Shame, labeling and stigma: Challenges to counseling clients in alcohol and other drug settings

BY REBECCA GRAY

This study explores the impact of perceptions of shame on counseling in alcohol and other drug (AOD) settings. While some recent research points to the potential treatment barriers that result from discrimination against AOD clients by health care professionals, there is a dearth of research on the impact of shame and stigma on the work of allied health professionals. The qualitative data presented here are drawn from 17 in-depth interviews with counselors and AOD workers based in New South Wales, Australia. The article focuses on the professional tensions arising in managing stigma, alongside the alienating and isolating manifestations of shame, by exploring three themes: (a) the application of negative labels such as "addicts" and "junkies," (b) the stigmatization of AOD settings, and (c) the impact of labeling and stigmatization on service provision. These findings point to the potential treatment barriers of stigma when counselling clients in AOD settings.

KEY WORDS: *Shame, stigma, counseling, drugs, addiction, treatment.*

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This article explores the impact of perceptions of shame on counseling in alcohol and other drug (AOD) settings. It was inspired by clinical literature that suggests that shame is a barrier to effective counseling processes. It was also informed by the author's professional experience as an AOD worker who regularly undertook counseling tasks. The article reports on perceptions of shame among counselors and AOD workers as they relate to: the negative labeling of clients as "addicts" and "junkies," the stigmatization of AOD settings, and the work of counselors and AOD workers. It argues that the interplay between shame and stigma compounds the challenges of counseling clients in AOD settings. The current gaps between knowledge development and practice implications in the AOD sector put undue pressure on service providers, which in turn impacts negatively on treatment processes. Further, rather than a forum through which clients might negotiate their own understandings of their drug use, participant statements demonstrate the ways in which AOD settings can create a dichotomous dynamic that label clients as either "addicts" or "sober" citizens. This dynamic is limiting and does not allow for more nuanced and complex conversations that are characterized by a therapeutic working alliance. This article aims to contribute to current research by describing some of the tensions that arise when attempting to formulate a therapeutic alliance with clients while working within frameworks that imbue the clients with negative and judgmental labels.

Background

Counselors who work in AOD settings must often respond to the feelings of shame expressed by their clients during therapeutic interactions (Potter-Efron, 1989; Fossum & Mason, 1989; Bradshaw, 1988). The aim of much research has been to provide practice suggestions for counselors working with clients who present with shame (Potter-Efron, 1989; Fossum & Mason, 1989; Bradshaw, 1988; Pattison, 2000; Tangney & Dearing, 2004; Dearing, Stuewig, & Tangney, 2005). Where

shame has been described in the literature as a treatment barrier, the focus has been on the client who may become embarrassed, anxious or speechless as they experience themselves as "dirty," "weak," or "inferior" (Lewis, 1971; Lynd, 1958). Moreover, shame carries a sense of negative social exposure (Kaufman, 1992, 1993; Pattison, 2000), which emerges from the projected sense of a disapproving other (Potter-Efron, 1989; Wurmser, 1995; Wheeler, 1997).

In *Shame, Guilt and Alcoholism* (1989), Potter-Efron emphasizes the distinction between shame and guilt. He describes "shame proneness" as related to a focus on the "defective self." It is a significant precursor to a variety of treatment barriers, which include: denial, rage, and maladaptive behaviors such as impaired empathy, low self-esteem, and defective interrelational skills. "Guilt proneness," on the other hand, is related to behaviors and is more readily adaptive (this is supported by empirical research; see Dearing, Stuewig, & Tangney, 2005). Treatment suggestions involve multiple phases of reintegration through talk therapies to moderate the affects of shame and guilt. Potter-Efron (1989) makes the point that intense levels of shame and guilt can be uncomfortable and overwhelming and, at times, can inspire the need for coping strategies. These may take the form of abusive or incongruent behaviors or the management of these affects through medicating, whether prescribed medications or problematic alcohol use (Potter-Efron, 1989; see also Potter-Efron & Potter-Efron, 2002). Other research on shame has yielded paradoxical results. In some studies, experiencing shame predicts avoidance, denial and externalized rage, while in others, experiencing shame predicts prosociality, such as restitution and internalized blame (Lewis, 1971; Tangney, 1991). A possible reason for this is that shame is often conceptualized in a way that conflates it with appraisals of damaged reputation and damaged morality, and feelings of guilt and rejection (Gausel, 2009).

Despite this, shame tends to be described as a deeply personal and individual experience, the result of innate attributions

(internal shame) and the internal processing of external and social cues (external shame). In contrast, stigma is characterized as being discredited by a social group. A person who is stigmatized is perceived to deviate from the expected norm of the social unit, which results in the individual being discredited. Stigma is seen as a relationship between attribute and stereotype that links a person to undesirable characteristics, which are manifested in social interactions (Goffman, 1963). A further issue is the power differentials between service users and health professionals. A client's fear of rejection or discriminatory behavior can create uncomfortable interactions with those who could potentially stigmatize, like health care professionals (Link & Phelan, 2001).

Byrne (1997) suggests that awareness of stigma creates a sense of shame and difference within individuals, and a sense that they might "stick out." This sense of shame may be provoked by experiences that call into question our preconceptions of self, through the eyes of an onlooker. Scheff (1998) asserts that when an individual is given a label, such as "mentally ill," the reactions of others and the person's self-perceptions are changed forever. For example, the identity "schizophrenic" becomes an overriding status. If the individual accepts the label, they begin to internalize the attributes (stigma) associated with it. Similarly, Dijker and Koomen (1999) describe stigmatization as a form of social control that aims to exclude the person from society, and which does not distinguish between the person and his or her behavior or temporary condition. Crocker and Major (1989), in contrast, are more reluctant to make direct links between stigma and lowered self-esteem, and demonstrate that membership in a stigmatized group can buffer individual manifestations of stigma, through group membership. The individuals within the member group collectively judge the stigmatization of its members as negative, thereby placing the wrongdoing onto the discriminating individual or group.

Nevertheless, recent research, both in Australia and internationally, has revealed the multiple and complex ways in which

stigma can create barriers to health care for people who engage in problematic drug use (Luoma, O'Hair, Kohlenberg, Hayes, & Fletcher, 2010). These include perceptions by health care professionals that drug use is within the control of the individual, who is therefore to blame for their condition (Holzinger, Matschinger, Lucht, & Angermeyer, 2010; Brener, Von Hippel, Kippax, & Preacher, 2010), and that drug users are more likely to receive poor health care and be denied access by health professionals (Ronzani, 2009). A study of the impact of using different terms to address drug-using clients in referral processes between health agencies found that individuals referred to as "substance abusers" were more likely to be viewed as personally culpable for their condition, and as requiring punitive measures, than those understood as having a "substance use disorder" (Kelly & Westerhoff, 2010). Clearly, being identified as a drug user can create barriers to health care. These may be the product of perceived stigma on the part of clients or of stigmatizing practices enacted by health care professionals.

Indeed, such dynamics may negatively impact on the health care professionals who are attempting to engage and consult with drug-using clients, and who often work alongside other professionals holding negative views of these clients. An Australian study that explored the experiences of nurses who encounter clients with AOD issues found that, due to the stigmatization of drug users, nurses were required to advocate for these clients to prevent inappropriate judgements and to ensure that professional conduct was upheld at all times (Lovi & Barr, 2009). Therefore, it is probable that the stigmatization of drug-using clients places an increased burden on health care professionals. Similarly, the current article revealed that counselors were sometimes frustrated in their professional tasks and that this led to increased levels of stress.

In Australia, contemporary counseling methods have been most influenced by Carl Rogers and Gerard Egan (Rogers, 1980; Egan, 2002). Counseling takes a person-centered

approach, which aims to facilitate the clients' change process through dialogue, and to help them gain a clearer understanding of self, and then develop strategies on how to retain this sense of self within a social context. A fundamental premise of person-centered counseling is to counteract the dependency of a client on a therapist, which is often a result of long-term psychotherapy, and to enhance client autonomy and personal empowerment (Nelson-Jones, 2001; Kirschenbaum & Henderson, 1989). The emphasis is on the relationship between therapist and client. Rogers argues that three factors are essential to this relationship: (a) the counselor should be congruent in what they say and how they act, (b) the counselor should be empathic, which requires the counselor to be nonjudgmental, and (c) the counselor should show positive regard for the client, which is displayed overtly in respectfulness and warmth (Kirschenbaum & Land Henderson, 1989; Rogers, 1980). Professional boundaries are set out in early sessions, and clients and their counselors may revise and renegotiate these as the work progresses (Egan, 2002). A review of the literature on ethics in counseling highlights the importance of trust and client perception of service, and goes some way to demonstrate why the continuation of negative and stigmatized practices renders the counseling process untenable and unethical (see Bond, 2006, 2007). The following analysis explores how the axis of shame and stigma creates challenges to working in a person-centered way in an AOD setting.

Methods

As part of a Ph.D. study, in-depth, semi-structured interviews were conducted with 17 counselors and AOD workers in New South Wales, Australia. The interviews were based on a number of open-ended questions used as prompts for broader discussion. Participants were offered opportunities to add information they felt to be relevant and pertinent. From the outset, it was expected that interviews would take on a momentum of their own as participants described events, thoughts, feelings,

and values that are significant in their professional experience. The opening section of the interview focused on ascertaining how participants understood and described "problematic" drug use before asking them to describe how they understood shame and the relationship between shame and their work. Throughout interviews, the participants' preferred terms were used. Participants were asked to reflect on their training and vocational experience, to describe the settings in which they had worked, and to discuss their preferred counseling models. Participants were also invited to describe an ideal scenario for counseling in AOD settings.

Data collection and analysis were structured through a process informed by grounded theory (Charmaz, 2006), and informed by the literature and the author's professional experience. The analytic process was both inductive and deductive and undertaken in three stages. First, a process of open coding was applied to five transcripts. Key words and prevalent themes gathered from open coding were combined with categories drawn from the interview guide and these were used to create the first coding framework. Using qualitative software (NVivo 8), this framework was trialed across the entire dataset and allowed for the operational addition or removal of coding labels. Initial analysis of the coding reports provided an opportunity to cluster statements. These were used to formulate emerging themes. The coding process included concepts from counseling (Rogers, 1980; Kirschenbaum & Land Henderson, 1989; Yalom, 1991; Nelson-Jones, 2001; Egan, 2002) and a reflexive research approach (Etherington, 2004). The selected counseling concepts were chosen due to their contemporary use in training forums in Australia. Grounded theory techniques allowed for reiterative data collection and analysis that sought to account for author bias, given the author's professional investment in the findings. Analysis was further verified through ongoing supervision and regular presentation at industry forums. Approval for the research was provided by the University of New South Wales Human Research Ethics Committee (07263). Transcripts were de-

identified and participant names have been replaced with pseudonyms.

Recruitment

The first recruitment phase (2008) sought counselors working in AOD settings in New South Wales, Australia. Through a process of strategic sampling, the data set was expanded to include AOD workers who engaged in counseling activities and then counselors who worked in other settings but saw clients presenting with AOD issues (2009). The participants self-selected through a study flyer which was disseminated electronically via administration departments and service homepages. Although 25 workers responded to the flyer, a large number canceled the scheduled interview due to time constraints. The strategic sampling aimed for a wide range of gender, age, and work experience. It should be noted that the final sample did not include any workers who identified as being of Aboriginal or Torres Strait Islander descent.

Participant profile

Seventeen counselors and AOD workers were interviewed between January 2008 and December 2009. The sample consists of eleven women and six men. Participants ranged in age from 21-63 years old. Four stated that they did not have counseling training and two were in training at the time of the interview. Previous training usually involved an undergraduate degree in psychology, with additional training in counseling techniques during registration certification. Other qualified workers had undergone vocational training at diploma or graduate diploma level, the goals of which included certification as an AOD worker or as a generalist counselor. Untrained workers (i.e. those without separate training in counseling) engaged in support activities which were described as "corridor counseling" or "check ins."

Findings

Participants were asked to reflect on how they understood "shame" and whether shame was an issue in their work in AOD settings. Participants provided a wide range of definitions of the term, which were consistent with previous research, including: comparisons with guilt, shame that was related to family-of-

origin events, and shame that was inspired by behaviors while intoxicated or during their "addiction," such as dysfunctional relationship patterns or criminal activities. These definitions were interchangable and overlapping. Definitions of shame were often articulated through reference to examples of clients who had been the subject of stigma and marginalization.

Similarly, understandings of "problematic" drug use were formulated through a combination of training experience, workplace policy and personal beliefs. Many of the participants reflected on their own drug use or that of a relative or friend. Participants offered multiple definitions and concepts of "addiction," "dependency," and "problematic" drug use, often in the context of descriptions of incidents involving their own clients or of conflict with other workers or services. Understandings of problematic drug use were not fixed and sometimes changed during the course of the interview as a result of dialogue with the author.

For the purposes of this article, the analysis of the interview data focuses on participants' understandings of shame as it relates to stigma, how the relationship between shame and stigma is expressed in AOD settings, and the extent to which therapeutic activities are affected by this relationship. The article argues that development in worker knowledge about problematic drug use, and how best to counsel clients presenting with AOD issues, are not necessarily consistent with current practice across the various AOD settings covered in this dataset.

Shame and stigma: The labeling process

Participants described shame and stigma as a labeling process in AOD settings. Stigma was most often described as an experience of shame or an extension of it. This was seen as a particular issue for clients as they enter settings that focus on problematic drug use. When asked how she understood shame, Elizabeth said:

> Shame? I guess it's because the person . . . I think that's projected from our society [. . .] there's a lot of shame . . . I think people can feel it, like looking at that person and saying: "You're just a junkie." (Elizabeth, counselor/AOD worker, community homeless shelter)

Shame was often described in these interviews as relating to the stigmatized identity of AOD clients. At times, participants reflected on the varying levels of shame and stigma that relate to different drugs or practices. Kristine described this in the following way:

> Most people, even if they're okay with their [drug] use, know that a lot of society shuns [them]. Because there's so much bad press about illicit drugs but not about alcohol because it's legal . . . but yeah, I think there is a difference between people's level of shame about their alcohol use. Whereas illicit drugs, most people have shame about that because it's illicit . . . and society's norms play a large role in where people's shame sits . . . and the morals . . . like we work on identifying morals that [our clients] have been taught. (Kristine, community psychologist/AOD worker, community residential setting)

In addition, labels were seen as crucial to how clients viewed their opportunities for recovery. For example, when Sally reflected on why she prefers not to use the term "addict," she said:

> I tend to avoid that word because I prefer "dependence" . . . because dependence, I feel like it's something that they've developed but they're not . . . they're not a victim to. Whereas I feel like "addiction" and "alcoholic" . . . they tend to be words that people use to relinquish responsibility and say, you know, "It's a disease and I'm a victim of that." (Sally, psychologist, community health setting)

In Sally's description of how a negative label like "addict" might shame a client, she explains why she prefers some terms over others. In doing so, she highlights that such terms are not neutral but value-laden. Moreover, using such terms might affect the counseling dynamic. Presumably, terms that mobilize the "disease model" offer less scope for helping a client to develop alternative ways of being. Similarly, Terry described his concerns that labeling a person might affect their perceived prospects or sense of agency:

> Because I think that […] stigma is: "I've got an illness or I'm this kind of person. I'm violent or you know I'm on drugs or whatever." That's one aspect of stigma. Therefore, if you give someone a label then they're gonna wear the label […] yeah it de-motivates you. [The client] gives up on trying to improve. And of course he can.

> But once you give him a label, he doesn't think he can. (Terry, family therapist, private practice and community counseling service)

Stigma and labeling, in Terry's quotation, are tied to an understanding of how a client identifies with negative attributes, and how these play out in relation to counseling dynamics. Therefore, in addition to being aware of the shaming potential of labels, participants were also mindful of the inherent therapeutic dynamics of their own labels and terms. In some cases, this included speculation upon the role of labeling in precluding the possibility of change for some clients.

Shame and stigmatized settings

Further, some participants described the labeling process as being connected to places and settings. For example, Sally said:

> Some [clients] prefer to go somewhere which seems a lot more innocuous, like the hospital . . . and some of them come to the drug-specific clinic . . . it's a stigmatized place, so they don't want anything to do with . . . the whole "junkie" [thing]. (Sally, psychologist, community health setting)

Sally's description suggests that, for clients, entering a drug-specific health care setting can be experienced as stigmatizing. In many cases, the stigma of being a client of an AOD service was described as a treatment barrier. Additionally, stigma could interact with a client's sense of shame to intensify feelings of demonization and marginalization. Again, this was thought to reduce the client's opportunities for self-directed change. For example, Kristine said:

> Most of these [clients] have been beaten up so much verbally and physically that walking in to an environment where you have authority figures that talk down to you . . . that's not teaching skills . . . it would be dictating. And I don't think it would be any different to what led them to drinking and drugging . . . I'm still trying to break through with a lot of my clients in here about a fear of judgement . . . They walk in here and voluntarily throw their hands up and say "I'm giving my life over to you" and then we do exactly what happened to them in the community! Then there'd be no point having a residential rehab. (Kristine, community psychologist/AOD worker, residential setting)

Kristine's statement highlights the potential challenges of working with clients who possess a negative self-concept, and how this might combine with an authoritarian approach, in certain settings, to reinforce the negative self-image, rather than to transform it. In settings in which counseling was guided by notions of "addiction" rather than "problematic" drug use, negative labels, such as "addict," were also applied to behaviors other than problematic drug use. For example, Joanne said:

> Well, I used to work in a private treatment centre. So that was all addictions, you know, so . . . Eating disorders and everything. Gambling. Everything. Internet sex. Love. Everything. Exercise. Everything. But predominantly drug and alcohol because a lot of those all feed in or, or are addictions or by-products of . . . an addict is an addict in whatever they use. (Joanne, family therapist, private residential setting)

While some clients might find it useful to experiment with such labels in their recovery, negative attributes are potentially shaming and, if located in the individual rather than the behavior, can tie the shame to the person. In contrast, Jane provided a description of how she saw her work in a community residential setting, which conceptualized drug use and recovery as heterogeneous:

> Each person is different. And some need to do the journey of recovery two or three times. Some need to do it for longer. Some can manage with just a few weeks and months. (Jane, family support worker, community residential setting)

These diverse descriptions of problematic drug use and treatment approaches demonstrate the complex range of frameworks used by counselors in AOD settings. These definitions were inspired by various concepts of addiction, as well as professional experience and personal opinion. AOD concepts interact with counselors' perceptions of their clients in ways that might inform therapeutic practice, and perceptions of clients' motivation, or potential for change. Moreover, in describing shame, and how it converges with stigma through the labeling process, participants emphasize how counselors work within the social

construction of the "addict." The participant descriptions indicate some of the possible concepts for working with clients in AOD settings, but the extent to which the terminology of the "addict" is negotiated between counselors and clients is unclear. Given that participants offered definitions of "addiction" that often altered as a result of discussion in the interview, it is possible that understandings of drug use can shift to incorporate client narratives and understandings.

So far, this article has focused on the construction of labels that relate to problematic drug use and the shame and stigma that is produced by these labels. Labels, in these excerpts, are tied to speculation about how the client will respond to counseling, and moreover how the wider community understands their conduct more broadly. In addition, entering an AOD space was seen to be potentially stigmatizing and some workers reflected on the potential treatment barriers for clients who avoid treatment through fear of being discredited. The following section will elaborate on how feelings of shame and stigma hinder the work undertaken in AOD settings and impact the workers involved.

Labels, stigma and their impact on workers

Many of the participants stated that entering AOD treatment can be shaming as the conduct of the person comes under scrutiny. Although these workers expressed the view that taking a nonjudgmental stance should characterize the therapeutic working alliance between clients and workers, this was not always possible due to the various treatment frameworks and structures of an AOD setting.

For some of the participants, colleagues' interventions were thought to be shaming. Mary, in particular, described shame in relation to treatment models and relayed her confusion and dismay at colleagues' interventions in what she viewed as unrelated issues. She talked at length about her confusion at unforeseen interventions used to deal with issues that she viewed as unrelated to AOD work, with the potential to further shame clients:

> And [a client] might dress a bit differently or whatever. And all the staff members [say]: "You can't wear that!" You know? And I think, "Well, what's that got to do with drug and alcohol issues? You know? You're shaming that person. You're embarrassing them. You know? She can dress in whatever she wants, you know?" (Mary, counselor, community residential setting)

Applying interventions to conduct that extends beyond drug use, by shaming, was seen to be counterproductive and potentially damaging by Mary. Similarly, John reflected on his experience in the AOD sector:

> I think that to judge or not judge as an AOD worker . . . may be informed by the professional context in which you're working [. . .] and by default nonshaming in your work, then you're unlikely to choose to work in a kind of morally-laden way [. . .] yeah, I was gonna say, I think you can be nonjudgmental . . . regardless of what institutional framework you find yourself in. But I think . . . that a particular kind of service works as a barrier to facilitate being more nonjudgmental. I think I found myself working in environments that fostered my commitment to nonjudgmental-ness . . . I didn't feel like I was gonna be marginalized or frowned upon or somehow heretical in that context. (John, health professional, nonresidential setting)

The shaming, labeling, and judging of clients were described as potential sources of tension between team members in AOD settings. This often presented counselors, who are positioned as person-centered, with a dilemma. At times, this dilemma would intensify as the participants attempted to manage this tension while working within a team or sector. Mary described this issue in the following way:

> [W]e have these rigid rules. And do they apply all the time? [. . .] You know? Because sometimes it just, it goes against my own personal thing to, to enforce the rules. And I'm always debating that because you don't want to minimize those rules or, you know, undermine the rest of the team, or anything like that. (Mary, counselor, community residential setting)

For Mary, following a person-centered approach could potentially alienate her from her colleagues and position her as a "maverick" worker. Her decision-making process was disrupted

by the alternative views of problematic drug use implicit in the workplace culture. Joanne also described this dilemma which led to her leaving the AOD sector:

> My current work is, is so much easier than working with addicts, addiction, you know. It's hard. It's tough. It's something about, about needing to be tough and hard in one sense and then in the other way of being compassionate and empathic. (Joanne, family therapist, private residential setting)

In addition to participants suspecting that stigma and labeling can negatively impact on the clients' experience of treatment, statements frequently focused on the negative impact of stigma and labeling on workers' professional experience. The labeling that occurs in relation to problematic drug use goes beyond the identification and treating of clients and can extend to the alienation of counselors who attempt to utilize more positive concepts of clients.

Conclusion

Shame has been described as a barrier to counseling, in both general and AOD treatment settings. Previous research has also demonstrated a connection between the affect of shame and "problematic" drug use. Consistent with previous research, this study found that counselors and other allied health workers perceive shame as prevalent in therapeutic interactions in AOD settings (see also Gray, 2009). This article has focused on participant perceptions of client shame that relate to stigma and discrimination.

Key findings indicate that shame is understood to be compounded by the stigma of drug use and the negative labels applied to clients, such as "addict" or "junkie." These phenomena could compel workers to use shaming treatment strategies such as instructions about conduct or dress. This was understood to be an outcome of the labels imposed on AOD clients, which render other behaviors as manifestations of addiction. Some participants described directive or punitive

strategies adopted by colleagues towards AOD clients, which were perceived to be potentially shaming. Such strategies go against the tenets of counseling, and in so doing, present counselors with professional dilemmas. In addition, a punitive approach compels counselors to treat clients without empathy and with an attitude framed by negative labels. The structure of an AOD setting, as described by these participants, throws up contradictory procedures that might render a counselor the victim of workplace alienation, should they not adopt these punitive approaches. In contrast, a heterogeneous understanding of "problematic" drug use provides a forum through which clients can seek to negotiate their own understandings of their drug use. Rather than being offered a dichotomous dynamic that labels them as either "addicts" or "sober" citizens, clients could be provided with the opportunity to develop or revise their own sense of morality, should they choose it, based upon their chosen identity and affiliations. This might allow for more nuanced and complex possibilities and prevent predetermined and loaded understandings of the client's sense of self, which are limiting and imbued with negative judgment.

This study assumes that no definition of "addiction" is neutral, and that each definition comes with a set of expectations and hypotheses that impact directly on the counseling process and the treatment setting. However, participants observed other colleagues using strategies to alter client conduct beyond the presenting issue of problematic drug use. Examining the relationship between shame and AOD counseling sheds light on treatment contradictions that are currently unsupported by practice guidelines. More research is needed to inform practice and such research might include client perceptions of health care, client experiences of shame, and the stigmatizing impact of labeling AOD clients. This study focused on shame that relates to alcohol and other drug use and, therefore, did not consider shame that relates to other phenomena, such as, gender, sexual identity, racial identity, or socioeconomic status. Given participant statements included descriptions of interventions that addressed clients' behavior beyond AOD

issues, it is suggested that additional analysis be undertaken to explore how shame interacts with these phenomena, in relation to counseling and to AOD treatment more broadly.

In conclusion, there are implications from this study for practice and future research. These include the need to retain an awareness that working therapeutically with stigmatized communities raises additional dilemmas in counseling practice that may hinder the person-centered approach. This tension can lead to unethical treatment of attending clients, impact negatively on the allied health worker, and increase levels of workplace conflict. Of course, in following professional ethics, counselors are subject to their own codes of conduct. Ruptures and fissures in these collective codes create dilemmas for counselors, as they may feel compelled to relinquish these codes in the face of more pervasive social mechanisms. When this happens, the peer support processes between workers could be undermined, thereby increasing the negative impact on workers and undermining the therapeutic process for clients.

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