CHAPTER 1 – INTRODUCTION AND REVIEW OF LITERATURE

Being a psychotherapist involves setting out on a journey of personal growth and discovery. The beginner therapist, equipped with knowledge and trained in skills, readies herself to sit on the practitioner’s chair to facilitate change and growth in the client. Theoretical knowledge, basic skills and techniques serve very well to initiate the therapist to the world of psychotherapy. However, through years of practice the therapist realizes that skills, techniques and knowledge will not, on their own, help therapy progress. The therapist’s self is an important instrument, that helps establish a therapeutic bond that facilitates the therapeutic process in catalyzing the client towards change and growth, and it is this instrument that needs tuning and work.

As the therapist moves forward in the journey of professional development she incorporates new insights through both personal and professional experiences and the self of the therapist evolves as an amalgam of personal attributes, beliefs, values, professional knowledge and skills. To understand the ‘self of the therapist’ the focus therefore has to be not just on acquired skills and techniques but additionally on the lens the therapist adopts and the person of the therapist that the client encounters.

The present study attempts to capture the essence of the practitioners’ self by understanding the beliefs and values that determine their world-view and obtain an experiential account of how this world-view impacts therapeutic practice.

This chapter presents an introduction to the concepts, theories and relevant research that laid the foundation in the formulation of the present study, as well as strengthened and contextualized the findings that emerged.
Therapist Variables in Psychotherapy Research

Scientific research on psychotherapy began around the mid-20\textsuperscript{th} century and continues to be an intriguing field of study for both researchers and practitioners of psychotherapy. Within the broad field of psychotherapy research, therapist variables, both personal and professional, have received attention and interest at different times for a range of reasons. The specific trends in research on therapist factors and variables have been discussed below in the context of the psychotherapy research movement.

Migone (1996, as cited in Ardito & Rabellino, 2011), in depicting how the field of psychotherapy research has evolved discussed three partially overlapping phases in time.

Phase 1: Investigating the outcome of psychotherapy (1950s – 1970s)

Phase 2: Research into the relationship between process and outcome of psychotherapy (1960s – 1980s)

Phase 3: Examining the therapeutic process and understanding the micro-processes involved in therapy (1970s onwards).

Psychotherapy research includes under its purview both outcome and process research. Psychotherapy outcome studies focus on the impact of psychotherapy on clients in terms of the effects of the treatment provided, and interests itself with how therapist, client, therapeutic alliance and extra therapeutic variables contribute to better psychotherapeutic outcome. Psychotherapy process research includes studies on psychotherapy process from therapist and client perspectives and documents therapist and client interactions and experiences during and between therapy sessions. Some research studies, on the other hand, include measures of outcome and process and
have been classified as process-outcome research (Orlinsky, Heinonen, & Hartmann, 2015).

The impetus for studying psychotherapy outcome came from the declaration made by Eysenck (1952), that psychotherapy had not demonstrated any effect on the improvements experienced by clients, and that any improvement in clients was a result of spontaneous remission. It was in response to this challenge that psychotherapy research gained momentum in the 1950s and 1960s, focusing heavily on outcome studies, and by the 1980s there was conclusive evidence to show that psychotherapy was more effective than no treatment at all (Lambert, 2013).

With the effectiveness of psychotherapy established, focus of psychotherapy research shifted to comparing the outcomes of various modalities of psychotherapy. As early as 1936, Rosenzweig wrote a seminal paper called “Some Implicit Common Factors in Diverse Methods of Psychotherapy” and made a claim that impacted psychotherapy research decades later. In his paper, Rosenzweig referred to the ‘Dodo bird verdict’, an allusion he took from Lewis Carroll’s ‘Alice in Wonderland’, to indicate there were no differences in the outcome of the different modalities of psychotherapy (Duncan, 2002). Groundbreaking meta-analytic research in the area proved that the Dodo bird verdict indeed existed and that the effectiveness of psychotherapy lay in the common factors inherent in the psychotherapeutic approaches (Duncan, 2002).

Amongst the factors identified to determine outcome, client factors were found to be the most potent contributor to psychotherapeutic change. Research showed that client preferences, expectations, motivations, and beliefs significantly impact therapy outcome and clients actively and positively contribute to therapeutic outcome (Bohart & Wade, 2013). Further, empirical findings supported the stance
that the quality of the therapeutic alliance (i.e. the quality of the cooperation and mutual understanding between the client and the therapist) was significantly associated with favourable outcome (Ardito & Rabellino, 2011; Hoglend, 1999; Karver, Handelsman, Fields, & Bickman, 2006). Orlinsky, Rønnestad, and Willutzki (2004) analyzed published studies over 58 years, including around 300 process-outcome studies, and found consistent association between the interpersonal aspects of process and psychotherapy outcome. With the therapeutic bond or alliance between the client and the therapist being the strongest predictor of outcome, the therapeutic relationship stance of the therapist was found to have an important impact on the treatment process.

Apart from the therapeutic relationship, research revealed that therapists accounted for about half the share of the outcome variance that was in any way related to treatment (Duncan, 2014). Therapist effects ranging from 5-8 percent have been reported in outcome research, which amounts to 36-57 percent of the variance attributed to treatment (Baldwin & Imel, 2013; Duncan, 2014; Owen, Duncan, Reese, Anker, & Sparks, 2014). The amount of variance accounted for by therapist factors was, therefore, about five to eight times more than that accounted for by model differences. Having established that differences in therapists led to differential outcomes, there was a great impetus towards generating research on the effect of therapist variables on psychotherapy outcome.

Within the realm of psychotherapy process research, Schröder, Orlinsky, Rønnestad, and Willutzki (2015) charted the trends in process research to have shifted from therapist accounts to objective third party observations and evaluations of the therapy process shutting out therapist voices on the therapy process. They mentioned that individual therapist experiences on which therapists themselves were experts,
helped generate a unique personal understanding of the psychotherapy process and practice that could be useful for practitioners, and therefore needed to be included. In the overview of the research on psychotherapy process, they enlist research on therapist accounts of therapy process as critical. Though therapist accounts may not predict therapy outcome or client experience, they emphasized their inclusion to facilitate the understanding of therapist influence on psychotherapy practice.

As the trends suggest, the movement of psychotherapy research embraced and promoted outcome and process research that was objective, in the service of promoting the profession and establishing its effectiveness. What resulted was that, in the bargain, therapists were viewed as agents of change, interchangeable, sometimes also as ‘noise’, or as a factor whose influence needed to be minimized.

However, beyond these borders, there lies the landscape of research that pertains to documenting therapist variables and experiences, personal and professional development and their practice characteristics, that has been receiving attention in the last few decades. This has been fueled by the view that advocates that therapists are of interest not just as variables that impact outcome and process and emphasizes that research on therapists is needed to further an understanding of how they develop as professionals and individuals and how their personal and professional ‘selves’ enter into their therapeutic practice.

Timulak (2008), in compiling psychotherapy and counseling research organized the research in the field of psychotherapy into outcome, process and an additional category of context research. Along with client contexts, it included research on the psychotherapist in terms of professional aspects such as therapist development over years of practice, theoretical orientation, etc., as well as personal aspects such as therapist personality, values and attitudes, style of relating and so on.
He mentioned that psychotherapy research has two main goals: justifying the therapeutic endeavor and informing therapeutic practice. He iterated that outcome research has often received more attention and interest due to its political influence in justifying the therapeutic endeavor, however, process and context research were more linked to therapeutic practice and had great potential to influence practice and thereby outcome.

On a similar note, McLeod (2013) in reviewing research in counseling and psychotherapy, albeit only that limited to qualitative research, mentioned that the research on the experience of therapy from both clients and therapist perspectives was critical in creating contextual knowledge, bringing in individual voices, and generating a nuanced insight into what it is like to be a client or a therapist.

However, the question on why the need to study psychotherapists was answered most convincingly by Orlinsky et al. (2005) in a beautifully crafted introductory piece to their book on therapist professional development. They documented how a range of other professionals: developmental psychologists who wanted to study wisdom, a team of sociologists who wanted to study pursuit of happiness, and so on, sought answers to their research questions by studying therapists.

If we psychotherapists are of interest to scholars and critics beyond our profession, we are (and should be) at least as interesting to ourselves. All modern therapeutic approaches are based on the notion, variously expressed, that self-understanding contributes importantly to professional effectiveness, rational self-management, and personal well-being. To facilitate that self-understanding, we rely individually on our supervisors, our colleagues, and our own psychotherapists; but we also need to understand ourselves.
collectively, as a profession (or, more accurately, as a set of related professions). To supervise ourselves as a profession, and to develop optimally as a profession, we need accurate knowledge concerning who we are, what we do, and how well we do it. Although our teachers, supervisors, and personal therapists can help to increase and refine our individual self-knowledge, the only real path to reliable collective self-knowledge is through systematic empirical research. (p. 4)

It was in keeping with this ‘spirit of the times’ that the present study was conceptualized to contribute to further the study of therapist variables, from therapist perspectives, and to generate a contextual understanding of how therapists’ beliefs and values enter into psychotherapy practice. The sections below document ideas and research that have contributed to generating an understanding of therapist variables and laid the foundation for drafting of the research questions.

**Therapist Factors in Psychotherapy Outcome**

As mentioned above, therapist variables have been researched and explored extensively in the context of psychotherapy outcome. With the establishment of the finding that differences in therapists led to different outcomes, psychotherapy research turned its attention towards the next question of ‘What makes some therapists more effective than others?’ This question was first considered in 1974, when D.F. Ricks described the exceptional therapist or ‘supershrink’ as one whose clients did better in therapy (Okiishi, Lambert, Nielsen, & Ogles, 2003). Research on therapists suggested that some therapists were consistently more effective than others (Lambert & Barley, 2001). In the light of these findings, the therapist’s use of the self emerged as a crucial aspect in therapy, and research on therapist factors began grappling with identifying factors contributing to differential outcome. As Hoglend
(1999) suggested, that while it was clear that “therapist differences produce differences in outcome”, what was not clear was “what is it that creates a skillful therapist” (p. 259).

Over the years therapist variables that impact psychotherapy outcome have been extensively studied. However, factors such as the therapist’s education, training, specific intervention used or demographic variables were not found to be predictive of outcome (Beutler et al., 2004). Okiishi et al. (2003) studied 1841 clients, who were seen in psychotherapy by 91 therapists over a period of 2.5 years. They found significant differences amongst the therapists in how much improvement their clients showed as assessed through the outcome assessment. Further, on analyzing the data using Hierarchical Linear Modeling, therapists’ differences were not related to the theoretical orientation of the therapist or the type of training and so on. In a review of therapist factors, Beutler et al. (2004) mentioned that observable aspects of therapists, such as sex and age, theoretical orientation, do not contribute to client outcome, suggesting the need for an emphasis on studying qualities that are identified through inferential processes, such as the therapist’s personality, values, and relationship qualities:

The strongest impression with which we are left at the conclusion of this review is that over the last two decades, there has been a precipitous decline of interest in researching areas that are not associated with specific affects of treatment and its implementation. Observable and inferred traits of the therapist have seen the greatest decline in research interest, even though several factors within these clusters of variables have, over the years, been viewed as being very promising predictors of treatment outcome. For example, recent research is noticeably sparse, or even absent, on the effect of therapist
personality, well-being, personal values, and religious viewpoints on outcomes (Beutler et al., 2004, p. 289-290).

Of particular note here, is the recommendation by Beutler et al. (2004) at the end of their review for further research on therapist personal or inferred factors. When looking at the therapist factors, it is evident as Reupert (2006) puts it, something is working and that could be the self of the therapist and that the ‘self’ or the ‘person’ is more important than the orientation chosen, or the interventions employed, suggesting the need for further study in this area.

Research conducted over the last decade has focused on this question and findings suggest that what makes some therapists better than others is their ability to develop a good therapeutic relationship across different clients (Baldwin, Wampold, & Imel, 2007). In an extensive review in search for therapist characteristics and techniques positively impacting the therapeutic alliance, Ackerman and Hilsenroth (2003) found that personal attributes of being flexible, honest, respectful, trustworthy, confident, warm, interested and open contributed positively to the therapeutic relationship.

Nissen-Lie, Monsen, and Rønnestad (2010) studied the relationship between self-reported characteristics relating to the therapeutic work of 68 experienced therapists based out of 16 outpatient clinics across the Norwegian healthcare system with working alliance rated by 235 patients suffering mostly from anxiety, affective, and co-morbid personality disorders. Therapists’ experiences of what the authors termed negative personal reaction (NPR, i.e., more hostility, empathic deficiency, and frustration with a patient) was predictive of lower patient-rated alliances. On the other hand professional self-doubt (PSD) was viewed as reflective of humility and sensitivity and facilitated the therapeutic alliance.
Heinonen (2014), while reviewing psychotherapy outcome research emphasized that the conceptual and methodological distinction between therapist pre-treatment factors (qualities that therapists initially bring to the treatment, independent of the therapeutic interaction) and process variables (therapist qualities and actions specific to the therapeutic process, client or therapeutic relationship) has rarely been made. This has led to gaps in knowledge on skills, traits, and qualities that therapists who are more effective tend to bring into the therapy processes with their clients.

With this in mind, the longitudinal Helsinki Psychotherapy Study, with 71 volunteering psychotherapists aimed to assess how therapists’ professional and personal characteristics predicted working alliance and outcome in therapies of different forms and lengths in the treatment of depressive and anxiety disorders.

Findings suggested that therapists’ experiences of skillfulness and enjoyment in therapy work consistently predicted better early alliances, when the alliance was rated by the therapists themselves. In comparison, therapists’ experiences of difficulties, stress, and negative feelings in practice predicted worse early therapist-rated alliance. This was indicative of the fact that how therapists viewed themselves was critical in predicting the therapeutic alliance. Further, it was found that therapists who were highly warm and open experienced the best early alliances if they conducted long-term therapy, and those who were highly task-oriented and skeptical experienced better alliances especially in short-term therapy. The research was unique in throwing light on the overlap in therapist personal and professional characteristics. Therapist ratings of professional characteristics of being more active in professional manner (highly invested and highly efficacious) predicted faster reduction in symptoms in short-term therapy. These results were mirrored by ratings of being engaging and extroverted in their personal life (highly intense, low in subtlety,
reclusiveness, aloofness, and skepticism). This finding suggested that the professional skills of effective therapists may be intertwined with their personal qualities and thereby influence therapy practice in myriad ways.

Not only did research findings point towards the role of therapist personal characteristics influencing therapy, what became amply clear alongside was that therapists awareness about their personal and professional self could also be contributing to how psychotherapy progressed. S. D. Miller, Hubble, and Duncan (2013) through reviewing research on therapist effects mentioned that therapist effectiveness was found to be determined by factors such as checking baseline effectiveness, engaging in deliberate practice and taking feedback from clients and suggested this as the path towards clinical excellence for therapists. Lecomte (2010) highlighted four basic factors that characterize effective psychotherapists. He mentioned that effective psychotherapists have skills in therapy, manage therapeutic relationships effectively (fluctuations, ruptures and restorations), can handle the tensions between the patient’s resistance and openness to change, and engage in self-reflective practice.

For those studying effect sizes, through Randomized Control Trials, the therapist effects are minimal and may be considered as noise: however, the therapist is the critical part of the treatment that is delivered, both the what and how, and that is one factor that can never be minimized without undermining therapy (S. D. Miller, Hubble, Chow, & Seidel, 2013). Within therapist factors, psychotherapy outcome research findings are accumulating in support of the role of therapist personal variables, that may interplay with professional variables and influence process and outcome, thereby generating interest amongst researchers to further explore therapist personal factors and their role in the psychotherapeutic practice.
Journey of a Therapist

Independent of outcome research, there has been an endeavor in the field of psychotherapy research to study therapist factors to generate knowledge on therapist professional development, pathways to professional excellence and expertise, emphasizing the role of factors and contexts that impinge on the development of the therapist self and therapeutic practice.

The journey of the therapist beginning with therapist motivations for joining the profession, the experience of training and supervision in psychotherapy, development of a theoretical orientation, pathways of professional development, making meaning of the therapeutic role, along with experiences and influences have been documented and researched. This section presents research on the professional trajectory of a therapist in an attempt to highlight the salience of the therapist self in psychotherapy and create the context or backdrop for the discussion on therapist beliefs and values.

Therapist Motivations for Joining the Profession

The reasons why therapists enter the profession of counseling and psychotherapy can be varied. Over the years, research has accumulated on the motivation of therapists to join the healing profession and reasons that draw practitioners to the field of therapy.

Henry, Sims, and Spray (1973), who focused on the career determinants of psychotherapists, conducted one of the earliest research in this area. They found that more than 60 percent of the more than thousand therapists surveyed mentioned having few friends in high school and feeling isolated. They concluded that although no one factor could be held accountable to settling on psychotherapy as a career, factors such
as being less authoritarian, more liberal, less religious, were important indicators for choosing the profession.

Recent research has also found therapists’ personal experiences, such as childhood experiences, family upbringing, life experiences, social circles, etc., to be strong motivators to pursuing the profession of therapy. Farber, Manevich, Metzger, and Saypol (2005), through in-depth interactions with eight practitioners, found that therapists reported experiencing isolation, loneliness and sadness in their childhood. According to them, therapists reported taking up roles of caretakers or parents early in their life and experiencing the warmth in caring for another individual. Farber et al. (2005) mentioned that they found most therapists to be very observant as children and having a keen interest in understanding themselves and others deeply. In a survey of 238 psychotherapists in the UK, Bager-Charleson (2010) found that forty seven percent of the therapists reported ‘own childhood’ as the top reason, and twenty two percent mentioned ‘later life crisis’ as leading them to choose psychotherapy as a profession. ‘Interest in people’ was indicated by sixteen percent of the therapists.

Among those who mentioned ‘own childhood’, both positive and negative aspects of childhood experiences were reported to have contributed to their decision.

In a similar finding, Richardson, Sheean, and Bambling (2009) found that the students in National Training Programs for Psychotherapy and Counselling in Australia stated having undergone certain life experiences that instilled in them a need to be a therapist. Beatty (2012) conducted a survey-based study among trainee counselors and psychotherapists in Ireland and found that an early experience of loss or a perceived lack of a confidant during childhood led the individual to undertake this prescribed role to others. Furthermore, ninety percent of Beatty’s participants highlighted experiencing at least one significant life event which influenced their
decision. These experiences included childhood difficulties, addiction, mental health issues within the family of origin, personal experience and loss.

Sussman (2007) indicated that unconscious motivations deeply rooted in the developmental past and the dynamics of the family of origin might have a role to play in those who choose to train and work as therapists. Sussman (2007) went on to say that ‘an important determinant of the desire to practice psychotherapy involved the attempt to come to terms with one’s own psychological conflicts’ (p.175). A cultural archetype coined by Carl Jung, ‘wounded healer’, refers to the therapist being eager to help clients as they themselves are wounded (Zerubavel & Wright, 2012).

Altruism as motivation to be a therapist was most stated by Beatty’s (2012) sample of trainee counselors and psychotherapists. Norcross and Farber (2005) explained that while the value of altruism is often stated as a motivation and is socially desirable, the decision to be in a helping profession could be more complex and multi determined, in terms of being influenced by unconscious motives and chance encounters. They mentioned that these experiences might not be understood by the practitioner until late in their career.

In exploring reasons for counselors in India to enter the helping profession, Bhargava (2011) elaborated that individuals were attracted to the field of therapy for various reasons, chief being the desire to work with people and help others. Other reasons included their own personal difficulties and being influenced by role models such as teachers or family members.

Therapist experiences in personal therapy have also been identified as a motivating factor for individuals to pursue therapy as a profession. Beatty (2012) reported that sixty percent of the respondents mentioned personal therapy to be a motivating factor for pursuing the profession.
The motivations and reasons for joining the field of psychotherapy and counseling may be varied and there is no one route to enter the field of psychotherapy. Existing literature in this area has highlighted a range of factors such as the therapists’ developmental history, experiences in the family, life experiences, personal experience with therapy, and the therapists’ value system, contributing to the decision to join the helping profession. It has been recommended that therapists be aware of the factors that motivated them to enter the profession, so as to ensure that personal needs or experiences do not interfere with the therapy process.

**Training to be a Therapist**

Psychotherapy training is a crucial aspect of therapists’ professional development, impacting not just the professional competence but also contributing to the development of the therapist identity (Boswell & Castonguay, 2007; Rønnestad & Skovholt, 2003).

Rønnestad and Skovholt (2003) outlined the phases of therapist development and highlighted two phases of development during training. Phase 2 called “The Beginning Student Phase” is when students find the start of professional training to be exciting but also intensely challenging. In this stage, the trainee is overwhelmed by theories/research, clients, mentors, one’s own personal life, peers and the socio-cultural environment. The student aims to counter the experienced anxiety by mastering theories and techniques and through gaining support from supervisors and peers. Phase 3, “The Advanced Student Phase” is when the trainee moves beyond the classroom to apply his/her training in the field. Hence, this phase is characterized by ‘learning on the job’ through internships, practicum or field placement, along with regular and formalized supervision. Typically, Rønnestad and Skovholt (2003) say, that the student in this phase is typically not relaxed and has internalized high
standards for professional competence, however, they appreciate that the training has supported them immensely.

In a survey of trainers from the Australian psychotherapy and counselling training bodies, Richardson et al. (2009) checked what level of prior education was needed to commence training for psychotherapy and counseling and how many years of training commitment was required. Of the participant trainers, 67.6 percent suggested a minimum of two to four years of study following an undergraduate degree.

Carkhuff (2000) outlined effective learning as involving three phases - exploring, understanding and acting. ‘Exploring’ refers to understanding the environment and people that surround the trainee; ‘Understanding’ implies being aware of one’s relation to the environment and ‘Acting’ involves consciously moving from one place to where one wants to be. Research has highlighted an integrated approach to training that combines didactic and experiential methods as being most effective in training (Traux & Carkhuff, 1967, as cited in Theron, 2008). The didactic approach aims to consciously ‘program’ the trainee with effective techniques and skills, while the experiential approach allows more freedom to experiment with various skills and techniques.

Experience or practice based psychotherapy training courses have been widely promoted and have been seen to have exceptional benefits. Mansor and Yusoff (2013) reported that trainee counselors’ experiences, during the counseling practicum in an undergraduate program in Malaysia, helped them gain insight into professional psychotherapy practice and also in their personal ability to handle the challenges and demands of the profession. In another study in Malaysia, Min (2012) used diverse qualitative methods to obtain data from ten counselor trainees. Trainee narratives
indicated that engagement with clinical practicum facilitated acceptance of professional tasks and roles, openness to new experiences and realistic perception of situations. As trainees learnt through experience their sense of self-efficacy as a counselor increased.

Interviewing twenty-four senior undergraduate psychology students in Canada, Pascual-Leone, Wolfe, and O’Connor (2012) found that over a semester of training, trainees reported identifying a variety of changes on both a professional level through skill acquisition and advanced learning in therapeutic process, as well as on a personal level through self-growth. Taking this work further, Pascual-Leone, Rodriguez-Rubio, and Metler (2013) recorded personal narratives of twenty-one graduate students after an introductory course in experiential-integrative psychotherapy and found a similar pattern of professional and personal development.

Training to be a therapist requires honing of skills and refinement of techniques, as well as, personal growth and development of the therapist, so as to develop a more reflective and mindful cognitive system. In 2006, Bennett-Levy proposed a contemporary model called the Cognitive Model of Therapist Skill Development. The model comprises of a basic three system cognitive model of skill development called the D-P-R, standing for the declarative system, the procedural system and the reflective system. The model is grounded in the information processing theory and provides a comprehensive framework that accounts for a range of phenomenon encountered by trainers and trainees (Bennett-Levy, 2006). The declarative system comprises of conceptual knowledge that is learned didactically through lectures, observational learning, supervision or reading relevant articles. This produces ‘inert knowledge’ which fails to transfer to the practical or procedural skills. The procedural system comprises of the knowledge of ‘how to’ and ‘when to’. The
procedural knowledge of experienced therapists is often tacit, which means that they just ‘do it’. The reflective system is identified as the key to therapist skill development. This system enables therapists and counselors to reflect and build on their conceptual (declarative) knowledge and procedural skills, thus playing a central role in the therapeutic procedure. A difficulty may be reflected upon, or taken to a supervisor, helping the therapist to conceptualize the problem and identify and develop strategies to deal with them.

Discussing critical elements of training in the Division of Counseling and Psychology at Lesley University in Cambridge, Massachusetts, U.S. that contributed to developing competent counselors, Reinkraut, Motulsky, and Ritchie (2009) focused on three domains. In keeping with their program philosophy of ‘self as instrument’ they emphasized developing student capacities for empathy, attunement, and self-awareness through the clinical skills courses, ensuring academic support for the development of critical thinking and multiple perspectives, and helping consolidate the theoretical, relational and cognitive capacities during the field training.

Moving away from a skill development perspective, Ridley, Mollen, and Kelly (2011) have recently developed a model of counseling competence to fill in the gaps present in establishing a relationship between training and expertise in psychotherapists. Through their model they highlight the importance of considering behavioral, cognitive, attitudinal and emotional components of competencies. The model focuses on therapeutic outcome, and mentions therapist cognitive competencies of flexibility when dealing with a client, openness and awareness of oneself so as to self evaluate and reflect on one’s skills, and capacity to develop multicultural competence as critical to it.
Over the last 10 years, mindfulness has also formally moved into psychotherapy and counseling training. Christopher and Maris (2010) explored the potential of mindfulness practices to the training of counselors and psychotherapists at the Montana State University, U.S. They found that through mindfulness training, programs can teach students strategies to counter burn out, compassion fatigue and other forms of traumatization.

Both research and training models bring to light the world-wide trend towards comprehensive and quality psychotherapy training that promotes knowledge and skill building, and at the same time promotes personal growth, development and self-care in therapists-to-be.

**Psychotherapy and counseling training in India.** Psychology training in India, began in the Euro-American tradition, in 1905 with the development of an experimental psychology syllabus by Sir Brajendra Nath Seal. In 1916, the first psychology department was established in the University of Calcutta (Ciccarelli & Meyer, 2008). Over the last hundred years, counseling and psychotherapy training in India has been steadily evolving. There has been an increase in specialized postgraduate degree courses in psychology, MPhil and PhD programs in clinical psychology, as well as practitioner based courses in counseling and psychotherapy (George & Pothan 2013).

As the demand for mental health professionals grows and specialized training programs for counseling and psychotherapy are introduced, there is an increasing demand from psychotherapy trainers and trainees for better psychotherapy training procedures (Manickam, 2010). However, reports or reviews on the status of psychotherapy training in India are limited.
With the objective to assess the status of training for counseling in the city of Mumbai, Nikam (2012) reviewed training and education in counseling across universities, colleges affiliated to universities and private institutes in Mumbai. These included two-year post-graduate programs, post-graduate diplomas in counseling, as well as short term certificate programs. Most courses relied on lectures as a method of teaching. The use of video and audio recording as a teaching method, case presentations, role-plays for practice-based learning was used in certain programs. It was the two-year degree programs that included fieldwork and visits, mock sessions, community outreach program visits and expert discussions, practicum, internship, and case study methods. Nikam (2012) also reported that courses on reflective practice were not usually included even in degree programs. Surveying university programs in counseling psychology in Bangalore, Thomas (2011, as cited in George & Pothan, 2013) found that the emphasis on components of personal and professional development varied across institutes/ universities, based on the vision and philosophy they adhered to.

Understanding experiences of postgraduate trainee counselors in India, Kongari (2014) found that courses focusing on the personal development of the trainee were essential in helping the trainee develop reflective processes and widening insight on therapist values and beliefs, which inadvertently impacted the therapeutic process. Kongari (2014) found that personal therapy, one-on-one supervision, and reflective journal writing were identified as important in furthering the personal development of the trainee counsellor.

Nikam (2012) emphasized, a need to standardize the curriculum across all training and educational institutes, along with the formation of a regulatory body to regulate and supervise the same, to minimize variations in structure, content and
practice and create a systematic training system in India. K. Rao (2010), in a comprehensive review of psychotherapy practice in India underscored the gap created by the absence of any regulatory body for psychotherapy training, and strongly emphasized the need for professional psychotherapy training and supervision in India. Having said that, the trends in psychotherapy training in India are similar to those seen world-wide, with the training programs increasingly being tailored to cater to both the personal and the professional development of the therapist/ counselor.

**Professional Development of the Therapist**

In the last three decades or so, there has been a growing interest in understanding aspects of therapist professional development. As Rønnestad and Skovholt (2003) explain, this growing interest has allowed for a focus on the competence and mastery of the therapist/ practitioner as a key influence on the therapeutic relationship, change process and outcome. Elman, Illfelder-Kaye, and Robiner (2005) define professional development as the developmental process of acquiring, expanding, refining, and sustaining knowledge, proficiency, skill and qualifications for competent professional functioning that result in professionalism. Professional development has been understood in terms of external criteria such as graduating, completing training, acquiring a license to practice (as it is mandated in many countries), and in terms of internal qualities, such as feeling competence or a sense of mastery required for being therapeutically effective (Orlinsky, Rønnestad, et al. 1999; Skovholt & Rønnestad, 1995). Existing research highlights the value therapists place on professional development across their career life-span (Orlinsky, Rønnestad, et al. 1999).

**Phase model of professional development.** The most comprehensive understanding of the journey and development of therapists was provided by
Rønnestad and Skovholt (2003), as they traced the professional development of therapists and constructed a model following the entire therapist life cycle. Using a longitudinal interview approach, they interviewed 100 American therapists at difference experience levels in the year 1988 and later re-interviewed 60 of the 100 respondents after a gap of 10 years. They named their model the ‘Phase Model’ that included:

- The lay helper phase
- The beginning student phase
- The advanced student phase
- The novice professional phase
- The experienced professional phase
- The senior professional phase

The Lay-Helper phase is the pre-training period in which through roles such as parents, children, friends and colleagues, people are continuously engaged in helping others make decisions, resolve problems and improve relationships. The Beginning Student Phase is at the start of the professional training where the process seems exciting but challenging. The student attempts to move beyond lay conceptions of helping others to more technically appropriate mediums. The Advanced Student Phase is toward the end of training when the student works as a trainee in internships or field placements and is receiving regular supervision, with the central aim as achieving professionalism. Phase 4, The Novice Professional Phase refers to the first years of the professional life which are characterized as being intense and engaging, with many challenges and involve a continual process of reformulation. Phase 5, the Experienced Professional Phase is when the therapist has been practicing for many years and has extensive experience with various clients and settings. Finally, the
Senior Professional Phase is when the practitioner is well established and is considered a senior in professional circles. Usually, this professional has practiced for 20-25 years and may be approaching retirement.

**Cyclical/sequential model of therapists’ professional development.** A strong source of research on therapist development comes from The Society for Psychotherapy Research Collaborative Research Network (SPR CRN) led by Dr. David Orlinsky of the University of Chicago. The CRN team developed the first of its kind survey instrument called the Development of Psychotherapists Common Core Questionnaire (DPCCQ) that focuses on a broad range of therapist professional and personal experiences (Orlinsky, Ambühl, et al. 1999). Up till this date, information has been gathered from approximately 11,000 therapists of diverse professions, theoretical orientations and career levels from more than two dozen countries. The revised Indian version of the DPCCQ – DPCCQ India rev. 12 (Bhola, Kumaria, & Orlinsky, 2012) has also been developed for use with Indian therapists.

Considering that research had focused particularly on early phases of professional development, Orlinsky, Rønnestad, et al. (1999) conducted an extensive study of 3,958 psychotherapists across all stages of professional development. They conceptualized professional development as including retrospected career development (this included perceived career development and claimed therapeutic mastery) and currently experienced development (currently experienced growth currently experienced flow and motivation to develop). They found that perceived therapeutic mastery was related to years of professional practice, possibly reflecting a genuine developmental trend. Therapists currently experienced growth was reflected in the experiences of ‘changing’, ‘improving’, ‘becoming more skillful’, ‘deepening understanding of therapy’ and a ‘growing sense of enthusiasm about doing therapy’.
This experienced growth did not decline as a function of years in practice and remained at a generally high level, even for therapists with more than twenty years of experience. It was also found that perceived therapeutic mastery and experienced growth by therapists were moderately but consistently, significantly positively correlated. In linking therapeutic mastery and experienced growth to psychotherapy process and outcome, Orlinsky, Rønnestad, et al. (1999) suggested that they could be one of the many number of contributing factors.

Through their extensive research using the DPCCQ, Orlinsky and Rønnestad (2005b) developed a Cyclical/Sequential Model of therapists’ professional development. In this model, both positive and negative influences were recognized as being crucial to development. Positive aspects led to a progressive enhancement of clinical motivation, understanding and skills across a wide range of clients, treatment modalities and problematic situations. The negative aspects led to deterioration and a decline in motivation, understanding and skills with clients, which could lead to practitioner burnout and an actual withdrawal from therapeutic work. As a result of this cyclical functioning, the course of development attained and experienced by each therapist would depend on the balance between the positive and negative cycles in practice over time.

Over a period of 15 years, from the reports of 5000 therapists, across all career levels and theoretical orientations, Orlinsky and Rønnestad (2005b) identified the pinnacle of therapist development, what they called healing involvement. This was understood as a mode of participation of the therapist, where they were completely attuned, committed, were able to communicate empathy and experienced feelings of flow within the session, they were at their best and were able to create a path for change for the client. Three sources of healing involvement were identified, namely,
sense of cumulative career development – improvement in clinical skills, increased mastery, and gradual surpassing of past limitations; sense of theoretical breadth – capacity to understand clients from a variety of conceptual contexts that enhanced the therapist’s flexibility; and the sense of currently experienced growth – experiencing themselves as developing now.

**Indian research on therapist professional development.** Tracking the professional development of the therapist is crucial feedback to their growth chart. Research in the area allows for an understanding of the kind of personal growth, as well as challenges and personal inhibitions faced by therapists in various stages of their professional life and allows for empirically supported programs for training and supervision. Research on therapist professional development has received some attention in India over the recent years.

In a study, done in Kolkata on 20 psychotherapists, using the Development of Psychotherapists Common Core Questionnaire (DPCCQ), Banerjee (2012) found that therapist mean ratings on ‘currently experienced growth’, was higher than the midpoint for all the items. The findings revealed similar trends as the original study by Orlinsky, Rønnestad, et al. (1999).

In an attempt to understand what therapists identify as their professional resources and vulnerabilities, Bhola et al. (2012), administered the Development of Psychotherapists Common Core Questionnaire (DPCCQ) on 250 psychotherapists all over India. On qualitatively analyzing the data they found that therapists’ professional strengths could be categorized into ‘therapeutic relationship skills’, ‘therapeutic skill competence’, and ‘therapist personal qualities’. Therapist professional limitations, on the other hand, were found to be in the area of ‘inadequate therapeutic competence…"
and ‘professional self-doubt’, ‘stress and burnout’, and ‘inadequate professional knowledge and experience’.

Other qualitative research in India that have explored challenges and experiences specific to certain phases of professional development amongst therapists and counselors have identified that therapist narratives in India provide an account of therapist development different from therapists from developed countries.

M. Rao (2012) found that novice counsellors in India faced challenges related to negotiating a professional space for themselves. As opposed to the protected and secure transition into work with defined job roles and a well-established professional identity in Western countries, M. Rao (2012) found that, in India, the same had to be negotiated by the counsellors. There was an ambiguity regarding roles along with other work life, supervision and organizational challenges.

Bhargava (2011) mentioned that to counter professional challenges, experienced counselors and therapists in India attempted to define their practice and role within the workplace and the domain of their practice. Through establishing themselves as service providers, addressing the help seekers as ‘clients’ and cementing boundaries through specifying area of expertise, duration of sessions, number of sessions and physical setting, therapists in India were attempting to move towards professionalizing their practice.

In-depth interviews with experienced therapists (Rangarajan, 2013) revealed training related challenges related to lack of focus on skills, process and application; organizational challenges involved a lack of freedom and autonomy; professional challenges included lack of networking and regulation and licensing challenges; client related challenges were due to lack of awareness, all factors that hindered therapist functioning. Rangarajan (2013) found that therapists cited the importance of
additional training, supervision, reflective practices, reading, and working in a team as effective coping strategies to deal with challenges. Indian therapists at different stages of professional development did highlight the importance of seeking psychotherapy supervision to facilitate professional growth and development (Kongari, 2014; Mondal, 2015).

Research on therapist professional development and pathways to the same is still at a nascent stage in India. Considering the lack of set systems that support psychotherapeutic practice in India, the journey of professional development for Indian therapists could be more challenging and demanding. As therapists create systems to foster their development, understanding how these are related to their functioning in the therapeutic space and how it further translates to better outcome for clients is yet to be explored. However, research findings across countries, indicate that the process of professional growth and development contributes to therapist beliefs and nature and quality of therapeutic work, lending credence to the need for giving due attention to the same.

**Developing a Theoretical Orientation**

Developing a personal theory for psychotherapy is essential for beginning practitioners (Spruill & Benshoff, 2000). Developing the same allows them to move beyond the external, client-specific information to organize and make meaning of the client narrative to develop goals and direct therapeutic intervention.

Norcross and Beutler (2000) opined that this process is complex and time consuming, with many factors influencing the same. On a similar note, Bitar, Bean, and Bermudez (2007) concluded that the choice of theoretical orientation is a complex process, and a range of diverse interacting factors determine the choice of orientation, and its further revaluation, revision or realignment. Bitar et al. (2007)
based on the findings of their grounded theory research on theoretical orientation development further elaborated on the influences and processes in theory development by dividing them into two categories – the personal context and the professional context. The personal context subsumed sub categories such as personality, personal philosophy, family of origin, own therapy experiences and own marriage experiences. The professional context, on the other hand, covered undergraduate course experience, graduate training, experiences with clients, professional development and clinical supervision.

Halbur and Halbur (2011) mentioned that the theoretical perspective can be influenced by various factors such as one’s goals and motives, seeking personal therapy, understanding one’s personality deeper and even through reviewing one’s counselling skills on videotape and feedback in supervision.

Ciorbea and Nedelcea (2012) explored the aspect of how the practitioners’ personality and theoretical orientation tied together. Working with a hypothesis that there are significant differences at the level of personality variables between therapists pertaining to different schools, they found that practitioners with a Humanistic-Experiential orientation and a Psychodrama orientation had a dominant function of feeling whereas practitioners with an Ericksonian orientation and a Cognitive-Behavioural orientation had a dominant function of thinking. In a similar vein, Buckman and Barker (2010), through interactions with 142 UK trainee clinical psychologists, identified differences in people subscribing to CBT and Psychodynamic schools of thought. They found that personality factors, such as preferring to make decisions objectively, rationally, analytically and rooted in reality, strongly led to adopting CBT as a primary theoretical orientation, whereas those who followed the psychodynamic school of thought did so due to their training.
experiences. Therapists with a preference for psychodynamic approaches were also seen to be more open to experience whereas CBT practitioners were more conventional in their approach.

Orlinsky, Botermans, and Rønnestad (2001) conducted a rating scale test with 4000 therapists from varied professional backgrounds, career level, theoretical orientations and nationalities. They found that practice-related interpersonal situations, primarily the experience of working with patients, formal supervision and personal therapy were strong influences on the theoretical orientation chosen.

Literature strongly suggests that a clinician’s theoretical orientation affects practitioner satisfaction and the type of treatment a client receives (Bitar et al., 2007). Moreira, Gonçalves, and Matias (2011) identified a variance in client narrative according to the therapists’ orientation. Analysing narrative dimensions along categories of process and content, the authors followed one client (Gloria) across her experiences with therapists subscribing to different theoretical orientations. Summarising the influence of the impact of the practitioners’ theoretical orientation on the client narrative, they went on to say that therapists with different therapeutic orientations will have different attitudes and thus, behave differently when in conversation with a client.

The development of a personal theoretical orientation is seen to be akin to the culmination of a clinician’s life experience which includes personal beliefs, values, as well as education and influential personal and professional experiences. Many therapists report that experience allows them to identify limitations in their originally preferred orientations propelling them to explore other frameworks that would benefit clients (Boswell, 2009, as cited in Hoogland, 2014). Rønnestad and Skovholt
(2003) go on to say that negative client feedback is a major impetus for shifts in theoretical orientation.

Research shows the development of a theoretical orientation to be influenced by multiple factors. Primarily, literature highlights the influence of personal factors such as life experiences, and professional factors such as undergraduate training, internship experiences etc. Beyond these factors, the practitioners’ personality also influences the choice. Further, the theoretical orientation adopted may be determined by therapist personal beliefs and values and in turn might influence them, making it critical to consider this factor.

**Supervision in Psychotherapy Practice**

Inskipp and Proctor (2001, p.1) defined supervision as, “A working alliance between the supervisor and counsellor in which the counselor can offer an account or recording of her work; reflect on it; receive feedback and where appropriate, guidance. The object of this alliance is to enable the counsellor to gain in ethical competence, confidence, compassion and creativity in order to give her best possible service to the client.” Leddick (1994) mentioned that clinical supervision involves construction of individualized learning plans for supervisees who are working with clients.

Supervision has come a long way from the previous ‘master-student’ relationship where the student learned the process through observing, assisting and receiving feedback, to now relying on a strong interpersonal relationship between the student and supervisor and focusing on reflection on the counselling and psychotherapy work. Thus, clinical supervision is now a complex exchange between the supervisor and supervisee, bringing forth the importance of understanding the relevance of the same in psychotherapy (Smith, 2009).
**Purpose and goals of supervision.** Proctor in 1986 outlined the three function integrative model (as cited in Centre for Addiction and Mental Health, 2008) to delineate the functions of supervision. He outlined the three functions as: Formative (educative) function which involved supervisee learning, skills development and professional identity development; Normative (managerial) function which involved accountability, best practice, ethical and legal considerations and Restorative (supportive) function which considered the impact of the work on the supervisee and involved offering psychological support to deal with stress and impact of the work.

Although there is not much agreement on a specific list of goals, expectations and techniques of supervision, R. F. Resnick and Estrup (2000) suggested that supervision be multidimensional and help the therapist understand his/her client better at both the content and process levels, help the therapist become more aware of his/her own reactions and responses to the client (actual and countertransferential), understand the dynamics of how the therapist and client are interacting – from both a clinical and a theoretical perspective, look at the therapist’s interventions and the consequences of these interventions, help the therapist learn and compare theories of psychotherapy, explore other ways of working (other models of psychotherapy) with this and other similar client situations, validate (support) and challenge the therapist.

Overall, literature on the purpose and goals of supervision highlights a general agreement regarding a primary objective of supervision to be ensuring client safety and for promoting professional development for the supervisee along with educational, supportive and managerial/ administrative functions. What is also clear is that the supervision relationship is probably the single most important factor that makes supervision effective, more important than the supervisory methods used (Kilminster & Jolly, 2001).
Models of supervision. With the development of the practice of supervision, many models of psychotherapy and counseling supervision have evolved. Smith (2009) provided a review of supervision models and categorized models of supervision into psychotherapy-based models, developmental models and integrative models. The earliest to develop, psychotherapy-based supervision models focus on the need to learn and develop competencies in specific psychotherapy frameworks. The developmental models of supervision focus on stages of professional development and help the supervisee through each stage by providing the right scaffold, and the integrative models are unique combinations of theories and techniques to facilitate and guide psychotherapy practice. Apart from the types of models mentioned, models of supervision with varying foci such as contexts, critical events, supervisory alliance and spirituality, have also been outlined.

Ladany, Friedlander, and Nelson's (2005) presented a pan theoretical three-phase, events-based supervisory model, for beginning and experienced supervisors. Stressing the interpersonal context of supervision, the model provides a roadmap for supervisors to navigate critical events in their supervisory practice through interpersonal sensitivity, knowledge, and good judgment. Aspects of skill development, multicultural awareness, parallel processes, countertransference, personal attitudes and beliefs to name a few, are considered within supervision using the supervision alliance as the fulcrum. The seven eyed process model of supervision by Hawkins and Shohet (2006) enumerated factors and contexts relevant to supervision in providing supervisory guidance, with client work being at the centre of supervision work. They mapped out supervision practice as encapsulating the client context, the therapist intervention, the therapeutic relationship, the therapist, the supervisory relationship, the supervisor and the wider context.
De La Lama and De La Lama (2010) developed a holistic relevance model of supervision aimed at facilitating adult transformative learning. They proposed a holistic (i.e. the mind-body-spirit interconnectedness) understanding of the teacher and trainer, facilitating interactive and creative learning environments that promote and nurture transformative learning – the change brought about in the cognitive and affective aspects of an individual through experiences. They explained that for transformational learning to take place, one needs to engage in critical reflection with all levels of experiential relevance—body, emotions, thoughts, meaning-making, identity, world-view and spirituality or existential concerns. This transformative learning helps one to challenge, expand and transform one’s conceptual understanding into a more cognitively complex, emotionally integrated and developmentally adaptive cognitive system. Thus, transformational learning through critical reflection becomes one of the key indicators of professional development through supervision, an aspect also reported by experienced therapists (Rønnestad & Skovholt, 2013).

**Process of supervision.** The supervisory process aims to cover new learning and relearning, specifically, corrective cognitive, corrective affective and corrective behavioural experiences (Watkins & Scaturo, 2013). As observed by Donovan, Halford, and Walters (2011), there is very minimal research which focuses on other processes in supervision, apart from the supervisory relationship, such as, supervisor instruction, modelling of therapeutic skills, etc., that may impact the goals of supervision. Supervisory practices generally entail a verbal reporting of the supervisee’s clinical experiences to the supervisor in terms of the content of the sessions, client responses, and future course of therapy. They suggest that assessing supervisee competence and client outcome could enhance the effectiveness of supervision practice.


**Impact of supervision.** Literature shows supervision to be deeply beneficial for therapist development. The efficacy of supervision is seen to be in relation to trainee attitudes, beliefs and skills, performance as a therapist, enhanced process techniques and positive client change (Holloway & Neufeldt, 1995). Rønnestad and Skovholt (2003) found that their participants relied on meaningful contact with supervisors or mentors to propel their growth. Therapists mentioned client interactions as the most impactful for their professional development and ranked supervision as second.

A systematic review of literature conducted by Wheeler and Richards (2007) highlighted the main areas of impact of supervision on therapist development. The review revealed that supervision enhanced self-awareness, skill development, self-efficacy, built in a transfer of understanding from supervision to therapy and impacted client outcome. On the other hand Ramos-Sánchez et al. (2002) highlighted that negative events in supervision can have destructive impact on supervisee development, leading to feelings of hopelessness, inadequacy and disillusionment with the profession. They recommended that supervisors should be very encouraging in the beginning stages of development, work towards building a strong working alliance so as to further the supervisee’s professional development.

**Supervision practice in India.** In a study of twenty psychotherapy supervisors in India, Mondal (2015) reported that most supervisors mentioned an eclectic/integrative theoretical orientation in their supervision practice. Supervisors used written reports, case presentation, interpersonal process recall and case consultation to accomplish the tasks of supervision. Supervisors shared that supervisees brought in many ethical dilemmas, value conflicts and crisis situation in their supervisory practice that related to the nature of psychotherapy practice in Indian
cultural context. Due to high workload, some supervisors reported experiencing exhaustion and burnout after years of practice.

Mondal (2015) found that supervisors reported that 58 percent of their supervisees were students, 25 percent trainees and interns, 9 percent were colleagues/peers and 8 percent junior team members, indicating that most supervisees receiving psychotherapy supervision were students or trainees/interns. While systematic individual and group supervision formats are becoming an integral part of postgraduate programs in psychology (Kongari, 2014; Thomas, 2011, as cited in George & Pothan, 2013) the need for trained psychotherapy supervisors and structured formats for obtaining continued supervision throughout the professional journey is the need of the hour (Manickam, 2010).

Though research in India on supervision is just making its beginning, world-wide research on psychotherapy supervision, indicates that experiences in supervision can facilitate practitioners awareness of their beliefs and values and provide a context for deliberate practice. Seeking supervision or providing supervision to others could be a crucial determinant to self-awareness and belief transformation.

**The Personal Weltanschauung of the Therapist**

In reviewing research on psychotherapy what becomes amply clear is that therapist personal needs and motivations, contexts, professional training, supervision, and in-session experiences influence beliefs and enter into the psychotherapeutic space and impact psychotherapy outcome and process in varied and complex ways. If the self of the person of the therapist is the critical agent in psychotherapy, the beliefs and values that the therapists hold and their lens of viewing the world could be important to consider. This section attempts to present research to throw light on this area.
Each individual possesses a comprehensive world-view or belief system, what Bilgrave and Deluty (1998) call the ‘Personal Weltanschauung’. This belief system or world-view comprises of beliefs and values. Koltko-Rivera (2004) defined world-view as “sets of beliefs or assumptions that describe reality” (p. 3). He mentioned that an individual’s worldview, or Weltanschauung, is the outlook towards life. In the Collated Model of Worldview, he outlined how the world-view comprises of beliefs under grouped dimensions such as - human nature, will, cognition, behavior, interpersonal, the meaning and nature of life, the world. Koltko-Rivera (2004) further emphasized that the world-views are created through both cultural transmission, as well as through abstraction from personal experience.

The study of individual beliefs and values continues to date. This section outlines important frameworks that contribute to the understanding of individual belief systems.

One of the earliest frameworks in understanding individual belief systems came from Rokeach (1973), who conceived of a belief-attitude-value system that guides the behavior of an individual. According to him beliefs are organized into attitudes and along with the hierarchically arranged values, form a functionally interconnected belief system. While attitudes are understood as complex evaluations of objects and situations, Rokeach conceptualized values as beliefs that act as life guides. His theoretical perspective on the nature of values (terminal and instrumental) in a cognitive framework and his instrument to measure values, the Rokeach Value Survey, were important contributions.

Drawing from Rokeach’s ideas, Hayden (1988) proposed a ‘social fabric matrix framework’ comprising of values, beliefs and attitudes. He defined values as cultural criteria or standards for judgment of what is ideal. Values are transcendental
and cut across all aspects of society and culture. He asserted that values by themselves are not goals or actions but end – existence criteria by which actions are judged. Cultural values feed into social beliefs that are activity and institution specific.

Hayden (1988) mentioned that each activity and institution has its own set of beliefs; these beliefs are in concurrence with cultural values. As social institutions change, societal beliefs also change but values are unchanging. Attitudes are several social beliefs that are focused on specific objects or situations. Social beliefs determine attitudes, which in turn determine response, action or behavior. Attitudes are the easiest to change, social beliefs are quite difficult to change and cultural values are unchangeable as the more transcendental the concept the more social entities there are for expressing, reinforcing, and maintaining it.

Similar to the concept of social beliefs, Leung and Bond (2009) call the general beliefs that are not limited to specific contexts as ‘social axioms’: social as they are acquired through social experiences, and axioms as these are beliefs that people endorse without checking for their validity. These social axioms are like cognitive maps of the social world and have a survival value in facilitating social interactions and problem solving. They propose that these general social beliefs complement values and help us understand cultures. Leung and Bond (2008) define social axioms as follows:

Social axioms are generalized beliefs about people, social groups, social institutions, the physical environment, or the spiritual world as well as about categories of events and phenomena in the social world. These generalized beliefs are encoded in the form of an assertion about the relationship between two entities or concepts (p. 198).
Based on their research across cultures they proposed a five-factor structure of social axioms, which included: Social Cynicism, Fate Control, Reward for Application, Social Complexity and Religiosity. They proposed that these are pan-cultural and can be used to understand individuals within a culture or across cultures.

Apart from the above frameworks in understanding individual belief systems that look at values in conjunction to attitudes and beliefs, it is important to note that the research on human values has a long history.

One of the most important contribution in the conceptualization of values came from Schwartz, who defined values as “desirable trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity” (1994, p. 21). They are hierarchically arranged and transcend specific situations and guide selection of behavior (Schwartz & Bilsky, 1987). Schwartz (1992) identified ten basic and motivationally distinct values, which he derived from the three universal needs of individuals: biological, social and survival. Through these ten values he intended to include all core values recognized across cultures and represent them in his value theory through motivational goals. He listed them as Self-Direction, Stimulation, Hedonism, Achievement, Power, Security, Conformity, Tradition, Benevolence and Universalism. Through a circular structure Schwartz arranged these values on a motivational continuum. The closer two values are on the circular structure, the closer their motivational goals, the further away two values, the more antagonistic their motivations. Schwartz proposed a two-dimensional motivational continuum of value structure: (a) conservation versus openness and (b) self-enhancement versus self-transcendence.

Knafo, Roccas, and Sagiv (2011) reviewed research in cross-cultural psychology and found that in the last couple of decades there is a growing interest in
studying values to differentiate between cultures while focusing on values at the individual and nation level. They pointed out that at the individual level values determine how people perceive and interpret the world and also guide their actions and choices; at the nation level values determine how institutions function and develop and how they respond to challenges.

At the national level, values are goals and objectives that members of a society consider desirable and worthy for pursuit. Hofstede (1984, as cited in Gouveia & Ros, 2000) proposed a model of understanding values at the national level. He focused on national-level patterns of values, and categorized societies by placing them on five statistically independent values dimensions: power distance (acceptance of inequality), uncertainty avoidance, individualism/collectivism, masculinity/femininity, and long- versus short-term time orientations.

Schwartz (1990, 1994) went on to critique this model; particularly the differentiation of cultures based on individualism and collectivism, and evolved an alternative theory of the structure of cultural values. He emphasized the multidimensionality of cultures and believed that certain values could serve individual and collectivist goals. He identified seven basic cultural values to understand cultures: conservation, hierarchy, intellectual autonomy, affective autonomy, competency, harmony, and egalitarian compromise. These seven cultural value types are structured in two bipolar dimensions of superior order, Autonomy versus Conservation and Hierarchy and Competency versus Egalitarian compromise and Harmony.

The above overview of theoretical frameworks on beliefs and values, provided the basis for conceptualizing the therapist Weltanschauung for the present study as comprising beliefs and values that developed and strengthened through personal and professional experiences and cultural influences. Beutler et al. (2004) in their review
on therapist factors over a decade ago, particularly flagged therapist values and religious beliefs as potential areas of study. The following sections attempt to document and review research that has been conducted on therapist values and beliefs.

**Therapist Beliefs on Psychotherapy**

Rønnestad and Skovholt (2003) in their path-breaking work on professional development highlighted that therapist beliefs go through a process of change and refinement to be more adaptable to the complexities of the therapeutic situation. Rønnestad and Skovholt (2003) illustrated how the experienced therapists’ beliefs drastically differ from those of the novice therapist. They elucidated that a central developmental task for the experienced therapist is to achieve congruence between their professional role and their individual self-perception (such as values, interests, attitudes). This allows the therapist to authentically and competently deliver services. Rønnestad and Skovholt (2003) highlighted that an attitude of openness to new learning was essential to experience professional competence and facilitate professional development. Hence, successful professional development is experienced with a continuous increase in the sense of competence and mastery. A lack of the same may be conceptualized as recurring feelings of self-doubt, dejection and hardship and is seen particularly in the early stages of professional development.

Thériault and Gazzola (2010) studied feelings of incompetence in ten novice therapists through semi-structured interviews in Canada. They explored the participants’ beliefs in their abilities, judgment, and effectiveness and found the reported experiences indicated perceptions that their efforts are inconsequential, self-perceived incompetence, low perceived mastery, professional self-doubts, sense of failure, self-perceived failure, doubts about their own therapeutic effectiveness, acute
performance anxiety and fear, and self-criticism about performance. The level of depth of feelings of incompetence varied from procedural and technical uncertainty, being bound to micro outcomes, professional uncertainty, to doubts about self and identity. Based on the findings they asserted the need for supervision and self-knowledge among therapists.

Hill, Sullivan, Knox, and Schossler (2007) qualitatively analyzed journals kept by five novice trainees pursuing doctoral training. The trainees tracked the challenges related to becoming psychotherapists, gains related to becoming psychotherapists and experiences other than supervision that fostered awareness. Feelings about self in the role of a psychotherapist, awareness of reactions to clients, learning and using helping skills, reactions to supervision and experiences that fostered growth emerged as important themes. The challenges related to being a therapist involved learning helping skills, being self-critical, having reactions to clients that were troubling, while the gains over the semester were identified as learning helping skills, managing clients and being less self-critical. As mentioned earlier, research suggests that the therapists’ beliefs of self-doubt, insecurity, incompetence and uncertainty about their effectiveness can impact the therapeutic alliance and the therapeutic process particularly in novice counselors (Rønnestad & Skovholt, 2003).

Misch (2000) in his paper on ‘mistaken beliefs’ of novice psychodynamic psychotherapists discussed six essential mistaken beliefs of novice therapists that have direct impact on psychotherapy practice —“I should completely see and understand everything, and I should do so immediately without having to struggle”, “I should always say and do just the right thing, and it will produce a magic cure”, “If I don’t say or do just the right thing, it will destroy or irreparably harm my patient”, “If my patient doesn’t get better quickly, I must not be doing a good job”, “My patient’s
failure to improve is a personal failure on my part”, “Neither I nor my patient should ever have ‘bad’ or ‘inappropriate’ feelings (e.g., anger, envy, sexual attraction) toward one another; and if either of us does have such feelings, it is an indication that therapy is going badly and that there must be something wrong with one or both of us” and, “Everyone else, including not only my supervisors but my peers, is doing better than I am”. According to Misch (2000) the aforementioned six mistaken beliefs of psychotherapists eventually could lead to counterproductive practice and potentially impede skill development and acquisition of an ‘appropriate identity’ as a therapist.

The core beliefs of the therapist that underlie the therapist’s faith in the treatment and the entire process of change can be very crucial in determining therapeutic outcome. Overholser, Braden, and Fisher (2010) identified certain beliefs of therapists such as the belief that people can change, that change is gradual and typically requires developing new actions and new attitudes, understanding precedes change, labels are not helpful and so on, that impact psychotherapy practice.

In a recent research, Sandell et al. (2007), attempting to link therapists’ beliefs with therapeutic outcome, studied therapist values, beliefs and attitudes in therapeutic matters by administering the Therapeutic Identity (ThId) Questionnaire to therapists. The ThId Questionnaire assesses beliefs of the therapists on the curative value of a number of elements of psychotherapy, manner of conducting psychotherapy and the basic assumptions about the nature of psychotherapy and the human mind. They concluded that the influence of the therapists’ therapeutic attitudes and beliefs on therapeutic outcome increases as the treatment progresses and takes effect. They found that clients whose therapists valued kindness as a curative factor, neutrality as a
therapeutic style and regarded psychotherapy as a form of artistry showed positive long-term effects of psychotherapy.

While there has been some research on novice therapists’ beliefs of competence and effectiveness, the only research that attempted to assess therapist beliefs about psychotherapy was conducted by Sandell et al. (2007). As the review reveals, the landscape of therapist beliefs about their therapist self and more so about psychotherapy has been left largely unexplored, lending support to the need for an initial exploratory research in this area.

**Therapist Religious and Spiritual Beliefs**

Apart from therapist beliefs about themselves and psychotherapy, therapist religious and spiritual beliefs can play a crucial role in determining therapeutic practice. Demographic findings of the world’s population show that more that 80 percent of the people across the globe are affiliated to some form of religion (Pew Research Center’s Forum on Religion & Public Life, 2012). Religious and spiritual beliefs contribute significantly to aspects of cultural identity, as well as individual world-view and perspectives (Bilgrave & Deluty, 1998). Thus, the religious and spiritual beliefs of the therapist become significant to consider in the therapy process.

**Defining and distinguishing between religion and spirituality.** As a prelude to the discussion on therapist religious/spiritual beliefs, this section deliberates on the distinctions and overlaps in defining religion and spirituality.

E. L. Worthington and Aten (2009) in an attempt to distinguish between religion and spirituality, mention religion as adherence to beliefs and practices agreed upon and practiced by a community, and refer to spirituality as a sacred closeness and connection with the divine. In a similar vein, Weiner (2002), mentioned, “When I speak of religion I am referring to the external form, structure and practices of a group
of people that help them find meaning in living. I use spirituality to mean the transcendent essence of the religion” (p. 151). E. L. Worthington and Aten (2009) go on to elaborate spirituality as being of four kinds—

- Religious Spirituality: Understood as the sense of connection and closeness to the sacred based on a particular religion, usually involving an entity, a particular god/goddess or higher power.

- Humanistic Spirituality: Understood as the sense of connection to humankind of being related to, or being close to a general group of people involving love, altruism or reflection.

- Nature Spirituality: Understood as the sense of connection to nature or the environment.

- Cosmos Spirituality: Understood as the sense of connection with creation often involving feelings of awe and magnificence.

However, many researchers like Post and Wade (2009) use the term religious and spiritual synonymously, due to difficulties in differentiating between the terms because of the overlapping meanings. J. E. Barnett and Johnson (2011) also do not specifically make distinctions between the terms religion and spirituality in their paper on integrating spirituality and religion into psychotherapy.

The discussion below presents research on the role of religion and spirituality in psychotherapy.

**Religion and spirituality in psychotherapy.** For many clients who come for therapy, aspects of their religious and spiritual beliefs form a significant part of their understanding of the world, themselves, and others. There is considerable research done in the area exploring and understanding the religious and spiritual beliefs of clients in therapy so that the effectiveness of psychotherapy may be improved.
Post and Wade (2009) in their review on religion and spirituality in psychotherapy cited several studies that examined clients’ religious and spiritual beliefs and values and based on their review underscored the fact that religious/spiritual clients do bring in religious/spiritual concerns in therapy, and there may be some clients who seek religious/spiritual interventions. They proposed that therapists would therefore need to routinely assess for religious/spiritual concerns, particularly in the light of the findings that support the effectiveness of religious/spiritual interventions.

In a qualitative study with twelve adult clients, Knox, Catlin, Casper, and Schlosser (2005) explored the role of religion and spirituality in their lives and in therapy along with their specific experiences of discussing religious-spiritual topics with nonreligiously affiliated therapists. They found that the clients engaged regularly in religious-spiritual activities, introduced discussions of religion-spirituality that were often related to their presenting concerns, and this was facilitated by the openness of the therapist, leading to positive effects. When judged negatively for their religious and spiritual beliefs, clients felt judged and it had negative effects on therapy.

Several other researches have also indicated that clients are bringing religion and spirituality into therapy and positive elements of a client’s faith could be useful for encouragement, inspiration and support during therapy. Research has also indicated that clients when committed to their religious or spiritual beliefs are drawn towards practitioners who include religious or spiritual aspects in their psychotherapy practice or share a similar faith (Erickson, Hecker, Kirkpatrick, Killmer, & James, 2002; Ripley, Worthington, & Berry, 2001).
Considering that religion and spirituality are important to clients, certain forms of psychotherapy have integrated religious and spiritual understandings to cater to client needs. E. L. Worthington, Hook, Davis, and McDaniel (2011) conducted a meta-analytic study to assess the effectiveness of religious and spiritual accommodation in psychotherapy. Findings revealed that religious and spiritually oriented therapy was effective and led to better psychological and spiritual outcomes; religious and spiritual psychotherapies offered spiritual benefits to clients that mainstream or secular therapies failed to; the integration of religious and spiritual aspects into psychotherapy should follow the desires and needs of the clients, and the authors encouraged therapists to discuss religious and spiritual beliefs with their clients. They further recommended that integration of religion and spirituality would be highly effective for those clients who identified themselves as being highly religious or spiritual.

To examine client experiences in psychotherapy with religious interventions, Martinez, Smith, and Barlow (2007), assessed the appropriateness and helpfulness of religious interventions amongst 152 religious clients. The clients reported that referencing of scriptural passages, teaching spiritual concepts, encouraging forgiveness, involving religious community resources, and conducting assessments of client spirituality were both helpful and appropriate in therapy.

Plante (2009) reviewed religious and spiritual tools such as meditation, learning through spiritual models, experiencing connection with the higher being that therapists could use to improve the psychological and spiritual health of clients in a sensitive and ethical way. Similarly Meichenbaum (2008) reported the use of confession, disputing, forgiving, giving, guiding, praying, referring, relating to, ritualizing, supporting and teaching in psychotherapy practice. Weiner (2002), using a
feminist therapy framework in her practice with women clients detailed integrative interventions that focused on exploring the meaning of life and death and what the religious and spiritual training taught them about personal responsibility. Moving from there she helped her clients to access relevant metaphorical example and spiritual activities to arrive at a world-view that was meaningful to them and that led them away from the negative impact of having been victimized. Frame (2001) recommended the use of spiritual genograms in the context of family therapy. The spiritual genogram, according to Frame (2001), was developed through the clinical experience of practitioners specifically to identify religious and spiritual issues, providing the practitioners with a mechanism to address an area of family life that was rarely ever approached in therapy.

To explore therapists’ practices in assessing clients’ religious and spiritual beliefs, Hathaway, Scott, and Garver (2004) conducted a survey of 1,000 APA members. The findings from their survey showed that 12 percent to 18 percent of the respondents never asked their clients about their religious and spiritual beliefs, experiences or practices. Frazier and Hansen (2009) also found among the 96 surveyed psychologists 90 percent of the respondents engaged in religious and spiritual psychotherapy behaviors less frequently than recommended.

According to Post and Wade (2009), “The practical question for clinicians is no longer whether to address the sacred in psychotherapy with religious and spiritual clients, but rather, the questions are when and how to address the sacred” (p.131).

In studies conducted in the US, mental health professionals have been found to be often less religious than the rest of the population. In a survey study conducted on 957 psychotherapists in the United States, Smith and Orlinsky (2004) found that therapists, though less religious in a traditional way, were, however, still quite
spiritual. Thus, while practitioners seemed to be low in traditional religion, nearly 78 percent of them were spiritual and/or religious.

E. L. Worthington and Aten (2009) mentioned that therapists end up believing that most people endorse a non-religious spirituality, as they most often only interact with similar professionals and practitioners across the globe, “They become convinced that non-religious spirituality is the worldwide norm” (E. L. Worthington & Aten, 2009, p.124), leading them to not emphasize it sufficiently in their work with clients. In another study on 341 Registered Clinical Counsellors in British Columbia, Plumb (2011) found that spirituality, more than religion, emerged as important for therapists, and fewer than half indicated that they were integrating spirituality into their practice. Although the discussion on religion and spirituality may be identified as beneficial for clients, practitioners often experience anxiety-provoking questions about the professional and ethical appropriateness of addressing religious beliefs and practices of their religious clients. Further, the uncertainty of clinicians could well be related to limited training and supervision, regarding the place of religion-spirituality in therapy, leaving them with little direction and guidance on how to bring this into their therapeutic work (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990).

According to J. E. Barnett and Johnson (2011), training programs often fail to help engage trainee therapists with issues related to religion and spirituality. They proposed a decision-making model in order to equip therapists with an ethical decision making process that may be used in times of dilemmas resulting from the topics of religion and spirituality.

Post and Wade (2009) further argued that therapists are quite unlikely to receive any form of encouragement to explore and evaluate their own religious and spiritual beliefs while in training, and therapists are likely to make poorer judgments
regarding religious beliefs of their clients for which they are unfamiliar with. Post and Wade (2009) mentioned that it was critical that therapists deliberated about their own stance on religion and spirituality and identified any attitudes and biases that may interfere with therapeutic work. Frame (2001) advocated and encouraged the use of spiritual genograms in the course of training and supervision, so that trainees and supervisees can become aware of the ways in which their religious and spiritual heritage impacts their therapeutic practice and work with their clients.

Therapists’ religious and spiritual beliefs and their impact on therapeutic practice. While research might indicate that therapists may be reluctant to bring up religion and spirituality with clients as may be required, there are findings that indicate that therapists’ personal religious/spiritual attitudes and beliefs have an effect on their therapy practice (Bilgrave & Deluty, 1998; Shafranske & Gorsuch; 1984; Shafranske & Malony, 1990).

Bilgrave and Deluty (1998) in their survey of 237 clinical and counseling psychologists in the US, found that 72 percent of the therapists reported their religious and spiritual beliefs played a significant role in their therapeutic practice. In exploring the link between religious beliefs and therapy practice, they found that psychologists who endorsed Christian beliefs tended to practice with a cognitive-behavioral orientation, and those who adhered to the Eastern beliefs were using more humanistic-existential models.

In a recent survey study on 895 German therapists, Hofmann and Walach (2011) found that more than half the participants reported being either religious or spiritual and considered religion or spirituality as relevant to their psychotherapy practice. Whereas CBT and psychodynamically oriented therapists were found to place less emphasis on spiritual issues, those following an integrative or humanistic
orientation were more inclined towards emphasizing them. Hofmann and Walach (2011) mentioned that their findings brought to the forefront the issue of questioning the secular stance of the discipline of psychology and engaging in more empirical research in the field of religion and spirituality in psychotherapy.

Novis-Deutsch (2015) asked 15 religious Israeli Jewish Orthodox psychodynamic psychologists and psychoanalysts to share how they perceived the interaction of their religious and professional identity, as both their religion and profession presented with their own set of values and world-views. The in-depth interviews with the participants revealed that the strategies they were utilizing could be organized as integrative, that included experiences of harmony, attempts at bridging, and adaptations, and non-integrative, that comprised of compartmentalization and experience of conflict. The authors pointed out that a majority of the participants recognized the conflict and acknowledged and preserved the authenticity of the complex plurality in their identity.

Apart from the study of therapist religious and spiritual beliefs in the context of theoretical orientation, research interest has also directed attention on the link between religion and spirituality of therapists and their therapy practice. In keeping with the trend towards studying religion and spirituality, in 1999, Prest, Russel, and D’Souza surveyed fifty-two graduate students pursuing marriage and family therapy in the US, regarding their spiritual and religious attitudes and practices and their impact on their personal and professional lives. All respondents reported being spiritual and identified spirituality as an influencing force guiding their decision to pursue marriage and family therapy as a career, a majority identified their work as a ‘spiritual path’, and about two-third of the participants reported that psychosocial problems had a spiritual aspect.
In a recent study, Elwafi (2011) investigated how religious beliefs and practices of music therapists impacted their professional practice. The narratives of four music therapists, practicing Christianity, Islam, and Judaism, in the United States were presented and the researcher drew links between participants’ religious beliefs and their clinical practice. The participant stories revealed that therapeutic work was seen as an extension of spirituality and religion and these were seen to influence music. Therapists also reported that using religious and spiritual practices helped them feel whole and connected that further helped their clinical work.

Using a grounded theory methodology, Blair (2015) studied nine counseling psychologists in the UK to explore ways in which their spirituality influenced their practice. All participant therapists mentioned that their practice of spirituality enriched their therapeutic work, such as meditation and prayer being helpful to personal well-being, spirituality providing an integrating function and facilitating self-care. Irrespective of the theoretical orientation, all participants found some consonance between their therapeutic orientation and their spirituality, despite the lack of training and dialogue in the profession about the same.

Research in this area reveals that therapists’ religious/spiritual beliefs have the potential to impact psychotherapy practice, however, barring a few studies not much has been explored in this area.

**Religion and spirituality in psychotherapy in India.** The integration of religion and spirituality and mental health has been acknowledged in Indian literature. Manickam (2013) recommended an Integrative theory of a person as depicted in Indian thought and an Integrative model of change based on specific reference to psychological concepts in Upanishads, Ayurveda, Bhagavad Gita and Yoga. Joshi, Kumari, and Jain (2008) have outlined various types of religious practices, such as
prayer, yoga and meditation, and beliefs about faith, hope, forgiveness and acceptance, which have a significant effect on psychological and physical well-being and propose their utilization in psychotherapy practice.

Singh and Modi (2011) similarly acknowledged that lessons from the Bhagavad Gita and techniques of Yoga and meditation that come from Ancient Indian thought are being incorporated in psychotherapy practice to promote spiritual well-being of people. They suggested incorporating ideas of karma, duty, acceptance, and consciousness from Hindu, Buddhist and Jain thought in psychotherapy practice. Nagpal (2009) mentioned the application of spiritual tools such as stories from mythology and anecdotes form religious texts, with Indian clients, to facilitate therapeutic work.

Verghese (2008) recommended incorporating spirituality and religious practices in psychiatry treatment as they are important to the clients. He suggested propagating the bio-psycho-socio-spiritual model, respecting and supporting patients’ religious beliefs, partnering with the religious workers, and including religious concepts in psychotherapy, e.g., some Christian, Gita, Buddhist and Quran passages to help the client cope with life situations. Sharma, Charak, and Sharma (2009) highlighted how psychology training rarely has any component on spiritual/transpersonal issues and practices and recommended that psychotherapy training and research included these.

While the intimate relation between spirituality and mental health, and the role of spirituality in promoting mental health and alleviating mental illness is highlighted in Indian literature, the focus of most research has been on using these ideas in treatment for client benefit. Therapist religious and spiritual beliefs and how they juxtapose with therapy process and practice have not received due attention in India,
thereby generating the rationale for the focus on the same in this research.

Considering the diversity in religious faiths in India, a study tapping aspects of religious and spiritual world-views would provide rich data and bring in diverse voices, thereby creating culture specific knowledge on how therapist religion and spirituality might be linked to psychotherapy.

**Therapist Values**

This section discusses the role of therapist values on psychotherapeutic practice, as well as on professional choice and professional development.

**Values in psychotherapy.** Emerging from the psychoanalytic framework and psychology’s attempt to be a natural science, the notion that psychotherapy is a value-neutral process was accepted till about the 1960s, until the debate around value-convergence and value-conversion of clients made a beginning. As early as 1963, Vaughan pointed out that psychotherapists have their own personal value systems that include religious and moral values that influence directly or indirectly the therapeutic process. Beginning with the work of Rosenthal (1955), research indicated that the clients whose values converged with the therapists’ values showed improvement in therapy and those whose values diverged from those of their therapists did not. Rosenthal (1955) found that not only did clients report considerable value change post-therapy, they also showed moderate similarity in values with their therapists, which was a predictor of positive outcome. Therapists also rated greater improvement for clients who were similar to them in values. Findings across research studies that supported client and therapist value convergence led to serious considerations in the therapeutic circles around the ethical issues concerned with value change in clients. Tjeltveit (1986) mentioned that this aspect of client and therapist value similarity, referred to as value convergence, was actually value conversion as it was the client
whose values were changing through the process in therapy. Citing the negatives, Burnard (1999) cautioned that a similarity in values between therapist and client might lead to a “cozy collusion” where the client might reaffirm his or her world-view with the similar value system in the therapist. Further, research conducted on how values were related to therapy outcome presented a picture that matching client and therapist values in psychotherapy, though not feasible, had the potential to impact outcome (Tjeltveit, 2003).

Over the years, both research and theory supported the idea that therapy is a value-laden enterprise and questioned the stance of value neutrality. It led to acknowledgement in the profession that psychotherapy is an interaction between the value systems of the client and the therapist (Tseng & Streltzer, 2004) and there are various ways in which values enter into the psychotherapy process. The values held by the therapist or counselor impacted the assessment and therapy process, as well as determined goals and conceptualization of change (Tjeltveit, 2003).

Professional codes may often caution against bringing values into therapy.

ACA Code of Ethics (2014) in the preamble mentions:

Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor’s values are inconsistent with the client’s goals or are discriminatory in nature. (p.5)

However, it is recognized that psychotherapy, as a profession is value based, and requires practice from a value framework, in terms of adherence to a specified set of values (Slife, Smith, & Burchfield, 2003). The process of therapy is itself based on values and the professional codes of ethics laid out by professional bodies in the field.
implicitly or explicitly include values such as autonomy, respect, beneficence and so on (Jackson, Hansen, & Cook-Ly, 2014).

**Therapist personal and professional values.** The upsurge in research to document and profile therapist or counselor values came soon after the recognition and agreement that values played an important role in the therapy process. This exploration began with assessment of what were called ‘mental health’ values that were considered relevant to the therapy process (Cho, 2007).

Jensen and Bergin (1988) conducted a study on 425 clinical psychologists, marriage and family therapists, social workers, and psychiatrists, through a national survey to assess mental health values. They distinguished the ten mental health value themes obtained into a combination of traditional values (forgiveness, satisfaction with work, commitment to relationships and family) and professional values (communication, being a free agent, having a sense of identity and feelings of worth, being skilled in interpersonal sensitivity, and nurturance, being genuine and honest, being, having meaning and purpose, adaptive coping, self-awareness). They found that there was considerable consistency amongst the participants in the values endorsed.

Another study, by Kelly (1995), assessed universal values, mental health values, individualistic-collectivistic values, and religious/spiritual values in a national sample of 497 mental health counselors representative of the 1993 American Counseling Association membership. On the Shwartz’s Universal Values questionnaire, counselors highly valued benevolence, self-direction, universalism, and achievement. Among mental health values were human relatedness, compassion, forgiveness, and autonomy and of the sample, 90 percent affirmed the influence of spiritual values. The findings obtained also revealed a general consensus amongst the
counselors in the values that they saw as important. Kelly surmised that the value profile obtained reflected a strong core valuing of holistic-humanistic empowerment for personal development and interpersonal concern. He suggested that the value profile lent itself to the therapeutic relationship in counseling and further ensured respect for client values and goals and recommended that it was not just about not imposing values on clients but ensuring that values were clarified and applied appropriately in psychotherapy.

Further attempts at documentation of value profiles of those in the helping profession have shown similar results. When Pirzadeh, Veach, Bartels, Kao, and LeRoy (2007) assessed values of genetic counselors using the Schwartz Universal Values Questionnaire they found that the counselors endorsed benevolence, self-direction, achievement, and universalism indicating a strong pattern of concern for the welfare of others. Benevolence values were also found as the most strongly endorsed motivation for volunteer work by Omoto and Snyder (1995).

In an attempt to obtain personal value profiles of experienced therapists using the Portrait Value Questionnaire and in-depth interviews with eight experienced therapists and counselors in India, Rangarajan (2013) found that benevolence, honesty, self-direction and universalism were important values for therapists. Sources of these values were in intimate relationships, parents, siblings, client interactions, psychology training, religion and spirituality.

Empirical findings across studies suggest that mental health professionals and those in the helping profession tend to have somewhat similar value profiles. Across theoretical orientations too, practitioners tend to endorse common values, which may be reflective of a shared professional culture (Consoli, Kim, & Meyer, 2008; Kelly, 1995).
Considering that across studies values have been assessed using a variety of tools, and the value definitions have varied (Cho, 2007), clarity on what would be included within mental health values has been understood to be difficult to attain (Kelly, 1995). Slife et al. (2003) also shared that values are linked to one another, are an integral part of the therapist world-view, constitute identity and are critical in determining behavior and goals, therefore therapy would need an open dialogue on values. Rangarajan (2013) noted that experienced therapists discussed the integration of the personal and professional values, and how they were influential both in their therapeutic practice and their personal interactions.

To address the lack of focus in research on assessment of how the values that therapists hold translate into practice, Cho (2007) conducted a qualitative research on mental health values and their expression in therapy process. The analysis of twelve therapy sessions between a White American male therapist and a Korean female client revealed a set of eleven values communicated. Cho (2007) organized these as values related to the client's or the counselor's self, values related to the therapy, and other values that did not belong in the first two groups. There were communicated by the therapist through a range of methods such as, stating them upfront, using self-disclosure, providing positive feedback and so on.

**Managing therapist values in therapy.** Efforts to reduce the impact of therapist values on clients and the therapy process, or limit the influence to only therapy related values, led to identifying mechanisms to manage values in therapy (Bonow & Follette, 2009). To ensure ethical and safe therapeutic practice, there have been many documented strategies for practitioners for value negotiations in the therapy process (Carlson & Erickson, 1999; Jensen & Bergin, 1988; Odell & Stewart, 1993).
Keeping in mind client benefit, recommendations were made to separate the personal or idiosyncratic values from the professional, to prevent them from impacting the client (Strupp, 1980). Williams and Levitt (2007) labeled this technique as value atomization. However, this was seen as difficult as personal and professional values could integrate in complex ways (Slife et al., 2003).

Value conflicts were acknowledged as a common challenge for therapists, in that the practitioner, at times, might not be able to avoid communicating his/ her values to the client. Patterson (1989) discouraged therapists and counselors from imposing their value system or philosophy on their clients. What was suggested was that values be communicated through acceptable forms such as establishing an ultimate goal and through the methods used in therapy (Strupp, 1980).

However, Fife and Whiting (2007), in discussing values in marriage and family therapy opined that avoiding values or discussion on values would not be the only way to respect client values, and a respectful open discussion of values may sometime be necessary.

On a similar note, Jackson et al. (2014) discussed methods of managing values in therapy such as maintaining neutrality, value atomization, or making outside referrals, and concluded that beyond these methods there was a need to create a new system to facilitate managing values that was based on awareness and articulation of values. They recommended that therapists would need to at the outset be trained to articulate personal and professional values and how they are linked. Farnsworth and Callahan (2013) also asserted that developing a larger understanding and awareness into personal and professional values while also understanding their impact on therapy practice could help practitioners manage values conflicts with clients in therapy. Further, therapists’ awareness of values, if highlighted in training therapists,
could create awareness of how individual cultural backgrounds and values interact and influence the process of therapy (Patterson, 1989; Tseng & Streltzer, 2004).

While theoretical and empirical efforts have documented therapist value profiles there has been limited research on understanding how therapists’ values influence practice. What is conspicuous by its absence is research on therapist perspectives on how their values enter the therapy space. It is increasingly being recommended that values cannot be kept out of therapy and there is a need for pathways to facilitate value articulation and discussion on how values and therapy practice are linked.

**Locating the Study in the Multicultural Perspective**

With the broad aim of studying therapist values and beliefs the present study was located in the multicultural paradigm. Laungani (2005) elucidates that multiculturalism is based on the understanding that human beings are products of the culture in which they live and each culture provides the individual with a world-view that helps the person make meaning of their lives. He describes multiculturalism as an umbrella term that includes discussions of culture, diversity, beliefs, values, attitudes and meanings.

The multicultural movement in psychotherapy and counseling began about 50 years ago with the concept of a ‘culturally encapsulated counselor’ as someone who exhibits tunnel vision and is unable to appreciate the cultural variations in clients (Wrenn, 1985). The movement gained momentum in the US after research showed that clients from disadvantaged backgrounds received poor mental health services (Patterson, 1996). Although the movement initially focused on the underprivileged groups and on immigrants who were struggling to fit into the host culture in the West, currently all counseling is considered to be multicultural. However, it is sometimes
questioned, if therapy is truly multicultural, as it often may preference the culture of
the privileged groups, to which the therapists belong. Pedersen (2001) proposed
multiculturalism as the ‘fourth force’ in psychology, so counseling and therapy can be
truly effective.

**Therapist World-view and Culture**

While an understanding of the sociopolitical and cultural context of the client
is critical to effective psychotherapy practice, this understanding needs to begin with
the therapists’ awareness of their own cultural values, biases, attitudes, that may
hinder or facilitate psychotherapy process. The frameworks that have been outlined to
set standards in multicultural counseling and therapy include dimensions of
competency that focus on beliefs and attitudes, knowledge, and skill of the
psychotherapist. Considering India is a culturally diverse nation, with therapist and
client from different communities, religion and regions interacting in the therapeutic
space, the role of cultural and diversity cannot be overemphasized.

Corey, Corey and Callanan (2007) point out that “Clients and counselors bring
a great variety of attitudes, values, culturally learned assumptions, and behaviors to
the therapeutic relationship” (pg. 112) and understanding the complex role of
diversity in therapeutic practice is a challenge for therapists. Thus a culture-centered
approach that factors in the client and the therapists beliefs and values is needed. In a
similar vein, Matsumoto and Juang (2003, p. 367) point out:

> There can be no value-free psychotherapy, because all psychotherapy is bound
to a particular cultural framework, and cultures are inextricably tied to moral
values and systems. It is useful to take a step back and examine how our
approaches to treatment are bound to our cultural norms, values, and beliefs.
They suggest that health care providers be aware of and deal with their attributions and beliefs about the etiology of illness and their attitudes about health, illness and treatment that are influenced by their cultural matrix. The socio cultural forces that exist in a culture impact the illness expression, treatment and the psychological reality of the person. Further, our cultural health beliefs and practices impact our individual beliefs about health and illness and therefore determine the way in which physical and mental health is understood (Gardiner & Kosmitzki, 2002).

In a powerful account of her multiculturally diverse identity Comas-Díaz (2005) documents how her personal identity and sense of self as a psychotherapist was shaped by her sociocultural context.

I have not separated my personal identity from that of a multicultural psychotherapist. Culture, ethnicity, gender, race, among many other diversity variables, have infused plurality into my development… I was given the blessings and the terrors of multiplicity. Accepting my ancestors’ traditions helped me to view psychotherapy both as a profession and as a calling. Thus, I embraced multiple ways of knowing, including scientific as well as intuitive approaches. (p. 980)

In a study of mental health practitioners Delsignore et al. (2010) found that informal (i.e., personal) experiences were seen as critical incidents more often than formal (i.e., professional) experiences as influencing the professional perspectives on multicultural diversity. The authors used these findings to lend credence to the theoretical supposition presented within a Person(al)-as-Profession(al) transtheoretical framework (P-A-P). Middleton, Erguner-Tekinalp, Williams, Stadler, and Dow (2011) furthered research with mental health practitioners based on the transtheoretical framework identified as the Person(al)-As-Profession(al) or P-A-P. The
model described four dimensions – personal aspects, racial identity development, multicultural competence, and Interpersonal Schemas – that together contributed to an understanding of the person as a mental health professional. Using structural equation modelling to analyse multiple variables they found support for personal variables, such as gender and racial identity on multicultural competence. They emphasized the need for mental health practitioners to be aware of how the development of their racial identity (personal) has the potential to affect the counseling dyad (professional). During training, the mental health practitioners culturally influenced development experiences need to be considered if multiculturalism is to be achieved and maintained.

Liu (2011) mentions that there are no ‘pristine world-views’ and counselors and therapists need to be aware of their own lens of viewing the world and the distortions and biases that they have. Roysircar (2004) highlights the recommended motto for trainees “Therapist, know thy cultural self” (p. 658), to ensure they become aware of their own cultural experiences and how they influence them and also value differences in others. When therapists are aware of their attitudes and beliefs, they “can identify the specific cultural group(s) from which [they] derive fundamental cultural heritage and the significant beliefs and attitudes held by those cultures that are assimilated into [their] own attitudes and beliefs” (Arredondo et al., 1996, p. 51)

Hardy and Laszloffy (1995) recommend the use of cultural genograms with trainees to promote awareness and sensitivity of how culture impacts their role as therapists and influences the lives of clients in treatment. Through illustrating in the genograms trainees could clarify the influence of culture on the family system and throw light on how their cultural identity gets formed. This could then be a context to become aware and challenge culturally based assumptions and stereotypes and also
understand how cultural experiences may impact their therapeutic style and effectiveness.

Multiculturalism and India

Though the term multiculturalism has become popular in the West in the last couple of decades, the concept is not alien to India (Ali, 2000). Indian society is extremely diverse in religion, community, socio economic status, geographic regions and languages spoken, all of which make psychotherapeutic practice in India unique. The psychotherapist has to be aware of the cultural plurality in India and not misperceive clients as belonging to a homogenous nation with uniform cultural contexts. That apart, therapists and counselors in India belong to different religions, communities, geographic locations and speak different languages. With such diverse experiences and cultural background, therapists too come with their own world-views and perspectives.

Indian culture is recognized as extremely heterogeneous. Sen (2004) asserts that India has a long history, influenced by Hindu, Buddhist, Jain, Islam, and Sikh thought, which has cultivated tolerance and celebration of diversity. He goes on to say that cultural factors have an important role in the formation of beliefs and values, and that value formation is an interactive process, which is facilitated by the culture of talking and listening. Chatterjee (1995) outlined the principal values of the Indian ethos as Tyaga (renunciation), dana (liberal giving), nishtha (dedication), satya (truth), ahimsa (non-violence) and upeksha (forbearance) and suggested that the concept of ‘Dharma’\(^1\) has helped sustain these values over thousands of years.

In a more recent article, Fusilier and Durlabhji (2001) outlined the Indian belief system and its core values. According to them, one of the core beliefs in India

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1 ‘Dharma’ is understood as duty to act in accord with our essential nature and purpose
is the belief that an individual life is part of the divine which leads to the feeling of
being one with the Universe, and the value related to this is that of interconnectedness
with others (Thou art that). The belief of Egolessness states that the goal of the
human life is enlightenment and that one is only an instrument of God. The value
attached with this is nonattachment or equanimity in meeting the desirable and the
undesirable. Human duty is to focus on action and not on result, good ‘karma’ leads to
more evolved births and finally salvation (The Law of Karma). The values attached to
this belief are nonviolence and contentment. And finally, to attain unity with the
Supreme Being one has to choose the path of Raj yoga, Bhakti yoga or Karma yoga.
The core values of yoga include tolerance and accepting family and work as destiny
and duty.

These attitudes, belief systems, values, myths, symbols, and perspectives on
various aspects of life prevalent in Indian culture impact the individual’s
understanding of the phenomenal world. The lens that the individual adopts to view
the world is heavily borrowed from the culture in which she/he is embedded.
Although there have been attempts to achieve an understanding of the core values and
beliefs that represent Indian culture, this has not been explored with Indian therapists.

**Need for the Present Study**

As is evident from the review, therapist factors are crucial to the therapeutic
process and outcome. Trends in research indicate that studying therapist beliefs and
values could provide a window to developing an understanding of how individual
therapists conceptualize and structure their therapeutic practice and work with their
clients. Considering that the Indian socio cultural context is so unique in its inherent
diversity and has a salient philosophical and religious framework of beliefs and
values, it becomes critical to understand the influence of the same on therapist worldviews and thereby on psychotherapeutic practice.

While the need for psychotherapy research in India has been expressed over the years to facilitate the development of a unique perspective on psychotherapy that is congruent with our culture, psychotherapy research in India is still in a nascent phase (Manickam, 2010). Though in the last couple of years, there has been a growing interest amongst Indian practitioners on researching therapist factors in psychotherapy process there is a need for much further research in the area.

Over the last few decades, Indian society has been undergoing tremendous transformation and change. With increasing education, awareness, career opportunities, and upward mobility there is rapid change in relationship patterns and family organization and dynamics. Community and extended family support in India is rapidly weakening because of nuclearization of Indian families. With globalization and modernization, Indian couples, families and youth are experiencing a range of personal and relational concerns that include family and relationship difficulties (sexual problems in marriage, disagreements over child-rearing and perceived under-involvement of husbands in dealing with domestic problems and issues, high pressures on youth to succeed from parents, violence, inter-generational conflicts), as well as, psychological problems (depression and suicide, anxiety and stress-related disorders, and alcohol and drug abuse, behavioral and emotional problems in children, disability concerns) (Carson & Chowdhary, 2000; Carson, Jain, & Ramirez, 2009). With the disintegration of communities, many of the age-old time proved mechanisms are being replaced by different mental health professionals who are most often trained in providing services that have been developed in the West (Mittal & Hardy, 2005).
Keeping these changes in mind, a focus on studying current psychotherapy practice in India becomes even more critical.

While western literature has tended towards quantifying and measuring therapist variables to manipulate them to check outcome effects, a more exploratory approach and qualitative methodology might be required to develop an understanding of therapist world-views. In a recent review of psychotherapy research, Orlinsky (2006) highlighted that the current dominant paradigm in psychotherapy research has been deeply influenced by ‘componentiality’. The focus on the therapist as a conglomerate of individual components that can be quantitatively measured is creating a decontextualized understanding of therapists. Keeping this in mind, an attempt was made to bring in the voices of the therapists, so as to develop a comprehensive understanding of therapist world-views and capture a contextual understanding of psychotherapy practice in India.

**Research Questions**

The researcher was keen to understand how therapist belief systems – that included their beliefs about themselves as therapists, about psychotherapy, their religious and spiritual beliefs and values – impacted and influenced their practice of psychotherapy. Thus, the broad aim of the study was to explore therapist beliefs and values and understand how they impact their therapeutic practice. The research questions were framed as follows:

- How do therapist beliefs about themselves as therapists impact/ influence their therapeutic practice?
• How do therapist beliefs about psychotherapy impact/ influence their therapeutic practice?²

• How do therapist religious and spiritual beliefs impact/ influence their therapeutic practice?

• How do therapist values impact/ influence their therapeutic practice?

The next chapter outlines the methods used to meet the objectives of the present study and documents the process of data collection and analysis. The findings of the research have been organized and presented in separate chapters, followed by a chapter showcasing the grounded theory model and culminating with the concluding comments.

² Elements considered within psychotherapy have been included in the conceptual map that will be informing the methods