

Good practice in action 056

Research Overview

Research Overview of equality, diversity and inclusion in the counselling professions



British Association for
Counselling & Psychotherapy

Equality, diversity and inclusion in the counselling professions

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t: 01455 883300 f: 01455 550243 e: bacp@bacp.co.uk w: www.bacp.co.uk

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Context

This document is one of a suite of resources prepared by BACP to enable members to engage with the current BACP *Ethical Framework for the Counselling Professions* (BACP, 2016) in respect of equality, diversity and inclusion (EDI) within the counselling professions.

Using the research and literature overviews

BACP is developing the *Good Practice in Action* resources, which are a new series of publications that are free for BACP members to download. It is hoped these will support good practice in the counselling related professions. They are all reviewed both by member-led focus groups and experts in the field and are based on current research and evidence.

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The *Good Practice in Action* resources are not contractually binding on members, but are intended to support practitioners by providing general information on principles and policy applicable at the time of publication, in the context of the core ethical principles, values and personal moral qualities of BACP.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends that you discuss practice dilemmas with a supervisor and/or consult with a suitably qualified and experienced legal or other relevant practitioner.

In these resources, apart from where research specifically refers to a particular field of therapeutic work, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy. The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

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1 Focus of the resource

This resource gives an overview of published research and articles addressing issues of equality, diversity and inclusion within the counselling professions. Studies included and summarised in this resource deal with the nine characteristics protected under the Equality Act 2010: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; gender; and sexual orientation. It is intended as an overview of equality, diversity and inclusion literature in these fields, rather than a comprehensive documentation of all research conducted in respect of each characteristic.

In 2010, the Equality Act drew together all anti-discrimination laws in the UK to ensure consistency in legal policy (BACP, 2010a), and also to ensure that the law is easier to understand as it seeks to protect people in the workplace as well as in wider society. This law forms the basic framework of protection for these characteristics in the UK (Government UK, 2013).

This resource also includes studies on issues of discrimination, diversity and inclusion as it relates to racial socialisation, racial bias, socioeconomic status, poverty, and low educational attainment. Studies that discuss concepts such as cultural competence, acculturation, inculturation and cultural mediation are also included. Studies that challenge the common model of a White therapist and a client who is from an ethnic minority group are explored, as are studies that probe whether or not persons with physical disabilities have access to, and those with intellectual disabilities can benefit from, therapy. The purpose is to broaden the understanding of issues involved in equality, diversity and inclusion in the context of the counselling professions.

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2 Aims and relevance of the resource

The legal protection against discrimination provided by the law under the Equality Act 2010 extends and applies to the context of counselling related services. BACP both as an employer and as a professional body adheres to the vision of providing therapy and counselling related services in a manner that is supportive, fair, just, and free from discrimination (BACP, 2010b).

This resource embodies the aim and purpose of BACP to actively promote equality and diversity within the counselling professions, to ensure that legislation and policy requirements are implemented in all working practices (BACP, 2010b), and to embed legal responsibilities under the Equality Act 2010 in everyday working practices (BACP, 2015). This resource is part of the commitment of BACP to create an environment in which all people have equal and dignified care, as well as ease of access to all services, facilities and activities of BACP (2010b).

This resource also helps flesh out in practical ways BACP members' commitment within the *Ethical Framework for the Counselling Professions* (BACP, 2016) to the ethical principle of justice, and to:

‘..respect our clients as people by providing services that:

- a. *endeavour to demonstrate equality, value diversity and ensure inclusion for all clients*
- b. *avoid unfairly discriminating against clients or colleagues*
- c. *accept we are all vulnerable to prejudice and recognise the importance of self-inquiry, personal feedback and professional development*
- d. *work with issues of identity in open-minded ways that respect the client's autonomy and be sensitive to whether this is viewed as individual or relational autonomy*
- e. *make adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service*
- f. *recognise when our knowledge of key aspects of our client's background, identity or lifestyle is inadequate and take steps to inform ourselves from other sources where available and appropriate, rather than expecting the client to teach us*
- g. *are open-minded with clients who appear similar to ourselves or possess familiar characteristics so that we do not suppress or neglect what is distinctive in their lives* (Good Practice, Point 22).

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To ensure that the resource appropriately meets the needs of BACP members, a survey comprising 211 members/respondents of the Good Practice focus group was conducted. Respondents proposed reasons why they think that a *Good Practice in Action* resource on equality, diversity and inclusion (EDI) would be personally relevant to them and to their practice. Among the cited reasons were that a resource such as this would improve their understanding and knowledge of EDI issues, develop the breadth of their skills and experience, and ensure that they can deliver the best service they can to their clients. Still, others who work within the context of supervision said that a resource on EDI will ensure that any gaps in the initial training of therapists in supervision may be addressed with relevant and up-to-date information.

The survey also highlighted the aspects of EDI that members would like to have further Good Practice resources on, including: cognitive disabilities and impairments; race and ethnicity; gender reassignment and identity; culture; spirituality; belief and religion; physical disabilities and impairments; sexuality and sexual orientation; and age. In sum, aspects of all but two of the protected characteristics (pregnancy and maternity, marriage and civil partnership) were of interest to the respondents. Therefore, the rationale for this resource is that it meets the needs of members within their practice context.

In particular, this resource supports good practice by offering insight into legal obligations to comply with statutory standards on EDI by providing definitions of protected characteristics within the context of therapy, information as to how these characteristics may become barriers to, or promoters of, help-seeking behaviour in mental health or to participation in clinical trials or studies, and techniques on how counsellors can increase self-awareness and identify unconscious bias, discrimination and unfair treatment of clients. It also illuminates the inherent power dynamics within the therapeutic relationship that may become a barrier to a good outcome for clients who have one or some of these protected characteristics.

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3 Definition of terms and concepts under the Equality Act 2010

This law defines new concepts and harmonises thresholds for the duty to make reasonable adjustments for persons with disabilities. The Equality Act 2010 sets forth an equality duty to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out activities (Government Equalities Office, 2011). The concepts introduced in the Equality Act 2010 are here defined:

Age. This refers to a person belonging to a particular age (e.g. 32 year olds) or age range (e.g. 18-30 year olds) (Part 2, Chapter 1, Section 5, Equality Act 2010).

Disability. A condition where a person has a physical or mental impairment, which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities (Part 2, Chapter 1, Section 6, Equality Act 2010).

Discrimination. Prohibited conduct including any unfavourable treatment or segregation of an individual from others because of their possession of any of the protected characteristics. Furthermore, this unfavourable treatment was conducted without showing that there was a proportionate means of achieving a legitimate aim (Part 2, Chapter 2, Section 13 Equality Act 2010).

Discrimination arising from disability. This comprises prohibited conduct involving any unfavourable treatment of a person with a disability. The unfavourable treatment arises as a consequence of disability and the unfavourable treatment was conducted without showing that there was a proportionate means of achieving a legitimate aim; or that it could not be known or it could not be reasonably expected to know about the disability (Part 2, Chapter 2, Section 15, Equality Act 2010).

Diversity. A mix of different people (young and old, men and women, people of different races, those with and without disability) (Government Equalities Office, 2011, p.8).

Equality under the Equality Act 2010. This is taken to mean that everyone has the same chances of doing what they can, with some people requiring extra help to have the same chances (Government Equalities Office, 2011, p.3).

Equality duty. This refers to the duty of the public sector to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out their activities (Government Equalities Office, 2011, p.12).

Gender reassignment. The process of transitioning from one gender to another. It includes individuals who propose to undergo, are undergoing, or have undergone a process or part of a process of reassigning their gender or by changing physiological or other attributes of gender (Part 2, Chapter 1, Section 7, Equality Act 2010).

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Harassment. Any unwanted conduct which violates the dignity of an individual who possesses a protected characteristic, or to the creation of an intimidating, hostile, degrading, humiliating or offensive environment. It also includes unfavourable treatment because the person with the protected characteristic has refused, rejected or does not submit to the unwanted conduct (Part 2, Chapter 2, Section 26, Equality Act 2010).

Inclusion. Bringing together people with diverse characteristics and harnessing their diversity in order to cultivate an environment of respect, co-operation, connection and involvement, which in turn creates a richness in perspective and creativity.

Indirect discrimination. Any provision, criterion or practice that results in unfavourable treatment relevant to a particular disability by putting persons with a disability at a disadvantage or giving an advantage to those who do not share the disability (Part 2, Chapter 2, Section 19, Equality Act 2010).

Marriage and civil partnership. Domestic relationships, which are more or less permanent and long term (Part 2, Chapter 1, Section 8, Equality Act 2010). In England and Wales, marriage is no longer restricted to a union between a man and a woman but now includes marriage between same-sex couples (Marriage (Same Sex Couples) Act 2013, Section 1). This will also be true in Scotland when the relevant legislation is brought into force (Marriage and Civil Partnership (Scotland) Act 2014). Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.

Pregnancy and maternity. The condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth (whether or not the child is born alive), and this includes treating a woman unfavourably because she is breastfeeding (Part 2, Chapter 2, Section 17, Equality Act 2010).

Protected characteristics. These are nine characteristics which are protected by law against discrimination in employment, services, public functions, education, associations, and transport (Part 2, Chapter 1, Section 4, Equality Act 2010).

Race. In this resource, this refers to a group of people defined by their race, colour, and nationality (including citizenship), ethnic or national origins (Part 2, Chapter 1, Section 9, Equality Act 2010).

Reasonable adjustments. The duty to take reasonable steps to avoid disadvantage to persons who possess the protected characteristics; to remove or alter any feature in the design, construction, access, furniture or elements that cause the disadvantage; to provide without cost to the person with a disability any auxiliary aid to prevent substantial disadvantage. This includes providing information in an accessible format (Part 2, Chapter 2, Section 20, Equality Act 2010).

Religion and belief. In this resource, this refers to the common meanings given in everyday use but also includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition (part 2, Chapter 1, Section 10, Equality Act 2010).

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Gender. This refers to being male or female (Part 2, Chapter 1, Section 11, Equality Act 2010).

Sexual orientation. This refers to whether a person is sexually attracted to their own gender, the opposite gender, or to both genders (Part 2, Chapter 1, Section 12, Equality Act 2010).

Victimisation. The subsection of a person with a protected characteristic to detriment for having brought proceedings under the Equality Act, for giving evidence or information in connection with the Equality Act, or for making an express or implied allegation of any breach of the Equality Act (Part 2, Chapter 2, Section 27 Equality Act 2010).

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4 Search strategy

Databases, such as the Web of Science and Google Scholar, were searched for relevant studies. The following search terms were used: ‘*counselling OR psychotherapy AND access OR barriers*’; ‘*counselling OR psychotherapy AND ethnic minorities*’; ‘*counselling OR psychotherapy AND ageism*’; ‘*counselling OR psychotherapy AND culture*’; ‘*counselling OR psychotherapy AND race*’; ‘*counselling OR psychotherapy AND discrimination*’; ‘*counselling OR psychotherapy AND prejudice*’; ‘*counselling OR psychotherapy AND gender*’; ‘*counselling OR psychotherapy AND sexual orientation*’.

To provide relevant and up-to-date information, only studies and articles published in English from 2009 until 2015 were included. The focus of the literature search was to identify literature that focused on: protected characteristics as they pertain to counselling professions in the UK, as well as how issues of equality, diversity and inclusion and the nine protected characteristics are integrated into the context and practice of counselling.

Since countries, such as the US, Australia, Canada, Italy, Japan, Turkey, Germany and Scandinavia, also have similar laws and professional practices that promote diversity and inclusion as well as protect similar characteristics, studies from these countries were also included in this overview as long as they were also published in English. Most studies found were qualitative and mixed methods’ studies. Excluded from this overview were books and chapters of books, although review articles and other opinion articles were included, along with systematic reviews and other analytical and descriptive studies.

A total of 73 studies were identified as relevant and included in the research overview.

4.1 Limitations and omissions from the scanning process

The focus of the literature sought to be included in this review is on the nine protected characteristics and how they impact the provision of therapy, or how protected characteristics can serve as facilitators or barriers for help-seeking and accessing counselling services. Studies were excluded even if they examined the nine protected characteristics but did not focus on the EDI aspects of these characteristics. The characteristics must have been investigated as factors that hinder or facilitate EDI in psychotherapy and counselling in order to be included.

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5 Overview of findings

One defining feature of the counselling professions is an appreciation for individual diversity, multiculturalism and cultural diversity (Hansen, 2010). Since 1965, the UK Parliament has enacted laws to protect certain characteristics with the purpose of ending discrimination (Government UK, 2010). However, ending discrimination by penalising discrimination is only an initial step towards the goals of: appreciating the diversity of clients in therapy practice; striving toward inclusivity; achieving equality; and, fully actualising the value of fairness and justice in practice. Even within the research in respect of the counselling professions, very few research studies include research topics with people who have protected characteristics, or other diverse needs.

Watkins (2012) poses the question of whether psychological research has been 'inclusive' enough. This article reports on a meta-analysis of 104 short-term and long-term psychodynamic treatments. The findings suggest that:

- while all 104 studies reported on gender and age information, most did not report the socioeconomic status or educational level.
- 75% of the studies provided no information about race or ethnicity
- when studies did report the race or ethnicity of participants, 75% were White, 21% were Black, and 4% were "Other" (which could mean Asian, Hispanic, American Indian, and participants with unspecified race or ethnic origin)
- it was noted that there were only three studies with more Black and Hispanic participants than White participants and these were studies comprising clients with cocaine and opiate addiction
- psychodynamic treatment data on non-White participants are exceedingly rare, and there is poor reporting of sample characteristics.

This study calls for more inclusion of non-White subjects in psychodynamic treatment research to make studies more accessible, more replicable and more racially and ethnically relevant.

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6 Diversity and Inclusion

One key theme among the studies identified for this research overview, is that poverty and low socioeconomic status (SES) are consistently associated with emotional distress. However, poverty and low SES are not protected characteristics under the Equality Act 2010. Studies on characteristics, such as poverty or low SES, class, or low educational attainment, could not be included under any of the protected characteristics, but these can be included under the heading of diversity and inclusion as, indeed, disadvantage often results from possession of these characteristics. Therefore, in order to make counselling more inclusive, these characteristics must be considered.

Appio et al. (2013) asserts that poverty is a difficult life condition not only because of the financial hardships, but also because of the social stigma that accompany it. Their findings show that:

- clients in poverty notice when therapists do not grasp that their poverty influences their emotional wellbeing
- clients feel misunderstood, frustrated, anxious and ashamed when their therapists ignore the influence of poverty
- clients are aware of the class differences between themselves and their therapists but often do not directly discuss it
- class differences can therefore create a barrier and affect the outcomes of therapy if they remain unacknowledged
- genuineness and directness by therapists is shown to be appreciated, especially when the therapists help with concrete needs such as needs for food, clothing and shelter.

The authors suggest that therapists increase and deepen their self-awareness by reading literature on poverty and exploring relational-cultural therapy as one way by which they can relate to marginalised clients. Relational-cultural therapy proceeds from the work of Jean Baker Miller, and is usually identified with feminist and multicultural movements in psychology as it embraces social justice principles from these movements (Comstock et al., 2008).

Holman (2014) asks the question why people living in poverty or those with lower socioeconomic status (SES) may not continue in counselling. Holman asserts that:

- talking therapies are underutilised by working-class people even if they are effective in tackling depression and anxiety and poverty, and the conditions of poverty, are a way of life – a culture - for the working class and should be viewed as factors of social structural conditioning
- in order for the clients to engage with treatment instead of stopping prematurely, they must be engaged to verbalise and introspect regarding their motivations for emotional health and their views about medical authority
- the conclusion drawn is that therapists must realise that material, health, occupational and educational characteristics of working-class circumstances shape clients' motivations and views about seeking and continuing with treatment.

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Therapy cannot be inclusive, if it is not accessible. This was something discussed by Green et al. (2009) who described community-based projects that accompany the social and economic regeneration of inner-city housing estates in East London. They described their counselling project as a participatory action research project which challenged stereotypical images of counselling. The project, they felt, demonstrated that locally-based counselling services which are also free and accessible are needed in regenerating communities, but that planning and funding are essential to the success of such counselling projects.

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7 Discrimination, prejudice and victimisation

The question of how therapists can prevent discrimination, prejudice and victimisation in their practice is another theme within the studies. For instance, Mintz et al. (2009) suggest the drafting of a values statement so as to prevent the scenario where counselling trainees claim that professional requirements for diversity and inclusion stand in conflict with their personal values. They argue for the necessity of a values statement in training programmes, which can clearly articulate the diversity-related values of therapy, and make the connection between individual, professional and societal value structures that either reinforce or challenge systemic oppression. They also assert that a values statement will enable trainees to develop philosophical sophistication by which they can reconcile their personal and professional values.

7.1 *Colour blindness*

Bartoli et al. (2015) suggests that past studies have focused on the impact of racial identity on the therapeutic process and the therapeutic relationship. They observe that multicultural competence in counsellors is based on an additive model where counsellors are White and clients are from racial or ethnic minorities. Within this model, racial identity must be openly discussed because discomfort in discussing racial identity preserves the normativity of what is described as 'Whiteness'.

They present the possibility of a scenario where the therapist and the client both belong to racial or ethnic minorities. In this case, they suggest that the issue might be who is a victim of oppression or who between their races (Latinos or African-Americans) experience more oppression. They discuss:

- the concept of racial socialisation, seeing this as the process by which individuals learn about, interpret, and interact with members of their own and other racial or ethnic groups. Informants such as parents, teachers and counsellors communicate racial hierarchies, ways of managing racial conflict, and norms for interacting
- they also comment that colour blindness is an ineffective but common strategy that is applied with the intent of erasing racial bias and promoting interracial relationships
- however, they assert that colour blindness merely breeds aversion to discussing race.

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Sue et al. (2009) observe that there has been an emphasis on cultural or multicultural competence, which initially meant cultural responsiveness or sensitivity. This definition, they consider, has developed to include an appreciation and respect for cultural differences and similarities within, among and between culturally diverse groups. It includes acknowledging the importance of culture and its incorporation in cross-cultural relations, vigilance toward dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs.

Bean and Titus (2009) observe that there is a lower level of accessibility to mental health care and a poorer quality of clinical services for ethnically diverse groups in the United States (US). There is an undersupply of clear, culturally relevant treatment. In order to appropriately serve diverse client populations, practitioners must have awareness of their own culture, values, biases and assumptions regarding their clients' ethnic/cultural group. They must also have knowledge of their clients' culture and worldview, as well as skills and therapeutic strategies and interventions relevant and appropriate for working with clients' cultural and contextual factors. A cultural milieu is imposed on the client and their social system as the clinical issue dictates acceptable behaviour, affect and cognition for clients.

7.2 *Impact of therapist's personal beliefs*

Bean and Titus conclude that:

- counsellors should engage in a self-evaluative process to become and remain aware of personal beliefs and values influencing the course of treatment. This evaluative process may be performed during supervision and when inspecting personal values for possible bias. In particular, it is necessary for counsellors to investigate the degree to which they hold stereotypical views regarding members of particular ethnic groups they are working with
- counsellors should also examine their personal views regarding specific issues such as death and grief. For instance, Western cultural beliefs conceptualise normative grief stages and symptoms of grief lessen over time
- these perspectives, are often ingrained and unquestioned but often facilitate a cultural gap and if it remains unquestioned, the counsellor will consciously, or unconsciously, take the stance of an expert of the client.

Katz and Hoyt (2014) conducted an online survey of 173 trainees and mental health professionals to examine whether or not it was possible to predict an anti-Black bias among them. They used the Implicit Association Test (Project Implicit, 2011) to measure any automatic prejudice toward people of Black ethnicity and the Multicultural Counselling Inventory (Sodowsky et al., 1994) to measure global multicultural competence (See Appendix 1 for details). They also used the Balanced Inventory of Desirable Responding (Paulhus, 1991) to control for socially desirable responding.

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The BIDR measures the tendency to give self-reports that are honest even if these are positively biased, and it also measures the tendency to deliberately 'self-present' denying psychologically threatening thoughts, or feelings, to an audience. They added a new self-report measure of anti-Black clinical prejudice which they designed specifically for this study. Their findings yielded that their self-report measure accounted for anti-Black bias in prognosis or clinical expectancies where the two measures (Implicit Association Test and the Multicultural Counselling Inventory) did not. They thus caution researchers that anti-Black bias may be revealed in prognosis and clinical expectancies.

Chao et al. (2011) investigated Multicultural Counselling Competence and explored whether multicultural training moderated racial or ethnic differences and whether or not it changed the relationship between colour-blindness and multicultural counselling competence. The findings suggest that trainees who belong to racial or ethnic minorities had significantly higher multicultural awareness than trainees with White ethnicity.

Bartoli and Pyati (2009) state that, as therapists, they often hear clients make racist and racially prejudiced remarks during therapy, but there are no clear guidelines as to how to address this. Their article suggests that people of White race have an aversion toward being perceived as racist and therefore may deny the significance of race or that there are racial hierarchies; they can also idealise colour-blindness. This has implications in the therapeutic relationship, creating stress and the need for appraisal and coping strategies to deal with such stress. Whether or not racism is acknowledged, it will still hold meaning and pose implications for both the therapist and the client.

Sue et al. (2010) reported that White trainees express feeling powerful emotions of anxiety, helplessness, and fear of being misunderstood. These feelings evoked defensive manoeuvres to avoid discussing topics related to race, giving reactions to racial disclosures, and avoiding racial dialogue. Thus, White trainees tend not to discuss the racial aspects of therapeutic relationships, which could perhaps be addressed in training.

Hollwich et al. (2015) probed the high proportion of unethical practice of therapists having sexual relationships with clients, with the purpose of finding a new and effective preventive intervention. About 421 participants condemned this practice as inherently careless, abusive and exploitative of clients. They also felt it creates a dependency in the client, and that it is inconsistent with the inherent intention of therapy. A total of 41.3% respondents indicated that much of the cases of therapist-client sexual relationships is attributed to clients (clients initiated the sexual/romantic relationship) and therefore there is a need for self-protection on the part of the therapist. The respondents exhibited a strong preference for confronting a colleague who is engaged in this kind of practice. It was concluded that there is a need to make any ethical requirements in this context more explicit, and for integrating this topic into training. There is also a call for a discrete procedure to report instances of therapist-client sexual relationships.

The *Ethical Framework for the Counselling Professions* commits BACP members to 'building appropriate relationships' and not having 'sexual relationships with or behave sexually towards our clients, supervisees or trainees' (Good Practice, Point 34) and goes on to state 'we will [also] avoid having sexual relationships with, or behaving sexually towards people whom we know to be close to our clients in order to avoid undermining our clients' trust in us'. (Good Practice, Point 35)

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8 Age

The common theme in studies exploring the issue of age is whether or not therapy can benefit specific age groups. The questions that these studies answer are: how can therapy be structured, offered or provided in such a way that clients in different age groups have increased engagement and access to mental health services? And, what benefits, if any, can mental health services and interventions give to specific age groups?

A US study by Pepin et al. (2009) examined barriers to utilisation of mental health services by using the 56-item Barriers to Mental Health Services' Scale, which were developed to identify reasons for reluctance to use mental health services among younger and older adults. The 10 barriers were seen to be: help-seeking attitudes; stigma; knowledge and fear of therapy; belief about inability to find a therapist; belief that depressive symptoms are normal; lack of health or medical insurance or concerns about payment; ageism; concerns about therapist qualifications; lack of a physician's referral; and transportation concerns.

In this sample of 76 younger adults and 88 older adults, the barriers for younger and adults (compared to older adults) from accessing mental health services were identified as being:

- a perceived fear of therapy
- a belief about being unable to find a therapist
- and insurance concerns.

Within this study, males perceived stigma to be a greater barrier than females, but females perceived finding a therapist a greater barrier than males (in both age groups). It was concluded that, in younger and older adults, stigma was not seen as a primary barrier to accessing mental health services.

Haugvik (2013) discussed parallel therapy work where children undergo structured therapy along with their parents. They interviewed separate families whose children were experiencing difficult family situations. Parents reported positive experiences with therapy, and positive behaviour changes in their children. The parents also reported changes in their perspectives about their family situation and deepening insight into the factors that influenced changes in their children's behaviour. Most importantly, the parents reported having increasing concern with understanding their children's expressions. They recommend this therapy method to give parents opportunity for reflection and what they describe as 'mentalisation' which, in turn, they considered also helps their children reach their therapeutic goals.

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Hall et al. (2013) conducted a qualitative study of the views of residents of a nursing home on participating in clinical trials for dignity therapy; a palliative care therapy. Participants were aged 65 and over with no major cognitive impairment and living in one of 15 nursing or care homes in London. Both the control and intervention groups reported that the benefits they derived from participating was:

- refocusing;
- making a contribution;
- interaction with the researcher or therapist; and,
- diversion from routine.

The findings suggest that participating in research, even when they were not part of the intervention group and did not receive dignity therapy, still led to benefits. The research also suggests that while dignity therapy may be beneficial to some residents of care homes, not all residents will benefit from it; for example, more research is needed to determine if residents, who may have major cognitive impairment, would also benefit from dignity therapy.

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9 Disability

The common themes which emerged from the studies included here in respect of disability are:

- there are two main ways of viewing disability – one is from a medical perspective, seeing the disabled person as ‘lacking’ or ‘damaged/injured’ in some way, and the social perspective, where the person is seen only to be disabled by societal exclusion and prejudice
- there is a difference in the experience of those who have ‘acquired a disability’ compared to those who have lived with disability from birth. There were less studies relating to therapeutic work with the latter group – who often viewed their disability from a social perspective in terms of exclusion and identity. The studies with those living with an acquired disability were shown to be helped by the therapeutic process, but that therapy was often not widely available
- questions of whether or not persons with intellectual disabilities can engage and be included as clients in therapy.

For example, in respect of the last point, Breckon et al. (2013) asked the question: how would 12 offenders with intellectual disability know that they are ready to engage with psychological therapy? The findings of the qualitative study suggest that persons with intellectual disability are ready to engage with psychological therapy when they show: stability or predictability, readiness to develop relationships with staff, accept reassurances about progress, and realise that change is needed.

Artman and Daniels (2010) assert that persons with disabilities constitute the largest minority population in the US, but the issues regarding treatment for this particular group has only recently been discussed beyond the traditional medical model. They stress that the most basic consideration in working with persons with disabilities would be the conceptual models of disability (Appendix 2) and the cultural competence of therapists working with this group. The cultural competence of therapists is necessary when living with a disability is considered as a “culture” or a specific way of living.

Barnes and Summers (2012) reflect upon a case study of their experience providing therapy for a couple who had cerebral palsy and learning disabilities. In this context, the most salient issues to be considered are: the power dynamics of the therapeutic relationship, the impact of physical disability, the capacity to give informed consent, and the effects of past abuse and whether or not these may be addressed in therapy.

Ueda and Tsuda (2013) studied young adults undergoing a four-month live-in rehabilitation programme for those with acquired visual impairment. Two groups were studied at two different rehabilitation centres. The intervention group of 37 adults were divided into two groups: one that received a Living Skills Training Programme with group counselling and one group that received a Living Skills Training Programme with group counselling and individual cognitive therapy. One limitation of this study was that the participants in the intervention group decided whether to also have individual cognitive therapy (they were not randomly assigned to receive the individual therapy).

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The researchers explored whether the psychological distress of the adults with acquired visual impairment in the intervention group was decreased when they participated in the Living Skills Training Programme and either group counselling or group counselling with individual cognitive therapy. A total of 42 adults were in the control group and they received only the Living Skills Training Programme.

Assessments were performed at the beginning of the rehabilitation programmes and measured anxiety, depression and acceptance of disability. Participants in the intervention group who chose to engage in individual therapy in addition to group counselling showed decreased anxiety, depression and fatigue as well as a significant improvement in their acceptance of disability. Those participants from both the intervention group and the control group who, at baseline, had low psychological distress, showed decreased anxiety and increased acceptance of disability even when they did not participate in group counselling or individual cognitive therapy. Those who had high distress levels at baseline did not show any improvement on these two outcomes even with group counselling or individual therapy at the end of the rehabilitation programme. The group counselling group, however, showed improved attitudes toward others in those participants with high distress levels at baseline. One remarkable development was the marked increase in anger levels of the participants from across all groups. The researchers hypothesised that the increased anger at the end of the study was caused by the knowledge that group counselling and individual therapy were not regular parts of the rehabilitation programme. The researchers believe that anger may be desirable in so far as it fuels the quest for justice and equality. These results indicate that group counselling combined with individual cognitive therapy can be effective as part of rehabilitation treatment for clients with sight loss or affected by sight loss.

Hodge et al. used a mixed methods' study to evaluate an emotional support and counselling service delivered within an integrated low vision pathway. The findings showed the service to be helpful to users, enabling them to normalise their experience by talking to an impartial listener and helping them to accept and adapt to the physical, emotional and social changes in their lives resulting from significant sight loss (Hodge et al. 2013).

Meyer and Kasubeck-West (2013) examine the relationships between disability factors and psychosocial outcomes in persons with acquired hearing loss. They differentiate between those who were born with a hearing impairment, those who lost their hearing after learning language as a child, and those who acquired hearing loss after the age of 12 (late-deafness). Hearing loss, they consider, makes basic conversation difficult to comprehend and thus affects the person's social and emotional quality of life. Late-deafness was considered unique because it is unexpected and requires psychosocial adaptation.

The researchers explain that there are three perspectives on hearing impairment. These being:

- the medical model, which focuses on the physiological aspect or anatomical issues of deafness and the dysfunction of the ear
- audiology, that focuses on the ability of the person to communicate
- deaf culture, which does not view hearing loss as a deficit, but as a natural and normal characteristic and part of one's self-concept. There is not a focus here on limitation, or loss, but rather embracing the culture and language of the population.

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They conclude that individuals with late deafness tend to perceive hearing loss either as a disability, or as a medical condition, rather than a cultural experience, and they must therefore come to terms with, or adjust to, a new self-concept or identity. They found that people in this category often experienced an identity-shift, but their community affiliation remained in the hearing culture, not in the deaf culture. As such, they experienced emotional turmoil when negotiating issues of identity and belongingness.

This group was also seen to undergo a process of adaptation to an acquired disability; and their reaction to their disability was the primary determinant of how well they functioned in the future. Adaptation within this study is seen as the process of acknowledging limitations, and adjustment in thoughts and actions to develop a new self-concept incorporating current conditions or limitations. The medical model the authors assert, assumes that adjustment, or adaptation to the new physical condition involves overcoming a deficit in functioning. Adaptation, however, was found not always to occur, and so loss of hearing greatly impacted on this group's level of happiness, quality of life and wellbeing.

They found that adaptation in late-deafness was affected by the extent of the disability, the age at the onset of the disability, perceived severity of the disability, self-concept and the person's social support networks. The authors point out that in adulthood, self-concept already has a solid foundation based on a person's vocation, partnership, parenthood and social networks. It is seen as a daunting task to shift from an able-bodied identity to a differently-abled identity at this stage of life. Inevitably, their perception of independence decreases. Individuals with late-deafness were seen as needing to constantly adjust to the varied social situations and contexts of their lives, which required a high degree of adaptation and coping ability.

They defined two types of adaption:

- emotion-focused coping, which involves the person changing their perspective, or redefining a situation such that they can emotionally adapt to the new crisis or situation, and
- problem-focused coping, which is action oriented and involves the development of an action plan, steps to take to negotiate a crisis, thus allowing the person to adapt to a situation. It is self-directed and is situational or transactional. Increased use of problem-focused coping may improve psychological wellbeing in the long-term.

Persons with chronic conditions such as late-deafness, however, they found were more prone to adopting passive approaches to coping, such as avoidance or denial, and these were less successful. They considered that disengagement, or withdrawal, contributed negatively to the adjustment to deafness.

Garnefski and Kraaij (2011) tested a self-help cognitive behavioural programme with 45 participants with acquired deafness. The participants were allocated to the intervention/self-help group or to the waiting list for psychological treatment. The researchers then investigated whether the participants' symptoms of depression and anxiety could be reduced using the intervention/self-help programme. The levels of depression and anxiety were measured pre-test, post-test and at two-months follow-up.

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The researchers assert that:

- people with acquired deafness increase the risk of developing emotional problems. Particularly, that they are 4.8 times more vulnerable to depression than people in the general population; usually, the more severe the hearing loss, the higher the risk for psychological dysfunction. And yet, few, they have found, receive help for their emotional distress. This could be, they consider, because the onset of late-deafness often limits communication options; rather than deal with their emotional distress, people with severe hearing loss often have to learn new ways of communicating
- counsellors working with persons with late-deafness often lack training and knowledge about adaptations they may need to make to their practice when working with this group. By contrast the self-help Cognitive-Behavioural programme used within this study did not require extensive clinical contact and could be done individually.

The self-help cognitive-behavioural intervention was found to:

- reduce waiting time for referral to mental health providers and for psychological interventions
- be easy to deliver through the postal service, internet and could therefore reach a number of people
- more importantly, the self-help component was seen to overcome barriers this client group had in respect of psychological treatment.

The results showed that the depression and anxiety symptoms in the intervention/self-help group significantly improved after completion of the programme compared to those on the waiting list. There was no relapse during post-test and during follow-up testing.

In a Turkish study of perceptions of public school counsellors about including disabled students in mainstream schools, Sakiz et al. (2015) found that counsellors held positive attitudes about such inclusion. However, the qualitative study revealed that those same counsellors understood disability based on the deficiency model (that persons with disabilities have deficiencies and, thus, cannot participate fully in society; this is in contrast with the social model in which the deficiencies of a person with disabilities is socially constructed and defined). Furthermore, they also perceived problems translating conceptual and methodological knowledge into concrete practices that foster inclusion.

The question of the complexities of engaging in a therapeutic relationship with clients who have learning disabilities was explored by Jones (2014). The study involved 8 semi-structured interviews with counselling psychologists who were working with this client group. It is suggested that the therapeutic relationship is fundamental in working with clients who have learning disabilities, but establishing such a relationship is difficult because clients may have experienced past negative relationships that make them wary of engaging in relationships. The counsellor participants also mentioned that there is often a need for dual relationships when working with persons with disabilities (counsellor and also advocate for needs, for example). In their experience, they found that persons with disabilities need reassurance and this necessitates the development of skills for varying therapeutic approaches.

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Haydon Laurelut and Nunkoosing (2010) investigated whether the systemic psychotherapy approach can be useful in working with clients with intellectual disabilities. They found that it was useful in describing the internal problems of the individual but that it was also useful in coordinating the relationship between the client and their paid carers. They suggest that the systemic psychotherapy approach may be most beneficial for people who live with, and those who work in, services for persons with intellectual disabilities. In this regard, the participant found that such an approach to therapy afforded him the opportunity to be listened to.

Flynn (2012) conducted a literature review to determine whether or not persons with intellectual disabilities were suitable for treatment with cognitive behavioural therapy in the public healthcare system. The review found very few research and commentaries regarding therapy for adults with intellectual disabilities, although there is a strong perception that therapy is necessary and valuable in this particular population. It was suggested that psychodynamic therapies and mindfulness approaches may be further investigated as suitable approaches to working with this group.

Brooks et al. (2013) designed and validated a questionnaire about feelings that may be used to psychologically assess persons with disabilities. This study brought together five people with learning disabilities, as well as therapists, to test a version of a previously validated questionnaire/outcome measure called Clinical Outcomes in Routine Evaluation – Learning Disabilities. The questionnaire sought to determine if living with a learning disability affected feelings and whether or not it may be used to measure if therapy was helpful. The overall conclusion was that using an outcome measure that is sensitive to the needs of persons with learning disabilities is a vital step to ensure inclusion.

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10 Gender

Rohlfing et al. (2014) ask the question of whether or not men and women can work together in group therapy. They examined a group with five female and five male clients. The researchers found that:

- women interacted more and were interacted with more frequently than the men in the group
- only 12.5% of the group interactions happened between men
- they also found that women uttered more expressive-emotional statements
- the women expressed equally positive and negative images of themselves, while the men presented themselves more negatively more often
- the researchers reached the conclusion that group therapy with a mixed group of males and females may favour women who have a more independent self-concept, while men strive more for independence and individual strength.

Pseekos and Lyddon (2009) worked with women experiencing disordered eating, agoraphobia, sexual violence, and sexual identity concerns. They discuss the presence of stereotypes within the context of therapy when using a framework of feminist therapy principles and how the use of metaphors in psychology may help move away from gender and sexual orientation stereotypes. For instance, when describing anger felt toward a significant other, the women may describe themselves as feeling like a dam that is filled with water that threatens to break its retaining walls.

Parker et al. (2011) conducted a literature review to determine whether gender impacts response to psychotherapy in clients with depression. Few studies were found, but some studies suggested that a differential gender response may occur in pharmacotherapy for depression, and that these differences may possibly reflect biological influences (hormones, etc.) and not response to therapy. There was no clear or consistent evidence to suggest that gender has any impact on response to therapy.

Hovey et al. (2013) explored whether therapists' beliefs about sexual offending affect their counselling practices with women survivors of child sexual abuse. A total of 164 Canadian therapists working with women survivors of child sexual abuse were surveyed about their beliefs as to what constitutes child sexual abuse, who commits child sexual abuse, and their practices when inquiries are made about abusive behaviour. It was found that how broadly or narrowly therapists define child sexual abuse does not impact therapeutic discussion. However, this was self-report and therefore it is questionable how accurately therapists are evaluating their own practice within this context.

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Shalev and Yerushalmi (2009), noting that classical psychoanalysis used sexuality to explain human behaviour, assert that sexuality is marginalised in psychoanalytic theory and practice. They ask: to what extent are sexual themes dominant in treatment? What importance do therapists attach to sexuality? And, what factors affect their role in therapy? To answer these questions, they gathered the views of 10 psychotherapists. Their findings suggest that sexual themes in therapy would be given emphasis depending upon: the therapist's belief in the centrality of sexuality in human motivation; the level of expressiveness of the therapeutic work; how narrow the concept of sexuality is described and how it is differentiated from intimacy; and finally, on the tendency to avoid sexual issues because of the discomfort that a discussion on this causes to the client or therapist.

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11 Gender reassignment

No studies were found (using the search criteria) that specifically considered psychological support in respect of equality, diversity and inclusion issues regarding gender reassignment, this absence in itself is perhaps very interesting, but three studies are included here to demonstrate that psychological support can assist with people who find their gender identity different to their biological body. All of these studies show psychological support as an important part of enabling good psychosocial functioning, but it is unknown whether more generally there is availability and access to therapists competent in working in this field for people seeking gender reassignment.

Fitzgibbons, Sutton and O'Leary (2009) provide definitions for concepts in the area of gender reassignment. Gender identity was considered to be the individual's categorisation of him or herself as male, female or ambivalent. The authors comment that transgender activists often differentiate sex, as a biological reality, from gender which is an artificial social construct. They define:

- transsexuals as persons who have interests, talents or other traits more likely to be found in women (or men) and who, at the very core of their being, are essentially a different gender but were mis-assigned at birth. Their desire is to be reassigned surgically and hormonally to the gender with which they self-identify
- gender identity disorder as a condition in which a person has been assigned one gender on the basis of their sex at birth, but identifies as belonging to another gender. They feel significant discomfort or inability to deal with this condition. It is a psychiatric classification that describes problems related to transsexuality and transgender identity.

This article distinguishes between sexual reassignment surgery procedures designed to restore organs that are deformed from genetic abnormalities, congenital defects, injury or disease; and elective sexual reassignment surgery. Those designed to correct abnormalities and deformities are medically indicated. It makes the point that elective sexual reassignment surgeries undertaken on psychological grounds require the destruction of healthy sexual and reproductive organs, administered hormones to create secondary sexual characteristics which may, in the long-term cause serious health problems.

The article asserts that when an adult who is normal in appearance and functioning believes that there is something ugly or defective in their appearance that needs to be changed, there is often also a significant psychological problem. People who desire sex-reassignment surgery without a medical indication for such, typically experience serious emotional conflicts often complicated by sexual self-rejection and depression. They point out that some therapists are not skilled in addressing these serious conflicts, and suggest sexual reassignment surgery prematurely.

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The authors acknowledge the suffering of persons who desire sexual reassignment surgery, commenting that many have been victims of various forms of abuse or neglect and of peer or parental rejection. They also consider that often the basic emotional need for secure attachment relationships to same-sex peers and to the same-sex parent may not have been met. They conclude that sexual reassignment surgery cannot necessarily heal the wounds of childhood trauma or satisfy unmet early needs.

The article stresses that immediately presenting sexual reassignment surgery as a solution does not encourage honesty within the therapeutic alliance, as patients seeing sexual reassignment surgery as a solution effectively prevents them from revealing anything that they perceive as leading towards nonsurgical resolution of problems.

Costa, Dunsford, Skagerberg, Holt, Carmichael and Calizzi (2015) probe the impact of psychological support and puberty suppression on the psychosocial functioning of 200 adolescents with gender dysphoria. Gender dysphoria is considered by them to be a stressful condition resulting in clinically significant levels of distress or impairment in important areas of functioning because the person experiences a marked incongruence between their assigned gender and their experienced gender. Psychological support was offered routinely to participants; some were also offered puberty suppression.

They considered puberty suppression as a treatment option when clients met the following criteria:

- presence of gender dysphoria from early childhood onwards
- increased gender dysphoria after the first stages of puberty
- absence of psychological or physical deterioration resulting from mental illness that interferes with the diagnostic work-up or treatment
- adequate psychosocial and social support during treatment
- a demonstration of knowledge and understanding of the effects of cross-sex hormone treatment, surgery, and the social consequences of sex reassignment.

The study concluded that whilst both puberty suppression and psychological support were associated with improved psychosocial functioning, those who had received both types of treatment showed a greater improvement.

Sandberg, Gardner and Cohen-Kettenis (2012) reviewed the psychological issues confronting clinicians who manage the care of persons born with disorders of sex development. They considered that:

- the presence at birth of a congenital anomaly affecting a child's genital appearance or future reproductive function could be experienced by those involved as a psychosocial emergency
- genital anomaly can cause parents and clinicians to make irreversible decisions including gender reassignment and urogenital surgery. Parents are often shocked if the sex of their newborn is not immediately apparent and can experience difficulty coping with uncertainties of the child's development

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- gender assignment should be guided by diagnosis and long-term adult follow-up studies that focus on gender identity stability and other psychosexual outcomes
- family attitude and function are acknowledged to affect medical and surgical decisions as well as the psychosocial development of children diagnosed with a variety of medical conditions
- family and cultural factors will also play an important role in the perceptions of the child's condition and in the interpretation of complex medical and genetic information.

The authors found that counsellors could help parents assess their capacity to manage uncertainty regarding psychosocial and psychosexual outcomes as their child develops. They could also help parents understand more about the genetic and biological origins of the disorder of sex development and its implications for the child's physical health and quality of life, this it was hoped would enable gender identity stability. Under normal circumstances (where there was no genetic abnormality), the authors considered that gender identity and gender role typically develop in accordance with each other. Sexual self-awareness gradually develops during infancy and childhood. Cognitive and affective learning during interaction with parents, peers and the social environment influence gender identity and gender role. Children acquire knowledge about gender stereotypes and display gender-role behaviour characterised as feminine or masculine. Parents and peers influence gender development by reinforcing or discouraging gender-role behaviours and indirectly by serving as role models. It was not always certain that where a choice of gender assignment made by parents when the child was still a small infant would result in a good quality of life.

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12 Pregnancy and maternity

Schmitz (2009) reports that Germany is seeking to change its abortion law. Under the old legislation, counselling committees support the physician who certifies the medical indication for testing as well as the need for a late-term abortion. Specifically, proposed new laws aim to strengthen the decision-making process of pregnant women when they receive a prenatal diagnosis of an illness or condition in the baby or the mother that may bring abortion as an option. This study asserts that pregnant women should undergo counselling before they are tested for genetic disorders and while they are considering late-term abortion, as this will enable autonomous choices and also protect the rights of the unborn child as the decision to terminate a pregnancy cannot be made only on medical indications.

Hall, Kusunoki, Gatny & Barber (2015) investigated the relationships between social discrimination, stress and depression symptoms and unintended pregnancy among adolescent and young women aged 18-21 in the American Midwest in this longitudinal population-based cohort study.

Unintended pregnancy is disproportionately high among poor and minority young women. They found that unintended or unplanned pregnancy during adolescence and young adulthood has significant health and social consequences for the young women and their families such as:

- increased risk of maternal and infant morbidity
- increased risk of maternal and infant mortality
- increased risk of ante-natal and post-partum depression
- domestic violence
- rapid and repeated unintended pregnancy
- interrupted education
- reduced employment opportunities
- substantial health care costs.

To determine whether or not they experienced discrimination because of their unintended pregnancy, they were administered the Everyday Discrimination Scale, which comprises nine items, such as:

- you are treated with less courtesy than other people
- you are treated with less respect than other people
- you receive poorer service than other people at restaurants or stores
- people act as if they think you are not smart
- people act as if they think you are dishonest
- you are called names or insulted
- people act as if they are better than you are

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- you are threatened or harassed
- you are followed around in stores.

The study found that the participants experienced chronic social stressors which include discrimination and marginalisation. These, they concluded, could lead to ongoing psychological and physiological stress. Perceived social discrimination was also not uncommon. The strongest predictor of discrimination found, was adolescent pregnancy. Race and socioeconomic status did not, within this study, predict discrimination and the effects of discrimination did not have a greater impact on groups of women who are vulnerable because of race or socioeconomic status. Factors that predicted decreased experiences of discrimination were seen to be: college enrolment, and employment.

Mental health disorders, such as depression, appear to be common during pregnancy. Antenatal depression has been implicated as one of the several risk factors for post-partum depression. Research (Grigoriadis et al.), shows that there are associations between untreated antenatal depression and pre-term delivery, foetal growth retardation, pre-eclampsia and miscarriage.

Canady, Bullen, Holzman, Broman and Tian (2008) examined the potential associations between depression, depressive symptoms and lifelong experiences of discrimination. Its findings suggest that African-American women had greater levels of depressive symptoms than White women in mid-pregnancy. Self-reported discrimination was positively associated with depressive symptoms in both groups of women. Gender, race and socioeconomic discrimination were positively associated with depressive symptoms. Employed White women scored lower on the depression scale than unemployed women. Depressive symptoms remained high in African-American women regardless of employment status; which may be explained by lower workplace control, fewer promotion opportunities and lower salaries experienced by employed African-American women. The study points to potential links between lifetime discrimination and depressive symptoms in pregnancy.

Ertel, James-Todd, Kleinman, Krieger, Gillman, Wright and Rich-Edwards (2012) assess the association between self-reported racial discrimination and prenatal depressive symptoms among Black women. The study sought to understand the relations between racial discrimination, response to unfair treatment and depressive symptoms so as to contribute to the knowledge regarding the prevention and treatment strategies for prenatal depression. They consider that:

- the causes of prenatal depression are caused by multiple factors, but literature gives evidence that social stressors play a significant role
- racial discrimination contributes to depression during pregnancy
- pregnant women who reported experiencing lifetime racial discrimination had more depressive symptoms than those who had not reported racial discrimination
- studies indicate the importance of how individuals respond to, or cope with, discriminatory events. Individuals with higher socioeconomic status may be more likely to report racial discrimination but the mental health impact of discrimination may be greater in individuals with low educational attainment or limited resources.

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Findings also suggest that pregnant women who report diverse types of discrimination have poorer mental health and higher levels of perceived racial discrimination, which may increase depressive symptoms during pregnancy among Black women in the US. The study suggests that Black women with more economic resources tend to self-report more racial discrimination and women with less power (that is, those who have lower levels of education and income) were less willing or able to confirm that they experience racial discrimination. It could be that women with more education may feel more empowered to recognise and name racism and thus report it more; it could also be that they may have a lower threshold for calling an action 'discrimination'. Women with lower economic resources report discrimination less often because:

- o they may have internalised oppression; that is, they have taken on the views of the dominant culture and may be likely to view unfair treatment as deserved and non-discriminatory;
- o there is an inverse relationship between power and social desirability; that is, people are more desirable when they say what they think others want to hear as opposed to saying what they truly think.

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13 Race

13.1 *Asylum seekers and refugees*

One group that is often excluded from psychotherapeutic provision and research is asylum seekers and refugees. The studies gathered here indicate that:

- with the increasing instance of migration, there must be a careful reflection on therapeutic techniques when dealing with migrants, refugees, and asylum seekers.
- Western treatment techniques cannot always be used in the same way that colonisers imposed behavioural rules, religious beliefs, education and health systems on colonised populations
- it is well to note that ceremonies, traditions and bodies of migrants and refugees may have already been judged as 'inferior' from the point of view of Europeans whose historic duty was to free other races from barbarity, ignorance and poverty
- thus, in treating migrants and refugees, therapeutic techniques must be culturally and racially sensitive (Caroppo et al., 2009, p339).

Caroppo et al. (2009) also explain that from a psychoanalytic standpoint:

- migration implies departure and separation from one's home culture. This can be highly traumatic as the separation leads to a crisis since there is a separation with the past and with the homeland
- this can affect physical and mental health as it brings about a disorganisation that must be dealt with
- when arriving in the adoptive country, manic defences such as denial may take place in order not to experience loss and abandonment
- as a migrant strives to adjust to their new social and working life, a "postponed" or late-onset depression may result long after the migration experience occurred.

Renner (2009) asks the question: would psychotherapeutic work among asylum seekers and refugees be effective? An Austrian non-governmental organisation offered therapy to 37 asylum seekers and refugees from Chechnya or Afghanistan; 85% of the participants self-reported significant improvements.

Kruse et al. (2009) evaluated the effects of trauma-focused therapy on war refugees from Bosnia. Seventy refugees who met criteria for post-traumatic stress disorder (PTSD) were recruited and divided into two groups: 35 refugees were offered therapy and another 35 were given usual care. After 12 months, those refugees in the therapy group self-reported significantly lower scores on the PTSD scale and a measure of psychological symptoms. The results suggest that therapy reduces refugees' PTSD symptoms even if their residence status in the country of asylum is not secure.

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13.2 *Racial ethnic minorities*

Ince et al. (2014) conducted a meta-regression analysis (comparing statistical data) from randomised controlled trials that explored the psychological treatment of depression among adults. They included all studies where the effect of the therapy was compared with a control group and the overall racial-ethnic minority proportion of the sample was reported. A total of 56 randomised controlled trials were found and the effect size was moderate, suggesting that therapy is equally effective regardless of the client's race or ethnicity.

Quinones et al. (2014) sought to determine whether there were differences in the treatment of veterans in the armed forces with chronic depression by examining antidepressant use and therapy use among non-Hispanic Black, Non-Hispanic White, Hispanic, Asian and American Indian/Alaskan Native veterans. They found that nearly all minority groups had lower odds of adequate antidepressant use, while psychotherapy was more common among veterans from minority groups. This study looked at the distance that had to be travelled to the Veterans' Administration and it was found that when the distance was controlled for, the difference in psychotherapy and antidepressant use was no longer significant. This suggests that client preferences, provider and system factors interact to generate differences in the care of clients from racial-ethnic minority groups.

Chen and Rizzo (2010) analysed the Medical Expenditure Panel Survey from 1996 to 2006 to investigate racial and ethnic disparities in psychotherapy use and expenditures. Little evidence was found of racial and ethnic disparities in access to psychotherapy services, but White people were more likely to use psychotherapy than Latinos. White people self-paid 29% of the total cost for each visit, but Latinos self-paid 19% and African Americans self-paid 14%. White people paid significantly higher out-of-pocket share than Latinos and African-Americans because Latinos and African-Americans have extensive Medicaid coverage for their psychotherapy.

Brown et al. (2014) found that the following factors may bar ethnic minorities from participating in clinical research:

- explanatory model of illness (some cultures may not believe that depressed moods are a medical condition requiring treatment);
- negative attitudes toward psychotherapy in favour of prayer, spirituality or community support;
- language;
- religious beliefs;
- trust or mistrust of research in general;
- gender, psychopathology or substance abuse;
- fear of being reported to immigration;
- lack of child care;
- lack of transportation;
- financial constraints;
- culturally inappropriate incentives;

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- lack of medical insurance, lack of time, distance to the testing centre;
- and, employment status.

Leis et al. (2011) investigated the perceptions of mental health services among low-income perinatal African-American women. Four themes were identified:

- perceptions regarding mental health care professionals;
- concerns about confidentiality;
- beliefs about effectiveness of psychotherapy;
- and, perceptions of psychotropic medication.

Overall, within this study perceptions of mental health services were largely negative and seeing a mental health care provider was equated with being prescribed psychotropic medication. The participants also perceived mental health providers as uncaring and emotionally detached.

Smith et al. (2014) decided to test the hypothesised relationship between poor mental health outcomes and minority status. This study was conducted in a college where the majority of students were from ethnic minorities. It was found that regardless of race or ethnicity and minority status, students who were not White had poorer mental health. They also found that minority race or ethnicity was associated with internalising symptoms.

13.3 Culture values and beliefs

Eltaiba (2014) emphasises the importance of considering culture when working with individuals with mental health problems. The author is a social worker with clients who are Muslim refugees experiencing mental health problems. It is suggested that, with this population, building rapport is significant in the earlier stages of the professional relationship. Building a rapport with clients from a diverse culture, religion or race may not be possible without knowledge about the client's culture, religion or race. BACP's *Ethical Framework for the Counselling Professions* commits members to build appropriate relationships with clients and to respect clients as people by providing services that:

'recognise when our knowledge of key aspects of our client's background, identity or lifestyle is inadequate and take steps to inform ourselves from other sources where available and appropriate, rather than expecting the client to teach us'

(Good Practice, point 22f).

It is also supported under the principles of beneficence and non-maleficence, and the ethical value of 'appreciating the variety of human experience and culture' (Values point 3 subsumed under the good practice guideline of providing quality care:

(BACP, 2016).

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In this regard, Caroppo et al. (2009) provide some cultural beliefs and practices among Arabic communities that may be significant in establishing a good rapport with clients and in enhancing the therapeutic relationship and therapeutic work:

- gender roles are more rigid in Arabic communities
- individualism and self-achievement, independence and psychological emancipation from parents and personal identity may not be as important and may be second only to a collectivist outlook, whereby the good of the family, the clan or tribe is put before the good of the individual
- psychiatrists and psychologists can be viewed with mistrust, especially when religious values are ignored
- distress is usually expressed with physical symptoms and so clients may expect to receive prescriptions for medication without the need for talking about personal problems
- talking about personal problems may be difficult and so metaphorical language may be used.

Nezu (2010) reflects upon his own practice as a non-White therapist. He is a Japanese American and believes that his ethnic diversity has influenced his clinical practice as well as his clients. He points out that being described as “Asian American” has created a stereotype that this group is successful – this is a myth, he points out, as the poverty rate among Asian Americans is five times greater than the general population. There is an overgeneralisation of the characteristics of this ethnic group. Nezu says that having a diverse background sensitised him to search for possible reactions to his diversity in his clients. He narrates how a client who was a member of the Green Berets in Vietnam had a negative first impression of him. He also found that Asian Americans are unfamiliar with the concept of counselling and so they have an unfavourable opinion of him and his work. Indeed, he has lost Asian-American clients because his scientific approach to psychopathology contradicts their beliefs with regard to the medical and spiritual explanations of psychopathology. Nezu makes the following recommendations:

- genetic make-up cannot be a guidepost to classify individuals
- there is such a thing as sub-cultural diversity; that is, people of similar cultures do not all act the same way or believe the same thing
- a therapist must be sensitive to all differences
- a practitioner must ask clients what they think and feel about their diversity; and
- often, clients do not have explicit views on issues of diversity and it is their implicit views that are more apt to predict their behaviour.

Zane and Ku (2014) investigated whether gender and ethnic match impacted client self-disclosure (ie. whether a Chinese counsellor impacts the self-disclosure of a Chinese client). They pointed to four aspects of self-disclosure:

- disclosure of personal values and feelings
- private habits
- close relationships
- and, sexual issues.

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They wanted to see if among Asian Americans, acculturation, cultural identity and 'losing face' had any effects on these four aspects of self-disclosure. The study suggests that gender match between participants and counsellors facilitated self-disclosure about sexual issues and ethnic match had no effect on the various types of self-disclosure. Losing face was seen as a negative predictor of self-disclosure of all aspects of self-disclosure.

Uebelacker et al. (2012) conducted focus groups with Latinos enrolled in a Medicaid health plan to ask about barriers to, and facilitators of, depression treatment and depression telephone care. Participants were 30 Latinos who reported having been depressed or having had close friends or family members with depression, stress, nervousness, or worries. Thematic analysis revealed that specific barriers are:

- poverty
- discrimination
- language barriers
- being uninsured
- having low socioeconomic
- or having to choose between spending money for living expenses or mental health provision
- lack of linguistically and culturally appropriate care
- lack of bilingual staff, counsellors and therapists
- stigma, and proximity and transportation issues.

Knight (2013) reports that in South Africa, race permeates every facet of life and practice even when it is unconscious and unacknowledged. This article suggests that therapeutic work can provide a space of meaningful engagement between races, and therapy may be the racial contact that triggers transference and countertransference of racial pain and struggle, which could be the space for healing of racial wounds.

13.4 Language

Espin (2013) reflects on bilingual and multilingual clients, asserting that choice of language is an issue in therapy. It is considered that this is because language is closely linked with identity, choice of language goes beyond choosing a tool of communication in therapy. Language the author concludes may aid emotional self-regulation and be linked with cultural expression. Specific languages have words for feelings that may not be directly translatable

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Caroppo et al. (2009) suggests 'cultural mediation' when working with clients from different cultural contexts and who cannot speak the language of the host country. Despite having another person involved within the therapy and the frustration the therapist may feel in not understanding what is happening between the client and the mediator, having a cultural mediator can assist greatly in the translation and de-codification of cultural issues related to the stress experienced. In this regard, the typical aversion to dual relationship should be rejected. When a translator or interpreter is present, the therapist must tolerate frustration when not being able to understand what is happening between the client and the mediator.

Corollarly, Tribe and Lane (2009) ask whether using interpreters in mental health contexts is effective. They observe that people increasingly move across national borders, also increasing the need for interpreters in mental health services. The main themes and findings emerging from this study are:

- the use of qualified interpreters in early mental health interventions is good clinical practice that is also cost-effective in terms of providing an adequate diagnosis
- it improves access and quality of care, which can then increase trust and rapport with the provider therapist and improves the ability of the client to understand and follow the proposed treatment regimen
- working with interpreters may produce anxiety in therapists and it may require the acquisition of new listening, communication and observational skills
- interpreters may also provide important cultural and contextual information that could have significant bearing on the psychological issue being discussed
- the point was made, however, that interpreters have to be adequately trained and supported as they may work with victims of torture or trauma and therefore are susceptible to vicarious traumatisation
- issues in respect of accountability of the interpreter must be considered. It would be very important for them to also protect client confidentiality
- working with an interpreter means working as a triad instead of a dyad. It makes therapists dependent on the interpreter, and increases the number of communication pathways. It would be helpful to match for gender, age and religion, particularly if this is relevant to the psychological issue or dilemma involved
- the authors recommend that it would also be helpful if the same interpreter attended all sessions. The interpreter must have experience working in mental health issues and the accountability of the interpreter must be considered.

Mizock and Russinova (2013) investigate whether culturally responsive counselling impacts acceptance of a serious mental illness. Their research indicated that:

- racial or ethnic culture may facilitate acceptance of mental illness or bar it depending upon the cultural attitudes toward mental illness
- some cultures associate shame and stigma with mental illness, and therefore acknowledgment of one's mental illness may initially reduce self-esteem, social status and social networking
- the authors suggest that cultures with low-stigma explanatory models of mental illness reduce blame on the individual and increase the likelihood of acceptance of mental illness

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- participants with multiple marginalised identities (racism, sexism and mental illness stigma) also had difficulty with acceptance
- mistreatment in the mental health system is associated with the double stigma of mental illness and being part of a marginalised group, also interfering with acceptance of mental illness
- the cultural stress experienced by immigrants added another layer to racial and ethnic factors in the acceptance process, which often results in social isolation with mental illness, thus, further interfering with acceptance.

Ward and Besson (2013) explored the beliefs of 17 African-American men about mental illness, their perceptions of stigma associated with mental illness, and barriers to help-seeking. The study suggests that African-American men tended to identify the factors that cause mental illness consistently with the biopsychosocial model of mental disorder ie. the theory that interactions between the person's mental health and personality, the social world in which they live, and their health and genetic make-up contribute to their experience of health or illness. They believed they knew the symptoms and causal factors of mental illness. They also held beliefs about the timeline, consequences, and controllability of mental illness. They believe mental illness to be chronic and to have negative consequences. These participants, however, did not perceive stigma to be associated with mental illness nor did they identify stigma as a barrier to seeking help. They were open to seeking help, optimistic about professional treatment, and encouraged others to seek treatment. They also expressed interest in participating in mental health research.

Ishikawa et al. (2010) conducted a qualitative study comprising 13 Latino men and women who utilised formal and informal treatment and support. They found that when seeking help, individual and family help-seeking perspectives usually intersect with Latino cultural norms. Their motivation for whether or not they seek help for their mental health issues depends on referral source and style, the identification of their needs, and prior help-seeking experiences. Client-therapist match (in terms of gender, language and ethnicity) and the relational style between client and therapist are factors that determine mental health treatment satisfaction.

Leong et al. (2011) assert that help-seeking among Asian-American college students may be influenced by loss of face, acculturation status (how much they have adopted the culture of their host country), and beliefs regarding the concept of mental health.

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14 Religion and belief

The work of Schnall et al. (2014) focused on Orthodox Jews in this 25-year follow-up of an earlier study. It was found that compared to the earlier study:

- there is an increased acceptance of mental illness, treatment and satisfaction with quality of care
- and a corresponding decrease in mistrust of the mental health field
- with a decrease also in the belief that religion and psychiatry conflict
- as well as a decrease in the tendency to attach stigma to psychiatric problems. In contrast, affordability and fear of stigma still continue to be obstacles to seeking treatment.

Brown et al. (2013) conducted a qualitative study of 15 therapists (14 of whom self-reported being Christians) to determine their views on the role of religion and spirituality as issues in therapy. This study asserts that:

- religion and spirituality are part of the individual's psychological make-up: it is related to cognitive processes, the affect and emotion, and in the study of personality
- religious and spiritual beliefs influence health outcomes
- from the perspective of a biopsychosocial-spiritual model holds that psychological illness arises from an interactive and dynamic process involving: genetic and biomedical factors; psychological, emotional, behavioural and cognitive facts; social and family factors and embraces the role of spiritual dimensions in the development of, recovery from and protection against, psychological illness
- spiritual beliefs are significant strengths and/or protective factors that can assist recovery or coping
- spiritual factors may contribute to clients' perception of the world and may predetermine the manner in which they make decisions. Religion and spirituality may be integrated into therapy using the basic therapeutic skills of empathy and non-judgmental and accepting attitudes.

Rosenfeld (2010) asserts that a psychotherapist has two main roles: identifying and understanding the client's problems and strengths, and treating problems. He explains:

- that there is a potential difficulty in treating patients from religious organisations that are hostile to psychiatry
- the relationship between religion and spirituality and wellbeing is not consistent as there are spiritual and religious beliefs and practices which may exacerbate symptoms
- there may also be an unhealthy misuse of religious or spiritual practices so as to avoid having to deal with psychological problems and issues.

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In respect of studies in this field, particularly, Rosenfeld (2010) cites suicide justification and rejection of medical treatment as religious teachings that are harmful to psychotherapy.

Herlihy et al. (2014) focus on the tension between counsellors and counsellor-trainees who believe that lesbian, gay, bisexual and transsexual (LGBT) relationships are normal and healthy expressions of love and intimacy; and those counsellors, who, because of their personal moral, religious and spiritual convictions consider these relationships as immoral. There is a consensus that LGBT clients should feel free to expect that they can discuss their relationship issues without fear of being judged by their counsellors negatively. There is also a consensus against counsellors imposing their own values on their clients. Thus, two counsellors and two counsellors in training have filed cases for having been dismissed from their employment because they refused to counsel clients who are LGBT. There seems to be a dilemma where two values of the therapy profession are in conflict (authenticity on the part of the therapist on the one hand, and respecting diversity as well as promoting inclusivity on the other hand). The *Ethical Framework for the Counselling Professions*, however, commits members to the ethical principle of justice, which is 'the fair and impartial treatment of all clients and the provision of adequate services' (Ethics point 5) and to respect clients by making 'adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service' (Good Practice, point 22e). Which means that BACP members may not choose to discriminate against working with clients on the grounds that they have different personal values from their own.

Cornish and Wade (2010) differentiate religion from spirituality: religion is seen as formal or an institution or structure that surrounds the search for the sacred; spirituality comprises personal ideas, feelings, thoughts and views to which meaning is attached. Historically, they consider, spirituality and religion have not been attended to within counselling research as there is an historic reluctance among therapists to integrate such topics in therapeutic work. They feel this hesitancy is because they consider:

- often therapists have little, or no training, to integrate these spiritual ideas into their therapeutic practices
- therapists may be less religious than their clients
- therapists view discussions of religion and spirituality as inappropriate in therapy
- some fear imposing their own values on their clients.

Treatment, the authors consider, should not be used to promote the therapists' personal views, but the therapists' should be able to navigate many topics on which they hold strong personal opinions, without imposing their views.

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Cornish et al. (2013) conducted an online survey of therapists whose work involved group therapy. They found that therapist characteristics influence perceptions and practices regarding integration of spirituality and religion into group therapy. They found that:

- therapists with higher self-reported spirituality use spiritual and religious interventions more frequently
- therapist spirituality and religious commitment were also related to perceived barriers to attending to spirituality in group therapy: greater spirituality was associated with fewer perceived barriers; but, greater religious commitment (to a specific religious organisation) on the part of the therapist predicted greater perceived barriers.

The authors conclude that it may be the therapist's commitment to organised religion that was associated with greater perceived barriers. Therapists who were highly religious may also have a negative reaction to the concept of spirituality.

Mengesha and Ward (2012) observed that much research on the mental health of African Americans confirm that this group relies heavily on their religious and spiritual beliefs. The study then proceeds from the premise that the literature provides little guidance on how to incorporate religion and spirituality into psychotherapy with African- American women.

The study defines religion as an organised system of beliefs, practices and rituals designed to facilitate closeness to God; while spirituality is defined as a personal quest for understanding or an answer to the ultimate questions about life, purpose, meaning and relationships to the sacred. In order to more effectively incorporate religion or spirituality into psychotherapy, it is important they consider:

- explaining the relationship between religion and spirituality, its similarities and differences
- It is also important to describe religious and spiritual beliefs and practices in a cultural context.

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15 Sexual orientation

Appelbaum (2014) conducted a study and commentary on the reaction of therapists to a new law passed in California banning all therapeutic interventions for clients below 18 years old who seek to change the sexual orientation of children. In September 2012, Governor Jerry Brown signed a bill mandating that no mental health provider shall engage in any intervention defined as “sexual orientation change effort” (SOCE), which includes efforts to change behaviours or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Any intervention under SOCE is considered unprofessional and unethical conduct that will be subject to discipline.

This law was questioned as being unconstitutional and in violation of the rights to freedom of speech and parental rights to select treatments for their children. The argument is that counselling is a form of speech and should be constitutionally protected. The Court of Appeal has rejected this argument. The court states that child clients who have been subjected to these interventions may bring legal action and seek damages. This, according to the court, would provide less intrusive means for discouraging the use of these ineffective and potentially harmful therapies.

BACP along with other professional bodies has signed up to the Memorandum of Understanding in respect of conversion therapy (for more information see http://www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf) and members are committed to the *Statement of Ethical Practice* (see appendix 4) which includes: ‘BACP opposes any psychological treatment such as ‘reparative’ or ‘conversion’ therapy (BACP, 2013).

Moradi et al. (2009) observe that therapists are uniquely positioned to advance knowledge, practice and social justice through research on issues affecting sexual orientation minorities. They note the overarching challenge of conceptualising and defining sexual minority populations and also emphasise the significance and value of scholarship about sexual minority issues.

Shelton and Delgado-Romero (2011) discuss what they describe as ‘microaggressions’ against the sexuality of LGBQ clients. Microaggressions they define as communications of prejudice and discrimination expressed through seemingly meaningless and unhelpful tactics. For example within therapy they are usually expressed by:

- assuming that the person’s sexual orientation is the cause of all presenting issues
- avoidance and minimising of sexual orientation
- attempts to over-identify with LGBQ clients
- making stereotypical assumptions about LGBQ clients
- expressions of heteronormative bias (bias in favour of heterosexual orientation as the only “normal” type of sexual orientation)
- assumptions that LGBQ individuals need therapeutic treatment
- warnings of the dangers of identifying as LGBQ.

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They conclude that these attitudes and assumptions are discriminatory and hostile when they exist within the context of the therapeutic process. LGBTQ clients feel that this shows lack of support of their sexual orientation. Therefore, while microaggressions may not be overt forms of discrimination such as the practices of conversion and reparative therapies, they are seen as biased and unhelpful and treatments are subtler forms of heterosexism.

Stracuzzi et al. (2011) investigated if gay and bisexual male clients' counselling experiences were impacted by their perceived similarity in sexual orientation to their therapist, as well as what is called the therapist's universal diverse orientation during the counselling process. Universal diverse orientation is seen as a therapist's positive attitude to accommodate and accept other diversity characteristics such as male or female gender, race and ethnic background, religion, and disability – a therapist may not identify or have especially positive attitudes toward gay and bisexual clients, for example, but may have positive attitudes towards people with other clients with other diversity characteristics. The findings of this study suggest that the higher the therapist's universal diverse orientation, the more positively associated it is with client ratings as to the working alliance, session depth, and session smoothness. Perceived similarity in sexual orientation was not directly related to any of these variables. Low self-reported universal diverse orientation among therapists was negatively associated with client-rated alliance and perceived improvement.

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16 Same sex marriage and civil partnership

Stephenson et al. (2014) investigated male-male dyads as to their willingness to undergo couples' voluntary HIV counselling and testing. Data were collected from 3,245 couples in seven countries. In Australia and the UK, willingness was at 79%, while in Brazil willingness was up to 90%. Older dyads who did not know if they were HIV positive had lower willingness to use HIV counselling and testing. The association between being in a relationship and willingness to use counselling and testing were variable from country to country, perhaps because of local perceptions about couples counselling and testing.

Grove et al. (2013) hypothesised that the manner by which same-sex couples construct their relationships impacts the way they manage the process of seeking help for their relationships. They conducted 12 interviews with 16 people who had engaged in same-sex couples counselling. Their findings indicate that some couples positioned themselves as part of a minority group while others positioned themselves as part of a generic group of couples struggling with relationship issues. These constructions of their relationships impact how they discuss and decide to seek help. Therefore, the call was for therapists to be aware of the ways in which couples construct their relationships (as part of a minority group or as part of a generic group of couples).

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17 Dual characteristics

The following synopsis of studies involves clients and participants who possess two or more of the protected characteristics including or in addition to low socioeconomic status, poverty or low education.

Lovell et al. (2014) recruited 57 clients from four disadvantaged localities in the northwest of England to test the feasibility and acceptability to ethnic minorities and older people of a culturally sensitive wellbeing intervention. They sought to probe why groups such as older people and ethnic minorities, who experience high levels of mental distress, face barriers in terms of access to care. They hypothesise that despite evidence that psychological therapy may be effective for reducing symptoms of mental distress, current interventions may not be sensitive to the specific mental health needs of these populations. Their findings suggest that in the elderly participants, those who received the wellbeing intervention improved. It is acknowledged, however, that the number of recruited participants is only half of the target sampling.

Schuengel et al. (2009) conducted a controlled multiple-case design study to determine how therapeutic relationships developed in six children with what they describe as visual disabilities, severe intellectual disabilities, severe challenging behaviour, and prolonged social deprivation. The group had sessions with an experimental therapist who simulated therapeutic attachment. A control therapist alternated and provided only positive personal attention. In a second phase of the trial, both the experimental and control therapist applied behaviour therapy. Findings suggest that the children sought more proximity to the experimental therapist than to the control therapist. Psychophysiological arousal was lower when the experimental therapist applied behaviour modification than when the control therapist applied it. They concluded that attachment behaviour in the children appeared responsive to stimulation and the attachment regulation may explain the success of behaviour modification approaches.

Scott et al. (2009) probed satisfaction with counselling in young Black adolescent males who were transitioning from 'foster care' to 'custody' (within the US often adolescents will go into 'custody' rather than 'prison' which is a very structured detention facility with counselling, group therapy and classes so that they can finish high school). These participants were in custody, undergoing counselling, diagnosed with major depression or disruptive behaviour disorder, and had a history of being in group care settings. The researchers sought to determine the participants' attitudes toward mental health services, their beliefs about stigma, and their perspectives on masculine norms. It was found that the attitudes of the participants contributed to their satisfaction with counselling. That is, those participants who expressed more positive attitudes toward mental health services, and confidence in mental health professionals and the therapeutic process reported greater satisfaction.

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Pattison (2010) conducted a survey and qualitative interviews of school counsellors in secondary schools across the UK to build a model for inclusive counselling practice for young people with learning disabilities. A total of 369 school counsellors participated in the survey and 15 participated in the interviews. The counsellors' responses to the question of how to ensure greater inclusivity centred around the need to: raise awareness of the counselling service; specialist training and knowledge or experience with learning disabilities; having an integrated partnership approach; expert supervision; and, advocacy and active promotion of counselling services. They also believed that the most effective factor is in developing rapport with clients to enable them to access counselling services; there is a need for the target clients to understand the therapeutic process and the guarantee of confidentiality. They consider that there is also a need for imaginative and creative presentation of the counselling process to make it accessible (for example, through art). There must be flexibility and eclecticism to ensure that counselling can be accessed by all. Their final model of inclusivity can be seen in Appendix 3.

De Haan et al. (2015) sought to determine the characteristics and factors that influence counselling drop-out risk among youth, exploring factors such as ethnic background, socioeconomic status, and problem severity. For adolescents, the following risk factors were determined: ethnicity, being female, being older, and having lower parental socioeconomic occupation levels. The study shows a higher drop-out rate from some specific ethnic backgrounds among which there are higher drop-out rates, such as children from Turkish, Moroccan, Surinamese and Antillean ethnicity.

O'Mahony and Donnelly (2010) conducted a literature review to examine the factors that impact help-seeking behaviour among immigrant and refugee women who were experiencing post-partum depression. The goal of the review was to raise awareness and understanding of the mental health needs of this population. Their findings suggest that literature investigating the needs, issues and risk factors for post-partum depression among immigrant and refugee women is limited. There are numerous studies describing the culture of immigrant and refugee women with post-partum depression but there are few that address the impact of factors that determine or predict help-seeking. In particular, there are few studies that examine how social support, gender, organisational and institutional structures bar help-seeking behaviour.

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It seems that whilst strides have been made to ensure justice, fairness and equality in access, engagement and experiences with counselling therapeutic services, there is still much ground to cover to ensure that client diversity is identified, acknowledged and respected. Especially the covert discrimination described as ‘microaggressions’ within Shelton and Delgado-Romero’s study, or through practitioners not having an awareness, or not speaking about EDI issues. There is also a long way to go before services are made inclusive for all.

There is a need, it seems, for therapists to be ‘culturally competent’ whether they are working with clients from different countries and cultures, or who have had a different life experience in respect of disability, gender or sexuality.

Whilst legal and statutory policy have laid down conceptual definitions of characteristics which may be more prone to discrimination, and have provided punitive measures to protect people who possess those characteristics, recognising the impact of these protected characteristics on clients, on their help-seeking behaviour, on their engagement with therapy, and their satisfaction with it remains a fertile ground of research inquiry. For instance, therapist attitudes, beliefs, and convictions regarding one, some, or all of these characteristics largely remain unexamined in research, despite them playing a role in determining the efficacy and acceptability of therapeutic interventions.

If the goal is for more diverse cultures of people to engage in therapeutic services. In order to accomplish this, it may be necessary for therapists to confront their personal biases, prejudices and stereotypes and understand their own world views to increase their self-awareness and their awareness of others who may have diverse characteristics. It is not good enough to simply say ‘I treat everyone the same’ this is not what equality, diversity and inclusion are about. It is about ensuring that diversity is about ‘putting the client first’ (*Ethical Framework*, commitment 1) and enabling people to participate in ways that include their diverse needs. It may also be necessary to acknowledge that power is always a part of the therapeutic relationship, especially when clients belong to groups who have one or more of the characteristics protected by law (Borges, 2014).

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Content for this resource has been authored by: Dr Nicola Davies, BSc (Hons); MSc Comm.; PhD; DipC; MBACP; MBPsS

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Appendix 1: Multicultural Competency Inventory (MCI, Sadowsky, 1994)

The MCI Instrument consists of 40 self-report statements rated on a 4-point Likert scale (4 = very accurate, 3 = somewhat accurate, 2 = somewhat inaccurate, 1 = very inaccurate). Items are worded so that a score of 1 indicates low multicultural competence and a score of 4 indicates high multicultural competence; seven items are presented in reverse to reduce the effects of a response set. Items are behaviourally stated, including the attitudinal and sensitivity items (e.g. statements begin with expressions such as “I am able to”, “I use”, “I am skilled at”, “I am effective with”, “I am comfortable”, “I make”, “I recognize”, and “I am successful at”). A summary of the MCI item contents, loadings on the four factors, and related psychometric information for Studies 1 and 2 are shown in Table I.

The 40 items are summarised as follows:

1. Client mistrust of racially different counsellor.
2. Counsellor over-compensation, over-solicitation, and guilt
3. Case conceptualizations not stereotypical or biased
4. Differences between counsellor world views and client world views
5. Cognitive differences make communication difficult
6. Understanding the effects of age, gender roles, and socioeconomic status
7. Innovative concepts and treatment methods
8. A “world-minded” or pluralistic outlook
9. Self-examination of counsellor cultural biases
10. Minority clients compared with majority group members
11. Research on minority clients’ preferences applied
12. Aware of the changing practices, views, and interests of people
13. The range of differences within a minority group considered
14. Referrals and consultations on the basis of clients’ minority identity development
15. Self-examination of personal limitations shakes counsellor confidence
16. Counsellor defensiveness is self-monitored and corrected
17. The socio-political history of the clients’ respective minority groups is applied
18. 50% of clients seen more than once
19. Client differences causing counsellor discomfort
20. Cultural mistakes quickly recognized and recovered
21. Use of several methods of assessment
22. Solving problems in unfamiliar settings
23. Understanding client’s level of acculturation
24. Counsellor philosophical preferences are understood
25. Having an understanding of specific racial and ethnic minority groups

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Context	26. Able to distinguish between those who need short-term therapy and long-term therapy
Purpose	27. Understanding the importance of the legalities of immigration
Using the research and literature overviews	28. Extensive professional or collegial interactions with minority individuals
1 Focus of the resource	29. Multicultural case load has doubled in the past year
2 Aims and relevance of the resource	30. Interactions with people of different cultures are enjoyable
3 Definition of terms and concepts under the Equality Act 2010	31. Involved in working against institutional barriers for minority services
4 Search strategy	32. Well-versed with nonstandard English
5 Overview of findings	33. Extensive life experiences with minority individuals
6 Diversity and inclusion	34. Frequently seek consultation and attend multicultural workshops or training sessions
7 Discrimination, prejudice and victimisation	35. Effective crisis interventions
8 Age	36. Various counselling techniques and skills used
9 Disability	37. Concise and to the point in verbal skills
10 Gender	38. Comfortable exploring sexual issues
11 Gender reassignment	39. Effective in getting a client to be specific
12 Pregnancy and maternity	40. Compatible nonverbal and verbal responses
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Appendix 2: Conceptual Models of Disability (Cornell University, School of Industrial and Labor Relations, Employment and Disability Institute)

The two major conceptual models of disability are the World Health Organization's (WHO, 2001) International Classification of Functioning, Disability and Health (ICF) and the disability model developed by Saad Nagi (1965, 1979). They recognise disability as a dynamic process that involves the interaction of a person's health condition, personal characteristics, the physical environment and the social environment. Changes to any one of these factors over time can have an impact on a person's ability to function and participate in activities. A detailed description of these models, as well as a comparison of these models, is in Jette and Badley (1998).

We use ICF concepts to create operational definitions of disability. The concepts used include *impairment*, *activity limitation*, *participation restriction*, and *disability* (see WHO, 2001). A prerequisite to each of these concepts is the presence of a health condition. Examples of health conditions are listed in the International Classification of Diseases, Tenth Edition (ICD-10) and they encompass diseases, injuries, health disorders, and other health-related conditions. An *impairment* is defined as a significant deviation or loss in body function or structure. For example, the loss of a limb or vision loss may be classified as impairments. In some surveys, impairments are defined as long lasting health conditions that limit a person's ability to see or hear, limit a person's physical activity, or limit a person's mental capabilities. An *activity limitation* is defined as a difficulty an individual may have in executing activities. For example, a person who experiences difficulty dressing, bathing or performing other activities of daily living due to a health condition may be classified as having an activity limitation. In some surveys, activity limitations are identified based upon a standard set of activities of daily living questions (ADLs).

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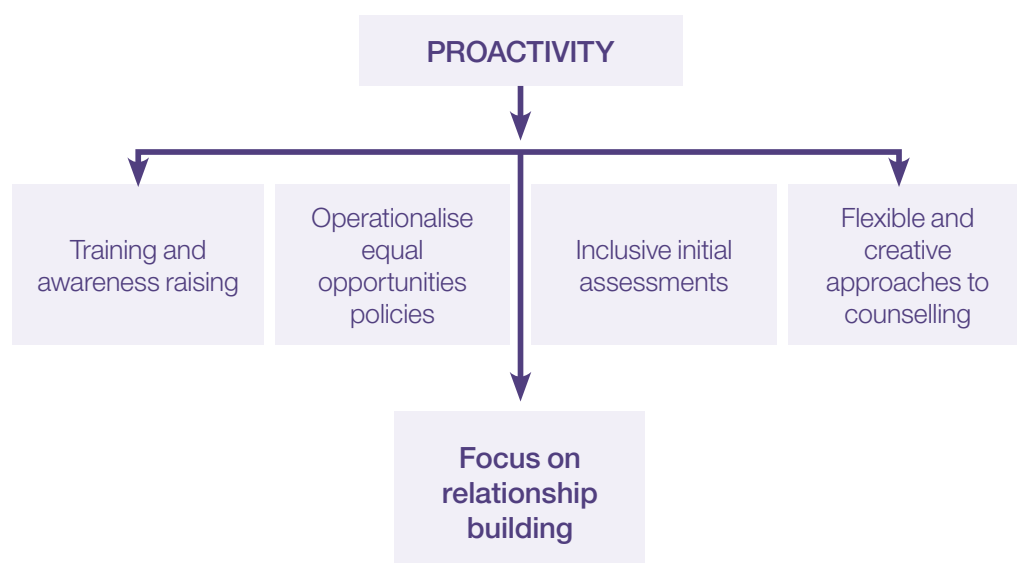
Appendix 4

A *participation restriction* is defined as a problem that an individual may experience in involvement in life situations. For example, a working-age person with a severe health condition may have difficulty participating in employment as a result of the physical environment (e.g. lack of reasonable employer accommodations) and/or the social environment (e.g. discrimination). In some surveys, participation restrictions are identified by questions that ask whether the person has a long lasting health condition that limits his or her ability to work, or whether health conditions affect his or her ability to go outside his or her home to go shopping, to church or to the doctor's office.

The final ICF concept that we use is a *disability*. The term disability is used to describe the presence of an impairment, an activity limitation and/or participation restrictions. This concept is similar to the definition used in the Americans with Disabilities Act of 1990 (ADA). The ADA defines a disability as “a physical or mental impairment that substantially limits one or more of the major life activities, a record of such an impairment, or being regarded as having such an impairment.”

While these concepts may seem to follow a progression, that is, an impairment leading to an activity limitation leading to a participation restriction, it is not necessarily the case. It is possible that a person may have a participation restriction without an activity limitation or impairment. For example, a person diagnosed as HIV positive may not have an evident impairment or activity limitation but may not be able to find employment due to discrimination resulting from his health condition. Similarly, a person with a history of mental illness, but who no longer has a loss in capacity or activity limitation, may also be unable to find employment due to discrimination resulting from his health condition.

Appendix 3: Proactive Model for Counselling in Secondary Schools (Pattison et al., 2010)



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BACP Statement of Ethical Practice

1 July 2016

The statement of ethical practice has been given effect since 18 September 2012 at which time it was incorporated into the *Ethical Framework for Good Practice in Counselling and Psychotherapy* (2013). The statement of ethical practice retains its status and is therefore incorporated into the *Ethical Framework for the Counselling Professions* (2016).

Statement of Ethical Practice (1)

18 September 2012

The British Association for Counselling & Psychotherapy (BACP) is dedicated to social diversity, equality and inclusivity of treatment without discrimination of any kind. BACP opposes any psychological treatment such as 'reparative' or 'conversion' therapy which is based upon the assumption that homosexuality is a mental disorder, or based on the premise that the client/patient should change his/her sexuality.

BACP recognises the PAHO/WHO (2012) recent position statement that practices such as conversion or reparative therapies 'have no medical indication and represent a severe threat to the health and human rights of the affected persons'.

BACP recognises that the diversity of human sexualities is compatible with normal mental health and social adjustment (Royal College of Psychiatrists). A recent research review (King, et al. 2007) showed that those who do not identify as heterosexual may be misunderstood by some therapists, who see the client/patient's sexuality as the root cause of their presenting issue. The ability to appreciate differences between people, to commit to equality of opportunity, and to avoid discrimination against people or groups contrary to their legitimate personal or social circumstances, is central to ethical and professional practice (BACP 2016, Ethical Framework).

BACP believes that socially inclusive, non-judgmental attitudes to people who identify across the diverse range of human sexualities will have positive consequences for those individuals, as well as for the wider society in which they live. There is no scientific, rational or ethical reason to treat people who identify within a range of human sexualities any differently from those who identify solely as heterosexual.

Pan American Health Organization (Regional Office of World Health Organization): *"Cures" for an illness that does not exist*, 17 May 2012.

Royal College of Psychiatrists:

King, et al. (2007): *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people*. BACP, Lutterworth.

BACP (2016): *Ethical Framework for the Counselling Professions*. Lutterworth: BACP.