CHAPTER IV

ON NEUTRALITY

Section I
Introduction

It is a prevalent idea from the early development of psychotherapy that the therapist must be neutral in attitude while she is involved in the therapeutic process. However, skeptical doubts have often been expressed regarding the possibility of remaining neutral as well as the need for maintaining neutrality. The therapist has to establish a specific kind of relationship with her client. Without establishing such relationship, she would not be able to initiate the therapy. To establish the desired communication with the client initially and then to interact with the client for unveiling her deep-seated emotional feelings, the therapist must develop a kind of trust-relationship with her client. This kind of relationship between the therapist and the client is unique in nature. It is technically known as transference. A pertinent question which arises here from the layman’s viewpoint is: how is it possible to establish and maintain such a relationship without getting involved into the situation, and if the therapist gets involved in any way then how she will remain neutral? Because perhaps neutrality means, one should keep herself detached and yet carry out her responsibilities properly. Hence, in order to be neutral also, the therapist should take a stance of neutrality. Now the question is, ‘is this a kind of contradiction?’ How far is it possible at all? An associated query from the perspective of medical ethics would
be, ‘even if it is possible to maintain a neutral stance in psychotherapy, is it at all ethical for a psychotherapist to remain so?’

In this chapter our focal point shall be ethical issues that may emerge in relation to the concept of neutrality in psychotherapy. Moral dilemmas, centering round the neutral stance of a therapist, precisely speaking, conflicts like – ‘is it always ethical for a therapist to be neutral?’, ‘what kind of harm may follow if a therapist can not maintain a neutral stance in therapy?’, etc would be focused here. We shall also examine whether it is desirable to keep neutrality from the side of the therapist in each and every therapeutic context. We can start this discussion by putting up the question – ‘what do we mean by neutrality in psychotherapy?’ The pertinent dictionary renderings of neutrality are – not allied with, not supporting or favouring either side in a dispute; belonging to neither side nor party. It can be observed that the claim of neutrality in psychotherapy implies that a neutral therapist means she will be impartial, detached or value free, non-judgmental, non-directive and objective, in therapy.

The traditional view of neutrality means, as we can observe in the text of Psychoanalysis, the analyst does not take sides in the patient’s conflicts, express feelings about the patient, or talk about his or her own life. Therapist’s neutrality is intended to help the patient, stay focused on issues related to sufferings of the patient only. There may be some other senses too. However, as decided earlier, certain significant moral dimensions of neutrality in psychotherapy only remains to be highlighted in this chapter. Consequentially, we would like to take up those related concepts of neutrality in the field of psychotherapy, which may be viewed as the proposed meaning of neutrality and scrutinize them to get a clear picture of what kind of moral dilemmas may follow in therapeutic situations. If possible, we would go for certain justified solutions to these problems which may be of help to the profession of psychotherapy in general. The clients
may also be benefited from such suggestions. Generally many of the clients rate their therapy experiences as positive. But the need to discuss about problematic therapy seems more urgent which leaves dangerous and harmful moral implications. If the client feels abused, diminished, trapped, powerless, misunderstood and alone, what would be left for medical ethics to be concerned about? This practical as well as moral aspect of client-therapist relation provokes the philosophers to open a dialogue in the domain of psychology as an exercise of applied ethics.
Section II

On Impartiality

So far as normative aspect of psychotherapy is concerned, the claim which strikes first is- ‘we ought to subsume health care under a principle of justice guaranteeing fair equality of opportunity.’¹ Norman Daniels interprets this from the perspective of distributive justice and claims that- ‘if an acceptable theory of justice includes a principle providing for fair equality of opportunity, then health care institutions should be among those governed by it.’² In the realm of psychotherapy if this principle of distributive justice, i.e. ‘providing equal opportunities’ is to be accepted then obviously the therapist should not discriminate clients’ class, race, caste, religion, gender, age etc. This implies that she should not take any side or become partial about any of her clients. This concept which we have already put-forward is the core concept of the traditional understanding of neutral psychotherapy. But what if the therapist does not remain impartial and shows favouritism? What if the therapist does not remain neutral either? Should her actions be treated as ethically correct in the above circumstances? This query can not be instantly replied, it needs a deep analysis. Before going to reflect upon the normative aspects of the query, we shall put-forward the linguistic analysis of ‘impartiality’ which may help to identify the underlying moral conflicts with respect to neutrality in psychotherapy.

According to The Little Oxford Dictionary, impartiality is defined as "not favouring one person or thing more than another"³. It means you have to treat all persons in the same way. This leaves no room for bias and discrimination. Individuals of different classes, casts, races and religions are to be treated alike. So, impartiality can be understood as an inclination to weigh both views and opinions equally. In other words being impartial is a quality which stands for freedom from bias
or favouritism. It may also be characterized as disinterestedness, equitableness and fairness. Since impartiality is freedom from bias it strips the mind of all kinds of prejudice and passion. To mention here, 'bias' means 'inclination or prejudice for or against one thing or person'. To be more specific 'biased' means 'a person who is influenced unfairly'. Again ‘to be free from prejudice’ means – ‘free from preconceived notions without reasons’. This can be taken also in the sense that it prevents the play of any kind of feeling and emotion in making moral assessment.

In contrast 'partiality' has been defined ordinarily as 'an inclination to favour a particular group or a particular opinion over alternatives'. One is partial in the sense that he is predisposed to like or support something or someone. A person is partial if she looks at things with all her bias and commitment. She overlooks a fact that a certain question can be many faced. In other words, it displays a tendency to side with a certain position which is unfair and undue. Webster’s 1913 dictionary defines partiality as, "the quality or state of being partial, inclination to favour one party or one side of question more than the other and undue bias of mind."

Here we can mention a code of Canadian Psychiatric Association. It says: "The psychiatrist maintains professional objectivity and impartiality in presenting legal evidence. The psychiatrists acknowledge and strive to overcome unjust discriminations. Psychiatrists are acutely aware of how biases regarding age, gender, race, ethnicity, religion, disability, socio-economic status, sexuality and abuse may interfere with their objectivity and impartiality in the therapeutic encounter..."

Thus 'impartiality' if we take the lexical meaning or as it has been focused in the above code, seems to include certain terms like bias, prejudice, discrimination, fairness which are frequently used in moral contexts. The significant question here is: ‘would it be ethically
detrimental if the therapist ignores these factors?’ The principle of justice or fairness (already focused in the introductory chapter) is a well-accepted principle in the realm of psychiatric ethics. Moreover discrimination, i.e. favouring one more than the other due to some bias or prejudice like age, gender, race etc. is against human rights and dignity. This triggers a lot of problematic questions which are very significant in the history of human civilization. Controversies regarding gender discrimination, racial discrimination are long debated in the domain of practical ethics. Here we are going to study two cases and see whether any serious ethical conflict would occur if the therapist does not remain neutral or impartial (considering the lexical meaning of neutrality as impartiality, meaning thereby, not favouring anybody or making no discrimination).

A) Suja, a health care worker in her 40s, had recently moved to Mumbai from Pune in order to break away from her very disturbed and enmeshed family. Anxiety and depression over such a huge physical and psychic separation led her to seek psychotherapy. She worked with an experienced female colleague, at first quite effectively. However, she gradually developed an intense negative maternal transference that culminated in a suicide attempt. After a short hospitalization, it was decided to refer her to a male therapist for outpatient treatment, and she came to see another psychotherapist. Initially, the treatment was primarily supportive, given her suicide attempt and her high levels of anxiety and depression (which were also being treated by medication). After they had worked out some of the meanings of her suicide attempt, Suja got “down to business” (her phrase). Her primary goal in therapy was to become a full person. Suja at this time of therapy started complaining recurrently about stomach pain which according to her was quite unbearable. She had spent much
of her adult years taking care of the disturbed members of her family and working. She could not make relationship with men and be able to live with and or marry someone. The therapist was well aware about this fact. He quite surprisingly quickly came to the conclusion that this pain was nothing but psychosomatic. Since she is not married and can’t conceive, it is only a kind of anxiety and insecurity feeling which triggers this kind of somatic sensation, which is not real. Suja got very upset. She became very depressed too. But one of her close associates took her to a gynecologist and fibroid in her uterus was diagnosed. Suja was lost amidst confusion and broke down completely.

In the said case the therapist was very much partial, coloured by his biased belief system. He was very much influenced by his patriarchal value system according to which a stereo-typical role of women can offer them only a secured and anxiety free life. The stereo-typical life of women implies that she should get married. Also motherhood is one of their identities of them. Here the therapist was acting out of the stereo-typical notion which makes male-female discrimination on the basis of female reproductive system. That’s why his thought process was entirely coloured by gender bias. This kind of attitude of the therapist is directly detrimental to the client’s both physical and mental health. In the case-study referred above, since the therapist did not hold his neutral, impartial attitude, as he was completely influenced by biasness or favouritism Suja had an attack of nervous breakdown. Such a situation led her to even a worse mental state of destruction. Is it not going against the principles of non-maleficence and beneficence rather than maintaining it? This kind of gender-bias actually leads the therapist to make hasty generalization. Thus by no means this can be considered as something ethical.
It envisages an interesting aspect that even when in the above case the therapist was offering the biased decision that the feeling of pain was merely a mental construction on the part of the client, the intention of the physician was to help her in overcoming the crisis situation. Unfortunately, the stereotypical upbringing of the therapist made him judgmental; he could not see beyond the existing socially constructed stereotypes. For this he could not possibly think that a woman’s identity can also be framed beyond ‘motherhood’. As a result, he failed to address categories beyond heterosexuality. It is claimed in support of neutrality that in medical profession, whether it is a case of mental health crisis or a physical health problem, the physicians should take a totally non-stereotypical and unbiased approach of solving the problem. Otherwise the physician cannot be able to address his/her client’s difficulties properly. A space, therefore, needs to be created outside the norm of reproduction when a therapist is attending to a female client. Insensitivity towards different needs and ways of life of the ‘other’ (here the other is the patient) impedes medical diagnosis and cure, as proper congruence can not be formed between the therapist and the client.

Another case may be cited in this context.

B) Due to a disturbed marital relation Suva and Rajan went for couple therapy. At that time because of their marital problems Suva was staying at her parent’s place. After 7-8 sessions, the therapist asked Suva to go back to her in laws’ place. Because as the therapist said, whatever the situation may be, it is ideal for a married woman to stay with her husband and to continue conjugal relationship. Suva went back to her in laws’ place but could not accept this suggestion and discontinued the therapy. As a result of which the relation between Suva and Rajan got even worse and Suva underwent a state of deep depression. Her self-
esteem became very low. She became quite dysfunctional and had to depend on medicines.

What can be said about this situation? Was the therapist morally right in his attitude towards Suva? In our society a female individual has to play the double role of a neutered human being and a gendered woman. As a result, in most cases she does not get the opportunity to reveal the problems of her real self (i.e., not her tainted patriarchal self). Particularly in a crisis situation relating to mental health, this may pose a hazard in understanding the real problem area of the client. In a client-therapist relationship, the therapist may enjoy power in terms of gender as well and thus there is every possibility that he may become partial in his therapeutic attitude which exactly happened in the case of Suva. The therapist often assumes that it is easier to communicate with male patients in sharing any medical information as they can be approached in an emotionally detached and rational manner and female patients being ‘lesser individuals’, can hardly qualify as rationally fit individuals to be communicated regarding difficult facts of medical science. This biased thinking and understanding on the part of the therapist affects the communication between the client and the therapist. As a result, the therapeutic decision suffers badly.

The therapist may inadvertently convey restrictive notions about women’s roles in relationships and also in therapeutic settings with women and couples, which we can notice in the attitude of Suva-Rajan’s therapist while he was treating Suva. This partial and judgmental stance of the therapist certainly upsets Suva so much that it brought her at the darkness of a dead end, i.e. an absolutely dysfunctional state of deep depression instead of the optimal state of care and cure. It is undoubtedly unexpected from therapy which is well known as a helping profession. It is unfortunate that therapy in
this instance violates the principle of non-maleficence and patient beneficence and turns out to be harmful for Suva, the troubled client. The therapist favouring Rajan in this case becomes partial which is also against the concept of distributive justice mentioned earlier. Following J.Fienberg it may be held that fairness may require that, if ‘X’ is given to some, it should be given to all\textsuperscript{10}. Thus it may be unfair if, in a distribution of proper treatment of care and cure the therapist being partial does not provide equal opportunity to all his clients. According to the view of comparative justice, whether people are unjustly treated depends on whether they are treated differently from other people or not\textsuperscript{11}. Thus it is quite unfair on the part of the therapist in the above case as he failed to treat Suva and Rajan equally due to his bias. Justice require a certain outcome, but only because it avoids a procedural flaw. One such flaw is partiality.

The voice of human rights sometimes get obstructed due to differential treatment of males and females (Stein, DelGaudio, & Ansley,1976) which is out and out immoral since it goes against human dignity\textsuperscript{12}. Women receive more prescriptions for psychotropic medications and are seen more for therapy sessions than men. Hare-Mustin suggests that the pathological labels often assigned to women by mental health practitioners actually reflect conditions of society in which females experience prolonged powerlessness and inequality\textsuperscript{13}. Hence, clinicians may perpetuate societal assumptions about women’s responsibilities in relationships by continuing to hold traditional casual views of problems in women’s lives.

Additionally, Fitzgerald and Nutt\textsuperscript{14} and the most recent revision of the APA Ethical Principles of Psychologists\textsuperscript{15} strongly emphasize the ethical responsibility of therapists for competent, informed, nondiscriminatory, and respectful treatment and research along gender lines. How gender bias may be reflected specifically through
clinician attributions in couple’s therapy is the focus of this investigation which indicates that stereotyping, diagnostic and treatment biases, sexism, and sexual abuse of women in therapy are prevalent issues (Nutt, 1992, and Nelson, 1993)\(^{16}\). Feminist critique of family therapy includes concerns regarding the structural/hierarchical placement of males in dominant roles in the family, mother-blaming, assumptions about sharing power and responsibility embedded in the systemic concepts of circularity and complementarity, and assumptions about therapist neutrality (Nutt, 1992)\(^{17}\). Recently, family therapy has also received scrutiny for its biased treatment of men, for example, by reinforcing the socialized limitations of male roles (Brooks, 1991; Deinhart & Avis, 1994)\(^ {18}\).

The importance of exploring gender bias in marital therapy per se has certainly been mentioned in some literature, e.g., Weiner & Boss, 1985\(^ {19}\), but very little empirical research on gender bias in marital therapy seems to exist. However, in their excellent review of gender-linked factors in communication that might affect marital therapy, O’Donohue and Crouch (1996) found no studies of therapists’ communication patterns. They note, "Another important question concerns the extent to which therapists are aware of their own gender-related communication expectations and patterns and the effects that these may have on clients"\(^ {20}\). Nonclinical dyads and couples in counselling have been studied, but it is striking that therapist behaviour remains largely unexamined.

From the discussion so far, we can say that, in brief ‘impartiality’ means ‘taking or favouring no side’. If we take any side, we are not free from bias and discrimination. In that case we become partial. Here, if we raise the question, why do we take any side? We may come up with the answer that because we consider something as right and something as wrong, i.e., we become evaluative. We take the side of those things we consider as right. Taking a side in this way implies
that we are not remaining impartial and in that sense neutral anymore. In case of psychotherapy, whether a therapist can afford to act in this manner is a crucial question. We have already seen that there is a strong trend which suggests that the therapist is not supposed to act in this way. She should not be partial, i.e., should not take any side, he should not become evaluative in the course of therapy as we have observed the unethical implications in the above two case studies. As a supportive reason it is pointed out that client comes to a therapist to take help and therapist as a helping professional is supposed to provide such help through the procedure of therapy; he is not supposed to critically assess his client and/or to give moral verdict either in favour or opposing him. The question of assessing arises since certain contexts can be observed where dependence on therapist from the client’s side is quite clear and evident. In Indian context there is a common man’s notion that the therapist-client relationship is like a ‘guru-chela’ relationship which is very much supported by sociologists like Neki according to whom therapist is like a ‘religious guru’ on whom the client is very much mentally dependent. The client generally expects that her therapist like a guru is always there to solve her problems and to show her the right path. If she makes any mistake, her guru is there to correct it. But such a view can really be contested. This view of ‘therapist as guru’ has to face criticism from even traditional Freudian notion. Freud opines that a therapist should not take the role of an authoritative teacher or parent. We shall reflect on this view later in the dissertation. But here the point is, the role of the therapist is something else than that of a religious guru.

Actually the purpose of therapy, which the therapist and the client both have in mind is healing or cure, in other words to do away with the suffering. For this reason the therapist has to establish a relationship (working alliance/congruence) with the client, without which the therapeutic procedure can not be initiated. Such alliance can not be established if at the very outset the therapist becomes
evaluative, and also partial. Because in that case if the therapist takes any side (when client-party is a couple) or takes any particular position (in other cases, when client party is an individual) and becomes partial thereby, he will not be able to accept all the things coming from the other end unconditionally which is essential to part of therapy (we shall discuss later) and thus is really important for providing a mental relief to the client. Here we can again quote from the 'Guidelines for Psychiatrists of Canadian Psychiatrists Association' that - "... issues of cultural/social/ethnic diversity need to be carefully considered. Psychiatrists strive to be aware of their professional beliefs and values to avoid advancing their personal agendas which are inconsistent with those of the client..."\(^{23}\)

The therapist is not supposed to accept some feelings in the client and disapprove some others. It is overt, positive and non-possessive warmth\(^{24}\) without reservation and without evaluation that is required for therapy. This is a kind of attitude that is most likely to lead trust and further self-exploration and to the correction of false statements as trust deepens. From the therapist’s side it would be possible to show this attitude if she is fully able to accept the client unconditionally as her client may be stressed or otherwise a vulnerable person, yet with enormous potentialities for growth.

While discussing the issue of impartiality' some other concepts like 'being evaluative', 'values' have been referred which need clarification in order to observe whether these kinds of concepts invoke further moral dilemmas in the field of psychotherapy. In the context of psychotherapy, perhaps the most important question related to value is – whether a therapist should involve her personal values or beliefs in the process of therapy or should she remain absolutely detached or value-free in the therapeutic context. Again, is it practically possible for a therapist to be absolutely value-neutral in therapy?
Each person has her system of values by which she is guided. Though few people workout consciously and consistently their personal value system, everyone has at least some values of which she is acutely aware and which she holds strongly. For instance – “No one has the right to kill,” “One should always try to help someone in serious need,” “It is wrong to discriminate against people on the grounds of colour, gender, age, physical or mental handicap” and so on. These kinds of values can be considered as accepted values which everyone shares. Thus a therapist, as a person, also shares such values. Here the question is, in order to be neutral in attitude whether the therapist should allow such values to enter into the therapy or should keep them aside?

Sometimes it may so happen that the patient wants to get an idea of the therapist by delivering a political, ideological, religious or antireligious speech or credo. The patient may want to see how the therapist reacts, whether s/he is on her side or not, whether s/he gets angry or is pleased or remains indifferent. S/he may just want to know more about the therapist. It can even happen that the patient is collecting signature for a good cause on which public opinion is divided (e.g., petition to the government against animal experiments). However the therapist is not supposed to come up with self-disclosures.

It is often believed that a neutral and accepting stance by the therapist is the backbone of the therapeutic endeavour. The therapist suspends judgment by attentively listening and being objective towards the client and the nature of her problem. We shall come to the discussion why at least theoretically this means that practitioners are expected to exercise professional restraint and are admonished against imposing their personal views and values. We need to enquire whether the traditional ideology regarding the value-free nature of psychotherapy that the belief-system of the therapist, existing social
norms, should not enter into the scope of therapy, is to be maintained or not.

There is a line of thought that although the therapist does not disclose to clients her religion, political opinion or any other aspects of her life or beliefs, her values do influence the kind of therapist s/he is. According to this line of thought it follows that strictly speaking, there is no such thing as being perfectly neutral, objective and unbiased psychotherapist. In this context McMahon’s reflection is – “Even when a psychotherapist’s therapeutic approach does not include assessment in a formal sense it would be difficult to avoid some form of subjective evaluation or internal assessment of the client and her needs. The evaluation of situations and people is a process learned from an early age as a necessary survival technique. Training may reduce the negative effects of such judgments, but whether it is ever possible to be totally judgment-free and ‘with’ the client in a completely accepting spiritual meld is more debatable.” We all are influenced by the attitudes and values in the midst of which we live and grow up. As one's value system operates mostly on an unconscious level, a psychotherapist must make a deliberate effort to become fully aware of it.

Perhaps none of us is able to avoid being guided by ideals and by value judgements, implicit or explicit, about ourselves and others. Both the client and the therapist are guided all the time by value judgements, indeed by moral judgements about each other. Problem arises when the therapist does not know that this is the situation. Can the therapist afford to have unmonitored unconscious aims of her own during the process of therapy? It is her responsibility to become fully aware about the personal, theoretical and ideological biases that might influence her professional functioning. It is up to her to protect the therapeutic situation and her relationship with the client from undue interferences including her own particular biases. We may
notice that in the traditional or classical view (originally proposed for psychoanalysis, but also applied to analytically oriented psychotherapy), the therapist was thought to be capable to stay clear of the interaction with the client acting as a 'blank screen' and being the individual onto whom the client transfers her feelings and thoughts. In this process the therapist is relatively anonymous in personal terms and subordinates her needs and personality to the requirements of the role so as not to contaminate the interpersonal field. The 'blank screen stance' is thought to be enhanced by the therapist's 'value free' neutrality.

A useful modern concept of value free neutrality posits a therapist who brackets out judgement and criticism from the therapeutic procedure. She uses the therapy sessions to listen to and understand the client and to make interventions based on this listening and understanding. The intervention always focuses on the client, her problems and her life. In this way, the therapeutic process is enhanced when the therapist both experiences and communicates to the client a deep caring for her as a person; her caring is total rather than conditional. This caring, according to Carl Rogers is to be, “…uncontaminated by judgements or evaluations of the thoughts feelings or behaviours.”

In contemporary times the positivist position (where the therapist is thought to stand outside the interaction in search of the objective truth) has been challenged by newer perspectives. These include relational models, self-psychology, inter-subjectivity, social constructivism and post-modern thinking. It is observed that many therapists of the classical school have changed some of their views in accordance with these newer perspectives. With these changing perspectives, the concept of authority of the therapist and value free neutrality has been questioned. Contemporary thinkers often view
value-free neutrality as a theoretical ideal impossible to attain in actuality.

T. Byram Karasu in his "Ethical issues in Psychotherapy Practice" mentions that therapists embody particular social standards, value orientations or personal preferences unconsciously, if not consciously. Therapists and other helping professionals, according to him, are 'secular moral agents' who implicitly represent certain good values like beneficence, fidelity and responsibility to others, the general values, which we have mentioned before. They are also licensed to apply some of the basic tenets of their professional belief systems. He thinks that at bottom, they must inevitably decide what constitutes health or adaptation and the difference between normality and psychopathology. Even diagnoses can represent a form of value judgment. Accordingly, as Karasu observes, the requirement of neutrality can at best claim that the values which may affect the therapy are to be bracketed in the belief system of the therapist, while those which may have the least chance to affect the therapeutic procedure may be left untouched.

Coming back to the original issue of values in the psychotherapeutic context it becomes clear that there is no unanimous opinion regarding the role of values in the process of therapy. Here our concern is to see, be psychotherapy value-free, be it value-loaded, whether any ethical conflict breaks out in either of the cases; and if so how those are to be handled. The analysis may begin once again highlighting T. Byram Karasu’s position, according to whom therapists embody particular social standards, value-orientations or personal preferences unconsciously, if not consciously. He also maintains, as we have already mentioned, that from the very bottom, therapists must inevitably decide, what constitutes health or adaptation and the difference between normality and psychopathology. At this point the role of value may become very much significant. Regarding 'normality/abnormality', it is more or less admitted that (we have
mentioned in notes & reference) in the mental health arena nowadays no such strict compartmentalization exists. It is believed that the concepts like ‘normality’ and ‘pathology’ float in the same continuum. We may refer to the view of anti-psychiatrists in this context who contend that the distinction made between ‘normality’ and ‘abnormality’ is actually a social construct. According to Dr. Joseph Berke, “…we’re up against a whole society which is systematically driving its members mad. Individuals might feel that the problem is within them but it isn’t. It’s a social problem which is experienced at an individual level. This is the reason why we shouldn’t try to perpetuate the individual suffering, try to trick the individual people into thinking something is wrong with themselves.”30 We find Thomas J. Scheff’s opinion in Morton Schatzman’s *Madness and Morals* which says that people in a group label behaviour which breaks rules of the group as bad, criminal, malicious, sinful, selfish, immature etc. They themselves develop criteria to judge which behaviour breaks those rules and how to label it. They cannot apply any of these labels to the behaviour of some individuals who persistently break such rules. Men in other times and places ascribed those behaviours to witchcraft etc. Today, men in the industrialized nation of the world see the same behaviours as ‘symptoms’ of ‘mental illness’31.

Some even question whether opting for ‘cure’ for presumed psychopathology violates one’s freedom to decide what change one wishes to make. Should the therapist help a client to rebel against a repressive or abusive environment or to adjust and compromise with her present situation? This issue has arisen in relation to psychiatry’s traditional definition and treatment of homosexual clients. From the diagnostic point of view, the earlier nomenclature of homosexuality as a perversion or sexual deviation has been challenged and also changed. The recent view of such types of behaviour as a sexual orientation or preference rather than psychiatric disorder reflects greater acceptance of alternative life styles and is less stigmatizing to
the client by removing the phenomenon from psychiatric nomenclature.

In the present scenario, ADHD (i.e., Attention Deficit Hyperactivity Disorder) or ODD (Oppositional Defiant Disorder) have entered into the scope of psychiatry which were not considered so, few days back. Here we can observe that one kind of social standard, social norm, i.e., one kind of social value is guiding the psychotherapists to select which is to be accepted as normality and which is to be treated as pathology. Again in psychotherapy, when a therapist makes any hypothesis regarding the diagnosis or treatment procedure of any client, confirmation is required for accepting or rejecting such hypothesis in such case too. It may be observed that in psychotherapy too, if the confirmation is not 'strong enough', if any mistake occurs, then accordingly the consequences that follow would be very grave and serious according to the moral standards. In this case, it is the client or patient who primarily will be harmed and not the community. Again on a broader spectrum if society’s harm is not considered the question of value-laden-ness of therapy may arise. If public peril or society’s harm is not considered then it may be asked that – is it ethical from a social point of view to encourage clients during therapy to blame others for their misfortunes and to focus on the needs of self too exclusively and therefore at the expense of community needs? Do some psychotherapists encourage an individualistic and selfish mindset? Is there sufficient awareness of the concomitant negative impact on the society in which the therapy is taking place? If we put importance in such queries then perhaps therapists’ diagnoses and treatment related hypotheses formation also become value-loaded with respect to both social and moral values.
Section III

Moral problem, if value-laden

In the context of value-laden or value-loaded psychotherapy a complex moral problem may be observed. If psychotherapy is known to be a procedure for regaining normality or sound mental health from a state of abnormality which according to anti-psychiatrists is only a social construct and if it is also assumed that this can be made possible claiming psychotherapy as value neutral, then a very queer conclusion would follow from this position. Ultimately in such case the study of psychotherapy and the notion of value neutrality would become a faithful machinery to sub-serve the society. This naturally provokes us to be critical and to raise the query: ‘can we consider sub-serving the society in this way as something ethical? One may ask, ‘what is the harm in saying so?’ In response to such query it can be said that if the therapist always conform to the social values, she may take a biased attitude towards her client, which as we have already discussed in the context of impartiality of therapist, can be detrimental from the ethical point of view.

An interesting point that may be noted is that in a sense value-laden-ness of therapy or the therapist is not contradictory to the value neutrality of the therapist in psychotherapy, i.e., even if we can accept that value enters at some point in psychotherapy, at some other level we can talk about the value-neutral stance of psychotherapy. If we can establish this, then we will have to conclude that value-judgment is not involved in each and every level of psychotherapy and that psychotherapy is not totally value-laden. Precisely speaking, this position can be maintained if we say that a value-neutral therapist is someone whose process of therapy is not affected by any kind of subjective-value, bias or any social norm. If a therapist can be value-neutral in this way, then s/he can also be non-judgmental in attitude.
Roughly speaking non-judgmental attitude means to learn to accept everything that comes from the client’s end, even that which the therapist says ‘no to’ and thus does not support. This attitude of the therapist helps the client to divulge even that confidential information which the client may not herself be ready to accept. Thus, we can understand how being non-judgmental which is again possible by being value-neutral may initiate the therapeutic procedure.

As far as the clinical success of psychotherapy is concerned it has just been laid down how important it is to take a non-judgmental stance for a therapist. But keeping a non-judgmental stance from the side of the therapist is also ethically very much significant. Therapist’s being judgmental in attitude is directed towards making a kind of imposition on her client. Imposition leads to a kind of intrusion. It actually affects the autonomy of the client, while to be respected as an autonomous agent is a well accepted right. The aim of psychotherapy is directed towards health which, in a way or other attempts to regain the autonomy of the client on one which we shall concentrate in detail later in the dissertation. Thus looking from this angle therapist’s being judgmental is out-rightly unethical/immoral. Therefore we can say that in psychotherapy, keeping non-judgmental stance, which again is not possible if the stance of being value neutral is not maintained, is very significant as far as morality is concerned.

Let us explain this point. If a therapist cannot remain value-neutral, if she becomes value-laden then she would become judgmental. In that case, the therapist would not be able to accept whatever will be coming from the client’s end unconditionally and that would be problematic indeed. In such case the therapist would evaluate her client from her own value-system and belief-system and accordingly would also put a label on the client in her own way. Hence it may so happen that the therapist would fail to accept some of the client’s attitude. This position may lead even to that extent where the
therapist may face serious problem to accept her 'client as a person'. Obviously in such a situation the therapeutic procedure would be at stake. For instance – X is a lesbian who has not come to the therapist to change her sexual orientation but to work out her difficulties that she is experiencing in being true to herself with her family members. Now the therapist believes from her value system that homosexuality is morally wrong. In this situation, would it be possible for the therapist to respect her client’s belief and her desire to live differently? Here the therapist is very much coloured by her value-system which makes her judgmental in her attitude as she assumes the root cause of her client’s difficulties is nothing but her sexual orientation. The therapist is so much influenced by her values and is unable to bracket out her values during the therapy that in most of these cases involving issues regarding the client’s sexual orientation, the root of the problem faced by the client is hardly related to her sexual preference. Although often coloured by the experience of being a sexual minority, an individual may be oppressed in a discriminatory society, but it is also a fact that lesbian, gay and bisexual people may present themselves for counselling or therapy with a range of life issues like- relationship breakdown, bereavement, anxiety, depression, work-stress etc; as in this case X has come to therapy session due to her problem of maladjustment in her family. Here the therapist was unable to identify her client’s problems since her belief-system had acted as an obstacle to accept her client unconditionally as a person.

In such cases the therapist will not be in a position to provide appropriate care to her client which is the aim of therapy. Owen states that a therapist can provide an appropriate care to her client if she respects her client’s personality, culture, and educational moral, political, sexual, religious and other relevant considerations. If she does not consider such factors and act according to her own belief system, then the therapeutic bond between therapist and client
cannot be established which is essential for therapy\textsuperscript{32}. Moreover can we say disrespecting a person as something ethical? It is against human rights not to recognize one’s freedom and dignity. The right to live is implemented in accordance with one’s own choice. It is not unlikely that a therapist who is not ready to honour her client’s freedom may become very much authoritative like a parent or a teacher. Thus it is a very significant moral question as to whether in a proper therapeutic relation the therapist should remain impartial and detached or not. It may be observed that since the involvement of the therapist is a pre-requisite factor in the therapeutic process, the attitude of the therapist is desirably to be attached with the situation, but in a detached way. Otherwise serious moral issues would encroach.

In this context we may refer to Sigmund Freud. According to Freud also, an analyst should not be an authoritative parent or teacher, or else in such cases certain difficulty may arise. The client or the analysand may take the analyst either as a guardian or a teacher, but that is not ideal. The analysis will be successful, if the analyst functions in a different mode. What it is, can be narrated in Freud’s words: "We serve the patient in various functions, as an authority and a substitute for his parents, as a teacher and educator; and we have done the best for him if, as analysts, we raise the mental processes in his ego to a normal level, transform what has become unconscious and repressed into preconscious material and thus return it once more to the possession of his ego."\textsuperscript{33}

Freud opines that as a result of positive transference, the patient may put the therapist in the place of her father (or mother). In such case, to some extent, an advantage can be seen. In Freud's words, "If the patient puts the analyst in the place of his father (or mother), he is also giving him the power which his super-ego exercises over his ego. The new super-ego now has an opportunity for a sort of after-
education of the neurotic; it can correct mistakes for which his parents were responsible in educating him.”

At the same time here, Freud also gives a warning that a therapist should not take the role of an authoritative teacher just as he should not be an authoritative parent too. As we have just seen, an over-protective, dominating and authoritative therapist may also be responsible for fallible attitudes and behaviours in the patient. Freud thus says: "But at this point a warning must be given against misusing this new influence. However much the analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that, that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclinations. If he does, he will only be repeating a mistake of the parents who crushed their child's independence by their influence, and he will only be replacing the patients' earlier dependence by a new one. In all his attempts at improving and educating the patient the analyst should respect his individuality...”

In this context we will present a case-study where we can observe what kind of ethical implication may follow if a therapist becomes strongly authoritative and goes for suggestions in a directive manner.

Anthony Smith started seeing Doctor Jones (belonged to the psychodynamic school) since he had had a phobic reaction to being trapped in crowded places and this made his working life extremely difficult. Initially after two or three sittings he thought it was absolutely a waste of time reporting any dreams he had had in the week. But after several months, one day he had a particular distinctive dream about being lost in a crowd as a boy at a jumble sale with his mother, which was terrifying. Till then he had idolized his mother and hated his father who was deceased.
Doctor Jones during sessions showed it to him, on the basis of dream-interpretation, how his mother treated him in his childhood. His interpretation was queer as he analyzed that Anthony’s mother never showed affection to him and always considered him as a burden. Anthony at the beginning was not convinced by the thought. But ultimately under continuous and repetitive pressure surrendered and said ‘OK, you win, yes, she was a cow’. From that moment the phobia vanished and his life was changed. He cut himself off from his mother and started living his own life. He was able to see the good side of his father. But his mother was devastated. His brother would beg him to talk to her because he was destroying her. But Anthony thought she was just being manipulative and trying to use guilt to get him back under control. But after a pretty long gap of twenty years when he looked back at the therapeutic process with objectivity, he asked himself –‘was I simply brainwashed by Doctor Jones’ authoritative suggestion that I was the victim of my mother’s emotional brutality? Perhaps from the practical point of view the story is something else.’ After such realization, despite those losses of years, Anthony and his mother get on very well. Anthony felt in a sense that the old Anthony was psychologically killed by the therapy. He thought it was a harsh thing to do to him just because he was worried about freaking out in crowded school corridors.

Anthony’s story is quite unusual, says Y.Bates, since it describes the gradual shift in his approach to life over twenty years following his therapy: from his impression of that therapy, it was revealed that, it was extremely beneficial to his current position, but it could indeed have been harmful\textsuperscript{36}. But why? What is the ethical significance of it? It is to be scrutinized why Anthony ultimately came to the conclusion
that therapy sometimes kills the ‘person’ too. According to Bates, from the client’s perspective, perhaps the most significant question is: ‘Was I simply brainwashed?’ Bates questions the power of authoritative suggestion and its role in counselling and psychotherapy. Anthony not only wonders whether this may happen but also asks about its ethical implications. We can observe here the clear consequences, as Anthony’s therapist suddenly made a hasty conclusion and dumped it on his client. Can we accept this sort of intrusion and authoritativeness as morally acceptable and fair action from the side of the therapist? The therapist, in this instance, like an authoritative parent or teacher became judgmental and hence directive too which practically confused the client very much. This kind of stance in turn, put down the client’s self-reliance. Accordingly, if not at the time of therapeutic sittings but after some considerable years, Anthony was compelled to rethink over the matter. He questions himself, ‘isn’t it a coincidence that in virtually all therapy sessions whatever I say, it always turns out to be the parent’s fault (and most often, the mother) that the patient is exploited, ignored and dominated?’ He changed his mind too; in his words, ‘to look at the process with objectivity’, that ‘this was a practical era, no nonsense mothering... it was the way Scottish families of that era interacted – and still do...’. Thus the question of being brainwashed is raised which is neither clinically nor morally ideal in case of psychotherapy. Of course the question of diminished autonomy pricks our conscience here, which is again immoral in the realm of medical ethics. This kind of diminished autonomy makes the client totally dependent on the therapist. Anthony was unable to make any decision without first consulting his doctor as he mentioned about buying a leather jacket for which, he thought to ask his therapist first. Thus we can see such a stance of authoritative, judgmental, directive mode of suggestions from the therapist involves other kinds of moral problem too. This kind of dependency that the therapist actually tries to induce and considers as necessary for the therapy to be successful may be claimed to be
termed as transference bond. In counselling and therapy this
transference is admitted for initiating therapist-client congruence that
is essential for starting the therapeutic process. But the question is,
can such kind of transference actually be treated as clinically sound
and morally right? Carl Rogers wrote: "In the therapeutic interaction,
all of these attitudes - positive or negative 'transference' feelings, or
therapist–caused reactions – are best dealt with in the same way. If
the therapist is sensitively understanding and genuinely acceptant
and non-judgmental, therapy will be more forward through these
feelings..." 38. But here this is not the case. As the therapist is very
much authoritative in nature, client’s sense of autonomy is
diminished. One of the most important questions that can be raised
about the therapy of Anthony is: how long would it take for Anthony to
regain normal functioning or to get back into normal life without
dependent on the therapist? Is therapy intrinsically addictive? It
seems that too much dependence on the therapist creates problem in
carrying out responsibilities or keeping commitments with others.
This sort of over dependence which takes away one’s will to take
responsibility has been considered to be immoral from certain views
which emphasize on human freedom and hold that anything that
tends to make man un-free is immoral. We can refer to the
existentialist theories for elaborating this point.

According to the existential theory man is free. But such freedom is
not synonymous with unbridled power. Human freedom is a freedom
to choose, and it implies limited, finite alternative. Each choice limits
another, and a person is limited by the facticity of his body and the
things around him. Thus, the resistance of others and the situation of
the material world is the matrix from which human freedom
grows39. The concept of human freedom follows from, according to the
existential position, basically the concept of human act. Since human
consciousness is intentional, every human act has a goal, and it has a
cause. Although the determinist locates the cause outside the person,
the existentialist holds that each act is caused or motivated by the 
person in light of those things he has freely chosen to value. ‘My 
behaviour is undoubtedly caused, but it is I who has freely determined 
the cause, the motive for my act.’

But it has to be noted that humanist existentialist psychologist rejects the behaviouristic and the 
Freudian determinism in relation to the concept of human freedom. To 
the existential therapist, the therapeutic task is the fostering of 
explicit awareness which according to John Fowels is whole sight.

It may be noted here that the goal of existential therapy for a person 
(here the client) is to utter and clarify her projects, her basic per 
personal myth; to assume ownership, validity and responsibility for 
her projects; to embrace both the positive and negative aspects of her 
relationships with others and the world, so that the divided, 
unattended parts of her personality become integrated and lead to 
much greater autonomy. Thus we can understand in the light of this 
discussion that any individual human being enjoys freedom and she 
also carries out responsibilities as motive for her act which she has 
chosen. Thus anything which comes in the way of enjoying freedom or 
carrying out responsibilities (if transference in case of therapy) then it 
would be immoral. So if anything (both transference and judgmental, 
directive, value-laden attitude of the therapist) stops Anthony to think 
and act freely then certainly that should be regarded as immoral.

Finally somebody may argue for the therapist that whatever be the 
stance of the therapist, ultimately ‘the end justifies the means’. In fact 
Anthony was cured of his phobias, he felt happier than he had 
dreamt. So what if he was brainwashed? In response to this type of 
argument it needs to be mentioned that since therapy is done on a 
‘person’ it always matters as to whether the procedures are 
acceptable to the client or not. If certain procedure is not acceptable to 
an individual she can opt for an alternative one. Accordingly 
imposition of a therapeutic procedure which affects the quality of a 
goal may appear to be unethical. Thus in Anthony’s case we find him
clearly saying: ‘I don’t think that the end justifies these sorts of means.’ Further the familiar criticism against such popular utilitarian position also manifests the meaninglessness of it.

It can be mentioned here that from the point of view of Freud and existential therapy, we can understand that an analyst should not be authoritative in nature. He should not preach his patient by being evaluative and judgmental. This line of thought may also be seen in Carl Roger’s account. He also propounds a kind of non-judgmental attitude of the therapist in an ideal therapeutic relationship. Rogers also talks about a non-evaluative attitude of therapist that the therapist should not let his emotions, belief system enter into the therapist’s way of acting during therapy. Rogers acknowledges the existence of ‘emotions which have little or no relationship to the therapist’s ‘behaviour’ but see them as of little practical relevance.

In describing the attitudes or conditions which appear to be most important for the success of therapy, Rogers talks about the therapist’s, complete acceptance or unconditional positive regard for the client and a sensitive and accurately empathic understanding of the client’s feelings and personal meaning. While reflecting on these issues, Rogers repeatedly mentions about therapist’s non-judgmental and non-evaluative attitude. Rogers writes - “The therapeutic process is enhanced when the therapist both experiences and communicates to the clients a deep and genuine caring for him or her as a person with many constructive potentialities. When this caring is uncontaminated by judgments or evaluations of the thoughts, feelings or behaviours, it deserves the ‘unconditional positive regard’.” Rogers mentioned several key concepts which he believed must be present in order for healthy change to take place. ‘Unconditional Positive Regard’ is one such concept. According to him without unconditional positive regard the client will not disclose certain
information, could feel unworthy and may hold onto negative aspects of the self.\(^\text{46}\)

In this context he further comments that “...the therapist prizes the client as a parent prizes his child-not because he approves of every expression or behaviour but because his caring is total, rather than conditional. He does not accept some feelings in the client and disapprove of others. It is outgoing, positive non-possessive warmth without reservations and without evaluations.”\(^\text{47}\)

So according to Rogers, therapists are supposed to be non-evaluative. Since in that case they would be able to accept their clients ‘unconditionally’ i.e. ‘as they are’ with their positive feelings as well as negative feelings. In Rogers’ words- "For many therapists it is more difficult to accept the positive and joyful feelings than the negative, because therapists tend to look on these positive feelings, with suspicion thinking that they may be defensive. Yet in many ways the kind of caring that the client-centered therapist desires to achieve is a gullible caring in which the client is accepted as he says he is not with a lurking suspicion in the therapist’s mind that he may, in fact, be otherwise. This is not stupidity from the therapist’s part, it is the kind of attitude that is most likely to lead to trust, to further self-exploration, and to the correction of false statements as trust deepens. It appears that this caring, this positive regard is possible for the therapist when he is able fully, within himself, to accept the client as he is - often a defensive, vulnerable, conflicted person yet with enormous potentialities for growth."\(^\text{48}\)

So, from the above reflection we can understand that such acceptance of the client from the therapist's end can only be possible if he remains non-judgmental and non-evaluative in attitude. And from Rogerian view point it is also important to accept a client
unconditionally, as this is essential for the course of therapy. On the basis of this as he puts it, three important things can be deduced.

- This can establish trust in therapeutic relationships.
- This can further self-exploration, and
- This may help to correct the false statements as trust deepens.

These can be considered as the primary aim of all kinds of healings, cure and care. And thus, we can understand how important it is for a therapist to be non-judgmental in attitude and if it is not the case, what kind of detrimental moral consequences may follow. This kind of a journey is complex, demanding strong yet subtle and gentle way of being. According to Wood, “The person-centered approach is not a psychology, psychotherapy, a philosophy, a school, a movement or many other things frequently imagined. It is merely what its name suggests, an approach. It is a psychological posture, a way of being, from which one confronts a situation.” Still it is very important for psychotherapy. In the moment - to moment encounter in psychotherapy, the most notable element of the work of the therapist is the ability to understand accurately and sensitively the experiences and feelings of the client and the meanings they have for her. Its purpose is to help the client to attend to what is being experienced at that movement so that she may feel it openly and carry it to its full, uninhibited experiencing. And this journey would be possible, may come to an end if, as it has been just mentioned, the therapist is both non-judgmental and un-evaluative in attitude.
Section IV

Moral problem, if value-free

But again question may arise regarding the value-neutral status of therapists. Is it always ethical to remain value-free or value-neutral in the name of neutrality? On a practical level, the therapist may still be obliged to take a stand with regard to her own view of the patient’s clinical status and purpose of treatment. In this context Karasu very relevantly puts forward the question – ‘Is it always unethical to take one or another position?’ For instance – if a homosexual clients visit the therapy session, what would the therapist do? Does the therapist opt for heterosexuality as an ultimate goal or rather help these individuals to maximize the quality of their lives with respect to their sexual orientation? It may be observed that a therapist encourages directly or indirectly the unmarried lady to get an abortion, the troubled couple to divorce, the failing student to remain in school and so on. In doing so the social, cultural and religious values are expounded in therapist’s attitude towards her client. Again can the therapist be expected to withhold good advice or renounce sound standards in the name of neutrality? In this way serious moral dilemmas may occur regarding value-neutrality in the context of psychotherapy. Question arises – ‘whether psychotherapy is supposed to be value-laden or value neutral?’

It may be thought that in the ‘value-neutrality-value-laden-ness of psychotherapy’ debate, the point needed to be scrutinized is whether the psychotherapist may use an objective scientific method; but that is not all. Her patient may possess, let us say, a strong sense of guilt. The therapist may ask herself many questions. Was the act morally good or bad? Does the patient need psychotherapy for neurosis or not? Does he need a therapist or a spiritual counsellor? Making such discriminations obviously requires value judgements on the part of the therapist. What code of ethics is to be applied in arriving at such
judgments? Shall she apply her own ethical code or not? Shall she discard the patient’s set of values or abide by it? As long as she functions as a scientist and according to this view, the scientist must be ethically neutral; the therapist can also legitimately claim to be ethically neutral. But when she begins to make value-judgments, and as we have just seen, it may so happen easily when dealing with human beings in conflict, the therapist forfeits a neutral status and accordingly moral complications can arise.

Psychotherapists like Gerald Corey holds that both the choice of the method and its application are affected by the therapist's own philosophy of life. In the process of psychotherapy, a relationship is established in which, either by spoken words or by non-verbal cues, the therapist's value system is soon discerned and may even be appropriated by the patient to serve his own needs. This direct or subtle communication of his own world to the patient soon compromises the therapist's imagined neutrality. Even if a therapist always tries to maintain a value-neutral stance, then also moral problems may occur.

As we have observed, it appears as quite obvious that there is a strong knot between psychotherapy and value-neutrality. But the questions that are raised by Byram Karasu mentioned earlier in the chapter should be reconsidered once again. Should the therapist withhold his values in the name of value-neutrality? The point here is that, in therapy a situation may arise where the therapist may clearly observe that the client is either committing a wrong action which may harm her immensely or the client is having such thoughts and ideas which may become harmful for her in the long run or near future. In both of these cases it is most likely to think that the therapist should become directive and should give some instructions to guide the client for preventing her from doing any harmful action; because the non-maleficence and patient-benificence principles of medical ethics exactly claim this. So it appears that in certain instances it is moral to
be directive and employ the therapist’s own views and values and immoral to be non-directive and keeping silent, since this goes against non-maleficence principle.

In this context it should be noted that certain schools of psychotherapy are directive in nature. If in such course of psychotherapy the therapist maintains a directive stance one can be skeptical about whether a neutral stance can at the same time go hand in hand with it. Keeping in view with the fact that psychotherapy can both be directive (like all kinds of behaviour therapies and partially psychodynamic therapy) and non-directive (like client-centered therapy), can we say that all kinds of therapies falling under the general umbrella of psychotherapy, are neutral in the same manner? In behavioral therapies, giving instructions from the therapist’s end is the basic requirement. In such case, can we claim such actions of the therapists as absolutely neutral? But this objection can be handled by saying that being neutral means (according to our analysis) being value free, impartial and non-judgmental. In these cases therapists are not imposing any kind of value from their side. The instructions or directions that they give to their clients are there within the very model of the therapeutic system. Thus it can be contended that from this point of view there is no problem in considering even directive therapies like CBT as neutral.

In support of the value-neutral stance of the therapist it can be suggested that the therapist should actually look at the beneficence of the client. In other words the client would be benefited properly from therapy if the therapist can maintain a value-neutral stance. The therapist may have her own values, biases, belief system with her, but these are to be bracketed out from her inferential procedure, i.e., her cognition should not be affected by her values, beliefs etc. If her cognition gets affected by her value system, she will not be able to empathize with her client and accordingly she cannot have a proper perception of her client’s state of mind. Consequently, either her
diagnosis may become invalid or she will not be able to help her client properly to understand or un-scrabble the latter’s problems. In both cases the process of psychotherapy will be affected and thus the aim of therapy, namely cure, can never be attained which goes against the professional interest of the therapist. In such case the therapist as a professional would not be able to meet the needs and requirements of her profession and would fail to provide proper help to her client which she has ensured through either implicit or explicit promise at the very beginning of treatment. Now since the concept of breaking a promise is generally considered as immoral and the therapist actually fails to keep her promise, thus in such a condition she becomes immoral or unethical in her behaviour. Thus, in order to be refrained from being immoral values of the therapist should not enter in the process of psychotherapy. Therefore, it can be admitted that it is desirable that psychotherapy in its totality does not involve value judgments on part of the therapist, that psychotherapy is not value-laden, from the therapist’s side.

It may further be argued that if client beneficence is to be considered then accordingly in some cases the therapist is to be directive, judgmental and thus the value-free stance of the therapist cannot be kept. If any question arises whether this is ethical or not, then in reply to this it can be argued that looking at the non-maleficence principle the therapist can offer guidance to the client in some specific situations to prevent harm to the client. This stance of the therapist can be accepted for the sake of client-beneficence which is morally very significant. For instance, a therapist may provide guidelines to a client for doing certain actions which can help the client to increase her self-confidence. If the client is supposed to appear in any interview for getting a job, the therapist can give certain guidance regarding how to face that situation. If that person succeeds in getting through the situation then obviously her confidence level may increase a lot. Such contexts require that the therapist give suggestion to the client for immediate decision making which are conducive to short term
beneficence of the latter. Since beneficence is being done (which is in accordance with the ethical principle, viz. beneficence) if not long-term and only short-term, the therapist is said to be moral in her action. But this instant-solution which leads to only a short-term beneficence may appear to be very effective, actually it is not that fruitful if client’s interest is properly considered. Because another situation may arise where the client may require such a solution and again a third one and this procedure may go on forever. Such cases of repeated dependence on the therapist show that the client is lacking a proper insight to take a right decision and her autonomy may not become functional if she goes on depending in this manner. We may remind that autonomy is also a very important moral right of the client in the field of medical ethics. So it is better not to provide any instant decision from the therapist’s end. The therapist, on the other hand, must try to help her client to develop a proper insight to take the right decision on her own, i.e., to develop an autonomous, functional self. This is ethically very important. This is the long-term goal for the client which is the ultimate aim (i.e., the cure of the client) of the therapist that is both clinically and morally valuable. Thus looking at the "long-term beneficence of the client", if the therapist withholds her values in the name of being neutral and does not offer any immediate solution in any particular situation, even in that case it cannot be said that the therapist is unethical or immoral. Thus, we can conclude from the above discussion that it is desirable that a therapist brackets out her own values and beliefs while following the therapeutic procedure.

Still some instances may be put-forward where it seems to be really difficult to keep the value-neutral stance of the therapist. The long-term beneficence principle also does not work there. Apart from the directive stance taken as a modality or technique by the therapist in certain types of therapies, it is generally believed that in some other contexts the directive or prescriptive stance of the therapist is needed to be maintained for protecting the client from being harmed. It has
just been suggested that due consideration and importance should be
given to the long-term beneficence of the client and accordingly (if it is
needed), client’s short-term beneficence has to be sacrificed. But
certain emergency case may occur where it is not possible to give
priority to long-term beneficence ignoring the short-term one. In such
cases clients are needed to be directed for protection from immediate
harm since even life-risk may be involved in such case. Here the
concept of long-term beneficence cannot be satisfactorily applied. In
such cases the instruction or prescription in the form of direction may
become value-loaded too. For instance- in case of an acute drug
addict, at certain point of time the therapist may feel the need to be
directive. Here primarily, therapist’s concern may be client’s health,
but the therapist may also be partially influenced from her value
system, like-‘everyone should live, maintaining one’s quality of life’.
Thus such an activity does not go with the value neutral stance of
therapy. In such cases we have to give a serious thought about the
necessity of value neutrality in psychotherapy.

Ethical dilemma of the same nature can arise in some other cases if it
is granted that the value neutral stance is ideal for the
psychotherapeutic process. In case of a dependent client, if the client
asks for guidance and desperately wants the therapist to show path or
give direction, what should the therapist do? As the requirements of
therapy suggest that, it is ethical on the part of the therapist to be
non-judgmental, non-directive towards the client, what the therapist
should do in such a context? It is undoubtedly a very critical ethical
dilemma that as to whether the therapist should maintain the non-
directive stance or become directive and prescribe suggestions to the
client for guiding her according to her need. What would be a moral
stance for the therapist? If the therapist remains silent and does not
become directive the client as part of her professional stance, then
even if the client wants to be dependent on the therapist, a question
can arise as to whether in such cases the process of cure would occur
satisfactorily or not. The client may not accept the therapist to be

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competent and trustworthy enough and may discontinue the sessions. This will ultimately go against the aim of psychotherapy as far as cure is concerned. Again since the therapist fails to keep her promise (to help the client) and thus also fails in that situation to maintain her responsibility, she becomes an immoral agent.

Another ethical dilemma may follow, from the following question: to whom is the therapist is responsible? Should the therapist only serve her profession without prioritizing the client or she should be loyal towards her client considering her professional role as secondary to the client’s needs? If the professional need and need of the client coincides then there seems to be no problem. But if the needs come into conflict then certainly the therapist faces a serious problem. In the above discussion value-neutrality has been considered as a proper gesture of the therapist, which she as a professional is supposed to follow. But this professional need may come in conflict with the beneficence need of the client when in some specific contexts (as discussed earlier in this chapter) client requires immediate guidance from the therapist. It becomes really crucial whether the specified non-directive or non-judgmental professional code of conduct should be maintained or client’s need for guidance should get priority? Should the therapist serve only her profession or her client? This is a very significant ethical issue in the context of value-neutrality. In this context, the issue of boundary transgression on part of the therapist is very significant. How far can the therapist stretch her professional boundary to give primacy to her client’s needs? This question becomes very important with regards to boundary transgression. To note, the word *boundary* is used in psychotherapy to cover multitude of factors limiting (in the sense of providing a framework for) work with clients.

Paul Wilkins in his “The Issue of Boundaries: Harmfully Sloppy Ethics” mentions, “Certainly, I know colleagues in the counseling and psychotherapy profession as a whole... For them, the ‘rule’ is ... and the structure takes precedence over the person”\(^52\). But Wilkins himself
opines that this position is quite uncomfortable. He clarifies that any practitioner should not be careless about professional ethics. But it seems that the therapists in general and particularly for person-centered therapists, for whom client is of paramount importance yet for whom taking responsibilities of the client is not possible, there is a tension. Jerald Bozarth (Personal Communication, 2001) also states, “The limits of person-centered practice are defined by the individual relationship and the dedication to the client’s world”\(^53\). Here we can also mention the name of Kitchener who criticizes professional codes of conduct as they reflect professional consensus rather than depicting ideal behaviour. She notices that these codes have many gaps and contradictions and they avoid tackling ethical issues. These provide one level of justification for taking or not taking actions and allow professional bodies to set basic limits. These provide only minimum standards of ethical practice but these should be developed by all practitioners\(^54\). Here actually lies the tension. If the professional codes are developed keeping an eye to the ethical issues which naturally cover the ethical concern relating to the client, then perhaps the probability of getting into the conflict between the need of the client and that of profession may be reduced and the question as to ‘who are the codes for: profession or client?’ would become a trivial one.

Moreover a person’s need for help, as mentioned earlier in this chapter, being refused may also create a serious moral problem. So the question is, for the client’s beneficence and also to offer fair treatment, i.e. to comply with the principle of justice in medical ethics, whether the therapist would be allowed to become directive and offer suggestions for a dependent client who is in need. Thus looking at the two instances viz. - the case of acute emergency and the case of dependent client, we are getting a hint that perhaps the claim of value neutrality cannot cover all the therapeutic situations in general. In that case what can we conclude about the moral/ethical aspect of Psychotherapy? How can we resolve the ethical dilemma that centers
round the issue of value-neutrality in psychotherapy? From this analysis one suggestion may follow: that value neutrality in psychotherapy is area specific, which means it is actually context sensitive. The implications in certain therapeutic situations can be marked where neutrality cannot be maintained, while the rest of the psychotherapeutic situations are to be considered as ideal for keeping neutrality. It is not an easy task to compartmentalize various types of cases in this way. Specification of factor/s on the basis of which an attempt can be made to mark the different zones is indeed complicated. Still on the basis of above account we can understand that neutrality cannot be maintained in all cases of therapy. In such cases the role of the therapist is crucial. If the therapist remains non directive and non judgmental in the name of neutrality, e.g. in case of an acute drug addict or a dependent client as mentioned earlier in this chapter, then the chance of disastrous harm to the client can not be avoided and it may lead to unwarranted consequences including discontinuity of treatment and fatal deterioration of health condition of the client. This position is absolutely unethical since it violates the non-maleficence principle. Still can we absolutely forget the voice reminding us that to be with the client requires that for the time being the therapist lay aside the views and values she holds for herself in order to enter into the client’s world without prejudice? We shall reconsider this issue in the conclusion of this dissertation concentrating on the moral perspectives of neutrality in psychotherapy.
NOTES & REFERENCES


2. ibid.


5. ibid

6. ibid

7. ibid

8. Webster’s Dictionary, 1913.


13. ibid

14. ibid


16. ibid
17. ibid
18. ibid
19. ibid
20. ibid
24. This concept is one of the core condition of Client-Centered therapy propounded by Rogers, Carl R., which was initially known as Nondirective therapy and later as Client-Centered therapy. Non-possessive warmth means that the client can feel received in a human way, which is not threatening. In such an atmosphere trust can develop, and the person can feel able to open up to their own experiences and their own feelings. It may be noticed here that these three qualities are really what we would hope for from any human being. And anyone who would not be capable of exhibiting these qualities would not be much of a human being. So there is a lot in this approach about learning how to be a human being. It is one of the paradoxical and exciting things about the humanistic approach generally that it assumes that everyone is capable of being fully human.


29. ibid.


35. ibid.


37. ibid.


40. ibid.


45. ibid.

46. ibid.

47. ibid.

48. ibid.


