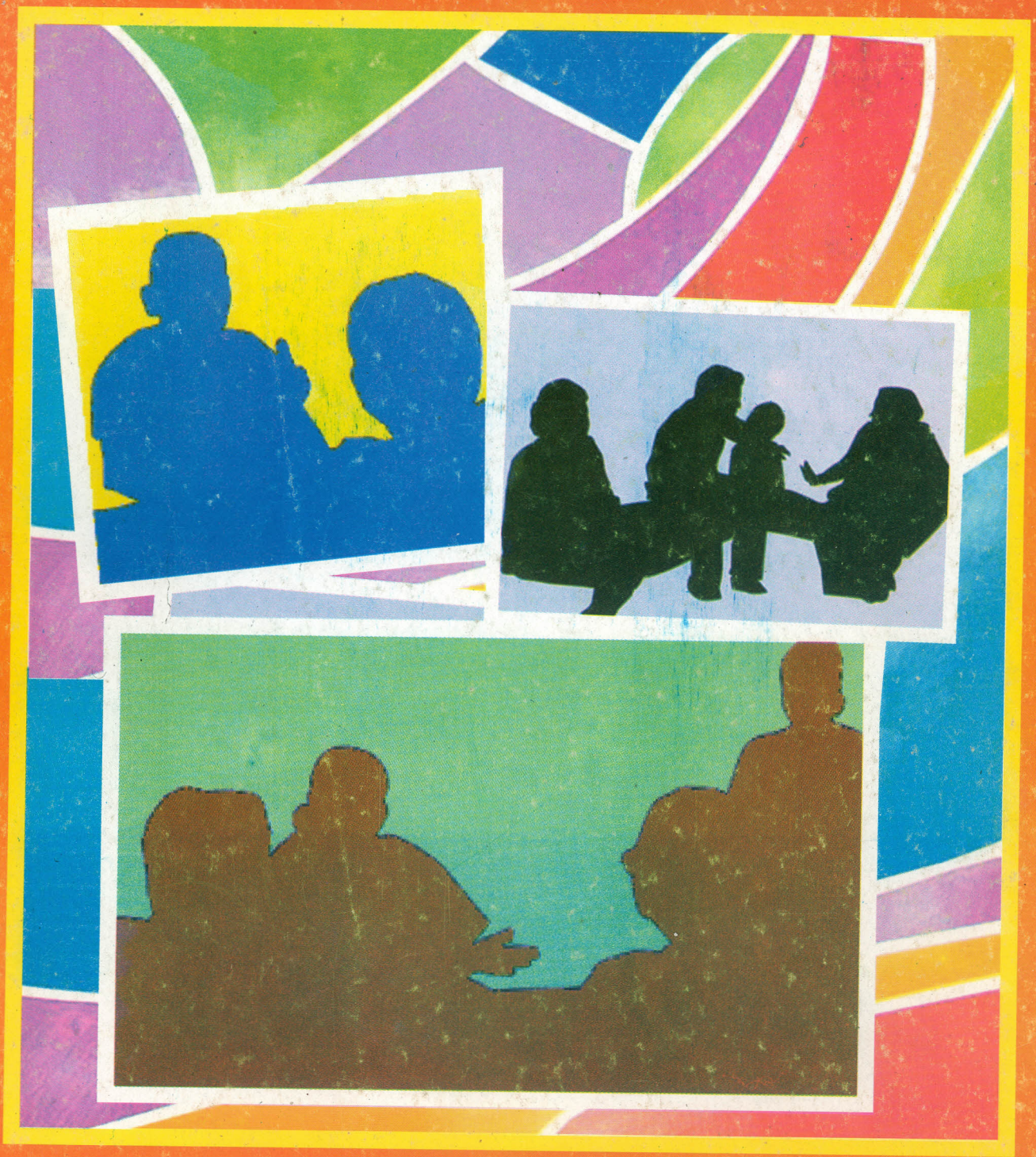
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MCFT-004
Counselling and Family Therapy: Applied Aspects



PROFESSIONAL ISSUES IN COUNSELLING AND FAMILY THERAPY

1

"शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्रा की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्गगत विषमताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।"

- इन्दिरा गांधी

"Education is a liberating force, and in our age it is also a democratising force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances."

- Indira Gandhi

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MCFT-004
Counselling and Family Therapy: Applied Aspects

Block

1

PROFESSIONAL ISSUES IN COUNSELLING AND FAMILY THERAPY

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Acknowledgment:

We acknowledge our thanks to Prof. Omprakash Mishra, Former PVC, IGNOU; Prof. C.G. Naidu, Former Director (I/c) P&DD and Head, Nodal Unit; Dr. Hemlata, Former Director (I/c) NCDS; and Dr. Arun Banik, Director, NCDS, for facilitating the development of the programme of study.

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Acknowledgment:

- We express our thanks to all those who have contributed their photo images for the cover page.

January, 2011

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ISBN: 978-81-266-5220-4

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Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi- 110 068 or the official website of IGNOU at www.ignou.ac.in.

Printed and published on behalf of Indira Gandhi National Open University by Registrar, MPDD.

Laser Composed by: Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sector-2, Dwarka), Uttam Nagar, New Delhi-110059

Printed by: Print Pack (India),215/21,Ambadker gali,Moujpur Delhi - 53

MCFT-004 COUNSELLING AND FAMILY THERAPY: APPLIED ASPECTS

"Counselling and Family Therapy: Applied Aspects" is the fourth Course of this programme of study. It comprises both theory and supervised practicum components. The theory paper on this Course is MCFT-004 and the Course on supervised practicum is MCFTL-004. You have to complete and clear both these components separately. For theory paper MCFT-004, you will have continuous evaluation through an assignment and a term-end examination. For MCFTL-004 you have to work under the supervision of the academic counsellor allotted from the study centre you are attached with. In the end as per the details given in the Supervised Practicum Manual, you have to submit your practical file to the study centre for evaluation. We would like to acknowledge the various authors, books, journals and websites from which matter related to this Course was researched; though they have been duly acknowledged in the relevant Units but might have inadvertently been missed. Throughout this Course, patient, client, family, individual, and couple have been used interchangeably. Further the terms counsellor, therapist and family therapist have also been used interchangeably.

MCFT-004 Course is designed to make you aware of the applied aspects related to counselling and family therapy and acquaint you with the various applications of counselling and family therapy in different situations. This Course will introduce you to the professional issues and practical aspects of counselling and family therapy. It will provide you knowledge on the processes of counselling and family therapy.

MCFT-004 Course would help you to develop the understanding that is required of counsellors and family therapists to have deeper knowledge about the applied practical aspects of counselling and family therapy. The Course consists of four theory Blocks.

THE BLOCKS

Block 1 is on "Professional Issues in Counselling and Family Therapy". This Block introduces you to essentials for a counsellors and family therapist in the field of counselling and family therapy. The Block also emphasizes on self of the counsellor and family therapist. Further, we will study therapist/counsellor and client relationship and its importance in therapy. We will discuss professional approach and ethical issues in counselling and family therapy. On studying this Block, you will be able to understand self of therapist, define counsellor-client relationship and explain the professional approach and various ethical issues.

Block 2 is titled "Practical Aspects of Counselling and Family Therapy-I". The Block consists of five Units. The Units explain how to create a therapeutic climate. The Block helps you to understand the various communication skills for counselling; that are active verbal skills and non-verbal skills. The Block acquaints you with the concept of mediation in counselling and family therapy. Further, you will learn about mediation in family disputes. After studying this Block you will also be able to explain life skills education.

Block 3 is on "Practical Aspects of Counselling and Family Therapy-II". It continues to talk at length about practical aspects of counselling and family

therapy. The Block consists of five Units. It will acquaint you with the knowledge of various reflective relationship techniques like immediate reflection, implied reflection and summary reflection. The Block also discusses relationship building strategies like opening techniques, structuring techniques , leading techniques, reassurance and suggestion methods and termination skills. The Block further discusses the strategies for facilitating and evaluating change. The Block also helps you to identify the barriers to actualizing therapeutic relationships and coping with difficult situations in counselling and family therapy.

Block 4 is titled "Processes of Counselling and Family Therapy". The Block orients towards various processes of counselling and family therapy like referral and intake, initial phase, middle phase and termination phase.

Manual for Supervised Practicum MCFTL-004

MCFTL-004 is the practical course of Counselling and Family Therapy: Applied Aspects. This Block will provide you the framework for hands on experience. The details regarding the same are provided in the Manual. The Manual for Supervised Practicum provides you step wise directions for doing the practical activities and recording observations.

Audio-Video Programmes

Various audio and video programmes have been prepared on the different aspects of counselling and family therapy. These would be available at your Study Centre. It is advisable to keep in touch with the coordinator of your study centre so as to know about new audio and video programmes. You must go through these audio and video programmes.

HOW WILL THIS COURSE HELP YOU?

After studying this Course, you will be able to understand professional issues in counselling and family therapy. This Course will introduce you to the practical aspects of counselling and family therapy, and will help you to understand the processes of counselling and family therapy.

BLOCK 1 PROFESSIONAL ISSUES IN COUNSELLING AND FAMILY THERAPY

Introduction

The Block 1 of Course MCFT-004 is on "Professional Issues in Counselling and Family Therapy". This Block introduces you to essentials for a counsellor and family therapist and also emphasizes on the self of counsellor and family therapist. Further, therapist/counsellor and client relationship and its importance in counselling and family therapy is discussed. The Block will acquaint you with the professional approach and ethical issues in counselling and family therapy. The Block consists of four Units.

Unit 1 is entitled "Essentials for a Counsellor and Family Therapist". The Unit begins with the decisions about which theory and therapy to use. Futher, it acquaints you with the knowledge of issues and concerns for beginning counsellors and family therapists which include managing stress and personal issues, anixety, managing theory and practice gulf, confidentiality issues and boundary issues. Normative needs, felt needs, expressed needs and comparative needs are the various needs of counsellors and psychotherapists, which we will discuss in this Unit. Skills of an efficient counsellor and family therapist are also explained in this Unit. These skills are therapeutic skills, interviewing skills, personal qualities and skills, interpersonal skills, objectivity skills, intervention skills and cultural competence skills. As you go through the Unit, you will learn about the various qualities of counsellors and family therapists, including important do's and don'ts for them and common traps for a beginner family therapist.

Unit 2 is on "Self of the Counsellor/Therapist". The Unit defines the self of the counsellor/therapist. Further, it deals with some theoretical approaches related to the role of the self of therapist like psychoanalytic theory by Sigmund Freud, Bowen's theory by Murray Bowen, experiential therapy by Carl Whitaker, Satir's model by Virginia Satir and contextual theory by Boszormenyi-Nagy and Krasner. We will learn how to use the self of therapist in therapy. At the end of this Unit, we will discuss research on the use of self of therapist.

Unit 3 is on "Therapist/Counsellor and Client Relationship". The Unit defines the concept of the therapist-client relationship. Further, the Unit acquaints you with the knowledge of evolution of the concept of therapist-client relationship. The role of therapeutic relationship in different modalities of psychotherapy is described in this Unit which includes psychoanalysis and psychodynamic psychotherapy, client-centered therapy, cognitive behaviour therapy, supportive psychotherapy, couples therapy, family therapy and group therapy. Associated factors that affect the formation and maintenance of therapeutic relationship are also discussed in this Unit. After going through this Unit you will learn, how the relationship between therapist and client affects the therapy outcome.

Unit 4 is entitled "Professional Approach and Ethical Issues". The Unit begins with the introduction to professional approach and rights of clients. Further, it defines ethics and elaborates role of ethical codes of conduct. Principles of ethics like beneficence, nonmaleficence, autonomy, justice, fidelity, and cultural determinants are described in this Unit. The Unit deals with ethics in history taking, psychological assessment, counselling, psychological research, training and supervision.

UNIT 1 ESSENTIALS FOR A COUNSELLOR AND FAMILY THERAPIST

Structure

1.1 Introduction

1.2 Decisions About Which Theory and Therapy to Use

1.3 Issues and Concerns for Beginning Counsellors and Family Therapists

14 Needs of Counsellors and Psychotherapists

- 1.4.1 Normative Needs
- 1.4.2 Felt Needs
- 1.4.3 Expressed Needs
- 1.4.4 Comparative Needs

1.5 Skills of a Counsellor and Family Therapist

- 1.5.1 Therapeutic Skills
- 1.5.2 Interviewing Skills
- 1.5.3 Personal Qualities and Skills
- 1.5.4 Interpersonal Skills
- 1.5.5 Objectivity Skills
- 1.5.6 Intervention Skills
- 1.5.7 Cultural Competence Skills
- 1.5.8 Qualities of Counsellors and Family Therapists

1.6 Some Do's to Remember

1.7 Some Don'ts to Remember

1.8 Common Therapist Traps

- 1.8.1 The Question Answer Trap
- 1.8.2 The Taking Sides Trap
- 1.8.3 The Expert Trap
- 1.8.4 The Labeling Trap
- 1.8.5 The Premature Focus Trap
- 1.8.6 The Blaming Trap

1.9 Let Us Sum Up

1.10 Glossary

1.11 Answers to Check Your Progress Exercises

1.12 Unit End Questions

1.13 Further Readings and References

1.1 INTRODUCTION

To become an effective family therapist or counsellor one needs to cultivate certain personal and professional skills necessary for being efficient and effective

in counselling and family therapy. In both counselling and psychotherapy, an affective, personal response is expected and relationship with the client is both a medium as well as an essence of the relationship. For any therapeutic procedure to be effective, client's trust and belief in the therapist is a must as much as the therapist's own belief and adherence to the particular theory of psychotherapy (McLeod, 1998).

Issues related to beginning therapist have been discussed in this Unit. As you would now be aware, we have used the terms counsellor, family therapist and therapist interchangeably, as also the term patient and client. Here, index patient is the key person for which the therapist has been approached by the individual or the family. Client means the 'whole family' seeking therapeutic intervention and may at times also mean 'individual person' seeking therapeutic interventions. The terms counselling, psychotherapy, and family therapy have also been used interchangeably.

Objective

After studying this Unit, you will be able to:

- List therapeutic skills necessary for an effective counsellor and family therapist;
- Understand how to make decisions regarding the therapy to be used; and
- Identify the problems a therapist can face during therapy.

1.2 DECISIONS ABOUT WHICH THEORY AND THERAPY TO USE

As you have studied in Course MCFT-003, there are many theories which can be used in counselling and family therapy. Effectiveness of each theory to be used depends upon the conditions under which it is to be used. Most of the theories and therapies have certain common characteristics. Grencavage and Norcoss (1990) suggested the major common characteristics among all therapies as follows:

1. *Client characteristics:* Most of the clients have positive expectations from therapy regarding alleviating their distress.
2. *Therapist qualities:* Qualities advocated by most theorists are include warmth, empathy, acceptance etc.
3. *Change processes:* Therapy provides opportunity for catharsis, practice of new behaviours and fosters awareness among the clients.
4. *Treatment structure:* All theories have a specific use of techniques, a healing setting, adherence to a particular theory.
5. *Relationship elements:* In all therapies there is alliance formation and transference taking place in therapist-client relationship.

Frank (1974) identified the following four shared features of successful therapies:-

1. It is a relationship in which client has confidence in the therapist's competence and desire to help her or him.

2. The setting for therapy is defined as a place of healing and therapy arouses the client's expectation of help. The setting would contain defined boundaries of place and time. It is a safe place to discuss one's problems.
3. The therapy is based on the rationale or myth on which an explanation of illness and health, deviancy and normality is given. According to Frank, most of the Western therapies focus on distress as being rooted in early life experiences and this view is not effective for clients who attribute psychological distress to spirit possession.
4. The therapy provides a task or procedure, which requires some effort on the part of the client outside the therapeutic setting also.

According to Frank, these factors lead to success of the therapy since therapy provides client new opportunities for learning at both cognitive and experiential level; giving client hope of change and experience of self-efficacy; provides understanding to the client; and, client experiences emotional arousal which is an important factor in facilitating therapeutic change.

So, any therapy may be chosen based on the type of problem, client characteristics, therapist attitude, goals of therapy and what role is conceptualized for the client to play during the therapy.

1.3 ISSUES AND CONCERNS FOR BEGINNING COUNSELLORS AND FAMILY THERAPISTS

As a counsellor and family therapist, you would enter into an arena that is new to you. You may experience fears and worries about the new role you have to play. Bernard & Goodyear (2004) said that beginning counsellors often experience fears and worries about their new role. These concerns include managing stress, personal issues, managing anxiety and managing the inevitable gulf between theory and practice (T. Anne Hawkins, 2005). The concerns of beginning therapists are discussed below:

- **Managing Stress and Personal Issues:**

Managing stress is a key factor on how you manage your life later. As a student at IGNOU you have stress related to the different roles you play, managing your time, money matters, study related issues, familial roles, competition and some personal problems. In addition to these, there may be many issues related to counselling which have an impact on the self. Hazler and Kottler (1994) listed the following list of common unresolved issues that many counsellors experience:-

1) Being adult children of alcoholics..
2) Being victims of childhood sexual/physical/verbal abuse.
3) Undergoing a separation, divorce or other family problems.
4) Living through an age-related developmental transition.
5) Being substance abuser or having other addictions.
6) Living through culture, race, or gender related developmental transitions.
7) Lacking self-esteem.
8) Dealing with dependence/independence issues with a significant other.

- **Anxiety:** Anxiety in all forms affects the individuals. Anxiety about competency and evaluation is critical among the beginners.
- **Managing theory and practice gulf:** The beginner counsellor would realize that there is a bridge between theory and practice which is passed only by experience. Also identifying a perfect theory and intervention strategy and the need to be 'perfect' always can hamper this counselling/ therapeutic process.
- **Confidentiality issues:** The beginning counsellor like experienced therapists have to keep confidentiality of their clients preserved. In some situations an ethical crisis may also arise.
- **Boundary issues:** In some cases counselling need is required by some one related to us. In such cases you should avoid counselling/therapeutic intervention to people associated with you by love, friendship, blood or other close associations.

1.4 NEEDS OF COUNSELLORS AND PSYCHOTHERAPISTS

Bradshaw's taxonomy of social needs (1972) provides a framework for defining the needs of counsellors and psychotherapists. These are discussed below:

1.4.1 Normative Needs

Normative needs constitute the different sets of standards laid down by different professional bodies of various counselling and family therapy organizations. The normative needs are varied among all professional bodies associated by their theoretical orientations, social responsibility, cultural differences, and evaluating effectiveness.

1.4.2 Felt Needs

According to Bradshaw, felt needs are what individuals think they want, but are limited by individual perception and by subjective experience and represent an inadequate measure of 'real need'.

1.4.3 Expressed Needs

Expressed need is the need which is expressed. Especially when under training, therapists may sometimes articulate their need to understand their clients and need to be an expert with their clients' problems.

1.4.4 Comparative Needs

This refers to the need to compare characteristics of various counselling and psychotherapy practices.

1.5 SKILLS OF A COUNSELLOR AND FAMILY THERAPIST

This section contains specific skills which should be present in an efficient and effective counsellor and family therapist.

1.5.1 Therapeutic Skills

Therapeutic skills are the skills that should be present among individuals practising counselling or psychotherapy or family therapy. Many of the skills discussed below need to be developed in the counsellors and family therapists irrespective of the theory they apply or their theoretical orientation.

Rogers (1957) and Truax and Crakhuff (1967) identified three qualities essential among counsellors; which are — empathic understanding, unconditional positive regard and congruence and their accurate communication. Later Crakhuff (1969) added four more skills – concreteness, self-disclosure, confrontation and immediacy – as essential among counsellors. Ivey (1971) gave the idea of micro-skills among the counsellors, identifying clearly distinct discrete behaviours like attending, paraphrasing, reflection of feeling, summarizing – as essential skills to be learnt.

Kagan (1975) gave the Interpersonal Process Recall (IPR) system of training. In this there is development of skills of internal awareness. For this purpose, the trainee is guided while they review their video or audio-recorded sessions with clients. This aims to encourage counsellors to become more aware of the interaction process, interpersonal behaviour, own thoughts and sensations through recall method. This is a time consuming method. Kurpius (1986) delineated four key elements on which counsellor–client relationship is built. These are human relations, social influence, skills and theory. Human relations are based on empathy, respect and genuiness.

1.5.2 Interviewing Skills

Skills are an important criteria in interviewing. These are developed with experience. Egan (1988) listed the following skills as essential for effective counsellors/therapists:-

- Establishing working relationships.
- Basic and advanced communication skills.
- Helping clients challenge themselves.
- Problem clarification.
- Goal setting.
- Programme development.
- Programme implementation.
- Ongoing evaluation.

1.5.3 Personal Qualities and Skills

There are some common characteristics which make a person a good counsellor. These characteristics, skills, attributes and qualities make for an efficient counsellor and family therapist. Personal qualities according to Hamrin and Pulson, which comprise characteristics of a good counsellor are — understanding, sympathetic attitude, friendliness, sense of humour, stability, patience, objectivity, sincerity, tact, fairness, tolerance, neatness, calmness, broadmindedness, kindliness, pleasantness, social intelligence and poise. Robert E. Farson (1954) found that tenderness, gentleness, receptiveness and passivity were fundamental characteristics among counsellors.

According to Hackney and Cormier (2001), there are five personal qualities that are found in effective counsellors — these are: self awareness and understanding; good psychological health; sensitivity to and understanding of racial, ethnic, and cultural factors in self and others; open mindedness. Another important quality in addition to the ones given above by Cormier and Hackney (2005) is the counsellor's ability to promote the welfare of the client.

According to Steffler and Stewart, the essential qualities of a counsellor are:

1. **Ethical behaviour:** Ethical values among the counsellor is of prime importance. He/she should be able to keep secrecy and maintain confidentiality the information obtained from the client. Full faith and trust in the counsellor helps to establish a cooperative relationship with the client.
2. **Intellectual competence:** Counsellor should have logical thinking, be intellectually competent and be able to link individual's behaviour and present incidents.
3. **Flexibility:** The counsellor should be flexible with the changing thought processes of the client.
4. **Sensitivity:** Counsellor should be sensitive and sincere towards their job. He/she should be honest and be aware of his/her responsibility.
5. **Acceptance:** Counsellor should accept what is narrated by the counsellee.
6. **Understanding:** Counsellor by accepting the counsellee gives him/her understanding and acceptance of self.

1.5.4 Interpersonal Skills

Interpersonal skills are the characteristics that determine how counsellors relate to clients. Egar (2002) enumerated qualities like empathy, respect, genuineness, and the promotion of client empowerment and self-responsibility. Interpersonal skills also include the listening and hearing skills of communication; to communicate your competence and trustworthiness. To have collaborative and respectful relationship with clients is important (Norcross, 2002).

1.5.5 Objectivity Skills

The counsellor or family therapist needs to be objective even when becoming a part of the client's life and world. According to Cormier & Hackney (2005), the counsellor must be able to listen, to comprehend, to relate, to think through, to recognize connections and contradictions, to conceptualize in relation to the theoretical framework, to react, to instigate, to support, to challenge and to empathize — all within the span of a counselling session. According to them, these conceptualization skills involve the ability of the helper to be reflective about his or her work and about clients and their issues as well as have a spirit of inquiry.

1.5.6 Intervention Skills

Therapeutic interventions used by the counsellor or family therapist need the usage of specific skills like skills of thought processes or behaviour. Some skills are common with all clients and some are client specific.

1.5.7 Cultural Competence Skills

Therapists/Counsellors should develop skills which are able to deal with cultural issues and view points and give culture specific therapy. Cultural competency for a specific culture does not entail that one would be successful with another culture too. Here, one needs a deeper understanding of the client's culture so as to better understand the family. You as a therapist have to do research and upgrade your knowledge regarding the client's cultural background without your client knowing that you don't have insight. If required you may postpone a visit by the client to learn more about their cultural ethos before meeting the client.

1.5.8 Qualities of Counsellors and Family Therapists

Let us now take a look at the various qualities or characteristics that need to be present in an efficient counsellor/family therapist.

Empathy: Empathy includes active listening, focusing on both expressed and unexpressed feelings and meanings experienced by the client. Empathy has been considered as a key element by various researchers. Empathy influences the content, emotional tone and language style and content of the client. Ivey (1988) listed three types of empathy — subtractive, basic and additive empathy. Subtractive empathy is the one in which the counsellor's responses substract or take something away from the client; basic empathy is the one in which the counsellor response parallels the client's statements; and additive empathy is the one in which the counsellor expands or adds on the ideas and feelings of the client.

Respect : Therapist should respect clients and give them their personal share of dignity.

Caring : Therapist should show the client that she or he is cared for and whatever information is elicited is a valued information.

Warmth and Acceptance : Counsellor and therapist should express warmth towards their client and acceptance of client as they are and not on the basis of any conditions to change, etc.

Genuineness : The counsellor should say and express genuine feeling with the client. At times may share genuine ideas, experiences or feelings with client.

Influence : The counsellor should be able to make a mark on the client. He/she should execute power or social influence to make the client think of change.

Positive Regard : The therapist should show positive regard to the client. The client should be shown that his or her views and ideas have been received appreciatively and each client's problem is unique and worthwhile. It helps to give the clients a basic sense of worthiness expressed by the therapist with genuine warmth, positive attitude and respect towards the client.

Self Disclosure : The therapist should be open to make self disclosure in front of the clients. He/she should be willing to express about himself/herself. Self disclosure here means talking about relevant issues which are related to the client, your role in therapy, giving feedback to the client, your reactions and not to have primary focus on self.

Curiosity : For a counsellor or therapist to be able to help the client, he/she has to be curious. They have to explore the various relationship issues, family dynamics which may seem irrelevant to the client but are very important from the therapy point of view. Generally, the client would have a habit of making you move around the points/areas which are of immediate interest/problem to them. But, your role as a family therapist is to ask questions about other aspects of their life too, to be able to draw some conclusion about persisting factors or maintaining factors and precipitating factors about the problem.

Interpretation : You should be able to interpret the data received with insight and understanding about the problem as well as about the theoretical orientation you feel the problem can be best addressed with.

Reinforcement : You should reinforce positive behaviour in your clients. Any attempt of the client in answering the difficult questions related to anxiety provoking issues should be reinforced like, "I understand how difficult it is for you to face this situation/answer this question"; etc.

Relaxation Technique : You should be able to use relaxation technique for self for release of tensions and also be able to guide your client in use of appropriate relaxation techniques where ever required.

Dealing with Inadequate Progress : As an efficient counsellor/family therapist you should remember that some clients will drop out before completion of the therapy. Some clients may have a problem in facing or confronting a problem. At times therapy may not give you the desired effect. In such cases you need to reassure yourself and support your client.

Active Listening : Family therapist should be an active listener. He/she should present open ended questions as far as possible so that the client has more opportunity to speak and the therapist listens more and finds cues, feelings, expressions reflected by the client.

Reflections : Family therapist should ask the same question to all the family members. He/she should ask questions reflecting feelings of one family member to the other, and vice-versa.

Interactive Empathy : Family therapist should have interactive empathy when asking questions to each family member and listening to replies of each family member.

Identifying and assessing feelings : Therapist should be able to identify client's feelings and also assess them right. He/she should be able to know the right emotion being expressed through words, expressions and body language. Emotions expressed too often should be noted down along with their frequency of occurrence. To be effective in understanding others' emotions it is important that therapist note down what and how one expresses different emotions. Then responding to affective content is an important task. Therapist response and understanding of the affective content, is an important skill which one acquires through practice. Mostly messages contain both cognitive and emotional or affective component. At time either one of the components may outweigh the other, e.g. talk of death of some one close, divorce, separation, etc. may have more affective component. You should be able to identify both

affect words and cognitive words in a statement. Identification of non-verbal cues of affect is also important. You should be able to note-down complete the client statements for later understanding. As a therapist your role is also to clarify the feelings with the client and also summarize the same to the client in clear words.

Having Facial Expressions : Facial expression of the therapist is key to tell the client how receptive you are. Attentiveness shown through facial animations at the narratives of the client encourage the client to speak further and feel that they have therapist's empathy and acceptance. The body tension of the client is also conveyed during the meeting.

Eye Contact: Eye contact with the client especially when they are speaking or you are speaking is good. Fixed eye contact on your client is not correct. Also, remember in some cultures direct eye contact is not considered appropriate.

Body Position and Space : Body position or how the therapist sits tells the client the therapist's interest in the whole process. How the counsellor moves, greets the client, takes turn in speaking, time and space given to say sentences has an impact on the therapy sessions. The space between the counsellor's and counsellee's chair is also determined by one's culture rules, like in some cultures one sits side-by side, in another opposite to each other or sit with some space in between. Gender of the therapist also determines the space between the therapist and client.

Selective Attention : The emphasis laid by the therapist on any part of the conversation leads the client to talk in that direction. It is called selective attention. Here, as a therapist especially beginning therapist, you should not shift the discussion away from what the client thinks important because you don't like to discuss on that issue. At the same time, the therapist is not to give importance to all what the client is saying.

Contextual Listening : After listening to your client, you should be able to contextualise what are the important points; on what topic the discussion took place. To contextualise a session you have to carefully listen to understand and attend the client, understand both verbal and non-verbal cues, understand both indirect and direct talks.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List down any 12 affect words.

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2. List down any at least 10 non-verbal cues.

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1.6 SOME DO'S TO REMEMBER

Beginning therapists and counsellors during their training should remember the following points in order to become an affective helping professional:

- **Theory:** You should be familiar with the relevant theory to be practised and be client centric in your approach towards the client. You should do enough research about dealing with a specific client problem. This means that you should have indepth understanding of the problem at hand, for example, schizophrenia, alcoholic husband and family distress etc.
- **Self-exploration:** Exploring one's own beliefs, thoughts, values and feelings should be done before trying to explore the client for the same. Clarity of your thoughts would prevent you from harbouring biases in therapy.
- **Skills outline:** Framework regarding the learned skills should be made which are manageable. Therapy should be provided which is clear to the therapist.
- **Skills rehearsal:** At time mock sessions of dealing with clients should be done so that competence among the beginners could be increased.
- **Reflecting on self:** Self evaluation and reflection should be emphasized and regularly used by the therapist.
- **Relate practice to theory:** Practising theory in real life scenarios is a challenging task and needs supervision in the early stages.
- **Application to real life:** Therapeutic skills learnt should be applicable to one's real life to make one more effective as a person and as a helping professional.
- **All learning has to be continuous and done as a life long process:** You should keep learning to modify and enhance your knowledge with the changes in the research and development in treating various psychological problems.

1.7 SOME DON'TS TO REMEMBER

There are some common mistakes which a therapist tends to make during therapy. These mistakes are more common in the beginners, rather than the

experienced practitioners. Following is the list of a few such dont's which one needs to remember during any therapeutic intervention:

- Don't moralize to your clients.
- Don't compare your client's experience(s) with your own life.
- Don't keep thinking and reaching conclusions based on incomplete knowledge and information. Try to pay attention and listen more.
- Don't criticize and/or be judgemental towards how the client has dealt with their life in general and their problems in particular.
- Don't forget to give your client home assignments or tasks to be performed.
- Don't 'over help' your clients. Don't try to find answers to client's problems as a ready made solution; instead, help the client to reach the solutions by selves.
- Don't 'under help' your clients in acute crisis. At times clients would need your immediate help to tide over a crisis they face in their life, may be death, loss of job, natural calamity etc.
- Don't forget to collect relevant information to deal with your specific client's specific problem. The 'research' for all problems of varied clientele group has to be done. By now, we expect that you understand the variation of problem envisaged due to varied age group, socio-economic status etc. For example, in the case of an adolescent who is alcoholic, and an alcoholic father of a 12 year old child, the problem though is same — alcoholism, but the manifestation, root of the problem, impact on family etc are different in both the cases, and for eradication of the drug abuse behavior in both the cases there would be a difference in the family therapist's approach.
- Don't over judge yourself. After all the interviews, self reflection by the therapist is a must. Here, at times you would find some crucial data was not supplied by the client or you forgot to ask them. In such a case, plan for the same to be asked in the next session but don't feel too guilty or be over critical on self.
- Don't forget to take regular feedback from your client regarding how the sessions are proceeding, whether the problem has been dealt with properly during therapy etc. If you have a co-therapist(s), don't forget taking their opinion regarding how the session took place as well as about the therapy process.
- Don't forget to discuss in detail with your Supervisor/Counsellor the case you are handling. Also, if you have a co-therapist, you both should discuss the case in detail and decide before hand who will ask whom during the family therapy session. During sex therapy it is advisable that there should be two opposite sex therapists while meeting the heterosexual couple so that the couple is able to discuss their problems easily with the same sex therapist. One may also use one way mirror technique,

and have 2-3 therapists sitting on the other side of the mirror and observing the therapeutic process. At times, they may inform the therapist through use of headphones any query or question or suggestion to be given during the case or after the therapy session is over. So, don't forget to take the other therapist's views after the sessions.

- Don't reach the diagnosis too soon. Do thorough assessment and interviewing to avoid misdiagnosis. Don't try, to reach conclusions regarding client's problems fast.
- Don't take it on yourself to correct the client's problem. You are there as a helper and regardless of how much you try, you cannot fix everything in the desired fashion.
- Don't develop any close association with your client. Avoid liking the client or disliking the client — be neutral towards them.
- Don't develop any alienation with any one member of the family. Remember that you are dealing with multiple clients (all family members) in one go and all have their viewpoints which have to be respected by you. As family therapist you should give regard to the view points of all the family members who may or may not be present in the therapy session.
- Don't wait too long to give your opinion in the therapy. Find opportune time soon so that the client is able to gain from the sessions as fast as possible. These days clients are more demanding of problem specific brief therapeutic intervention.
- Don't solve the problem too quickly. Though we say don't wait too long to help or form your reflective opinion but at the same time don't be too quick. Give yourself enough time to reflect upon the problem and to comprehend it completely to reach any conclusion.
- Don't ask questions starting with 'Why'.
- Don't show pretence of empathy but be empathic in your approach in this healing profession.
- Don't plan every session too much such that you are not able to take in any new revelations made by the family. During therapy it is seen that some important information is disclosed by the members after the initial assessment is over.
- Don't forget to keep evaluating your client's progress in therapy.
- Don't terminate early or delay termination. You should be aware of the right time to terminate a case. Any difficulty should not prompt you to terminate the case early neither any attachments should make you linger on the therapy. Before termination is about to come, prepare your client regarding termination of the sessions.

Check Your Progress 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List down 4 Dont's to be remembered by a beginner therapist.

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1.8 COMMON THERAPIST TRAPS

Counsellors, psychotherapists, family therapists often get stuck with particular interaction pattern of their clients. It is generally noticed during the counselling process, that one of the family member dominates the interview, that is, responds more, expresses emotions more, and the therapist starts focussing his/her attention more towards them/him/her. Donohue et al. (2006, p. 28-30) describes various problematic interactions as traps for the therapist. These are discussed below:

- The Question Answer Trap
- The Taking Sides Trap
- The Expert Trap
- The Labeling Trap
- The Premature Focus Trap
- The Blaming Trap

1.8.1 The Question Answer Trap

In this, the therapist asks many questions one after the other and gives space only for short answers by the client. Here, the client has a passive role and therapist has the active role. This is a problem situation for the therapist as the client would always be passive which will not help much in therapeutic sessions. Use of open-ended questions, allowing the client to complete sentences or formulate reply, enhancing listening skills among the counsellors, use of reflection by the therapist for the narratives of the client, all these things would help you to avoid this question-answer trap.

1.8.2 The Taking Sides Trap

Here, the therapist may take side of the family member (client) who is either more responsive, attends therapy regularly, does what is recommended, expresses oneself more openly, is more emotional, etc. All this should be

avoided by the therapist. This can be done by asking all clients to be regular, to ask more open ended questions from the clients who are not forthcoming. Use of selective reflective listening technique with the clients also helps.

1.8.3 The Expert Trap

As therapist, one acquires a lot of knowledge about attitudes, behaviour, strategies, problems, etc. Here, one may think of giving advice and direction to the client with regard to appropriate behaviour, right attitude, suggestions to bring about change, etc. This would lead to dependence on therapist by the client; including regarding decisions for effective behaviour change. The expert trap has to be avoided. This can be done by being a guide to the clients rather than directing the clients and, also, by strengthening and motivating the client's capacity to change.

1.8.4 The Labeling Trap

Therapist often label their clients like being addict, responsive, warm, unsympathetic, uncaring, mentally retarded, etc. In family situations, one of the family member may use labels to describe the other family member/life partner. In such situations, therapist should be careful not to use labels and take sides. Instead, you should focus on the traits that need to be cultivated or changed among the clients. Labeling of any sort should be avoided as this would de-motivate your client.

1.8.5 The Premature Focus Trap

This refers to the tendency of the therapist to "jump on" a specific problem too quickly, and potentially divert attention from the client's most pressing concerns. This means that the therapist should not arrive at any premature conclusions regarding what the problem is and what the client wants. Instead therapist should use open-ended questions, reframe questions to ask more information and then use reflection to understand what the clients want to convey, and then reach any conclusion of the behaviour problem of the client.

1.8.6 The Blaming Trap

There are times when client complaints of others being at fault for their problems. The therapist may also follow this procedure and tell their clients that they are blaming others for their faults. This leads to the blaming trap, which the client is already suffering. You should avoid blaming your client for any of the faults, 'No-fault policy' should be established with the client at the onset of therapy (Miller & Rollnick, 2002).

1.9 LET US SUM UP

In this Unit we have discussed the essential characteristics for an effective and efficient therapist and counsellor.

In particular, terms with meaning of empathic understanding, respect and positive regard, genuineness and congruence, concreteness, warmth and immediacy are important attitudes and skills essential for counselling and family therapy. Most of the therapists and researchers have used these terms. Skills like listening, reflection of feeling, reflection of content, challenging, coping with feelings, starting and ending the relationship, timing, giving information and

supporting are some of the common skills in various therapeutic approaches.

In this Unit we also discussed the common mistakes made by beginner therapist, some don'ts to be remembered during therapy and the common traks in which the family therapist falls.

1.10 GLOSSARY

Empathy : To understand the other's perspective.

Interviewing skills : Skills required by the therapist while interviewing the client.

Reflection : Evolving by introspection.

Therapeutic skills : Skills required by the therapist during the therapy.

Therapist trap : Particular interaction pattern of the client and therapist.

1.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Following are twelve affect words:

i) Joy	v) Worried	ix) Thrill
ii) Happy	vi) Fear	x) Depressed
iii) Sad	vii) Pleased	xi) Surprised
iv) Anger	viii) Glad	xii) Irritation

2. Following are twelve non-verbal cues:

i) Head Bent down

ii) Looking at the door constantly

iii) Gazing awkwardly

iv) Drawn to self

v) Folding handkerchief

vi) Making facial gestures

vii) Eyes roll up

viii) Smiling

ix) Hands folded in front of the chest

x) Leans forward towards the table

xi) Looks straight faced

xii) Kneading the hand which is paining again and again.

Check Your Progress Exercise 2

1. a) Don't solve the problem too quickly.

   b) Don't reach the conclusion to the precipitating problem of the client without listening to the client.

   c) Don't like or dislike the client.

   d) Don't terminate the therapy sessions abruptly.

1.12 UNIT END QUESTIONS

1. 'Counsellors should be able to reinvent themselves'. Do you agree with this statement? Discuss it with the help of concrete examples.

2. For counselling, counsellors must acknowledge that they make mistakes and be willing to admit them or they should not admit mistakes and dismiss their errors. Explain the statement and discuss it with the help of concrete examples.

3. List down your two personal strengths and weaknesses while conducting therapeutic sessions. Now list two ideal personal strengths that a counsellor and family therapist should possess and in your opinion you don't. Write how can you cultivate the same in yourself.

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UNIT 2 SELF OF THE COUNSELLOR/ THERAPIST

Structure

2.1 Introduction

2.2 Defining Self of the Therapist

2.3 Role of the Self of the Therapist in Some Theoretical Approaches

2.4 How to Use the Self of the Therapist?

2.5 Research on Use of Self of Therapist

2.6 Let Us Sum Up

2.7 Glossary

2.8 Answers to Check Your Progress Exercises

2.9 Unit End Questions

2.10 Further Readings and References

2.1 INTRODUCTION

The self of the therapist is probably one of the most important yet underemphasized aspects of psychotherapy training. Several pioneering family therapists like Murray Bowen, Ivan Boszormenyi-Nagy and Virginia Satir emphasized the use of self in therapy. The necessity and extent of use of self depends on the theoretical approach used in therapy. For instance, behavioural and cognitive behavioural therapies that focus more on immediate change in cognition and behaviour pay less emphasis on the therapist's own reactions in the sessions. It is perhaps more common to discuss use of self in insight-oriented and client-directed approaches. In family therapy where the therapist inadvertently becomes a part of the "system", it is very likely that the therapist will experience emotions and reactions as a result of her or his interactions with clients. Therapists may identify with the child, for instance, in a family where the parents are considering divorce, or may identify with the mother who is trying to juggle both outside work and parenting. Even experienced therapists are sometimes thrown off balance (if only momentarily) by the intensity of the emotional field in the therapy room. The reactions that one has in the therapy room are not necessarily bad and unwanted. A therapist's reaction in the room may in fact be a vital indicator of interactions in the family system. For instance, if the therapist feels intimidated every time the father raises his voice, it is highly likely that the mother in the room feels the same too. The idea that such parallel processes may occur in a system is called isomorphism (Hanson, 1995). The implications of *isomorphism* and the usefulness of being aware of one's own reactions as a therapist delineate the importance of learning to use self of the therapist.

This Unit will focus on the use of self in therapy by introducing the learner to the definition, its place in various theoretical approaches and tips on how to incorporate it in training. In this Unit, we use the term therapist and counsellor; and therapy and counselling interchangebly.

Objectives

After studying this Unit, you will be able to:

- Define and understand the term "self of therapist";
- Explore the role of the self of therapist in various theoretical approaches; and
- Provide strategies to explore the influence of the self in therapy.

2.2 DEFINING SELF OF THE THERAPIST

Before examining the use of self of therapist in family therapy, it is essential first to define it. What does self of the therapist mean? While different approaches offer their own description, broadly defined, the self of the therapist is, "...the active and purposeful use of personal aspects of the therapist to further the aims of therapy" (Tester, 1992, p. 157). This refers to the use of the therapist's own experience in the session with the clients, as well as in her or his own life in relation to the goal of providing a healing environment for the client. It does not mean using the therapeutic experience to "therapize" oneself. The goal of fostering change in clients' lives should always be foremost. "The practitioner's use of self is a process and can be said to begin as a conversation with self in which she or he constructs ideas, hypotheses and predictions *about interaction with the client family*" (Tester, 1992, p.1, emphasis added). Thus, while examining personal experiences in sessions, the therapist should always ask oneself "how does this affect my relationship with my clients? Are there potential roadblocks I might face because of my reactions to them?".

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) State 'True' or 'False':

i) Self of therapist means use of the therapist's own experiences in the session with the client, as well as in her or his own life in relation to the goal of providing a healing environment for the client. _____

ii) Self of therapist means using the therapeutic experience to "therapize" oneself. _____

iii) The goal of fostering change in clients' lives should always be foremost. _____

2.3 ROLE OF THE SELF OF THE THERAPIST IN SOME THEORETICAL APPROACHES

The development of the self of the therapist is regarded as a significant aspect of an effective therapist (Lum, 2002). Many theories consider it as an important factor in the development of a therapeutic relationship. In this section, the role of self of the therapist in some of the major approaches will be examined.

Psychoanalytic Theory

Therapist's use of self can be traced to Sigmund Freud's psychoanalytic tradition which insisted that all aspiring psychoanalysts should work toward getting rid of any wish-defense complexes or neurotic anxieties that might interfere with the therapeutic process (Horne, 1999). The therapist needed to be a blank wall onto which clients could project their own anxieties and fantasies. Treatment involved the therapist then making interpretations from these projected wishes. The therapist therefore could not allow her or his own wishes to colour the projections. An inability to provide a "blank wall" could interfere with the treatment of the patient. While notions of role of the therapist has changed from the image of a "cold and detached" analyst, the idea that the therapist should work toward freeing herself or himself from the clutches of her or his own fantasies in therapy is echoed by other theorists too.

Bowen Theory

Murray Bowen was one of the pioneering family therapists who insisted that therapist-trainees work on their own levels of differentiation (Aponte & Winter, 1987). At a family therapy conference he presented a genogram of his family and offered narratives of how he struggled to achieve higher levels of differentiation and decrease emotional reactivity (Bowen, 1972). He encouraged his students to explore family-of-origin issues because he assumed that the individual or family in therapy would automatically pull the therapist into their emotional field. If the therapist is pulled into this field, then it would impede the process of self-differentiation of the family (Kerr & Bowen, 1988). For example, a family of parents and three children present to therapy because the middle child is acting out and is being suspended from school. The family may believe that the problem is with the middle child and that she or he has to be "fixed". If the therapist working with them is triangled into this belief system, then she or he may indeed see the child as the problem and align with the parents against the child to "correct" her or his behaviours. A therapist who is able to be less emotionally reactive may be able to view the issue systemically and be present to hear all sides of the story, instead of forming coalitions against the "identified patient". Thus, from a Bowenian perspective, a therapist's reaction and consequences of this reaction could deeply impact the therapeutic process. Awareness of one's reactions and the ability to recognize red flags about possible triangulation is deemed important. However, it should be noted that "It is not necessary for a therapist to have complete emotional autonomy to be effective. She or he just needs to be more autonomous or less reactive than the family" (Kerr & Bowen, 1988, p.283). Through adequate supervision and continual work on family-of-origin issues, a therapist can gradually increase her or his competence in dealing with anxiety and potential for triangulation in the client system.

Box 1 : Case Vignette

A student therapist was seeing a middle-aged couple in therapy. They had an 18 year old son who had recently moved away from home to attend college. The couple had sought therapy to address the issue of "distance" in the relationship. The wife felt that she had suffered all through the marriage because of the constant moving warranted by the husband's job. She reported that since the son moved out they did not seem to be communicating as before and she felt depressed and alone. For about a week before seeking therapy, she said she had been "crying non-stop". The husband on the other hand, said that he had no idea that his wife had suffered over the years in their marriage. He, however, had felt a change in their relationship after the son's departure. He noted that he did not feel attracted to her anymore but felt responsible for her welfare. One of the main reasons that kept him in the marriage was his belief that she could not survive without him. This belief was fueled in part by his knowledge of her troubled childhood and youth. In therapy, the couple seemed cooperative and willing to change. Sessions were emotionally intense with the wife crying for the most part. At several instances, it felt like the husband agreed with the therapist more than the wife did. After about eight sessions, after a particularly intense interaction, the wife accused the therapist of not listening to her and of taking the husband's side. This was surprising to the therapist who believed she was being fair to both of them in the session. In supervision, the therapist was asked how she viewed the presenting problem. Specifically she was asked to examine her perspective of the function of the symptoms. Through this exploration the therapist realized that she had inadvertently bought in to the couple's belief that the wife could not survive without the husband. The therapist's belief had in turn translated into actions in the session that seemed disempowering to the wife. Further in supervision the therapist was encouraged to explore where the belief came from. Active exploration with the assistance of the supervisor led to the therapist's discovery about her belief about people in therapy as "fragile" which originated from her own family-of-origin experiences. The therapist then was able to constructively use feedback from the supervisor and pull herself out of the emotional triangle which she had been entangled in. This changed stance seemed to empower the wife who then was able to stand up for her self in the relationship.

Experiential Therapy

Carl Whitaker also proposed a similar assertion that the therapist's own psychological health is an important factor in the therapeutic process (Whitaker & Keith, 1981). Whitaker believed that more than theory or techniques, a therapist's effectiveness was a result of the level of personal authenticity, openness and spontaneity. He also emphasized the use of transference in the therapy process (Horne, 1999). In Whitaker's experiential approach to therapy, the therapeutic process is conceptualized as an opportunity for corrective emotional experiences *via* the therapeutic relationship. In fact Whitaker & Keith (1981) state that "The therapist's personality and psychological health yield the greatest rewards in treatment" (p.217). Contrary to the Bowenian approach where the therapist strives to reduce interpersonal anxiety, the experiential therapist seeks to increase anxiety in sessions. The increase in anxiety is assumed to create "encounters" in therapy that challenge the status quo in the family. In order for

these encounters to occur, the therapist has to be aware of her or his own emotional reactions and be willing to withstand an increased level of anxiety. Building this skill requires a therapist to identify her or his reactions that could potentially obstruct the encounter. For instance, in the session if the therapist is intimidated by the increased levels of anxiety, creating meaningful encounters and providing a "holding" environment to contain clients' emotions may be difficult.

Satir's Model

Virginia Satir emphasized the importance of resolving family-of-origin issues in order to remain therapeutically congruent (Lum, 2002).The main aim of Satir's model of therapy is to help clients be more congruent and in touch with their self. In order to facilitate this process, therapists are required to be "emotionally healthy" so that they can be fully present for their clients. If therapists are themselves hesitant to address issues that block their emotional health, it is unlikely that their clients would be able to do so. "The family system will be supported to heal and change when therapists are able to be clear and congruent" (Lum, 2002, p.191). Thus, addressing one's own biases and struggles with incongruence is important.

Contextual Theory

The use of self of the therapist assumes great importance in the contextual approach. In fact Boszormenyi-Nagy and Krasner (1986) contend that the "person of the therapist is his or her principle tool (in therapy)" (p. 396). The overarching goal of contextual therapy is to restore imbalance in relationships. Issues of fairness, justice, trust, loyalty and entitlement constitute the core concepts in this approach. In order for the therapist to facilitate repair of the imbalance in relationships, she or he should be able to offer a trustworthy relationship and be willing to take a multilateral stance. Taking a multilateral stance requires one to be "partial" to everyone in the therapy room, as well as to those who could be affected by the therapeutic process. Being partial means acknowledging one's pain and suffering as well as strengths and resources, while not aligning against anyone in the system. Adoption of this approach requires personal freedom from one's own entitlements, conviction in the belief that fairness can be restored in relationships, courage to bring up issues of unfairness, and capacity for empathy towards all family members (Boszormenyi-Nagy & Krasner, 1986). Self-reflection is thus an integral part of learning to be a competent contextual therapist. The more aware the therapist is of her or his own entitlements and struggles with fairness in relationships, the better she or he will be in being "fair" to the client system.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Fill in the blanks:

i) According to Sigmund Freud, _____ should work towards getting rid of any wish-defense complexes or neurotic anxieties that might interfere with the therapeutic process.

ii) _____ insisted theraptist-trainees work on their own levels of differentiation.

iii) According to experiential therapy, _____ own psychological health is an important process in the therapeutic process.

2.4 HOW TO USE THE SELF OF THE THERAPIST?

In the previous section we discussed the use of self in some of the major approaches to therapy. All of them essentially view work on self of the therapist as paramount to the success of therapy. The underlying theme in all of them is that the therapist should be able to achieve the tasks that the clients are expected to, as conceptualized by the respective theoretical assumptions. Thus, if the aim of the therapy is to increase differentiation of the client system, the therapists are required to work on their own differentiation levels; if the aim is to foster congruence, then the therapist should be aware enough to be congruent with her or his self; and if the aim in therapy is to restore fairness, then the therapist should explore issues of fairness in his or her own life. Lum (2002) states, "how therapists view clients will affect how therapeutic relationships will develop" (p. 187). Beliefs about the clients are shaped by therapists' own experiences. The examination of the therapists' experiences then needs to be an integral part of training. Timm and Blow (1999) suggest that with necessary ground work, this exercise could result in personal growth for the therapist. If the ground work is not laid, then negative consequences could occur when therapists' attempt to access and explore their emotional reactions. The presence of a safe environment with a supervisor offers the best place for such an exploration. Confidentiality must be ensured and both supervisor and supervisee must be willing to explore self of therapist issues.

While work on use of self is a continuous, ongoing process, Timm and Blow (1999) suggest a few techniques to initiate it. The main aim of these techniques is to increase therapists' awareness of themselves and to keep a watch for potential obstacles in the therapeutic relationship. To this end, it may be useful to draw a genogram of one's family and identify patterns of interaction. Interviewing family members is recommended to get an accurate picture of members' relational styles. Some questions to ask are:

1) How do members in my family express emotions?

2) How do they deal with stressors?

3) Have there been any significant losses?

4) Have there been any mental illnesses?

5) What is the predominant coping style?

6) How do members cope with conflicts?

7) What are the strengths present in the family system?

Identifying both constraints and strengths in the family could provide the therapist clues about one's own relating styles (Timm & Blow, 1999). Examining one's family-of-origin experiences also helps identify therapists' beliefs about the clients and about their role in the client system (see case example cited in previous section). A step above formulating a genogram is doing a double genogram (Timm & Blow, 1999). Here, the therapist lays out her or his genogram and the client's genogram in order to examine similarities and differences. This exercise can be particularly useful when a therapist begins to identify with the client very closely. While constructing the genogram, it may be helpful to note the developmental stage of the therapist. Sometimes issues presented by clients could be similar to the ones currently faced by the therapists. For instance, a therapist eager to leave her or his parents' home and live independently may suddenly have an influx of clients struggling with issues of autonomy. Or a therapist who is currently debating whether to stay in her or his marriage could see clients facing similar dilemmas. In such cases it would important to find out whether the therapist is "looking" for particular issues in the client system or whether the problems were genuinely presented by the client.

Use of self is a process; it starts at the first contact with clients and continues until termination. Sometimes, lessons learned with one client may be useful in another situation. Thus, one cannot pin point a time when a therapist should cease using self of the therapist. For beginning therapists, this may seem overwhelming at first. For instance, a first year doctoral student had just started seeing clients in therapy. She or he was being supervised individually as well as in group and she or he had just been introduced to the importance of use of self. One supervision session she or he noted that in sessions she or he was juggling a lot of things at the same time. Questions like "What does the client mean by this? What reaction am I experiencing? What does that mean? What am I supposed to say next?" simultaneously plagued her or his mind, thus paralyzing her or his in the session. It is always best to remember that in therapy too, one should walk before starting to run. Consider it as a skill just like any other, for example, driving. When you first drive a vehicle, you have to pay attention to many things at the same time. If it's a two-wheeler, then you would wonder if you have the right balance, whether you are on the right side of the road, whether the light is on in the dark, when to indicate a turn, how to navigate the traffic, etc. It seems a tremendous task at first. But as you learn and as you become aware of the necessary steps involved, you don't have to think about it all the time. You will be able to hop on the vehicle and easily weave through traffic. The skill of using one's self needs to be practised, discussed with peers and supervisors and then ultimately should become second nature to you as a therapist. But remember, you don't have to dive before learning to swim first.

2.5 RESEARCH ON USE OF SELF OF THERAPIST

In a review of research examining the impact of use of self on outcome in therapy, Horne (1998) noted very few studies. Even among the studies, there was "marginal" empirical evidence for a relationship between the therapist's intrapsychic health and outcome, specifically among trainee therapists treating moderately and severely dysfunctional clients. This conclusion was based on the lack of uniform strategies to measure use of self of therapist and outcome

of therapy among these studies. Moreover, the available research was limited in their designs making it difficult to generalize from the studies' conclusions. The lack of empirical evidence therefore does not negate the importance of use of self in therapy. Obviously, more research is needed to describe the impact of a therapist's work on use of self. Meanwhile, personal development of therapists remains a critical issue facing psychotherapy training programmes (Schnarch, 1991).

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) State some questions, which the therapist should answer while drawing her or his own genogram.

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2.6 LET US SUM UP

In this Unit, we explored the importance of using self of the therapist. Major therapy approaches, especially those that are insight-oriented, advocate the need to train therapists to use their self as a tool in therapy. Increased awareness of one's self and the ability to use personal reactions in understanding clients contribute to a healing relationship. Though empirical research in this area has been limited, one cannot dispute the need to use one's self in therapy. For the development of a therapeutic relationship and to create meaningful encounters, the therapist should be aware of and acknowledge her or his reactions and responses in the session and be able to use them for the benefit of the clients.

2.7 GLOSSARY

Isomorphism : The idea that some parallel processes may occur in a system.

Self of the therapist : The active and purposeful use of personal aspects of the therapist to fulfil the aims of therapy.

Experiential apporach to therapy : The therapeutic process is conceptualized as an opportunity for corrective emotional experience *via* therapeutic relationship.

2.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. i) True

   ii) False

   iii) True

Check Your Progress Exercise 2

1. i) psychoanalysts

   ii) Murray Bowen

   iii) therapist's

Check Your Progress Exercise 3

1. The therapist should answer the following questions while drawing one's own genogram:

   i) How do members in my family express emotions?

   ii) How do they deal with stressors?

   iii) Have there been any significant losses?

   iv) Have there been any mental illnesses?

   v) What is the predominant coping style?

   vi) How do members cope with conflicts?

   vii) What are the strengths present in family system?

2.9 UNIT END QUESTIONS

1. A couple married for two years has sought therapy because of their constant fighting. Prior to marriage they studied in the same college and upon graduation decided to get married. Their parents reluctantly agreed to the match as they were from different religions. He is a Hindu and she is a Catholic. What are your beliefs about inter-religion marriages? Where do they come from? How will these beliefs affect your work with the couple?

2. A forty year old woman has sought individual therapy. She is married, has two children and works in a Central government office. She complains about her husband abusing alcohol. From the description given to you, he is not physically or verbally abusive and uses alcohol as a way to cope with high levels of stress at work. She wants you to provide ways in which she can get him to stop drinking alcohol. What are your beliefs about a person abusing alcohol? Have you experienced alcoholism in your family while growing up? Have you known anyone with such experiences? What are your reactions towards people abusing alcohol?

2.10 FURTHER READINGS AND REFERENCES

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UNIT 3 THERAPIST/COUNSELLOR AND CLIENT RELATIONSHIP

Structure

3.1 Introduction

3.2 Evolution of the Concept of Therapist-Client Relationship

3.3 Role of Therapeutic Relationship in Different Modalities of Psychotherapy

- 3.3.1 Psychoanalysis and Psychodynamic Psychotherapy
- 3.3.2 Client-Centered Therapy
- 3.3.3 Cognitive Behaviour Therapy
- 3.3.4 Supportive Psychotherapy
- 3.3.5 Couples Therapy
- 3.3.6 Family Therapy
- 3.3.7 Group Therapy

3.4 Formation and Maintenance of Therapeutic Relationship: Associated Factors

3.5 Relationship Between Therapeutic Relationship and Therapy Outcome

3.6 Ethical Issues in the Therapist-Client Relationship

3.7 Let Us Sum Up

3.8 Glossary

3.9 Answers to Check Your Progress Exercises

3.10 Unit End Questions

3.11 Further Readings and References

3.1 INTRODUCTION

Each of us would have both sought from and provided guidance, advice, and help to family, friends, and acquaintances in an informal manner. In some ways this may appear similar to a relationship between therapist and client. However, the therapeutic relationship differs from a personal relationship in a number of ways.

The therapeutic relationship is a professional helping relationship wherein the interests of the client always come first. The onus is on the therapist to create a safe environment that facilitates communication. Social conversation is often laced with casual advice, suggestions, recommendations and even firm demands. Unlike other social contacts, the therapist is a trained professional who uses appropriate techniques and skills that may help the client.

The client can take certain aspects of the therapeutic relationship for granted; for example, the confidentiality of communication within the interaction. The reciprocal nature of social interactions is not typical to therapy. The client remains the focal point of the discussions and there is always an inherent power imbalance present in the relationship. Unlike casual social contacts, the therapy sessions

are planned, with a specific beginning and end. The therapeutic interaction also involves collaborative planning of goals. The interaction is also time-limited as therapy moves towards a planned termination.

People often develop a close relationship with their therapist. The two of them have been sitting in a room talking about very personal subjects — often once a week for at least several weeks. Does this make them friends? The therapist usually does not see it that way. Specific boundaries define the therapeutic relationship.

It is sometimes difficult to achieve a sense of objectivity in close personal relationships. Therapists need to understand their client's emotions but also keep the appropriate emotional distance in the relationship. Although the therapeutic relationship is a collaborative relationship, rich with feelings and a sense of connection, there is a certain degree of inherent objectivity.

This Unit focuses on the role of the relationship between the therapist and client during family therapy.

Objectives

After studying this Unit, you will be able to:

- Define the concept of the therapist-client relationship;
- Describe the role of the therapeutic relationship in different modalities of therapy;
- Explain the client, therapist and therapeutic technique related factors associated with the formation and maintenance of the therapeutic relationship;
- Discuss the relationship between the therapeutic relationship and therapy outcome; and
- Illustrate the ethical issues pertaining to the therapeutic relationship

3.2 EVOLUTION OF THE CONCEPT OF THERAPIST-CLIENT RELATIONSHIP

Therapeutic alliance is not a new concept for clinicians and it has a long and rich history. The recognition of the importance of the therapeutic relationship can be traced back to writings on psychoanalytic theory by Sigmund Freud.

Freud recognized the value of the contract between client and therapist and the significance that the therapist's attitude had on outcome. He explained that when the therapist invested in a relationship with the client, the client was able to form an attachment with the therapist. In addition, he recognized the importance of that relationship from the beginning by explaining that any therapeutic success would be lost without it (Freud, 1912; 1966b).

The central component of Freud's analytic work was the interpretation of transference, the client displacing repressed wishes, fantasies, and aspects of past relationships from childhood onto the therapist (Freud, 1912; 1966a). The therapist then used this transference, interpreted it, and assisted the client in being able to rationally see that projection as distorted. Freud began to question why a client would endure this and still remain in therapy (Freud, 1912; 1966b). He concluded that the client was able to view the therapeutic relationship as positive aspects of previous relationships and that the client could bond with,

or have an alliance with, the therapist to work together to fight against the client's negative past experiences. Sigmund Freud stated that "Transference of friendly or affectionate feelings...which is admissible to consciousness and unobjectionable...is the vehicle of success in psychoanalysis" (Freud, 1912; 1966b).

Anna Freud pointed out that, apart from transference, "We should leave room somewhere for the realization that analyst and client are also two real people in a real personal relationship to each other".

Carl Rogers defined a helping relationship as , "A relationship in which one of the participants intends that there should come about , in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual (1961)." He placed the therapeutic relationship at the centre of the healing process and believed that it was necessary for the therapist and client to have an authentic relationship, initiated by the therapist, for therapy to be successful. The therapist's main task was to establish a relationship that was accepting, empathic, supportive, and genuine and the remaining elements of a successful relationship came from the client (Rogers, 1957).

Rogers believed that for personality change to occur, certain conditions had to exist and continue over a period of time. Those conditions were:

- Two people had to be in psychological contact;
- The client would be vulnerable and anxious;
- The therapist needed to be *genuinely* invested in the relationship. Rogers discussed the vital importance of the clinician to "freely and deeply" be herself or himself. The clinician needs to be a "real" human being, rather than an all knowing, all powerful, rigid, and controlling figure. All facades should be left out of the therapeutic environment;
- The therapist needed to have *unconditional positive regard* (accepting each aspect of the client's experience without any conditions) for the client. The clinician needs to care for the client as who they are as a unique individual. One thing often seen in therapy is the treatment of the diagnosis or a specific problem. Clinicians need to treat the individual, not a diagnostic label;
- The therapist needed to have an *empathic* understanding of the client. An accurate empathetic understanding of the client's awareness of her or his own experience is crucial to the helping relationship. It is essential to have the ability to enter the clients' "private world" and understand their thoughts and feelings without judging them; and
- The client perceived the therapist's interactions as acceptance and empathy.

These six conditions were considered to be both necessary and sufficient for therapeutic client change to occur.

Greenson (1967) referred to the therapeutic alliance as the client's ability to work purposefully and decisively in treatment and, thus, was the first person to use the term *working alliance*. The client was seen as contributing to the alliance by being motivated, willing to cooperate, and being able to follow the instructions and insights of the therapist. He maintained that a reality-based positive collaboration between client and therapist was one of the essential components for therapeutic success.

Bordin (1979) took all of these views into consideration and fused their contributions to redefine the working alliance. According to Bordin, the alliance is a conscious, collaborative relationship between the client and the therapist. He distanced himself from the idea that a working alliance accompanies transference and viewed the alliance as a vehicle that facilitates the effectiveness of therapeutic techniques and processes.

A successful therapeutic alliance consists of three aspects which are as follows:

- **Tasks:** Having an agreement on therapeutic tasks, including activities that the participants engage in during their therapeutic sessions, such as role play and cognitive restructuring. The tasks need to fit the client's lifestyle, worldview, and expectations for therapy;
- **Goals:** Having an agreement on therapeutic goals, wherein the client and the therapist agree about the targets of change while in therapy; and
- **Bond :** The bond, a mutual fondness, attachment, and trust between the client and the therapist. The clients must also perceive that the therapist is truly interested in helping them to achieve their goals.

All three components illustrate the respective roles and responsibilities of each participant in successfully achieving the goals of therapy. The working alliance is what makes it achievable for the client to accept and follow treatment and, in order to be most effective, the alliance needs to be mutual (Bordin, 1979).

The nature of the therapeutic relationship may well reflect the differences between typically individualistic Western cultures and traditionally collectivist cultures, such as in India, the Middle East, China, and Japan. These societies emphasize interdependence rather than independence and view the individual in relation to social roles, obligations, and situational restrictions (Kakar, 1997, Roland, 1988). The *Guru-Chela* model of the therapeutic relationship has been proposed in India (Neki, 1976). The therapist is seen as a benevolent authority figure and assumes a role with more activity and direct guidance and advice. Unlike the Western models that require personal responsibility and decision-making within a collaborative therapeutic relationship, Indian clients may assume a submissive position, and expect a more directive attitude from therapists.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Match the following:

i)	Freud	a)	Working alliance
ii)	Bordin	b)	Unconditional positive regard
iii)	Rogers	c)	Transference
iv)	Greenson	d)	*Guru-chela* relationship
v)	Neki	e)	Task, goal, bond alliance components

3.3 ROLE OF THERAPEUTIC RELATIONSHIP IN DIFFERENT MODALITIES OF PSYCHOTHERAPY

While all modalities of psychotherapy agree on the importance of the therapeutic relationship, there are differences in their conceptual understanding and the relative emphasis on its role.

3.3.1 Psychoanalysis and Psychodynamic Psychotherapy

Sigmund Freud emphasised three principles as crucial to the therapeutic relationship in psychoanalysis; these are – *anonymity, neutrality*, and *abstinence* in psychoanalysis. Traditionally, the analyst strove to remain as a blank screen, in a non-judgemental atmosphere, neither approving nor disapproving of the client's wishes and fears. Abstinence implied that the analyst should abstain from revealing hereself or himself while anonymity referred to staying anonymous or unknown.

Transference and the here-and-now collaboration between therapist and client, together make up the therapeutic alliance. In other words, the client would begin to experience in the relationship with the analyst, unconscious conflicts experienced with significant others during childhood. Working through this transference was the key avenue for change in psychoanalysis. The analyst's *countertransference* – unconscious feelings about the client that stem from the analyst's own life experiences and issues – also influences therapeutic interactions.

Alexander and French described the importance of the 'corrective emotional experience' in psychodynamic psychotherapy. Ideally, the therapeutic relationship should provide a new experience that most effectively counters client's maladaptive interactional patterns. For example, if a client was raised by an intrusive mother and tends to replicate this pattern in interpersonal relationships, the therapist must respond and behave in ways that counter her or his expectations of intrusiveness. This new emotional experience in the therapeutic relationship itself may be the cornerstone of therapeutic change.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Fill in the Blanks:

i) In psychoanalysis, _____ refers to the feelings expressed by the client toward the therapist which are indicative of the unconscious feelings toward significant people in her or his personal life.

ii) The term _____ refers to the emotional experiences between therapist and client, which are contrary to the maladaptive relationship patterns and emotions experienced by the client in the past.

iii) Three important aspects of the therapist's behaviour in psychoanalysis are _____, _____, and _____.

3.3.2 Client-Centered Therapy

Rogers (1957) held that the therapist's primary effectiveness is through the therapeutic relationship. The therapist must show empathy to the client, be genuine with the client, and have unconditional positive regard for the client. Showing empathy requires understanding the client's feelings and reflecting them back to the client to help them understand these feelings as well. Being genuine involves being open and honest with the client and sometimes self-disclosing to help the client feel the therapist has empathy. Having unconditional positive regard means valuing clients as people, without conditions of worth. Rogers holds these therapist characteristics and behaviours, along with the client's ability to perceive these characteristics, as both necessary and sufficient elements of therapeutic change. Various studies empirically support the importance of these therapist characteristics.

While Rogers acknowledges that therapeutic techniques may be helpful to the client, they are helpful only to enable the client to gain a greater sense of self-efficacy. However, this end is mostly accomplished by unconditional positive regard of the client by the therapist. Thus, the therapeutic relationship is important as a primary factor in psychotherapy and as an end in itself.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Describe the three important therapist characteristics and behaviours proposed by Rogers as part of client-centered therapy.

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3.3.3 Cognitive Behaviour Therapy

Beck (1995) used the term 'collaborative empiricism' to characterise the relationship between therapist and client in cognitive behaviour therapy. Therapist and client work together using a rational, logical approach to understand and test the client's thoughts and assumptions. Cognitive therapy emphasizes the role of a collaborative relationship in which the therapist-client team mutually decide on the problems to be discussed, rationales for intervention, homework assignments, frequency of visits, and so on. The alliance is strengthened by the focus on eliciting and responding to clients' feedback. The therapist is active and goal-oriented and plays an educative role. The cognitive behavioural therapist understands the importance of relationship issues as they affect the primary goals and the effectiveness of cognitive behavioural techniques. The therapeutic relationship is seen as a secondary factor of therapy.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) State 'True' or 'False':

i) The therapeutic relationship is viewed as the primary factor contributing to change in cognitive behavioural therapy. _____

ii) The therapist-client relationship is defined by collaborative empiricism in cognitive behavioural therapy. _____

3.3.4 Supportive Psychotherapy

The internalisation of the positive 'real' therapeutic relationship is considered the primary fulcrum for change in supportive psychotherapy, more so than in many other modalities. The stance is empathic and active in helping the client improve her or his coping and social functioning. The conversational style is more informal and the therapist may engage in relevant self-disclosure. The therapist may serve as an 'alter ego', by acting for the client in relevant situations with others and help solve problems. At the same time, a dependent therapeutic relationship must be avoided. Unlike psychoanalytic and psychodynamic psychotherapy that emphasise the transference, supportive psychotherapy focuses more on the real relationship between client and therapist.

Check Your Progress Exercise 5

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Select the answer from the choices below:

i) Which of the following therapist behaviours contribute to building the therapeutic relationship in supportive psychotherapy?

a. Empathic listening

b. Analysis of transference

c. Challenging dysfunctional assumptions

d. Scheduling daily therapy sessions

3.3.5 Couples Therapy

The first formal definition of therapeutic alliance as it applies to couples therapy has many similarities to the concept of working alliance in individual therapy (Pinsof & Catherall, 1986). However, some important differences and clinical considerations are also highlighted.

The therapeutic alliance in couples therapy consists of the collaborative bond that exists in therapy between the therapist system and the client system. The alliance comprises two dimensions. First, the *content dimension* encompasses:

(a) The affective bond between client(s) and therapist,

(b) Agreement on the goals and objectives to be pursued in therapy, and

(c) Agreement between client(s) and therapist on the tasks and methods used to achieve the goals agreed upon.

Second, the *interpersonal dimension* covers:

(a) The alliance between one spouse and the therapist,

(b) The alliance between the other spouse and the therapist, and

(c) The alliance between the couple and the therapist.

When doing couple's therapy, the therapist needs to work with two clients and multiple systems simultaneously, bringing about unique challenges, demands, and processes (Garfield, 2004). In other words, the couple's therapist needs to build and maintain an alliance with both partners, as well as with the couple system. Garfield proposed that, when working with couples, there are three different therapeutic alliances;

- The *individual alliance* (where each member has her or his own alliance with the therapist),
- The *subsystem alliance* (the alliance with the therapist as a couple), and
- The *system alliance* (the alliance with, among, and between the couple and the therapist).

Consequently, there is a greater likelihood in couple's therapy than in individual therapy for at least one relationship to develop poorly and, thus, increase the risk for premature termination. Regardless of what brought them into therapy, both partners may attempt to form individual alliances with the therapist in hopes of the therapist taking her or his side. '*Split alliances*' occur when the perceptions of the therapeutic alliance are significantly more positive for one spouse than for the other (Pinsof & Catherall, 1986).

Strategies to solidify the therapeutic relationship in couple's therapy include the therapist's efforts to avoid splits and alignments with one spouse, and the need to keep marital distress (*versus* individual symptoms) as the primary focus of treatment. In addition, identifying the partners' early family-of-origin distress can help predict and respond to strains in the therapeutic alliance that may occur later in therapy. Finally, the therapist needs to help the couple to balance the power differences in their relationship during therapy in order to strengthen the therapeutic alliance (Garfield, 2004).

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Fill in the blanks:

i) The alliance between the therapist and each partner during couples therapy is the _____.

ii) The alliance with, among, and between the couple and the therapist is the _____.

iii) The alliance with the therapy as a couple, and not as individuals, is the _____.

iv) _____ refers to a situation when the perceptions of the therapeutic alliance are significantly more positive for one partner than for the other in couples therapy.

3.3.6 Family Therapy

The family therapist needs to establish and maintain multiple alliances within the family system. Validating and supporting the family as a system and attending to each individual family member's experience are particularly important aspects of developing and maintaining a good therapeutic relationship (Diamond and Liddle, 1996). This is particularly challenging, as family members are likely to be in conflict with each other.

Inexperienced family therapists often take the side of one family member against another, behaving as though one was right and the other was obviously wrong. In establishing relationships with the family, the therapist must join all family members, not just those with whom she or he agrees. In fact, frequently, the person with whom it is most critical to establish an alliance or bond is the most powerful and unlikable family member.

Structural Family Therapy (SFT) specifies a number of techniques to establish a therapeutic relationship in family sessions and prepare the family for change. One of the techniques is "joining", or becoming a temporary member of the family for the purpose of treatment. This is done by *tracking* (therapist following the content of the family facts to identify the interactive patterns in the family, and to determine which of these patterns may be causing the family's problems or symptoms), *mimesis* (therapist becomes like the family in the manner or content of communications), *confirmation* (using a feeling word to reflect an expressed or unexpressed feeling of a family member), and *accommodation* (therapist makes personal adjustments in order to achieve a therapeutic alliance).

Check Your Progress Exercise 7

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Describe the following in 2-3 sentences:

i) Joining:

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ii) Tracking:

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iii) Mimesis:

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iv) Confirmation:

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v) Accomodation:

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3.3.7 Group Therapy

Cohesiveness within the group is considered the equivalent of the therapeutic working alliance in the group context. *Cohesion* generally refers to the emotional bonds among members for each other and for a shared commitment to the group and its primary task. Cohesion defines the therapeutic relationship in groups as comprising *multiple alliances* (member-to-member, member-to-group, and member-to-leader) that can be observed from three structural perspectives—intra-personal, intra-group and interpersonal.

Intrapersonal cohesion includes members' sense of belonging, acceptance, commitment and allegiance to their group. *Intra-group definitions* of cohesion

focus on the group-level features such as attractiveness and compatibility felt by group-as-a-whole, mutual liking or trust, support, caring and commitment to "work" as a group. Finally, *interpersonal definitions* of cohesion focus on positive and engaging behavioural exchanges between members.

These multiple alliances reflecting group cohesion are seen as important mechanisms of change in group therapy.

Check Your Progress Exercise 8

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Briefly discuss the concept of cohesiveness in group therapy as the equivalent of the therapeutic working alliance.

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3.4 FORMATION AND MAINTENANCE OF THERAPEUTIC RELATIONSHIP: ASSOCIATED FACTORS

Therapist and client related characteristics affect the strength and success of the therapeutic relationship. Some of the important factors related to clients, therapist and therapeutic techniques are discussed below.

Client Factors

For clients, one determinant is the level of *motivation*. Clients who are ready for change are more likely to have a positive therapeutic alliance with their therapists, stay in treatment, and have better outcomes.

The strength of the therapeutic alliance is largely unrelated to diagnosis or severity of psychopathology.

Clients with personality traits of perfectionism may have a strong relationship with their therapist in the initial phases of therapy. However, the alliance is less likely to strengthen and build over time. This may be because perfectionistic clients could have greater difficulty in dealing with the normal fluctuations that occur in the therapeutic relationship.

Evidence also suggests that the quality of a client's early attachments and family experiences may influence her or his ability to form an alliance early in individual psychotherapy. Researchers have linked insecure attachment styles with poor initial alliances in individual psychotherapy (Eames & Roth, 2000; Ogrodniczuk, Piper, Joyce, & McCallum, 2000).

In general, clients who are *better adjusted*, have *better coping skills* and *social support*, at the beginning of treatment tend to form better therapeutic

relationships. Some research results suggest the role of gender wherein male clients prefer a more practical utilitarian approach, while female clients respond better to a more empathic, caring approach. The centrality of relationships in the lives of adolescent girls and women might make them more sensitive to the relationship with the therapist and also to any fluctuations within the therapeutic alliance.

The process of forming and maintaining a therapeutic alliance can also be influenced by the client's developmental stage. For example, adolescent clients may present specific challenges related to cognitive developmental changes and emotional processing during adolescence. Therapists would need to respect their heightened needs for autonomy and intense concerns with trust and confidentiality.

Therapist Factors

A number of therapist interpersonal styles are associated with positive alliance formation. These include being alert, confident, empathic, engaging, flexible, friendly, genuine, helpful, honest, intelligent, open, prepared, respectful, skilful and warm. Other therapist factors like rigidity and hostility are negatively associated with alliance quality. These findings point to the importance of self-reflection and observation on the part of therapists. Some research has found a small positive relationship between the therapists' experience and the quality of the therapeutic relationship early in treatment, while other studies did not find this link.

Therapy Techniques

Therapist techniques such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the client's experience have been found to contribute positively to the therapeutic relationship.

Check Your Progress Exercise 9

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1) Select the right answer from the choices given:

i) Client characteristics associated with the development of positive therapist-client relationship:

a. Level of motivation

b. Early attachments and relationships

c. Social support

d. All of the above

ii) Therapist factors and techniques linked with positive alliance formation are:

a. Empathy towards the client

b. Therapist's age

c. Encouraging expression of affect

d. Both a. and c.

3.5 RELATIONSHIP BETWEEN THERAPEUTIC RELATIONSHIP AND THERAPY OUTCOME

The nature of the therapeutic relationship exerts a powerful influence on the how the therapist-client encounter is likely to turn out. The therapeutic alliance has been related to successful therapy outcomes in all forms of psychotherapy (Bordin, 1979; Horvath & Symonds, 1991). The therapeutic alliance functions as a common or pantheoretical factor that influences outcome (Krupnick et al, 1996). It had been estimated that at least 30 percent of client improvement can be attributed to relationship factors (Lambert, 1992).

Researchers have provided evidence that client ratings of the alliance are stronger predictors of treatment outcome than are therapist ratings (Horvath & Symonds, 1991). This implies that therapists cannot afford to rely solely on their own perceptions of the relationship but must find a way to elicit the client's view of it.

The early stage of therapy is critical for the formation of a positive relationship between clients and therapists. When compared to the middle and late phases of therapy, the alliance that is established in the beginning phase of therapy is more predictive of outcome and dropout (Horvath & Symonds, 1991). If the therapeutic relationship lacks this alliance from the beginning, a positive outcome is less likely, This has implications for therapists to be focused on alliance-building as they begin therapy and to have collaborative discussions on therapeutic tasks and goals.

Does the therapeutic relationship remain the same or change through the course of therapy? The answer to this question is that the therapeutic relationship is seen as a dynamic, rather than static, phenomenon that is responsive to the changing demands of different phases of therapy. It is possible that the therapeutic relationship may go through strains and disruptions. This should not make therapists despair as these ruptures can be worked through and repaired in a direct, open and nondefensive manner. This might even strengthen the therapist-client alliance. It may also be an excellent opportunity for the therapist to gather information about the client and also to understand what behaviours and events led to the rupture. It would be important to maintain a dialogue with the client and discuss feelings. For example, the therapist could say, "It seems to me that something has changed in our relationship ....." Successful repair of alliance ruptures has been related to better therapy outcomes.

The question of "Which is the more important, the techniques or the relationship?" in psychotherapy has been debated over the years. Most would agree that both contribute to the effectiveness of psychotherapy. What emerges is that, the therapist-client relationship has a unique contribution to the therapeutic outcome. The alliance is thus therapeutic in and of itself. The relationship may also be a prerequisite for therapeutic interventions to be effective. The relationship allows the client to actively and cooperatively work with the interventions provided by the therapist. To conclude, this view holds that the relationship is a necessary, though not sufficient element for change to occur.

Check Your Progress Exercise 10

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) State 'True' or 'False':

i) Therapist's perceptions and ratings of the therapeutic alliance are the strongest predictors of the outcome of therapy. _____

ii) The strength of the therapeutic relationship in the first few sessions of therapy is most predictive of outcome. _____

iii) The therapeutic relationship remains the same throughout the course of therapy. _____

3.6 ETHICAL ISSUES IN THE THERAPIST-CLIENT RELATIONSHIP

The American Psychological Association (A.P.A.) Code of Ethics clearly specifies the ethical issues related to therapy and the therapeutic relationship. Some of the important aspects are discussed below.

Informed Consent to Therapy

Therapist must inform clients about the nature and anticipated course of therapy, fees, and limits of confidentiality and provide sufficient opportunity for the client to ask questions and receive answers. Therapists in training must inform clients of this fact and give them the name of the therapy supervisor. In deciding whether to offer or provide services to those already receiving mental health services elsewhere, therapists need to discuss treatment and client welfare issues with all involved parties before proceeding.

Confidentiality and Limits of Confidentiality

Confidentiality is one of the most important aspects of the therapeutic relationship. Clients need to be confident that their personal secrets, strong opinions about others, or sensitive emotional expressions, will not go beyond the relationship with their therapist. Confidentiality and its limits must be discussed at the beginning of therapy. The limits include disclosure without consent only as mandated by law, or under specific circumstances. This includes situations where the client, therapist or others need protection from harm. For example, instances when a client discusses a suicide plan, or intent to harm the spouse, or threatens the therapist. Another situation might involve appropriate discussions with professional colleagues either after consent or with care not to reveal confidential information that could lead to the identification of a client.

Dual or Multiple Relationships

A multiple relationship occurs when a psychologist is in a professional role with a person and;

- at the same time is in another role with the same person,
- at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or
- promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

Therapists must refrain from entering into a multiple relationship if it could impair their objectivity, competence, or effectiveness in the therapeutic role or otherwise risks sexual, emotional or financial exploitation of the client. This has been most often discussed in terms of sexual intimacy. Therapists must not engage in sexual intimacy with clients or their relatives or significant others. Therapists should also not engage in therapy with persons with whom they have engaged in sexual intimacies. The A.P.A guidelines also specify that therapists should not engage in sexual intimacies with former clients or patients even after a two-year interval, except in the most unusual circumstances. In this event, they would bear the burden of demonstrating that there has been no exploitation.

The guidelines also imply that it is unethical for a therapist to treat a close friend or relative. It would not be good practice for a therapist to enter into dual professional role, for example as a client's therapist and as the same client's employer. Financial relationships (for example, the therapist borrowing a large sum from a client to buy a new car, or inviting a client to invest in the therapist's new business venture) are incompatible with the therapeutic relationship.

Other Ethical Guidelines

Some other ethical guidelines point to the therapist's responsibility to refer and provide continuity of care in the event of interruption due to therapist's illness, relocation or unavailability or client's relocation, financial constraints etc. Therapists should not continue in therapy when unfit to do so due to illness, personal circumstances or intoxication. Likewise, therapy should be terminated when client no longer needs it, is not likely to benefit, or is being harmed by continued therapy.

There are a number of warning signs that indicate when a therapist may be crossing the boundaries in the therapeutic relationship. Some examples of these are:

- Spending time with a client beyond what is needed to meet the therapeutic needs,
- Responding to personal overtures from a client,
- Disclosing personal problems to a client,
- Spending time outside of the therapeutic relationship with a client, and
- Providing the client with a home phone number unless it is required in the context of a therapeutic relationship.

When a psychotherapist honours professional ethics, she or he not only protects clients from exploitation but also creates an environment that facilitates a strong therapeutic alliance and potential for positive change.

Check Your Progress Exercise 11

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1) Read the following hypothetical therapeutic situations and mark if the therapist's behaviour is ethical or unethical

i) Greeting your client if you unexpectedly meet the client in a public setting.

Ethical/Unethical

ii) Discussing a case with a colleague in a crowded elevator with other staff, clients and families.

Ethical/Unethical

iii) Borrowing money from a client.

Ethical/Unethical

iv) Breaking confidentiality if a client is suicidal.

Ethical/Unethical

v) Agreeing to see your best friend's daughter in psychotherapy.

Ethical/Unethical

3.7 LET US SUM UP

In this Unit, we have learnt about the importance of the relationship between the client and the therapist. Specifically, you should be able to define the historical roots and current concepts of the therapist-client relationship.

You learnt the similarities and differences in the role of the therapeutic relationship across different modalities of therapy. Now, you can explain the client, therapist and therapeutic technique related factors associated with the formation and maintenance of the therapeutic relationship.

The Unit elucidated the links between the therapeutic relationship and the outcome of therapy. At the end of this Unit, we also discussed the ethical issues pertaining to the therapeutic relationship.

3.8 GLOSSARY

Alliance rupture : A breakdown in the collaborative process between therapist and client, a poor quality of therapist-client relatedness, deterioration in communication, or a failure to develop

a collaborative process from the beginning of therapy.

Dual or multiple relationships : Any situation where multiple roles exist between a therapist and a client.

Individual alliance : Each family member's own alliance with the therapist, in couples or family therapy.

Subsystem alliance : The alliance between the therapist and a subgroup within the family system.

System alliance : The couple's or family's shared sense of purpose about the need, value, and goals of therapy.

Therapeutic relationship : The technical term for the cooperative relationship between therapist and client that is considered essential for successful psychotherapy.

Working alliance : The quality and strength of the collaborative relationship between the therapist and client; measured as agreement on therapeutic goals, consensus on therapeutic tasks, and a relationship bond.

3.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) i) - c); ii) - e); iii) - b); iv) - a); v) - d)

Check Your Progress Exercise 2

1) i) transference

ii) corrective emotional experience

iii) neutrality, abstinence, anonymity

Check Your Progress Exercise 3

1. Rogers felt that a therapist, in order to be effective, must have three very special qualities; theses are as follows:

   i) Congruence or genuineness: Congruence or genuinenes means correspondence between the therapist's thoughts and behaviour. The therapist must be a "real" person without any facades or pretences.

   ii) Empathy: Empathy refers to profound interest and care for the client's perceptions and feelings. The ability to feel what the client feels.

   iii) Unconditional positive regard: Unconditional positive regard states unconditional acceptance of the client. Therapist's regard or attitude remains unaltered regardless of the client's choice.

These core conditions of client-centered therapy are said to be "necessary and sufficient" for improvement in therapy. Rogers stated that if the therapist shows these three qualities, the client will improve, even if no other special "techniques" are used.

Check Your Progress Exercise 4

1) i) False

ii) True

Check Your Progress Exercise 5

1) a. Empathic listening

Check Your Progress Exercise 6

1) i) individual alliance

ii) system alliance

iii) subsystem alliance

iv) Split alliance

Check Your Progress Exercise 7

1) i) Joining : Joining as a family therapy technique refers to therapist behaviours aimed at becoming a temporary member of the family for the purpose of treatment.

ii) Tracking : Tracking as a family therapy technique refers to the therapist following the content of the family facts to identify the interactive patterns in the family, and to determine which of these patterns may be causing the family's problems or symptoms.

iii) Mimesis : Mimesis is a family therapy technique which refers to the therapist becoming like the family in the manner or content of communications for the purpose of treatment.

iv) Confirmation : Confirmation as a family therapy technique refers to the therapist using a feeling word to reflect an expressed or unexpressed feeling of a family member.

v) Accomodation : Accomodation as a family therapy technique refers to the therapist making personal adjustments in order to achieve a therapeutic alliance.

Check Your Progress Exercise 8

1. Cohesiveness has been viewed as the group psychotherapy equivalent of the therapeutic alliance in individual treatment. Cohesion is defined as the therapeutic relationship in group psychotherapy emerging from the aggregate of member leader, member-member, and member-group relationships. It generally refers to the emotional bonds among members for each other and for a shared commitment to the group and its primary task.

   Intrapersonal cohesion includes members' sense of belonging, acceptance, commitment and allegiance to their group. Intra-group definitions of cohesion focus on the group-level features such as attractiveness and compatibility

felt by group-as-a-whole, mutual liking or trust, support, caring and commitment to "work" as a group. Finally, interpersonal definitions of cohesion focus on positive and engaging behavioural exchanges between members. This group process variable is linked with positive outcome in group therapy.

Check Your Progress Exercise 9

1) i) All of the above

ii) Both a. and c.

Check Your Progress Exercise 10

1) i) True

ii) True

iii) False

Check Your Progress Exercise 11

1) i) Unethical

ii) Unethical

iii) Unethical

iv) Ethical

v) Unethical

3.10 UNIT END QUESTIONS

1. Discuss the differences between a therapeutic relationship and a personal relationship.
2. Describe Bordin's concept of the therapeutic working relationship.
3. Compare the role of the therapist-client relationship in psychodynamic and client-centered psychotherapy.
4. Illustrate the conceptualisation of the therapeutic relationship in couples therapy.
5. Explain some important client, therapist and therapeutic technique related factors associated with the formation and maintenance of the therapeutic relationship.
6. Explain the importance of resolution of alliance ruptures in psychotherapy.
7. Describe the important ethical issues in the therapist-client relationship.

3.11 FURTHER READINGS AND REFERENCES

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UNIT 4 PROFESSIONAL APPROACH AND ETHICAL ISSUES

Structure

4.1 Introduction

4.2 Professional Approach and Rights of Clients

- 4.2.1 Informed Consent
- 4.2.2 Confidentiality

4.3 Definition and Role of Ethical Code of Conduct

4.4 Principles of Ethics

- 4.4.1 Beneficence
- 4.4.2 Nonmaleficence
- 4.4.3 Autonomy
- 4.4.4 Justice
- 4.4.5 Fidelity
- 4.4.6 Cultural Determinants
- 4.4.7 Client Welfare

4.5 Ethics in History Taking

4.6 Ethics in Psychological Assessment

4.7 Ethics in Counselling/Therapy

4.8 Ethics in Psychological Research

4.9 Ethical Issues in Training and Supervision

4.10 Let Us Sum Up

4.11 Glossary

4.12 Answers to Check Your Progress Exercises

4.13 Unit End Questions

4.1 INTRODUCTION

Dealing with clients, counselling the family is a professional work. In practice counselling has to be done with a professional approach adhering to ethical guidelines. This Unit will help you to understand the meaning of ethical code of conduct and its principles. Application of ethical guidelines in counselling requires utmost sensitivity. The counsellors or therapist are challenged to deal with question or situations, which have no clear solutions. One has to think of all possible solutions, discuss with colleagues, and decide how to act in ways that will be in the best interests of the clients. One of the ways of solving ethical dilemma is to know about the ethical and professional issues. This Unit will

help you to understand these issues and provide support to make decisions pertaining to good ethical practice.

Objectives

After studying this Unit, you will be able to:

- Understand meaning of ethics and principles of illness;
- Know application of confidentiality and informed consent;
- Comprehend ethical issues in history taking, assessment and counselling of clients;
- Understand role of ethics in carrying out research; and
- Know the ethical guidelines for providing training to students and other professionals.

4.2 PROFESSIONAL APPROACH AND RIGHTS OF CLIENTS

Our professional relationships with clients exist for their benefit. A useful question that we as a counsellor or therapist can frequently ask ourselves is, 'Whose needs are being met in this relationship, my client's or my own?'. It takes considerable professional maturity to make an honest appraisal of your behaviour and its impact on clients.

We all have certain blind spots and distortions of reality. As helping professionals we have responsibilities to work actively toward expanding our own self-awareness and to learn to recognize areas of prejudice and vulnerability. If we are aware of our personal problems and are willing to work them through, there is less chance that we will project them onto clients. If certain areas of struggle surface and old conflicts become reactivated, we have an ethical obligation to seek our own therapy, so that we will be able to assist clients in confronting these same struggles.

Personal power is a quality that every effective helping person possesses. It is a vital component of good therapy, and many clients improve as a result of sharing in the power of their therapist. One aspect of modeling is for therapists to be powerful persons. People who genuinely feel powerful do not dominate the lives of others and do not encourage others to remain in a dwarfed state so that they can feel superior. They are able to appreciate other people's potency and their own at the same time. The impotent therapist uses clients in an attempt to achieve a sense of power. To a powerful therapist, the client's accomplishments and strengths are a source of joy.

Consider also the counsellor's need to nurture, which certainly attracts some students to the helping professions. These are the people who may be inclined to 'teach people how to live the good life', to 'straighten people out', and to 'solve others' problem', all with the intention of being nurturing. Others at one point recognized that they were miserable, or at least that they wanted

to make basic changes in their life, and then embarked on a successful journey of self-exploration. Such people may now deeply desire to help others find their own way and, in so doing, provide for themselves a sense of meaningfulness and personal significance. One aspect of therapists' need to nurture is their need for others to nurture them through respect, admiration, approval, appreciation, affection and caring. The helping person quickly learns that the rewards for nurturing others are abundant.

4.2.1 Informed Consent

The therapist should take informed consent from the client with regard to the therapeutic process to be used as well as if and when some confidential matter has to be disclosed.

4.2.2 Confidentiality

The counsellor/therapist should safeguard information about a client that they have obtained in the course of their clinical work, teaching or research in order to safeguard the client's interest and protect her or him from social stigma, discrimination and harm. They should treat this as a primary obligation and not reveal unto others any such information unless certain ethical conditions are met, or when there is clear and imminent danger to an individual or society and then only to the appropriate authorities or concerned co-professionals. Confidentiality of the clinical records should be meticulously guarded and identity of the clients should not be revealed even in scientific communication.

No data about a client should be ordinarily revealed to any agency without the consent of the client or her or his family.

4.3 DEFINITION AND ROLE OF ETHICAL CODE OF CONDUCT

Ethics is a code of moral standard of conduct for what is 'good' and 'right' as opposed to what is 'bad' or 'wrong'. Ethical behaviour is concerned with what is 'right' or 'good' in the context of governing moral code. Ethical behaviour is value driven. Ethics is different from values, as values are concerned with broad beliefs about what is appropriate behaviour.

Reasons for Various Ethical Practices

1. Individualism view: Does a decision or behaviour promote one's long term self-interests?
2. Moral-rights view: Does a decision or behaviour maintain the fundamental rights of all human beings?
3. Utilitarian view: Does a decision or behaviour do the greatest good for the most people?
4. Justice view: Does a decision or behaviour show fairness and impartiality?

Sources of Unethical Practice

The sources of unethical practice are discussed below:

Structural determinants – These are often most directly related to systems of communication and consultation, transparency and accountability. Typically modification of structure is the first 'port of call' in organizational change. Structural change achieves little in the absence of cultural and behavioural change.

Cultural determinants – These are the aspects of organizational style and rhetoric. Ther are often harder to modify than structural determinants, mainly because they are less readily identifiable and understood. These are essentially tied to the style or ethos of an organization's management and leadership, and are typically determined from the top – largely dependent on the example set by senior management.

Behavioural determinants – These are aspects of individual character, conduct and commitment. Behavioural determinants are much harder to address than structural or cultural determonents because these are based in personality and character. Behavioural determinants often are based in problematic features of character and conduct that are not recognized as such by individuals concerned. Behavioural determinants are often related to features of character and conduct that are positively selected many organizations – that are encouraged by the organizational culture.

4.4 PRINCIPLES OF ETHICS

Ethical codes are basic guidelines which help the counsellors to practise in professional manner. These principles are like basic foundation of the profession. There are five basic ethical principles which are to be followed in our practice. In simple words these principles are to benefit others, do no harm, respect other's autonomy(independence), be fair and be faithful. Each of these principles are described below:

4.4.1 Beneficence

Beneficence implies accepting responsibility for promoting what is good for others. In counselling relationships, it refers to doing what enhances the client's well-being. When clients enter into a therapeutic venture, they do so with the expectation that they will benefit from the services. The interest of the clients and their health should stand paramount with them in their professional practice. Personal interest should find but a secondary place. Financial arrangements should never contravene professional standards. Therapists should always safeguard the, interests of the client and the profession.

4.4.2 Nonmaleficence

Nonmaleficence, which means doing no harm, involves the commitment of practitioners to exercise care in avoiding activities (such as situations involving conflicts of interest) that have a high risk of hurting clients, even inadvertently. The therapists must know that she or he bears a heavy social responsibility because she or he not only deals with disturbed human behaviour but also contends with intimacies of life.

As a scientist, she or he would serve the society through observation, investigation and experimentation, and well planned and ethically carried out research.

4.4.3 Autonomy

Autonomy refers to the client's self-determination. It pertains to the belief that clients have freedom of thought and freedom to choose their direction. Counsellors have an ethical obligation to decrease client dependency and to foster independent decision-making. This principle implies that therapists do not have the right to interfere in the lives of their clients by making decisions for them. Instead, counsellors are charged with helping their clients think clearly and weight the consequences of their actions.

4.4.4 Justice

Justice refers to the commitment of counsellors to provide equal and fair treatment to all clients. This includes doing what is possible to ensure that all people are given equal access to counselling services, regardless of factors such as age, sex, race, ethnicity, cultural background, disability, socioeconomic status, lifestyle orientation, and religion. This principle also refers to the fair treatment of an individual when her or his interests need to be considered in the context of the rights and interests of others.

4.4.5 Fidelity

Fidelity refers to making honest promises and faithfully honouring these commitments to clients. This involves a counsellor's willingness to do what is necessary to create a trusting and therapeutic climate in which people can search for their own solutions. This principle involves being careful not to deceive or exploit clients. The maintenance of high standards of professional competence is (the) responsibility of all therapists in the interest of both, the public and the profession. Therapists are responsible for their own continuing education and should realize that for them it means a lifetime learning process.

As members of the profession, they should not violate ethical standards and when such violation comes to their notice, should take steps to correct it.

4.4.6 Cultural Determinants

Cultural context can determine ethical behaviour. In each culture certain principles may be difficult to practise. For example, in a study conducted by WHO it was found that in India client's autonomy cannot be followed in all situations; for example, a person from a rural background or low education does not have knowledge about certain advantages of counselling or psychotherapy, and so, she or he cannot decide whether she or he should accept the suggestion of the therapist's to undergo counselling. In many situations clients think their counsellor should decide about their treatment. Besides, the basic principles of ethics, each culture can add certain ethical practices according to the need of that culture. In India, there is need for the moral codes and expectations of the community they serve, and they should not let their behaviour in any way malign their profession.

4.4.7 Client Welfare

Counsellors/therapist should not treat a case that does not clearly fall within their competence. The ones they accept, they should treat with the best of

their ability and with the highest regards for the client's integrity and welfare, as also that of the communities in which they work. They should terminate the clinical or consulting relationship with the client when it is reasonably clear to them that the client is no longer benefiting from it. In case of referral, they should continue to feel responsible for the client's welfare until the responsibility has been formally transferred.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List the principles of ethics.

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4.5 ETHICS IN HISTORY TAKING

Confidentiality

As you just read, counsellors and family therapists should safeguard information about a client that they have obtained in the course of their clinical work, teaching or research in order to safeguard the client's interest and protect her or him from social stigma, discrimination and harm. They should treat this as a primary obligation and not reveal unto others any such information unless certain ethical conditions are met, or when there is clear and imminent danger to an individual or society and then only to the appropriate authorities or concerned co-professionals. Confidentiality of the clinical records should be meticulously guarded and identity of the clients should not be revealed even in scientific communication.

No data about a client should be ordinarily revealed to any agency without the consent of the client and/or her or his family.

4.5 ETHICS IN PSYCHOLOGICAL ASSESSMENT

Psychological tests are used in a wide range of situations and not just limited to clinical practice or to child guidance clinics. The so-called 'IQ testing' being done by a large number of psychologists is somewhat ending up in a type of labeling an individual. Testing is big business and psychological, educational and personnel corporations sell many thousands of tests each year. Children, school-going and non-school going, studying in different classes, showing poor academic performance, etc. undergo testing to find out their capability to carry on adequately academic performance, or their capability to carry on adequately

with the requirements of the teaching learning process in the school. Also, children in class wanting to opt for certain course stream in the class are required to undergo psychological testing by the school, so that they could be given the right stream and appropriate education to take up a more suitable career in future. Admission to college, or to professional courses such as engineering courses, medical courses and others, require the students to undergo certain tests. So also students aspiring to go abroad for higher studies or any professional courses are expected to undergo aptitude and other tests. Admission to employment such as selection and recruitment to certain jobs, selection of candidates for training purposes, and using of tests to find out the suitability of the personnel for higher level jobs and for a particular assignment – all these are decided by tests. In addition, a whole lot of personality tests available in the market are administered at different time to different persons in different settings to draw a personality profile of the candidates and to decide who would fit a particular post or a particular assignment.

While one does agree that fitting the right persons to the right course stream, or courses, or jobs or training is important, it is equally important to see that such tests are not conducted as a routine and just because someone wants it and also by anyone and everyone.

Who Should Conduct the Psychological Tests?

Psychological tests have to be conducted only by trained persons and they should only use those tests for which they have the competence to administer, score, diagnose and interpret. While in USA, UK and other countries these aspects are to quite an extent taken care of by the State Certification and Licensing Boards, in India such certification is still a far cry and not formalized for the profession of psychology or counselling and family therapy.

Who Decides When and What Tests to Administer?

Furthermore, many widely used tests in India such as the CPK, APA, KBD, BG Test, CAT etc. are all entirely standardized in the Western conditions though a few of the personality and IQ tests have Indian version developed. The issue is not so much 'which test', but the manner in which these tests are administered. In many settings, a psychology professional takes the role of a technician who routinely tests every subject – child or adult – referred to her or him and gives a label regarding the IQ or the personality of the subject concerned. In many cases, except for routine noting down the name, age, sex and such factors, no attempt is even made to interview the subject or the accompanying members of the subject to find whether a test should be at all conducted and if so what test. As is well known in many a clinical setting, the clinical psychologist is told to conduct the Rorschach Test, and it is just carried out without the detailed interview which should precede the test even consider not administering a test because she or he does not think that the particular test was appropriate but another one was more suited. It is the ethical responsibility of the professional to investigate a problem and to be convinced that a particular test is essential or needed to provide additional information for rendering better service to the client.

Labelling a Subject

In addition, 'labelling' of a client or subject as having a certain IQ below average or otherwise, harms the person concerned in two important ways: (i) It brings

down the self esteem of the individual; and (ii) It makes the family members of the subject to use it as an explanation for many of the subject's behaviours which could otherwise be improved upon. This mind set created by labeling, on the subject and her or his family members, leaves very little scope for the individual to even make an effort to improve hereself or himself. Thus, the important ethical issues to be considered are:

a) Investigate the problem with a proper interview and not just administer a test indiscriminately,

b) Decide whether a test is needed and if so which one should be administered,

c) Not to give labels in the first instance and to avoid indicating the label in the prescription slips or handing it over to the subject or to her or his family members. Ethics requires that the subject and the family members are given a clear idea about the problem that the subject suffers from and the possible remedies and where the same may be available and how much time this might take, and

d) Where such details are needed by another institution (school or clinics), the same could be sent by the professional who has tested the subject with due explanations and her or his own assessment and comments.

Such steps prevent any damage that may be caused to the individual by labeling and due to the revelation of the test results which is generally beyond the understanding of the lay man.

The ethical standards require that the therapist explain clearly about the test to the subject. The purpose for which the test is being administered, the type of assessment that will be done and how reliable it is. Thus, ethics requires that when an individual is tested, every effort should be made to explain the purpose of testing, the uses to which the results will be put, and the people or institutions who may have access to it.

Test Items Within a Test

Many tests (IQ or personality) have items which are such that the subjects who are not familiar with it may require some time to acquire a knowledge about the same, become familiar with it, and learn also the techniques of handling the same. Unless these are ensured, the response of the subjects to the test items can be highly misleading and result in labeling the subject concerned. The same subject once becomes familiar with similar or related items, would perform far better than even an expected performance from an average person.

Hence the experience, competence and integrity of the professional who administers the test should be of a very high order so that no person is 'labelled', inadequately or inappropriately, thereby adversely affecting the individual's future and life. In this context, Anastasi (1988), Lanypm & Goodstein (1982) and Sundberg (1977) have pointed out the inappropriateness of a test when it does not include a particular population sample while standardizing the test, leading thereby to the problems mentioned above.

Test Materials and Their Distribution

Another important ethical issue related to testing is the test materials themselves. It is normally expected that only certain firms sell these tests and that too to

only a professional in the field. The individual or institutions desiring to purchase a test, should demonstrate their competence in administering, scoring and interpreting the tests. Thus, the sale of tests should not be open to any user, but depend on the user's qualifications. Such precautions are extremely necessary because monitoring of violations of these restrictions is rather difficult and the possibility of misuse of tests by untrained persons may cause more harm than good to the subjects seeking help. As stated by Phares (1992) even in countries such as USA and UK, where these restrictions are very systematically implemented, neither the professional ethics nor the publishers' restrictions are totally successful in regard to sale of tests to many who actually should not be allowed to use the tests.

Standardization of Tests

Another aspect of ethical issue is related to the standardization of tests themselves. Ethics requires that the tests are standardized under the severest controls and norms. Every test manual should contain the normative data and instructions for administration and scoring in addition to providing enough data to enable the user to evaluate the reliability and validity of the tests. Even when a test is adapted to another country, as for example to Indian conditions, ethical standards require, according to Oakland (1995), that every item (statement/question) should be answered at least by 10 subjects of that particular age/sex/category for whom it is intended. This would mean that a test which has 40 items should be tried out on a minimum of 400 respondents of that particular category and standardization should be attempted on the 400 response data. In India very little such precautions are taken, and one often finds that a test in English language is translated into its vernacular counterpart and used without even trying out on a pilot sample or being used after trying on a sample 50 and less number of subjects.

Ethics require that the tests which are adapted to and translated into a particular regional language for a certain population, must be put through a rigorous test in a pilot study before accepting the same for use on the related Indian population.

Tests Results Privacy and Ethical Aspects

As explained elsewhere in this Unit, while the subject has the right to a full explanation of a test that is being administered on her or him, she or he is also equally entitled for her or his privacy in the revelation of the test results to anyone else. Ethics demand that the privacy of the individual subject in regard to sharing or revealing of her or his test results should be upheld and without the subject's permission the test results should never be given to anyone. In addition, if any test as for example, MMPI or the Rorschach test is administered as part of other tests or in addition to certain other tests, the psychologist is ethically required to explain the relevance of these testing to the subject.

Informed consent to the entire assessment process should be obtained and the subjects should be fully informed of their options.

4.6 ETHICS IN PSYCHOLOGICAL ASSESSMENT

During psychological assessment of the client, ethics should be strictly adhered to. The rapport with the client should be formed first before testing can be done. The

reason and purpose of testing should be explained to the client and the atmosphere at the time of testing should be calm and peaceful. The testing procedure should be followed. The instructions given in the test manual should be followed and due to paucity of time don't reduce the test items if the test manual does not recommend the same. The analysis and report of the testing should be provided to the concerned client and only after seeking written consent from the client the same may be disclosed to others.

4.7 ETHICS IN COUNSELLING/THERAPY

Competencies

In therapies and interventions, one of the most important ethical issues concerned is the competence of the counsellor or therapists. Competence has several components in it, as for instance, clinicians must always accurately represent their training. As mentioned by Piper and Davenport (1990), sub-doctoral clinicians should never make anyone believe that they possess the Ph.D.

If a person is trained as a counselling psychologist, he should be presented as such. This also means that clinicians should not attempt to treat or assess when they have neither specific knowledge nor past supervision in them.

Whenever there may be doubts about specific competencies, it is wise to seek out supervision from more experienced professionals in the field (Phares, 1992 p.58).

To the extent that a clinician has personal problem or sensitive spot which could affect her or his performance, the clinician should guard herself or himself against these while dealing with her or his cases. As mentioned by Overholser and Fine (1990), competence should be present in all aspects of clinical practice, which comprise knowledge, clinical skill, clinical judgement, and interpersonal skills.

Confidentiality

It is well known that clinicians have an ethical duty to respect and protect the confidentiality of client information. This is all the more so in the client therapist relationship, wherein confidentiality is the central principle that binds the two into a relationship which pivots them through the vagaries of the therapeutic sessions. One of the important ethical issues is of confidentiality in therapies and interventions. Many personal, private, conscious and unconscious aspects in the subject emerge during the progress of the sessions.

It is an accepted ethical principle that nothing of what the client conveys to therapist should be shared with anyone without the prior permission of the subject. At the same time, in the Western countries with their advanced technology and computer programmes and processing, and the data banks, it becomes relatively easier for one agency to gain access to the personal records in the files of another agency or institution, thereby violating the 'confidentiality' principle. Although the information revealed by the client to the therapist are kept confidential and regarded as highly privileged, it is getting increasingly difficult to withhold the information. This is well brought out in the Tarasoff Case wherein the California Supreme Court made it clear that information provided by a client in the course of therapy cannot remain confidential or privileged if that information indicates that the client may be dangerous.

Similarly, the information on the employees in the industrial settings, too are not absolutely confidential, as for instance, the insurance companies, enter the diagnosis of an employee's illness in the computer records, to which many companies may obtain access.

Even after the informed consent of the subject for undergoing testing, ethics demands that the therapist obtains prior permission before revealing or sharing of the test results with anyone other than the client.

While clinicians thus have a clear ethical duty to respect and protect the confidentiality of client information, it is to be recognized that all information may not be possible to be kept confidential, as for example, the school records that involve assessment data of the children which are all less than inviolate.

Also, as pointed out by Rubanowitz (1987), there are also many other areas such as child abuse, potential suicides and homicides etc., which cannot be kept confidential. There are also cases where the client may be potentially dangerous and the counsellor or therapist may have to share the client's problems with her or his colleague, which may be done with or without the consent of the client (Baird & Rupart, 1987). In this context, Pope & Vetter (1992 p.399) cited a case of a psychologist whose client claimed that she was raped, but the police knowing the mental history of the client from the psychologist refused to register the case.

Unsupervised Interventions by Trainee Students

However, along with these advantages, one finds the ignoring or being indifferent to many ethical issues embedded in field level researches. For instance, student trainees are asked to undertake such research very often even without supervision. How they conduct a therapeutic session or administer a particular therapeutic package programme, etc., is not known and thus could endanger and complicate the existent pattern of functioning of a client or subject.

It is therefore essential to have an ethical committee to examine the various ethical issues related to such unsupervised intervention research studies especially using a therapeutic technique with clients suffering from a certain disorder. As pointed out by Imber et al. (1987) and Heflinger (1987), the ethical problems in such studies is that one group gets the benefits while the other does not as is in the cases of the trials with psychotherapy or drug given to a particular selected client group suffering from a certain disorder with another group being denied of the treatment until the treatment is proven to be useful, which incidentally also raises the discrimination aspect of ethical issues. At the same time, therapeutic sessions by untrained students, and unsupervised therapeutic sessions may cause considerable damage to the subjects seeking help from the therapists.

4.8 ETHICS IN PSYCHOLOGICAL RESEARCH

Presently one finds in a large number of research work in clinical and counselling psychology areas, attempts to scientifically ascertain the efficacy of a particular therapeutic or counselling approach in the handling of a particular disorder. Research studies are extremely essential to refine, sharpen and modify the therapeutic tools and techniques helping thereby clients to become asymptomatic. Such research studies have resulted also in the emergence and standardizing

of the many new therapeutic techniques and packages. Many practitioners who have rich data available refuse to participate in research as they perceive a potential threat to their clients. (Hardy, 1995; Shipton, 1994; Mellor-Clark Shapiro, 1995). Finally, the basic principle of such research concerns is related to the rights of the person who may or may not want to participate in the study (informed consent) and such research work may perhaps in certain cases intrude into the therapeutic process about which considerable precautions have to be taken. (Meara & Schmidt, 1991). BCA (1996) has put forward in this connection certain important guidelines for research studies in counselling.

Fudging or Plagiarizing

While intentionally no researcher violates ethical guidelines, there are always marginal scientists who 'fudge' the data, take credit for the work of someone else, or plagiarize others' writing. Nedelson (1993), and Tangri and Kahn (1993) referred to the research on older persons and women and the researchers' conclusion that age and sex have contributed to the concerned problem being studied. They were of the view that lack of the grasp of the research literature on such subjects led them to attribute experimental effects to the wrong factors – age or sex – reinforcing stereotypes about the 'elderly' and 'women'.

Inappropriate Professional Practice

APA (1993) in their report on ethical violations by professional psychologists in USA, found that in 1991, there were 53 percent cases involved in inappropriate professional practice, which included testing abuses onwards to inadequate handling of cases, while in 1992, such violations came down to 32 percent. On the other hand, inappropriate teaching and research was only 8 percent which came down further to 6 percent in 1992, which included authorship controversies, inadequacies in supervision, improper and unsafe use of research techniques and plagiarism.

One of the inappropriate practice which has increased more conspicuously is that of 'dual relationship', that is, sexual misconduct with adult clients, sexual conduct with minors, sexual harassment and nonsexual dual relationships. According to the report, this type of ethics violations has increased to nearly double the number than what it was in 1991 (Wilson, et al., 1996. p.66-67).

Ethical Principles for Human Subjects Research

Following are the ethical principles for human subjects research:

1. In planning a study, the investigator has the responsibility to make a careful evaluation of its ethical acceptability. To the extent that the weighing of scientific and human values suggests a compromise of any principle, the investigator incurs a correspondingly serious obligation to seek ethical advice and to observe stringent safeguards to protect the rights of human participants.

2. Considering whether a participant in a planned study will be a 'subject at risk' or a 'subject at minimal risk' according to recognized standards, is of primary ethical concern to the investigator.

3. The investigator always retains the responsibility for ensuring ethical practice in research. The investigator is also responsible for the ethical treatment

of research participants by collaborators, assistants, students, and employees, all of whom, however, incur similar obligations.

4. Except in minimal-risk research, the investigator establishes a clear and fair agreement with research participants, prior to their participation, that clarifies the obligations to honor all promises and commitments included in that agreement. The investigator informs the participants of all aspects of the research that might reasonably be expected to influence willingness to participate and explains all other aspects of the research about which the participants inquire. Failure to make full disclosure prior to obtaining informed consent requires additional safeguards to protect the welfare and dignity of the research participants. Research with children or with participants who have impairments that would limit understanding and/or communication requires special safeguarding procedures.

5. Methodological requirements of a study may make the use of concealment or deception necessary. Before conducting such a study, the investigator has a special responsibility to (1) determine whether the use of such techniques is justified by the study's prospective scientific, educational, or applied value; (2) determine whether alternative procedures are available that do not use concealment or deception; and (3) ensure that the participants are provided with sufficient explanation as soon as possible.

6. The investigator respects the individual's freedom to decline to participate in or to withdraw from the research at any time. The obligation to protect this freedom requires careful thought and consideration when the investigator is in a position of authority or influence over the participant. Such positions of authority include, but are not limited to, situations in which research participation is required as part of employment or in which the participant is a student, client, or employee of the investigator.

7. The investigator protects the participant from physical and mental discomfort, harm, and danger that may arise from research procedures. If risks of such consequences exist, the investigator informs the participant of that fact. Research procedures likely to cause serious or lasting harm to a participant are not used unless the research has great potential benefit and fully informed and voluntary consent is obtained from each participant. The participant should be informed of procedures for contacting the investigator within a reasonable time period following participation should stress, potential harm, or related questions or concerns arise.

8. After the data are collected, the investigator provides the participant with information about the nature of the study and attempts to remove any misconceptions that may have arisen. Where scientific or humane values justify delaying or withholding this information, the investigator incurs a special responsibility to monitor the research and to ensure that there are no damaging consequences for the participants.

9. Where research procedures result in undesirable consequences for the individual participant, the investigator has the responsibility to detect and remove or correct these consequences, including long-term effects.

10. Information obtained about a research participant during the course of an investigation is confidential unless otherwise agreed upon in advance. When

the possibility exists that others may obtain access to such information, this possibility together with the plans for protecting confidentiality, is explained to the participant as part of the procedure for obtaining informed consent.

4.9 ETHICAL ISSUES IN TRAINING SUPERVISION

Postgraduate and above level of education in the field with specialization in the different areas, aims to train students in the techniques and skills in handling the varied problems manifested by the different groups of clients. This requires that the students acquire a thorough knowledge of the various theories and concepts, learn how to select tests, administer psychological tests, score and interpret them, knowledge of relevant literature, an orientation to the clinical and other settings in which they are planning to work after the training programme, as well as develop the knowledge, understanding and skills to make effective counselling and therapeutic interventions. Supervision is an important component in acquiring the hands on experience in the field.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. State 'Ture' or 'False':

   i) Confidentiality of the clinicial records should be meticulously guarded and identity of the patient not revealed even in scientific communication. _____

   ii) Therapist should not explain clearly about the test to the subject. _____

   iii) The investigator always retain the responsibility for ensuring ethical practice in research. _____

2. Write a few lines on:

   i) Ethics and national culture:

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   ii) How to build ethical organizations:

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iii) Challenges of ethics:

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4.10 LET US SUM UP

In this Unit, we have studied various professional approaches and rights of clients in which we dealt with informed consent and confidentiality. We also learnt about ethics and role of ethical codes of conduct. Principles of ethics including beneficence, nonmaleficence, autonomy, justice, fidelity, cultural determinents and patient welfare have been examined in this Unit. We also learnt about various ethics in history taking.

4.11 GLOSSARY

Code of ethics : A formal statement of values and ethical standards.

Ethical dilemma : A situation that, although offering potential benefits, is unethical. One of the most common ethical dilemmas occurs when a company's culture conflicts with an employee's personal ethics.

Ethics training : It seeks to help people understand the ethical aspects of decision making and to incorporate high ethical standards into their daily behaviour.

Utilitarianism : Seeking the greatest good for the greatest number.

Whistleblowers : Persons who expose organizational misdeeds in order to preserve ethical standards and protect against wasteful, harmful, or illegal acts

4.12 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) Principles of ethics are given below:

   i) Beneficence

   ii) Nonmaleficence,

   iii) Autonomy,

   iv) Justice,

   v) Fidelity

vi) cultural determinats, and

vii) Client welfare

Check Your Progress Exercise 2

1) i) True

ii) False

iii) True

2) i) Ethics and national culture: There are no global ethical standards. The ethical principles of global organizations that reflect and respect local cultural norms are necessary for high standards and consistent practices.

ii) How to build ethical organizations: Building ethical organizations is a matter of building personal character and integrity. Building character is a matter of establishing the right organizational ethos and style. Organizational structure can support ethos and integrity, but cannot create it.

iii) Challenges of ethics: Ethics require personal and organizational development. Ethics is not an option, but essential to personal and organizational well-being.There are no easy answers, no quick fixes, just on going attentiveness, reflection and commitment

4.13 UNIT END QUESTIONS

1. What are the various principles of ethics ?
2. What are the ethics of psychological research?
3. Explain the ethics in training and supervision.

MCFT-004

COUNSELLING AND FAMILY THERAPY: APPLIED ASPECTS

BLOCK 1 : PROFESSIONAL ISSUES IN COUNSELLING AND FAMILY THERAPY

Unit 1 : Essentials for a Counsellor and Family Therapist
Unit 2 : Self of the Counsellor/Therapist
Unit 3 : Therapist/Counsellor and Client Relationship
Unit 4 : Professional Approach and Ethical Issues

BLOCK 2 : PRACTICAL ASPECTS OF COUNSELLING & FAMILY THERAPY-I

Unit 5 : Creating a Therapeutic Climate
Unit 6 : Developing Communication Skills for Counselling
Unit 7 : Mediation in Counselling and Family Therapy
Unit 8 : Mediation in Family Disputes
Unit 9 : Life Skills Education

BLOCK 3 : PRACTICAL ASPECTS OF COUNSELLING & FAMILY THERAPY-II

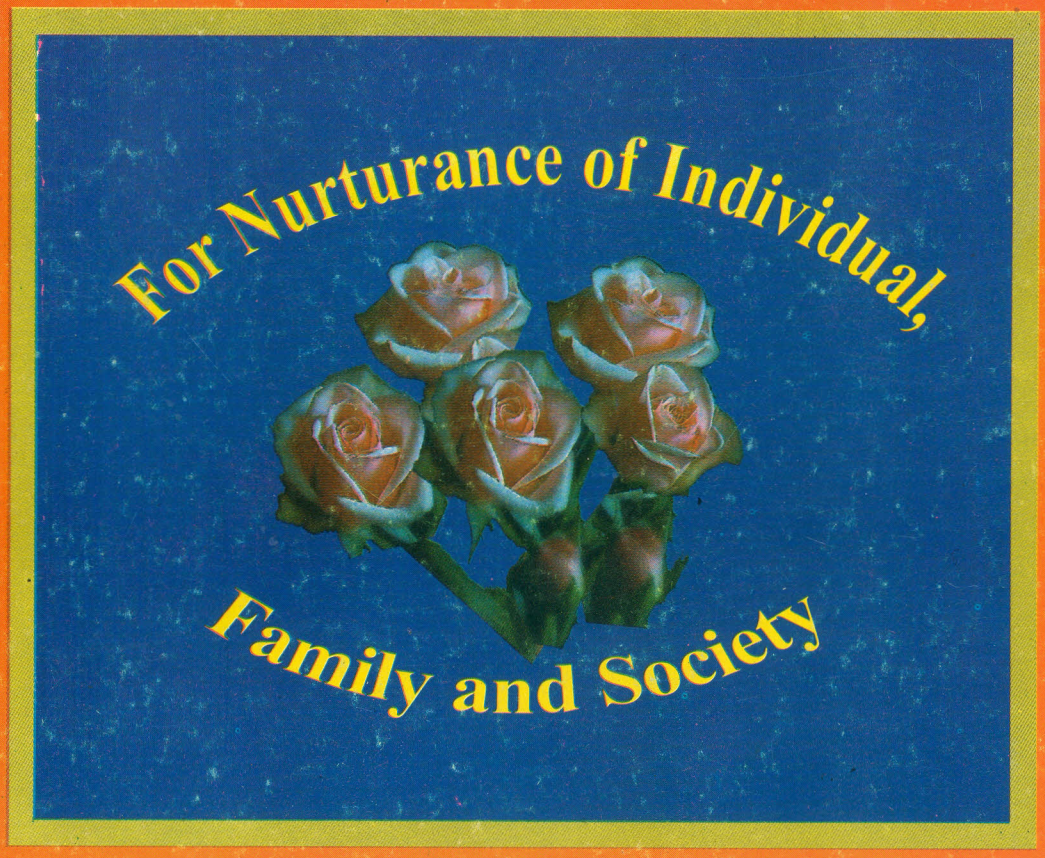
Unit 10 : Reflective Relationship Techniques
Unit 11 : Relationship Building Strategies
Unit 12 : Strategies for Facilitating and Evaluating Change
Unit 13 : Barriers to Actualizing Therapeutic Relationships
Unit 14 : Coping with Difficult Situations in Counselling and Family Therapy

BLOCK 4 : PROCESSES OF COUNSELLING AND FAMILY THERAPY

Unit 15 : Referral and Intake
Unit 16 : Initial Phase
Unit 17 : Middle Phase
Unit 18 : Termination Phase: End Processes

MANUAL FOR SUPERVISED PRACTICUM (MCFTL-004)

MPDD/IGNOU/P.O. 2T/Feb. 2011



ISBN : 978-81-266-5220-4