with BPD. [Ms B] stated that in hindsight, if she knew of the client's BPD diagnosis earlier on, she would not have gone on to do individual counselling sessions with her.

It is clear from the transcript of the counselling session of particular concern that [Ms B] was at times reacting at a personal level and was not able to maintain professionalism, due to experiencing some emotional dysregulation and defensiveness herself, as a function of the interaction with [Ms A]. It is known by therapists working with BPD clients that personal reactions can often be triggered and that regular supervision and/or attendance at a consultation group (in the case of DBT) is best practice to mitigate this risk.

It is the writer's view that it can be fairly concluded that [Ms B] did not have the necessary competency to work with a client with BPD, and that best practice in this case would have been to:

1. Consider the client's mental health history and screen for any diagnoses, such as BPD, which would be outside of her limits of competency
2. Consider the issues of multiple therapeutic relationships
3. Do not engage the client in individual counselling sessions, or if already started, cease sessions and refer on/back to primary therapist.

[Ms B] stated that she would typically do these things. She stated she had been complacent with this case due to the atypical referral process.

**Basis of, and Issues arising from, Complaint**

*How Counsellor Conducted Herself in Recorded Session*

[Ms B] has repeatedly stated the session recorded is not a representative sample of the counselling she typically provides. It was clear to the writer that there are genuine concerns about how: the session was structured, what was said, with the therapist not being client-focused and not responding to client requests, and how [Ms B] reacted during the session including her interpersonal approach and language to the client. [Ms B] acknowledged to the writer that she became emotionally dysregulated during the session, and that the session was not at the level of professionalism and competency to which she seeks to provide. It can be fairly concluded that the recorded session was not at an accepted level of practice for a counsellor or any other mental health professional or para-professional.

*Lack of Liaison/Collaboration with Other Service Provider/Therapist*

As noted above, best practice would have been for [Ms B] to have established what multiple relationships existed and how therapists could work together or the roles they would each take in a client's care. However, while this is recommended it does not always happen for practical reasons such as counsellor availability. It is noted in this case that [Dr C] (writer is not certain of his title/qualifications) did not make contact with [Ms B] until the session of concern/complaint issues emerged, with their being no initial collaboration on his part either.

*Inconsistency with Out of Session Communication*

It appears that [Ms B] was not consistent with frequency of text and email arrangements, as well as the nature of what was to be covered in such communications (i.e., administrative matters vs therapeutic matters). Consistency in out of session communication is accepted practice, and particularly necessary in cases where clients have BPD, where use of contracting helps establish the boundaries of contact outside sessions. It seems further in this case, that once [Ms B] realised the out of session communication to be inappropriate, she did not sufficiently talk to [Ms A] about changing this.

*Conduct in Relation to Transcript*
The writer concurs that a transcript should be an accurate factual record of a session. It seems that [Ms B] should not have called what she produced a 'transcript' of the session, but rather a summary of her session notes, as she had not recorded the session herself or kept written detail to the extent that she could produce a transcript. Nevertheless, there are indications that there is some distortion in [Ms B's] write-up of the session due to some inaccuracies in the record she produced for [Ms A]. It also appears that [Ms A] asked for a transcript/summary of the session even though she had her own one (i.e., a recorded session) for motives other than to check the accuracy of her own record.

*Nature and Quality of Counselling Model Used*
In terms of [Ms B's] self-proclaimed self-developed therapy model, … it is the writer's impression that it is a combination of other people's therapies and concepts. It is not indicated that this therapy is considered an 'evidence-based' or 'evidence-informed' therapy, in that it has not been studied and not found in research to be effective and treating certain psychological issues. It is certainly not a therapy frequently used for persons who have BPD. In any case, [Ms B] says she was not necessarily using this therapy with [Ms A].

In is the writer's impression that some of the sessions conducted by [Ms B] with [Ms A], and certainly the one recorded based on the transcript reviewed, were undertaken without application of a clear counselling model. Use of a model to give sessions structure and processes, alongside therapist skills and a solid therapeutic alliance between therapist and client, is typically required in order to provide a quality counselling service.

[Ms B] articulated the view that since [Ms A] stated that her first few sessions were helpful, and there was just the one below par session, that her overcall care therefore did not depart from accepted practice. In doing so, she seems to miss the point that due to operating without a clear counselling model with [Ms A] beyond mindfulness, a client with a condition that needed some structured therapy, she was always at risk of not providing a satisfactory counselling service. In addition, it is best practice before any counselling model is applied with a client, that the suitability of that model to the client is assessed. As noted previously, it is indicated that this did not occur in this case.

<u>Not explaining to client nature of therapy and obtaining consent</u>
It is indicated that [Ms B] did not operate within accepted practice in not advising [Ms A] what the therapeutic process was to be and ensuring she was agreeable. It seems to the writer that one of the reasons [Ms B] did not obtain informed consent from [Ms A], was that she was not clear herself what model she would be applying with [Ms A] once things moved beyond the initial mindfulness training. It seems she responded to the presenting issue [Ms A] wanted to talk about in a somewhat ad-hoc manner not considering the need for case formulation.

*Management of Complaint*

The writer identifies no major ethical or practice issues with how [Ms B] practically managed the complaint beyond not having provided policy information to [Ms A] in relation to complaints management. Regarding the suggestion that since she is the director of the organisation she does counselling through, it was therefore inappropriate for [Ms B] to process a complaint, it is the writer's view that does not give due consideration to the reality of a situation for many therapists in private practice or self-employment. Most peers would accept that it is reasonable for the complaint to come to [Ms B] in the first place, and if the response was not to the satisfaction of [Ms A], [Ms B] could then advise [Ms A] about how to pursue her complaint further i.e., through the HDC. In this case because of the involvement of another therapist, [Dr C], and [Ms A's] inconsistency about complaining and some covert behaviour, things did not go as they typically would/could have in terms of making a complaint. It is the writer's view [Ms B] cannot be held solely responsible for that, with [Ms A] and [Dr C] also making a contribution to how the complaint was dealt with.

The issue of [Ms B's] attitude towards, and response to, the complaint are covered elsewhere.

*Involvement of a Third Party/Another Therapist*

[Ms B] has stated that following legal advice and consultation with a counselling colleague she decided to not respond to communication from [Dr C]. The writer concurs with [Ms B's] view that the most appropriate response to the communication of [Dr C] was to communicate with [Ms A] directly. Further, it could be expected that [Dr C] would have suggested the same to [Ms A]. Most mental health professionals and counsellors would be of the view that a therapist's role is to help a client raise and solve issues themselves rather than do it for them. This is especially the case with clients who have a diagnosis of BPD due to the increased risk of splitting. In hindsight perhaps [Ms B] could have sent a brief email to [Dr C] advising him the reason she would not be responding to him.

*Lack of Supervision and Professional Affiliations*

[Ms B] has stated that counsellors are not required to belong to a professional body in New Zealand, and noted that counselling is an unregistered profession. She reasoned therefore that she is not required to belong to a body, though was in the past a member of the Christian Counsellors Associations. It is indicated that [Ms B] has not in the last decade been a member of any professional body for counsellors in New Zealand. She reported to the writer she was a member of some overseas associations that were aligned with the work she did. However, it seems these organisations are largely interest-based and do not promote professional standards or development through continuing competency requirements for maintaining membership or complaints processes. [Ms B] also seems to be confusing the issue of registration (which psychiatrists, psychologists, social workers, and some psychotherapists have) with professional membership. Only a minority of mental health professionals and counsellors are not a member of a relevant professional body in the jurisdiction they practice in. It is considered best practice for mental health professionals and counsellors

to be a member of a professional body and many agencies who contract these professionals require this.

Regarding clinical supervision, it appears that [Ms B] did not have in place a regular standard supervision arrangement when she was providing a service to [Ms A]. [Ms B] indicated at the time that she relied on 'specialist' supervision when she needed it, and peer supervision with her colleague [Ms B's colleague] who practices under the same organisation ([the counselling service]). Regular, recommended to be fortnightly, but at least monthly, supervision is expected for all mental health professionals and counsellors and is referred to in the ethics of all professional bodies for counsellors in New Zealand. The writer concurs with Ms Paton that what [Ms B] calls 'specialist supervision' is more akin to 'consultation' as there is no ongoing relationship and opportunity for the 'supervisor' to understand and monitor the nature of the [work of the person being supervised]. The letter from [Ms D] indicated that [Ms B] was not having 'supervision' from her as she had claimed.

[Ms B] stated that she has typically had regular individual supervision throughout her career including in the years since she saw [Ms A]. However, she has yet to provide evidence of this, being a supervisor's letter or supervision contract. [Ms B] ensured the writer she engages in regular self-directed professional development and sent through a list of courses she has attended in the last four years and books she has reportedly read. [Ms B] has also reported she has developed from having psychotherapy herself. The writer nevertheless gets the impression that [Ms B] is somebody who may prefer to operate in a bubble alongside others with similar interests/worldview to herself.

*Insufficient Self-Reflection and Consideration of Improvement Areas*
It is noted that the complaint is based a lot on [Ms B's] interpersonal style and behaviour, which can be confronting for any therapist to reflect on. In her response to the complaint and articulation of learnings for improved practice, [Ms B] made limited references to self-reflections and planned changes in the area of style or process. Furthermore, she has sought to limit the complaint focus to the one session of particular concern, rather than the overall counselling process with [Ms A].

It is noted that [Ms B] has stated that in the future she intends to use a written contract with all clients covering 'time, cost, contact method, limits of confidentiality, style of therapy, note taking, HDC client rights and regular review of contract agreements, including goals'.

She also stated going forward she would:

- Update policies and procedures booklet
- Have a written sliding scale for fee negotiations
- Have a list of specialist supervisors
- Have supervision around multiple relationships
- Decline the option to be a secondary therapist.

The writer notes that having a written contract with some clients is appropriate. However, it is not common practice to have written contracts with all clients and the writer wonders if [Ms B's] stated intention to do this could be an over-reaction.

Additionally, [Ms B] has stated that she would be guided by considerations similar to those presented in an article by Safran, et al 2011, being:

'• Provide a clear rational for techniques, actions and/or behaviour.
- Accept that there will be ruptures in the therapeutic alliance, and recognise that they provide valuable opportunities for exploration and change rather than obstacles to treatment.
- Pay careful attention to the level of agreement between you and your client concerning the overall goals of treatment and the tasks necessary to achieve those goals.
- Work with the client collaboratively to explore alternative ways of proceeding'.

Safran, et al's principles seem to the writer to be an appropriate framework for [Ms B] to apply for challenging client situations going forward. However, it is indicated that she needs to do more than that, particularly since the other stated changes do not get to substantive matters in terms of [Ms B's] counselling approach and style, and do not indicate much in the way of reflective practice. These seem to be more about protection from a similar future complaint or addressing some specific areas, rather than the broader matter of analysing self as a therapist and the methods and interpersonal approach one brings to counselling.

<u>Shifting of responsibility and focus on own suffering</u>
Ms Paton notes that in her response to the HDC complaint of [Ms A], that [Ms B] tends to refute concerns raised or justify her behaviour more so than reflect on what she could have done differently. The writer concurs with this and that at times [Ms B] focuses on [Ms A's] actions more so than her own. Further, it seems the predominant self-reflection [Ms B] may relate to is her own suffering and damage to her confidence (ego). [Ms B] notes she has been affected profoundly and negatively, and goes as far as to say that things related to the HDC complaint processing have been 'traumatising' for her.

In relation to justifying, the writer notes [Ms B] referenced more than once, after the fact, DBT principles as a rationale for some of her actions of concern. For example, she noted out of session contact can be seen as an adjunct to therapy. However, such contact should be done in a consistent and structured manner including in the form of contained and directed 'coaching', and not in the manner evident in [Ms B's] communications with [Ms A], even in the event of a crisis.

**Review of Advice Provided to HDC by Irene Paton**
Overall, the writer was of the impression that Ms Paton's assessment of [Ms B's] behaviour had emotive aspects to it including being somewhat harsh in parts. Nevertheless, the writer concurred with most of the substantive points made by Ms Paton in relation to *acceptable level of care and accepted standard of practice*, including:

- The need in this case for a written contract with the client.
- That multiple relationships needed to be discussed and potential difficulties explored before a therapeutic relationship was commenced with the client.
- That ultimately [Ms B] should not have worked with [Ms A] given her lack of competency with clients such as her and the multiple relationship situation.
- That there was a lack of professionalism and poor conduct in the recorded session.
- That there has been defensiveness in the way [Ms B] has responded to the complaint.
- That issues of integrity are raised with some of [Ms B's] behaviour that has not been in line with the ethics of counsellors or which would be considered unwise for a counsellor, such as some inaccuracies in session notes, an overly adversarial approach to a complaint, and misleading references to procedures and policies.

*Points of Questionable Validity Made by Ms Paton*
Ms Paton suggested that [Ms B's] practice could be viewed as 'cruel', which [Ms B] has stated has been profoundly upsetting for her as it is a characterological attack, and not a description of practice. The writer does not view the practice of [Ms B] as cruel or abusive, as that implies intention to hurt. However, aspects of [Ms B's] practice of concern can be considered harmful, and the writer is of the view that this was likely not intentional, including any reactions by [Ms B] due to a threatened ego.

Ms Paton suggests [Ms B] is unsafe as she expects clients to express a complaint about her when she is also the person processing the complaint. The writer is not of the view that this constitutes unsafe practice.

Ms Paton emphasis the incongruency between stated care (as per [Ms B's] website) and the lack of compassion and care occurring at the session of concern. It is the writer's view that it goes without saying that [Ms B] did not provide a service in line with what she aims to achieve and in the style that she promotes, however, it is likely she did not set out to do this and it cannot be concluded that she is incapable of providing the service she promotes under different circumstances.

**Summary**
The writer concludes that [Ms B] did not always provide [Ms A] with an appropriate standard of care or demonstrable accepted practice. There were some unethical, incompetent, unprofessional, and harmful aspects to [Ms B's] practice in relation to this particular client. It can be concluded that at times expected counselling and professional care standards were not met. Subsequently there has been insufficient self-reflection and practice review. However, some of the comments made by HDC expert Ms Paton are in the writer's view unfair, particularly around how the complaint was managed, and in relation to her lack of communication with another therapist. The writer would categorise [Ms B's] overall practice in this case to be a 'moderate' departure from accepted practice.

It seems what occurred in this case is that a counsellor operating in a particular bubble where they saw themselves as a 'thought leader and teacher', was caught out ill-equipped (lacking necessary skills and experience) to manage issues that emerged with a characterologically damaged client. This led to an emotional reaction from the counsellor and a loss of professionalism for a period. Rather than accept the range of failings and the full validity of the complaint and open herself up to change, the counsellor has become further defended. It cannot be determined based in the information available if the finding in this case means that there are concerns about [Ms B's] practice as a counsellor generally, though there are red flags raised.

*Recommendations*
It is recommended that to develop as a counsellor and mitigate further complaints, that [Ms B] makes some changes to her practice. The writer's view is that the changes [Ms B] could make to her practice include:

1. Not working with cases outside of the limits of her competency, and as a part of that be clearer about her primary therapy model and who is suited to it
2. Engage in regular individual supervision with somebody who is not a colleague she works/practices with, and join a local professional body
3. Regularly reflect on her strengths and weakness as a therapist and as a person, ideally through a reflective log.

Yours Faithfully

[Mr E]
Registered Clinical Psychologist

APPENDIX 1 Email from ACSB

**From:** ACBS <acbs@contextualscience.org>
**Sent:** Tuesday, 5 January 2021 4:17 a.m.
**To:** ACBS Staff <acbsstaff@contextualscience.org>; Irene Paton <
**Subject:** Re: [ACBS information] Membership

Hello and thank you for your email.

Anyone who complies with the Terms and Conditions of Use of our website, including members of the general public, may join ACBS. There is no verification of qualifications. We are not a licensing agency.

https://contextualscience.org/terms_and_conditions_of_use

Whether or not someone is a member isn't public, unless the member opts in to being listed in our online therapist directory here (this list is also by self-nomination).

https://contextualscience.org/civicrm/profile?gid=17&reset=1&force=1

We don't have a formal complaints policy for members, but if you believe we have a member who has violated the Terms of our website, you could send you concern to me and I would follow up if they are a member.

Sincerely,
Emily

Emily N. Rodrigues, M.A., CAE
P.O. Box 655
http://contextualscience.org
Executive Director
Jenison, MI 49429
ACBS
USA
Pronouns: she/her"

## Appendix C: NZAC Code of Ethics

The following principles and/or core values are relevant to this case:

**The core values of counselling are:**
3.1 Respect for human dignity
3.2 Partnership
3.3 Autonomy
3.4 Responsible caring
3.5 Personal integrity

**Ethical Principles of Counselling:**
**Counsellors shall:**

4.1 Act with care and respect for individual and cultural differences and the diversity of human experience.
4.2 Avoid doing harm in all their professional work.
4.5 Promote the safety and well-being of individuals, families, communities, whānau, hapū and iwi.
4.6 Seek to increase the range of choices and opportunities for clients.
4.7 Be honest and trustworthy in all their professional relationships.
4.9 Treat colleagues and other professionals with respect.

**5.4 Clear Contracts**

(a) The terms on which counselling is provided shall be clear and reasonable. Contracts negotiated between counsellors and clients may include matters to do with availability, fees, cancelled appointments, the degree of confidentiality offered, handling of documentation, complaint procedures and other significant matters.

**5.7 Documentation of Counselling**

(a) Counsellors shall maintain records in sufficient detail to track the sequence and nature of professional services provided. Such records shall be maintained in a manner consistent with ethical practice taking into account statutory, regulatory, agency or institutional requirements.

**5.11 Multiple Relationships**

(a) Counsellors assume full responsibility for setting and monitoring the boundaries between a counselling relationship with a client and any other kind of relationship with that client and for making such boundaries as clear as possible to the client.

**7.4 Collaboration with Counselling Colleagues and Other Professions**

(a) Counsellors should endeavour to achieve good working relationships and communication with other professionals in order to enhance services to clients.
(b) Counsellors should negotiate to work collaboratively with other professionals working with the same client.