THE JOURNEY TO BE A THERAPIST:

PERSONAL EXPERIENCES OF ETHICS IN TRAINING AND THERAPY

by

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I declare that

THE JOURNEY TO BE A THERAPIST:
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is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

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SUMMARY

The tone of this dissertation is in the first person as allowed by the lens of constructivism used in it. Being constantly self-reflective, the author takes the reader through his personal journey to be a therapist, and the ethical dimensions encountered in the process, to indicate that one cannot do therapy without considering ethics in the fusion of the professional and personal selves of the therapist.

What is lost in the delineated field of observation is hoped to be gained, in the richness of its personal material. Not aiming at drawing any generalisable arguments, the purpose of the dissertation is to provoke a dialogue about our ethical conduct with clients, indicating that our therapeutic conduct is enriched by constantly involving ourselves in the ethical dilemmas that emerge in the therapeutic process.

KEY TERMS

Therapist; ethics; journey; self-reflective; therapy; dialogue; dilemmas; constructivism; personal; professional.

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CHAPTER 1

INTRODUCTION

An Overview of the Dissertation

In support of Efran, Lukens and Lukens (1988), I see every moment in therapy as a moment in ethics. Inasmuch as becoming a therapist is a journey, so is becoming ethical.

It becomes imperative for all to realise that to be a therapist encompasses a commitment to a journey far beyond the training itself as delimited according to academic requirements - continuing over the three years required for the training. The Unisa training comprises two years of academic and some practical work at various therapy clinics. The third year is full-time practical training at various internship placements. Registration with the Professional Board as a clinical psychologist, who is also qualified as a therapist, follows the successful completion of the three years of training.

I also take a critical stance towards the taken for granted view that reading and training in professional codes of ethics will make one an ethical therapist. I believe that becoming an ethical therapist entails a never ending process of being constantly self-reflective, and that being an ethical therapist is not merely about learning rules, but entering into a process of being personally self-reflective as is shown in chapter 5.

However, it should be noted that the view held in this dissertation does not necessarily oppose the present view of ethics in training and therapy as stated in the professional codes of the various organisations. It therefore becomes necessary to look at the definition of ethics in therapy, and the professional codes of ethics and their principles in particular (chapter 2).

Hinged on the idea of the fusion of the personal and the professional selves, my central argument in this dissertation is that therapists are not supposed to be regarded as constants whose conduct is unquestionable. Having mentioned that being ethical goes far beyond the learning of codes of ethics, and that this entails a process of constant self-critique, this new understanding

calls upon each trainee and practising therapist to keep reflecting on how their personal selves impact on their professional practice.

I do this by shifting from objectivism which does not acknowledge such a fusion, or at least tries to shut off the personal from the professional, to a constructivist lens (chapter 3). Using the lens of constructivism, I argue that each encounter in therapy brings with it unique ethical dilemmas, depending on its context, the time and who the participants are. These dilemmas are a product of the therapeutic process, a co-evolved aspect of the broader therapeutic conversation.

Trainee and practising therapists carry inside them experiences from outside therapy and before embarking on the official training, that directly or indirectly sets the tone for their interaction with the clients they meet. Each one has been initiated before in some particular way to the work of therapy. To personalise my arguments, I often employ the pronouns 'I', 'we', 'us', 'ourselves' though I am aware that some practitioners of academic discourse frown on such a personal note. Part of the journey entails making these aspects of ourselves available or at least acknowledged (chapter 4).

I have taken some time to look at particular aspects of myself, for example, my own exaggerated sense of responsibility to save everyone (chapter 4). When one goes through chapter 5, he/she can clearly discern how this personal aspect of mine comes to influence my conduct and interactions with others in therapy.

These personal aspects enable us to locate the curative dimension of therapy within ourselves and not just in our supposed "mastercraftmanship". Making us humane, humble and respectful, they allow us to remain human with another human being. As our inner feelers, they can be used to gauge where the client is (chapter 5). We are also not just altruistic philanthropists. Our inner extra therapy experiences while giving us the advantage of being sensitive to others' pain, do also represent our inner bias from our life's experiences. I show in chapter 5 how, like being there, I used my own inner feelings of inner orphanage to sense this in Molahlegi, how by daring to expose my own lostness I was able to provide a holding space for Molahlegi. While representing the epitome of a healing therapy they can lead us into a mindless harming work with our clients.

We need to constantly ask ourselves why we act or respond to clients in those particular ways, by inquiring into our own personal journeys and the shadows we carry. To ask ourselves why we always make ourselves available. The significance of this for ethics is that we can become conscious of when we meet our own unmet needs at the expense of the client, when we take the client's healing space. It is this constant questioning of the subtle nature of our interactions with clients that will sharpen our therapeutic acumen and ethical stances. A realisation that each moment in therapy brings with it unique dilemmas of living in ethics (chapter 5).

Taking a reflective stance to look back at what it is like to be in the journey to become a therapist, I show in chapter 6 that we put ourselves in an authentic ethical position if we constantly involve ourselves in the dilemmas that arise each time we are in therapy. The journey to be a therapist entails this constant acknowledgment of how we personally impact on the unfolding of events between us and the client(s). This further defines being ethical, that is having a constant inner dialogue with ourselves. It further enables incorporating into our therapy work a dialogue with professional codes of ethics and not merely taking them as givens or rules to be adhered to. To be a therapist and to be ethical is a continuous journey of being self-reflective and acknowledging how the personal and professional selves are infused.

I chose the lens of constructivism because it allows me to accept my subjectivity, the not being an objective expert, but to situate monitoring of myself within myself, and not to shift such a responsibility to an outside body.

CHAPTER 2

DEFINITION OF ETHICS IN THERAPY

Preview of the Chapter

To build up a critique of the present view of ethics, as based only on the professional codes of ethics, and to introduce a holistic view of ethics, the chapter is started with a discussion of the definition of ethics as it is found in the literature. This is done by looking at the impact of the therapist's needs and values on his/her conduct. Codes of ethics of the various professional bodies are also discussed, including the context in which they were developed. The discussion includes also ideas on how to train someone to be ethical and how to train someone ethically.

Ethics Defined

Ethics in therapy has to do with what is right, what ought to be done in therapy, the moral question of what is proper and a right way of conduct (Bailey, 1990).

Facing up to the inevitability of impacting those the therapist interacts with in therapy entails acknowledging the importance of clients, of their lives and the result that professional actions, professional relationships and interventions can have on their lives (Pope & Vasquez, 1991). It calls for accountability on the part of the therapist in relation to the client(s).

Vesper and Brook (1991) view ethics as dealing with the shoulds and oughts, which are merely guidelines by which to administer therapeutic intervention.

As a set of habits and customs governing how the therapist relates to the client(s), it calls for the attention of the therapist to be placed on how his/her ideas and behaviour impact on those of the client, and also on how those of the client impact on those of the therapist (Inger & Inger, 1994). For Inger and Inger (1994) the ethical perspective of therapy is hinged on a cognizance of mutuality of influence for both the therapist and the client.

A therapist is seen as inescapably embroiled in working with a model of what is desirable and good for the client and other human beings. This, for Rosenbaum (1982), makes the therapist an ethical person. The therapist's moral values are always prevalent in what he/she believes in, wishes for and considers good or evil for the client, hence this will have an enormous influence on the client's life.

My personal definition of ethics in therapy, which prompted the writing of this dissertation, is that of the socially and professionally accepted behaviour of the therapist, the good, and non-harmful behaviour of the therapist in relation to his/her client. This implies questions about how the therapist can do what is good for the client without inflicting any harm for both the client and those related to the client, as a result of his/her interventions.

The Therapist's Needs and Values

Maddock (In Hansen, 1982) defines values as the lenses through which one views the world. They colour one's philosophy of life. Rosenbaum (1982) contends that a therapist is not a pure "cogito" or a "tabula rasa". He or she comes to therapy with a specific personal history, cultural information and ethnic background, all of which influence his/her interactions with the client. Therefore values are personal preferences and needs that we acquire from our process of growing up and interacting with others, for example, from our ethnic, cultural and specific personal events in our lives.

Therapy can never be value-free (Tjelveit, 1999; Bailey, 1990; Hansen, 1982). Questions reflecting the significance of values in therapy include: "Why advocate the adoption of certain therapy outcomes for the client and not others?" "Why encourage the client to choose a certain life style and not others?" Because the therapist can never be neutral, his/her values are likely to be highlighted when working with minority groups, mostly in the possible imposition of mono-cultural values, mostly western, middle class and male, when working in a multi-cultural context. In such a context therapists are expected not to impose their own cherished values on clients, for example, on religion, sexuality, ethnicity (Bailey, 1990; Hansen, 1982).

Having acknowledged the inevitability that therapy will be a value practice, therapists are

encouraged to seriously think about their own values so that they do not stand in the way of their therapies. It is Hansen's (1982) views that therapists need to resolve their own values before embarking on helping others who are struggling with value concerns. A value clarification module is deemed a necessity for trainees in therapy, to check the emotional investedness they have in their personal values. Therapeutic effectiveness, whether for the good or ill of the client, is not solely related to a particular technique or theory of therapy, but is also linked to the therapist's style, of which his/her personal values are a part. It is here that Hansen (1982) wants us to imagine the basis on which a systems therapist decides whether and how to intervene or resolve a problem determined by the family system; hence it is both in the training of therapists and in their actual practice that the impact of their values needs to be looked at.

In the same way that therapists have values that may impair their conduct in therapy, they also have areas of "unfinished business". Here I refer to unresolved issues in the therapist's life, for example, a trauma experience that has not been resolved yet. Because of this, when seeing a client who struggles with such similar issues, the therapist may want to or not want to focus on the issue because of his/her past experience, which represents what he/she needs and not what the client needs. The unfinished business or unresolved issues determine his/her needs, and this has an impact on the therapy. Therapists have needs that cannot be separated from their relationships with their clients.

Such areas of unfinished business and needs keep creeping in as blind spots or distortions of reality (Corey, 1996). Therapists need to be aware of this: unaware therapists can't differentiate between their needs and those of the client. They need the client more than the client needs them. Corey (1996) imagines that a therapist with needs for nurturance, to teach or preach and persuade, is one who needs to feel adequate, arguing that ethical issues arise when one meets his/her needs at the expense of the client. Therapists are warned against exploiting clients in either obvious or subtle ways, projecting their needs onto their clients.

An imaginary case is that of a therapist with a need for power going all the way to dominate the client and encouraging the latter to remain in a subjected position. For Corey (1996), most therapists enter into the profession due to their needs for power, to feel significant and their need to feel adequate.

As is the case with values, therapists need to recognise the imperativeness of continually evaluating the direction in which their personal issues might influence clients towards progress or not. This is an ethical responsibility for both the training therapist and those in practice, to undergo therapy themselves regarding their own vulnerabilities, to deal with their personal issues as a means of minimising the impact they might have on therapy. The same sentiments are echoed by Pope and Vasquez (1991) when they argue that the therapist's ability to conduct him-/herself with ethical responsibility can be affected by the mental, emotional or behavioural problems for which he/she would need therapy him-/herself.

Codes of Ethics in Therapy

In an attempt to deal with the above dilemmas (that arise from therapists' needs and values) adversely impacting on therapy and client's lives, various professional boards of psychology have came up with their codes of ethics.

The above discussion has shown that the therapist's values as embodied mostly in his/her unresolved issues, determine and allow his/her personal needs to encroach on the therapy. This brings with it the dilemmas of the impossibility of the personal not influencing the professional, of the therapist's values and needs not impacting on the therapy. An ethical responsibility lies in an awareness of this.

A code of ethics is defined as a list of guidelines and rules that encourage or forbid certain professional conduct by the therapist in interaction with the client. It prescribes the normative behaviour patterns the therapist should exhibit in relation to clients (Nietzel, Bernstein & Milich, 1990).

As guidelines for proper therapeutic conduct, they are developed by the professional bodies to which therapists belong, hence they are strongly enforced to protect clients from unethical practices by their therapists (Corey, 1996).

Another reason behind their enforcement is the realisation that clients are assumed to be vulnerable to harm from improper therapeutic practices (Todd & Bohart, 1999). Clients are to

be protected against the power and expertise that therapists have and may improperly use. Corey and Corey (1998) see the ability to apply ethical codes as a part of becoming a professional therapist. It is not only membership in the particular professional body that pins one down to adhering to the ethical codes, as Nietzel, Bernstein and Milich (1994) would like us to believe, but both practising therapists and trainee therapists may find those codes enforced upon them by the courts, psychology boards and other bodies whether they belong to those bodies or not (Todd & Bohart, 1999).

Although moral principles are too broad and ethical codes too limited in scope, the relation between the two is that moral principles always form the foundation on which codes of ethics are formulated when they are evaluated and changed regularly.

Kitchener (1988) in both Weifel and Kitchener (1992) and in Corey (1996), has mentioned five moral principles which are basic to most professional codes of ethics to therapy:

- Beneficence: The principle implies that therapists will put clients' needs first; ensuring clients get the best possible benefit from therapy according to the client's needs. Based on benefiting others, it is a principle for therapists to do what is good for others and the client in particular, in enhancing the client's welfare.
- Autonomy: One of the basics of therapy is to ensure that the client returns to a self-fulfilling, autonomous life. Therapy is supposed to facilitate and not hinder this. Clients are not supposed to be kept for too long in the client-therapist relationship because of the therapist's needs. Enshrined here is self-determination for the client, allowing the client a freedom of choice with regard to the direction of therapy and discouraging clients from being dependent on the therapist.
- Nonmalificence: This is based on refraining from any therapeutic activities that are harmful to the client physically, emotionally and otherwise.
- Justice: Therapists are supposed to avoid any discriminatory practices. Fair and just treatment is to be offered to the client when his/her rights are to be looked at in relation to those of others. This involves being mindful of factors related to age, sex, religion, culture, etcetera, when therapeutic services are to be offered.
- *Fidelity:* This calls for trustworthiness and loyalty. Being honest and willing to do what is

necessary and practically possible to uplift the client's living conditions. Being open and not deceptive.

Examples of Codes of Ethics

To indicate the interplay between moral principles and professional codes of ethics, the American Psychological Association, the American Association for Counselling and Development, and the Professional Board for Psychology of the Health Professions Council of South Africa, hereafter referred to as APA, AACD and the PBPHPCSA respectively, deal with the following codes of ethics as pertaining to therapy (Nietzel, *et al.* 1990; Corey, 1996; Pope & Vasquez, 1991; HPCSA, 1999).

(a) Confidentiality: The therapeutic relationship is built on the foundation of trust that the clients bestow on the therapist. It is due to this invested trust that effective disclosure of very intimate and personal information by the client is done (Gibson & Mitchel, 1990; Corey & Corey, 1998). It is precisely this, the knowledge that one is trusted that gives therapists a sense of power relative to their clients. Therapists are to safeguard the welfare of the client by keeping the deeply personal information shared by the client within the confines of therapy or to reveal it only when not to do so would be dangerous to the client and others.

Therapists are not supposed to disclose what was discussed with the client to others, except with the informed consent of the client. They have a responsibility to discuss the nature and purposes of confidentiality with their clients early in the process of therapy. Where possible and applicable clients are supposed to know about the limits of confidentiality.

With trainee therapists, clients are supposed to know that details of their conversations with the therapist will be discussed with the latter's supervisors and colleagues.

Corey (1996) suggests that if notes are to be kept about the clients, it would be wise if the therapist is open and frank, to show the clients what is written so that the clients can be assured that such information will be used for them and not against them - something that trainee therapists should also consider. This is being ethically responsible both professionally and legally.

(b) Dual relationships, social attraction and therapy. Linked to the ideal of conducting themselves with integrity, social responsibility and a concern with the welfare of others, therapists are always obliged to avoid engaging in dual relationships of any sort with their clients. Such relationships include doing therapy with friends, relatives, bartering for services with clients or being sexually involved with their clients (Corey, 1996; Nietzel *et al,* 1994; Todd & Bohart, 1999).

Having dual relationships is strongly advised against, because of the possibilities of damaging the image of the profession, the public's trust in what therapists do and of impairing the therapist's objectivity. It is argued that because of the power imbalances between the therapist and the client, possibilities for exploitation of the latter are likely to be rife. The client will be less motivated to use therapy effectively for his/her benefit because of the crossed boundaries (Corey & Corey, 1998).

Therapists are strongly advised against going into sexual relationships with both present and former clients (Kitchener, 1988; Pope, 1988; Vasques & Kitchener, 1988; Vasquez, 1988; Pope, Keith-Spiegel & Tabachnick, 1986). Besides impairing the therapist's objectivity, sexual relationships with clients are also seen to adversely affect those clients. Pope (1988) talks about the therapist-patient sex syndrome, which like other disorders manifests itself in various fashions in the client long after the therapist has once had a sexual relationship with the client. Some of the features in its profile include feelings of guilt, impaired ability to trust, and ambivalence.

It is further advised that the therapist in training should be allowed to speak about and deal with any tendencies of sexual attraction to clients. This can be done if the subject is not made a taboo in supervision (Corey, 1996; Corey & Corey, 1998; Vasquez, 1988; Pope *et al.*, 1986).

(c) Multicultural issues and therapy. As testimony to the value ladenness of therapy as indicated before, Tjelveit (1999) asks us to consider a situation in which traditional therapy goals reflect western cultural values and cannot be transported to other cultural settings.

Therapists are called upon to realise that the use of techniques and strategies that are not sensitive to various cultures is a defiance of other people's rights and dignity (Corey, 1996). It

is in the same vein that therapists are advised against the danger of imposing their own values on their clients. If this is refrained from, therapists will be able to listen to clients and determine why help is sought, and come up with appropriate goals as suited to the client's needs.

Using such culturally sensitive therapy strategies, therapists will be able to consider ethnic and cultural factors in diagnosis. They would realise that certain behaviours are only labelled as deviant because they are not characteristic of the dominant culture. When therapists are culture sensitive, they will ensure that diagnosis is associated with treatment (Corey, 1996).

On the basis of these, it is strongly advised that the training for therapists should equip them with cross-cultural therapy skills, knowledge and attitudes (Atkinson, Thompson & Grant, 1993). Trainees should be exposed to cross-cultural issues and the damaging implications of imposing mono-cultural views in therapy.

(d) Informed consent. It is incumbent upon the therapist to ensure that when the client intends to continue or discontinue in therapy he/she is doing so with all the information given to him/her and is therefore fully informed before deciding on any option (Nietzel *et al,* 1990; Nietzel *et al,* 1994; Todd & Bohart, 1999; Corey, 1996). The ethical pitfalls entailed here relate to clients who remain dependent on their therapists forever, unquestioningly accepting what the therapist says and not able to resume any sense of responsibility about their situations.

(e) Competence. Therapists are encouraged to maintain the highest level of effectiveness and competence in therapy. They need to keep up to date with any recent models of therapy so that they can handle problems they encounter in therapy. This goes with being aware of one's limitations and not insisting on doing therapy in areas that one is not trained in (Pope & Vasquez, 1991; Corey, 1996; Ivey & Simek-Downing, 1980; Corey & Corey, 1998; Todd & Bohart, 1999). Ethical pitfalls here are harming the client by imposing mono-cultural views in cross-cultural contexts, not wanting to refer clients when they need specialised services that one cannot offer, and not acknowledging that personal illness interferes with how one does therapy.

Codes of Ethics and the Family Therapist

Employing the systemic approach to therapy, a therapist working within this model faces more ethical dilemmas than other therapists ordinarily encounter (Hansen, 1982; Bailey, 1990; Vesper & Brock, 1991; Becvar & Becvar, 1996). The formulation of a distinct code of ethics as addressed by the systems approach was prompted by the realisation that existing codes of ethics designate only the individual as the client, and do not consider the wider context or system of relationships in which the client lives.

Espousing the same ethical principles to therapy as enshrined in both the APA, AACD and PBPHPCSA codes of ethics, it has been the American Association of Marriage and Family Therapy (AAMFT) that has noticed the uniqueness of family therapy (Vesper & Brock, 1991). In this regard the AAMFT brought about a refreshing view of ethical codes pertaining to family therapy as follows:

They considered not only the impact of their intervention on the individual client, but also on the client's living systems, for example, family, work.

(a) *Confidentiality.* As noted above, for the systems therapist confidentiality brings unique problems because the therapeutic relationship involves the therapist and more than one person all of whose welfare needs to be considered. While keeping in confidence what their clients tell them, systems therapists also have an obligation to others in their clients' living systems. Therapists have a responsibility to inform their clients about the limited confidentiality enshrined in the systems approach. In line with the principle of informed consent, the therapist is supposed to clarify the client(s) about his/her systems orientation at the outset. This gives the client the choice of deciding whether to continue or discontinue in this kind of therapy. The client(s) should know in advance that some information they reveal in confidence to the therapist may not be kept secret (Hansen, 1982; Bailey, 1990; Vesper & Brock, 1991).

(b) Along with the principle of nonmalificence, a family therapist is supposed to be fully aware that due to his/her interventions, previously asymptomatic clients may become symptomatic. He/she is aware that at times the amount of distress may have to be increased to arrive at the

desired therapeutic goal. He/she is also aware that the use of such interventions as paradoxical injunction may appear to undermine the client's confidence in him/her (Hansen, 1982). Based on these, the therapist will proceed with therapy only once it is fully indicated that it will benefit the client(s) (Bailey, 1990; Becvar & Becvar, 1996).

How to Train Someone to be Ethical

There is a conflict of opinion in the literature about how to train someone to be ethical. It is shown in Koocher and Keith-Spiegel (1998) that good intentions of not harming others, including self and peer monitoring, are not sufficient to ensure that one acts ethically. On the other side it is argued that the teaching of ethical principles such as compassion and caring is already imbedded in one's character (Koocher, *et al.*, 1998).

Lakin (1991) favours the informal approach to teaching ethics where ethical dilemmas are discussed in supervision with one's supervisor, rather than the more philosophical approach that is unlikely to sustain the trainee's involvement. Handelsman (Bershoff, 1995) opposes this approach by arguing that ethical dilemmas not recognised by the supervisor will not be recognised by the trainee, that the informal method of training is unlikely to prepare one to handle ethical issues in the future through the application of relevant principles. He further mentions the difficulty that therapists are not necessarily being well qualified to teach general ethical courses. His suggestion of inviting guest lecturers also has its own problem, of making the course just a mere appendage.

Besides these difficulties one notices that training for therapists should offer them a safe space encouraging them to discuss and work out their emotional, mental and behavioural problems openly without fear of being punished. They should be encouraged to openly discuss any feelings of sexual attraction to clients.

Therapy trainees are supposed to be taught to avoid dual therapy relationships, to adhere to the practice of confidentiality that might impair their professional judgement.

Their training should encompass recent models of doing therapy, encouraging them to stay

current and competent. The training should equip the trainees with cross-cultural therapy skills, knowledge and attitudes.

How to Train Someone Ethically

Training like therapy has to be ethical, although there is no information in the literature about a code of conduct for trainers.

One area being mentioned here is the prohibition of trainer-trainee sexual intimacies. It has been found that therapists who engage in sexual relationships with their clients have had their own trainers sexually engaged with them, or were trained in such a context in which the discussion of such a topic was never openly held and was taboo.

A Personal View

I fully support the principles stated in the codes of ethics of the APA, PBPHPCSA, AACD and AAMFT as indicated in the above discussion. It is with the help of professional ethical bodies like these that a sense of ethical responsibility is ingrained in therapists, both in training and professional practice.

A second opinion that I have is that ethical responsibility in practice should be something inherently embedded in the therapist's being. It should be a personal attribute and not only an enforced regulation from the outside.

Ethics, as defined by ethical codes, is like any technique that can be borrowed when needed and discarded when no longer needed. Everybody can be taught ethical codes. Whether and how he/she will apply it is unknown.

If everybody was sure that teaching of ethical responsibility and practice would be enough to ensure the application on ethical codes, why then enforce them by those professional bodies, states and courts? Why so much infringement? Perhaps Koocher (*et al.*, 1998) is right in saying that such ethical principles should be embedded in one's character for one to be ethical?

While I align myself with those who assert that ethical codes are a salient aspect of the therapist's ethical growth and practice, this should not be mistaken for a thorough self-exploration for ethical responsibility (Pope & Vesquez, 1991; Corey, 1996; Corey & Corey, 1998).

We therefore need in all encompassing view of ethics and ethics in therapy. The holistic view that I espouse is that of not seeing, for example, only professional codes of ethics or personal ethical being, to the exclusion of the other. It is about seeing both as equally important and sharpening one further for higher ethical responsibility. To expand on this view, I use the constructivist lens in the chapter that follows.

CHAPTER 3

A CONSTRUCTIVIST LENS

A Preview of the Chapter

The basic idea held in this and highly visible towards the end is of an all-encompassing or holistic view of ethics. To show this I use the lens of contructivism which enables me to embody the stance of being constantly self-reflective while still believing in the professional codes of ethics. To arrive at this holistic view, as hinted at also at the end of the last chapter, the discussion is started with a critical look at a different lens, for example, objectivism, and its implication for the trainee and practising therapist's ethical conduct in therapy.

A Critical Look at Objectivism

Depicted as the epistemology that dominates Western thought (Fisher, 1991), objectivism allows one to make absolutist claims of access to truth about reality. As related to therapy, it leads the therapist to believe that there are correct ways of knowing, that there are solutions to all the client's problems and that the therapist can ultimately arrive at the reality of the client's problems with gradual discovery. It allows the therapist to make claims to truth about reality with certainty, hence putting him or her in a privileged position of having access to reality (Fisher, 1991).

The following assumptions, as basic to objectivism, are discussed in Fisher (1991) as being related to therapy:

Reality: This is seen as existing out there independently of the observer, who is the therapist and/or the trainee therapist. This gives the therapist the power of being the expert who can remain neutral and only reflect on what he/she does, without personally influencing the purported reality he/she sees regarding the client.

Truth: In both practice and in training, the therapist can make statements that are objectively,

absolutely and unconditionally true. The reality that the therapist sees about the client stands as a valid truth that cannot be questioned.

Knowledge: Qualities are regarded as inhering in objects and clients independently of the context and our construing of them, with the implication that we regard our knowledge of the world as mere experiences. With the impossibility of the therapist's subjectivity encroaching on his/her observations, what is regarded as knowledge by the therapist is the truthful representation of reality. There is no acknowledgement of how the person of the therapist, and the context in which such claims of knowledge are made, impact on what is finally regarded as knowledge.

Meaning: As if it inheres in the words themselves, it is treated as being external to the users of language in both therapy training and practice. Those who use those meanings can judge them as being either correct or incorrect, elevating themselves to the privileged position of being able to define the truth, who is right and who is wrong. Therapists cannot personally be biased in the meanings they attach to their observations in therapy.

Process of knowing: With the convenience of easy cognitive storage and operation of knowledge in classes and categories, objectivism turns experiences into objects by categorising and classifying processes and people. An example is that of using various diagnostic labels and never fully realising that the labels exist only as we give meaning to them. Such objectified experiences are then acted upon as if they exist independently of the therapist and the trainee therapist espousing such an epistemology, impelling them to operate on the resultant objects as fixed entities. Clients are soon seen as having particular characteristics, without therapists realising the bigger ecology within which those characteristics are given meanings by therapists.

Science: It is an epistemology that is hinged on the perspective of discovery, on claims of ultimate, correct, definitive and general accounts of reality; on claims to discover facts such that it can be envisioned to be always progressing towards that reality. The therapists' rules become limited to being scientists, who are only interested in finding out facts, less interested in the interpersonal encounter of therapy.

Causality: An epistemology of viewing behaviour as determined, of linear causality, of the order

of x causes y, assuming that the therapist can untangle the causal link definitely. This may also lead to an impersonal practice of therapy where the therapist's role is merely that of a scientist discovering facts.

Person: The individual, and the client in particular, is portrayed as being determined. Imbued with objective qualities, we are able as therapists to know the final truth of any individual client, predicting behaviour absolutely.

Objectivism and What it Holds for the Therapist in Training and in Practice

Inger and Inger (1994) argue that objectivism requires the therapist to intellectualise, rationalise and to distance oneself from the emotional impact of the stories clients tell him or her about their lives.

It requires putting aside the genuine self of the therapist which is seen as constraining the therapist's opportunity to be human. It prevents one from relating to the client on the basis of the I-thou relationship (Inger & Inger, 1994).

Inger and Inger (1994) call for the embracing of one's own subjective perceptions, and to own one's senses in ways that will help enrich contact between the therapist and the client. They argue that a reliance on objectivism confines therapists to being just mere collectors of data so as to match already existing categories.

We are enjoined to risk putting ourselves in the crisis of uncertainty, shifting from believing that our own views represent the standard of conducting life, and to start listening to other's views (Inger & Inger, 1994). If we put away too much reliance on being objective, we open up possibilities for dialogue in which the client can be listened to from an inclusive point of view, wherein the latter's viewpoint is acknowledged as legitimate (Inger & Inger, 1994). But the prospect of co-constructing meanings with clients will not be realised if objectivism remains the ideal. We need to shed the shackles of objectivism, the belief in an objectifiable world of categorical thinking, hierarchy and absolutes (Inger & Inger, 1994).

Therapists have a tendency to tenaciously cling to their own beliefs about clients, thinking that they stand as valid proofs of reality. This is partly attributed to the fact that most psychological attributions and explanations of behaviour are impossible to disprove. In this regard, Furman and Ahola (Efran, *et al.*, 1988) require us to cast another look at several illusions that cause us to think that our views of the world in therapy reflect reality with certainty.

(a) Searching for confirmation. We normally find comfort in looking for evidence that would support our own views and disregarding what might challenge them. This is related to Furman's idea that "therapists go with an intervention already in mind and then come up with a hypothesis that supports it" (Hoffman, 1991, p. 13).

If a therapist believes that a child's difficulty relates to issues in the parental subsystem, the therapist will go all out looking for evidence to support this view.

(b) Anything that can be evidence for anything. Controlled by the above illusion, whatever happens in the family session the therapist will easily find evidence to the fact that the child's difficulty relates to difficulties in the parental subsystem, notwithstanding what each of the family members says or does individually or as a family.

(c) Making up causes. Lynn Segal (1986) argues that our belief in objective reality arises from being able to correlate that which we do see with our other senses. An example is seeing an object, touching it and operating with it and concluding that it is a pencil. This later enables us to think that object X causes object Y. Furman and Ahola (Efran, et al., 1988) view this as losing sight of the multiple causal nature of the X and Y objects. Maybe there is a third object or the appearance of X and Y together is just coincidental.

(d) Provoked reactions as evidence. In therapy, what the therapist says or does is limited or constrained by the social processes that include what the client says or does, inasmuch as what the therapist does constrains the client's behaviour (Fruggeri, 1992). Therapists normally come to therapy with certain beliefs that set the tone of their conduct with the client. We may gear the process of therapy to certain particular directions because of what we believe in. When the client responds in certain ways, we are unlikely to acknowledge this as a response provoked by us, but

as a proof of how things really are.

(e) Self-fulfilling prophecies. Believing in essentialism (Burr, 1995), that there are essences inside people and things to make them what they are, will blind us from noticing how and when therapy becomes a self-fulfilling prophecy. Furmand and Ahora (Efran, *et al.*, 1988) cite an example of generating resistance among one's clients because of the presumption that clients will resist therapy. When this happens our illusion is to believe that we were right from the very beginning.

(f) Regarding cure as proof. A therapy outcome is more likely to be determined by the therapist's expectation than the expectations and biases that the client brings to therapy (Goolishian & Winderman, 1988). From this it can be argued that a therapy outcome is a reality constructed by both the client and the therapist. It is not unilaterally determined by the therapist.

The likelihood of being blinded by this process is strong. When this happens, we attribute the outcome to our ability in having formulated the right assumptions, hence having made the most precise intervention to tap this assumed reality.

When a particular family ends therapy with the satisfaction that it has been beneficial to them, it might not just be that we were right at the beginning. It might not just be because our assumptions at the beginning of therapy were right. There could be many other factors in this explanation. Their ending therapy happily might not just be because we were able to devise the right treatment.

(g) The illusion of unanimity. We tend to believe that, because our clients agree with us, we are right along. With this, we fail to realise that what we jointly believe in is determined by our joint conversation with each other, and basically by our joint assumptions and by how each influences the other's assumptions.

While objectivism is useful, the above discussion has shown that objectivism, with its ardent striving for objectifiable, valid truth claims about reality, fails to acknowledge the wider context in which such claims to knowledge about reality are made. Of significance here is a failure to

realise that therapists, as creators, impact on the nature of the unfolding events in therapy.

Ushering in Constructivism

It is as a result of the above loopholes inherent in objectivism that constructivism was developed. Constructivism is seen by Fisher (1991) as an alternative to objectivism. "From a constructivist view, it is not possible to match our perceptions with items in the environment, what is important is that they fit sufficiently to ensure ongoing viability" (Hoffman, 1988, p. 113).

Construed reality. The possibility of the therapist being able to claim an objective view of the structure or sequence is seen as an illusion (Hoffman, 1988). Problems are seen to exist only in the realms of meanings, in our attempt to give meaning to our experiences. The reality of problems in therapy is viewed as constructed by us (Hoffman, 1988).

We need to take a critical stance towards the taken for granted knowledge that includes the view that our observations of the world yield its nature with clear certainty to us (Burr, 1995).

Burr (1995) further encourages therapists to challenge the notion that we can arrive at unbiased observations of the world, that what exists out there is what we perceive to exist, and to be suspicious of our own assumptions of how the world appears to be.

I consider Keeney (1983) to be the writer who most helps me to see this perspective fully. He perceives no direct correspondence between events occurring outside of us and our inner experiences of them, because the world as it appears to each one of us is constructed by ourselves. He wants us to look deep into our own epistemologies. He sees an epistemology as "being concerned with the rules of operation that govern cognition, as attempting to specify how particular organisms or aggregates of organism know, think and decide, a way of how people come to construct and maintain habits of cognition" (Keeney, 1983, p. 13).

What we do think about, is determined by our particular epistemology. It is therefore fitting to see that one's knowing about therapy inevitably changes how one does therapy. What one believes in determines what one perceives (Keeney, 1983). For Fisher (1991, p. 3), "the way in

which we know about things guides how we act". This relates to therapy too. It is here that numerous authors challenge the wish to have reality existing independently of us, to follow laws, to be predictable and discoverable.

The Observer and the Observed

As one of its tenets, constructivism sees no reality independent of the observer, views as a myth the belief that there can be any objectivity. It calls us to be sensitive to the limits of what we can know (Segal, 1986).

Von Foerster is quoted in Segal (1986, pp. 16-17) as saying that "constructivists challenge the assumption that reality exists independently of the observer. We fool ourselves by dividing the world into two realities, the subjective world of experience and the so called objective world of reality and then predicating our understanding and matching our experience with a world we assume exists independently of us".

This is not supposed to be viewed as finding fault with traditional epistemologies, but as a way of encouraging us to account for that which we say we know, without first assigning it an independent existence (Segal, 1986).

Fruggeri (Mcnamee & Gergen, 1992, p. 40) talks about reality as being self-referential to the observer, that "individuals in their processes of constructing the world are bound by the beliefs, maps and premises that they have about the world".

The self-referential nature of therapy and our observations shifts us to become aware of the impossibility of "separating the study of an object from the study of the knowing object" (Fruggeri in McNamee & Gergen, 1992, p. 40), and for that matter "psychotherapists are seen to be constructing through their own understandings and descriptions the interactional processes they are involved in with the clients".

When this happens, with the notion of self-referentiality, one notices that "the lawfulness and certainty of all natural phenomena are properties of the describer" (Segal, 1986, pp. 3-4).

Dell (1982) is quoted by Fruggeri (McNamee & Gergen, 1992, p. 42) as having echoed the same view when he said that "the regularities of individual/family's functions are not features of that person/family, but of the therapist's description, as what the therapist brings to the client".

Fruggeri (McNamee & Gergen, 1992) cautions us against equating this way of thinking with solipsism. We are reminded to realise that the constructed reality is in the social process between the therapist and the client(s), and not limited to the individual's mind, even the expert individual in the therapist.

Socially Constructed Meanings

For Burr (1995, p. 4), "people construct knowledge of the world between themselves in their daily social life interactions, particularly through language. What we regard as the truth is a product of the social processes and interactions in which people are constantly engaged with each other".

People's identity (who they are and what they know) is a result of the social relationships in which they participate (Boughner, Davis & Mims, 1998). "We create our understandings of ourselves and of the world through discourse with others in our own particular contexts" (Boughner, *et al.*, 1998, p. 6).

For Fisher (1991, p. 14) "constructivism proposes that we are substantially authors of our own destinies, but this is always in relation to others as a mutually constructed process", that each body of knowledge needs to be understood in terms of the particular frame of reference it was constructed for.

"Descriptions or constructions of the world therefore sustain some patterns of social action and exclude others" (Burr, 1995, p. 5).

There is no such a thing as a problem, except as a product of conversation between the therapist and the client. It is through the use of language between the therapist and the client around the given situation that a consensus is arrived at as to what the problem is.

Bogdan (1984), quoting Bateson's dictum of an ecology of ideas, helps one to realise that the sharing of ideas and meanings in what we say to each other defines both therapy and what we see as the problem.

It is in this shared ecology of ideas that therapy comes to be formed. Because the problem is not out there, except as created in this languaging together, it is when the conversation shifts from talking about the problem to solutions that the problem dissolves. When the problem dissolves, therapy too dissolves (Anderson & Goolishian, 1988; Goolishian & Winderman, 1988; Hoffman, 1988).

These authors further believe that it is the problem that determines the organisation of therapy. It is through the languaging between the client and the therapist that a therapy situation is formed. For that matter "social organisation is the product of social communication, rather than communication being the product of organisation" (Anderson & Goolishian, 1988, p. 378).

Having mentioned that therapy derives from the socially constructed meanings in language around the alarm situation of what gets to be defined as the problem, and that the epistemology of constructivism is far removed from being solipsistic, we can move to see what this means for Fruggeri (Mcnamee & Gergen, 1992).

The self-referential nature of what the therapist can construct and give meaning to is constrained by the client's meaning making and construction of reality, in the same way as those of the therapist's constrain those of the client.

What emerges is a recursive interplay of meaning making patterns of feedback loops, in which each keeps adjusting and readjusting to the context each is setting for the other.

Goolishian and Winderman (1988, p. 138) comment that "most therapists would agree that their names, theories and experiences influence what they observe, or that their information processing is selective. Yet very few would subscribe to the notion that their experiences (descriptive theories) determine client behaviour and the information that is discovered. As therapists, we tend to overlook our active participation in the behaviour confirmation of our

predetermined hypotheses and diagnosis. Equally important is the fact that clients also bring biases and values that influence their expectations of the therapist and the therapy".

Braten (1984, 1987) is quoted in Hoffman (1988, pp. 117-118) as saying "we each carry by our sides a space for the visual other, a space for another view". When as therapists we can realise this, the dialogical nature of therapy will be enriched and we will be able to adopt the perspective of others (Hoffman, 1988). We are encouraged to listen from an inclusive point of view (Inter & Inger, 1994), not to truncate the process of recursion by achieving closure (Fisher, 1991), not to turn therapy into a monologue (Hoffman, 1988), and to refrain from making our conclusions self-evidential (Fisher, 1991).

For Fisher (1991, pp. 29-30), "by recursion one develops an understanding of how each person in a system contributes to the operation of that system and we acquire some sense of how we as the observers are bringing forth our own observations".

Constructivism and its Implications for Ethics

"The ethical concerns of constructivist therapists go well beyond the usual issues of professional misconduct, such as having sex with clients. For constructivists, the entire therapeutic venture is fundamentally an exercise in ethics - it involves the inventing, shaping and reformulating codes for living together. In other words, from this point of view, therapy is a dialogue about interlocking wants, desires and expectations of all the participants, including the therapist" (Efran, et al., 1988, p. 32). Ethics goes well beyond the simple application of rules or codes of professional conduct. It is embedded in the context of therapy, the relationship and the multiple impact both the therapist and the client have on each other . It is not limited to specific conducts only, but is present in the bigger context in which those conducts are being enacted, and in the motivating or facilitating factors behind them. It is embedded in the multifaceted context of the therapeutic relationship, including all that is overtly and covertly shown.

It calls for the realisation that one's constructed reality is just one among many, within a multi-universe of others. This leads to the narrowing of the distance between the client and the therapist (Hoffman, 1991). Because the therapist's personhood influences his/her conduct in the therapy, the notion of being the expert who can remain neutral becomes a fallacy. One cannot not be in a relationship because one cannot not exert influence. The fact that the personal and professional lives of the therapist are infused implies that what is purported to be knowledge in therapy is relative to the context from which it comes and in which it is applied.

Realising the impossibility of not influencing the other, the therapist should acknowledge that what one sees is merely a partial arch of a bigger picture of a relationship. Taking competence as an example, this brings us to the realisation that assuming ourselves as competent implies that we are seeing our clients as incompetent. Both competence and incompetence are relative terms. What we considered as a difference is actually a relationship (Keeney, 1979; Fisher, 1991; Becvar & Becvar, 1996).

Having hinted at the relativity of truth, the limits of what one can know, constructivism calls for "the observer to account for himself in his observation" (Segal, 1986, p. 28). Being stripped of the comfortable illusion of certainty, we are ushered into the certainty of uncertainties. When ours is a socially patterned reality according to our epistemology, one is called "to examine the consequences of holding that position" (Fisher, 1991, p. 17).

We can no longer reify our own realities. We are offered a chance to explore our client's realities, and how he or she generates these realities. For Boughner (*et al.*, 1998, p. 13), accepting the notion that no final absolute truth exists will enable us to value our client's "stories as a valid construction of and for their very existence" (p.13).

Taking such a stance, though engulfed in uncertainty, we become aware of the many choices available to us. It is when our therapies are enriched with choice that cooperation, participation, and dialogue become the hallmark of our existence. When this happens both we and our clients become empowered (Segal 1986; Hoffman, 1988; Fisher, 1991): not really having given up objectivity, but acknowledging subjective objectivity (Becvar & Becvar, 1996), "that the observer is in the observed, the therapist is in the clinical problem, the reader is in what is read" (Keeney,

1982, p. 166). Hoffman (1988) speaks of the therapist as the one person who should be restrained from change, as wanting to unilaterally and unilinearly change the client without considering the context of the client-therapist relationship.

We further shift from an epistemology of doing something therapeutic *to* someone, to that of doing something therapeutic *with* them (Boughner, *et al.*, 1998), realising that therapy is a collaborative enterprise (Efran, *et al.*, 1988) and aware of the need to refrain from imposing our own views on others, the need to immerse ourselves in the larger system that includes ourselves and others (Hoffman, 1988).

The above discussion shifts us from objectivism, as the basis of a unidimensional therapeutic relationship characterised by a hierarchy based on competence, to start to appreciate constructivism and its implications for ethics in therapy. Leaving objectivism and embracing constructivism, we realise the ethical implications it calls us to take heed of: the constructed relative realities of possibilities, and greater potential for complexity. With constructivism ethics is seen as an issue with more pitfalls, requiring more complex understanding by the therapist.

Gelcer, McCabe and Smith-Resnick (1990) elucidate not only the practice but also the attitude enshrined in being a "respectful listener who does not know too soon nor understand too quickly" (Goolishian & Winderman, 1988, p. 141). Here, Gercer *et al.*, (1990) show how in circular hypothesising the therapist continues to subject his/her earlier hypothesis to adaptation or totally gives it up, with every fresh feeding back of information from the client. The stance is held again in circular neutrality in which one does not reify his/her observations, where one does not fix observations but allows oneself to co-evolve with all that is happening in the therapy.

In terms of the not knowing on the part of the therapist, the therapeutic conversation and not the therapist is the author (Hoffman, 1991). Hoffman (1988) again wants us to refrain from making therapy a matter of rational planning. This is furthered by Atkinson and Heath (1990), who view conscious control and willfulness to control others on the part of the therapist as bringing higher order problems.

Having given up the primacy of objectivity, "we cannot unilaterally control other people, but

only influence the interaction in which one interacts by changing one's behaviour" (Real, 1990, p. 259).

With a call for personal humility and responsibility (Auerswald, 1985; Segal, 1986; Real, 1990), Real (1990, p. 270) says that, "the expertise of the constructivist therapist lies not in intervention but in her/his capacity to promote a trans-personal poetic experience". Ensuing from the above discussion is the constructivist idea of personal responsibility because of the failure to enforce ethical codes as the only means of ensuring ethical conduct. This need for personal responsibility necessitates the development of the therapist's own personal ethical stance.

The constructivist epistemology should not be likened to encouraging the client not to take action (Efran, *et al.*, 1988; Atkinson & Heath, 1990), because Keeney (1979) believes that one cannot not have an epistemology. He quotes Bateson as saying that, "all therapists are based on theories of how to make descriptions. Those who claim so have nothing but a bad epistemology. And every description is based upon and contains implicitly a theory of how to describe" (Keeney, 1979, p. 118).

The not taking action is viewed as constructing another reality with its own constraints, again putting the self outside that reality and reifying it.

Having built on the notions of the fusion of the personal and the professional, the subjective and objective beings of the therapist influencing each other, the above discussion makes us realise that an involvement in therapy is itself an involvement in ethics which cannot be confined to specific actions only. It is an involvement of the self in the whole process of therapy. It leaves questions about the sole reliance on the professional codes of ethics as the enforcer of ethical conduct in specific situations. It starts to call for therapists to fully account for their own conduct in the therapy by taking personal responsibility.

Weaving the Threads Together - A Personal View

It might seem as if I have thus far arrived at different points of the same journey, so different that they might suggest a certain incongruence in my thinking.

This confusing incongruence has been spelled out in the second chapter where a discussion of professional codes of ethics was laid out. Following that, a different version (through a constructivst lens) was offered in this chapter.

I would like to take further the interlude to this discussion as hinted towards the end of the first chapter. As said in that section, I believe that an enriched, all encompassing way of looking at ethics can be arrived at when the professional codes of ethics are juxtaposed with the constructivist lens or vice versa. In that way it is not an either/or but a both/and notion wherein each provides a broader context to conceptualise the other.

I do not see my constructivist lens as meaning that the professional codes of ethics should be neglected. Instead the constructivist lens helps to put the professional codes in a way that is practically more meaningful for me. With this I can find comfort in applying the ethical codes in a way which is meaningfully justified by my way of thinking and being.

Several authors seem to concur on this view, where Pope and Vasquez (1991, p. 49), for example, caution against "viewing ethics as simply the obedient and unthinking following of a certain set of 'do's and don'ts'". Linked to this is Herliky's view (Corey 1996, p. 55) that "self monitoring is a better route for professionals to take than being policed by an outside agency". Corey and Corey (1998, p. 118) echo this by saying that the "ethic codes are a vital part of ethical awakening, but formal ethical principles can never be substituted for an active, deliberative and creative approach to meeting ethical responsibility". They further say that (p. 118) "although you have or will become familiar with the ethical guidelines of your specialization, you must still develop your own personal ethical stance that will govern your practice. You have the ongoing challenge of examining your own practice to determine whether you are acting as ethically as you might".

I see being self-reflective as my personal ethical position, which is facilitated by my constructivist lens. Embracing the lens of constructivism makes it possible to be self-reflective while still being aware of the importance of the professional codes of ethics. The advantage that this view offers is that it serves as a guard against the mechanical rule following of professional codes of ethics, enabling me to take the personal stance of being self-reflective, it carries for me

a caution that reminds me that, "although you are ultimately responsible for making ethical decisions, you do not have to do so in a vacuum. You should also be aware of the consequences of practising in ways that are not sanctioned by organizations of which you are a member of the state in which you are licensed to practice" (Corey, 1996, p. 54).

I therefore see my espousal of the constructivist lens as helpful in embracing the many ethical codes of therapy as enshrined in the various professional bodies. Allowing myself to be engulfed in the spirit of responsibility, humility, constructed realities, the multiple impacting nature of therapy, etcetera, the lens helps me to see the following ethical codes in a different and much more personally involving nature. In all the principles that follow, the constructivist lens helps me to realise that what is important is not to learn the rules or skills to apply out there, but to see them more as a matter of personal transformation, an attitude that is much more about the self than the principles themselves:

(a) Concern for the welfare of others. As the overriding principle, I can with the help of the lens, always be sensitive to and wary of pursuing my own needs in both obvious and unobvious ways (at the expense of the client). This is possible because I always acknowledge and monitor the impact I personally bring to therapy.

(b) Respect for people's rights and dignity. Coupled with being aware of the value ladenness and self-referentially of therapy, the lens helps in sensitizing me to know that what I do and say can affect the client's life in various ways, to see how my own needs can interfere with the effectiveness of my therapies.

(c) Informed consent. This too is still relevant. It does, like the many others, embody the principles of nonmalificence, beneficence, justice, fidelity and respect for autonomy (Weifel, 1998). I involve the client in the dialogue of therapy because I do not see myself as the expert.

Incorporating the lens in thinking and conduct in therapy, one's sensitivity to listening to others from an inclusive point of view (Inger & Inger, 1994) and not truncating the process of recursion by achieving closure (Fisher, 1991) or understanding too quickly (Goolishian & Winderman, 1988), helps in not turning therapy into a monologue (Hoffman, 1988), which is achieved by

constantly having the client share his/her view regarding any decisions to be taken throughout the whole process of therapy.

(d) Competence. This still holds. In line with what Pope and Varquez (1991, p. 100) call "staying current", adopting this lens helps one in realising the limited validity of what one says and can do. Called to realise that being competent is not an end that can be achieved and be completely dealt with, I keep asking for second opinions because I believe in the finiteness and subjectivity of what I know.

It is then fitting for one to forge links with other practitioners because on one's own one can get lost in the illusion of thinking that one is the expert, which can be harmful to the client(s). The necessity to continue learning is just a justification of the finiteness and limitedness of what one can know. With the help of the lens, competence is transformed from being a skill to being an attitude.

(e) Dual relationships. The lens offers a shift in thinking and practice beyond just a mere adherence to having such relationships, a fear of losing objectivity and impairing professional judgement. With warmth and humility, it gives one a practical sense of putting the welfare of the client first. I realise that the avoidance of dual relationships is not a skill that I need to apply, but that it is an attitude that should guide my conduct and sharpen my relatedness/conduct with the client.

(f) The ethic of working in a multicultural context. I find this to be at the heart of the constructivist therapy. Seeing subjective objectivity, having given up the expert role, being only certain of uncertainty, espousing the notion of self-referentiality, we cannot apply pre-packaged tools to any situation. Every situation needs a refreshed look. Everything we do and how we do it, is context specific. Working with minority groups and other foreign groups, we do not slavishly push for our own views to be accepted by them. We learn to tolerate self-restraint, to appreciate each new encounter, to truly immerse ourselves in it to gain a sense of what it is before even thinking of trying to fix it. Similarly to Hoffman's (1991, p. 13) view that "we let the conversation, not the therapist be the author", we allow each new context to teach us. I become aware that encountering with every client is like working in a multicultural context, where the

spirit is one of humility and not knowing should guide me where the need is not just to learn skills, but to transform the self to the suited needs of the client.

I find it is not a coincidence that a constructivist lens fits for me, as it helps in making me aware of my own fallibilities, the incompleteness in me. It offers me an opportunity to get in touch with my personal self in the practice of therapy, offering a tinge of the both/and, it enriches my practice in such a way that the personal and the professional complement each other as two sides of the same coin. It offers me an opportunity to be aware of how I can influence the client in terms of what I do or say in both obvious and unconscious ways.

Because the essay is about my experiences of ethics in therapy and training, and the journey to be a therapist, I am compelled to provide a picture of my personhood. This is to show how the self of the therapist is intertwined with the development of a personal ethical stance. My hope is that this will help one to see the link I am drawing between the personal and professional lives of the therapist; how I am grappling with drawing a picture of my personhood in the journey to be a therapist, how the journey and the context of the many events I went through (and still go through) helped shape (and still shape) in my personhood the ethics of responsibility, humility, respect and humbleness that constructivism so much engenders.

Because I find these traits reflected in constructivism, I do not see my view of reality as representing expert knowledge. I am aware of how my views of reality pervade my nature in terms of how I relate to others. I therefore need to take responsibility for what I do and say in relationship to others. A respect for others breeds humility and humbleness, a valuing of what the other is and stands for, which ultimately gives them a sense of growth.

Having said all this, I urge the reader to travel with me into the third part of the journey as fixed in this moment in time, in the chapter that follows.

The aim of the next chapter is to indicate to you how the journey has helped (is helping) me in coming to adopt this particular ethical stance. To show how my personhood has influenced my choice of the theory, how the two combined are influencing my understanding of the professional codes of ethics; and ultimately how my personal ethical style has developed (is developing) from

the three, that is, the personal, theory and professional codes of ethics.

It is also aimed at showing how the choice of the constructivist lens lends a testimony to the fact that I come to influence in the process of therapy in my own self-referential ways, how as a therapist I am in the therapy process in ways that structurally couple me to the process. As a testimony to the unfolding of my own subjective objectivity, it is aimed at showing how the need to be constantly self-reflective breeds a way of immersing oneself in the therapy process with the ethic of being respectful and humble.

CHAPTER 4

THE GALLERY OF MY SHADOWS

A Preview of the Chapter

Anchored around the constructivist lens of seeing the personal and professional of the therapist as infused, the discussion that follows looks at the notion of the therapist's shadows as an example of how such a fusion comes about. The argument in the discussion is that these personal aspects of the therapist, as shown in the shadows here, can be both a gauge and a bias of where the client is still situated in the personal life of the therapist, I also take a moment to reflect on my own shadows, how these evolved, by reflecting back on my own life history. To this, is added what the literature says about the motivating factors (shadows) in the lives of therapists-to-be, and about what shadows most therapists-to-be bring into the profession. Having reflected on my own shadows, and on what the literature says, I end the discussion by looking at the emergence of my own personal ethic which is guided by being constantly self-reflective.

Setting up the Stage

Part of my Unisa (Master of Arts) training in clinical psychology in the second year encompassed an attendance at forums where people would come and speak to us about some self-experiential issues in their lives that had a bearing on therapy. As part of this, I recall a day in the training, an open forum, where a man from Alcoholics Anonymous came to speak to us about his experiences of alcoholism. When, in the training group, we sat down afterwards to discuss our observations and experiences in listening to the visitor, the main theme that emerged was that of distress. We (the students) were upset by our own experiences, in our respective lives, of living with alcoholics. Upset and hurt by how living with alcoholics has disrupted our lives. How alcoholics are a bad omen and a scourge to our society. There was a pervasive sentiment of wanting to reform alcoholics, to repair their situation: a need for us to act as agents of social control.

I refocus back in my lens and hold on to the sage cautionary note of Hoffman (1988, p. 119), when she spoke of being less deliberate in therapy, the importance of minimising "the consciousness of the therapist in pushing for strategising, for change techniques".

Shifting again to come closer, to look at the shadows, I ask myself, why shadows and what are these? We harbour both some conscious and unconscious motives, needs that we normally repress to the back of our minds: the side of us that we mostly deny. These are the aspects of ourselves that I have come to call the shadows: some of these are those aspects that unknowingly impel us to want to be therapists, to do the healing work for others.

Looking back at our observations and experiences of listening to the visitor from Alcoholics Anonymous, my theory is that we could or did not want to look at the alcoholic in each one of us, the aspect in each one of us that reflects the struggle of staying confined to alcoholism. Denied as alcoholics are, and because we do not want to face them, we find ways of constantly keeping them covert. Streaten (Sussman, 1995, p. xii) mentions that "when I feel or act omnipotently in the therapeutic situation, I am trying to silence my impotence and vulnerable feelings. I also realised that when I am overtalkative and overactive, I am uncomfortable with my passivity".

Tick (Sussman, 1995, p. 27), in his work with war veterans in the combat zone, talks of the necessity that the therapist "look at aspects of the self and human condition that we would rather leave unexamined and that the public's conscious awareness, for the most part, denies. Such therapy requires that the therapist examine past personal experiences - and own them in a self-disclosing manner far beyond the usual demands of the therapeutic process".

Supporting Sussman's (1995) compelling argument about the need to acknowledge those aspects of ourselves in our being as therapists, Kottler (1995, p. 3) talks of "harnessing my pain in such a way that it has proven to be among the most cherished gifts".

My contention is that a healing atmosphere is created when we meet the client with the person who we are, when we bring our own shadows to the fore as our guide posts. The ethic of being humane, humble, respectful and accessible is embodied in acknowledging and accepting our

shadows in a way that would not be dangerous to us and our clients (Sussman, 1995).

Sussman (1995, p. 6) talks of the hazardous nature of therapy, the days of Freud when "acting as blank observers or reflectors of clients turned therapists into 'shrinks', literally shrinking their humanity".

Considering the work of doing therapy as a calling, it is regarded as antitherapeutic just to assume that every therapist involved in the calling is motivated by the pure need to help others. We are urged to reconsider ours and others' motives for wanting to be therapists, to enquire about the shadows that each one of us carries (Sussman, 1992; Sussman, 1995).

A question asked by Sussman (1992) is: How is the therapist's activity an exception to the rule of seeing sculpting as a sublimation of the wish to play with faeces, and of surgery as a constructive channelling of sadistic impulses?

Guggenbuhl-Graig (Sussman, 1992, p. 8) says that a therapist, like any other person, cannot be seen to act out of pure motives. "Even the noblest deeds are based on pure and impure, light and dark motives. Because of this, many people and their actions are unjustly ridiculed or compromised. A generous philanthropist is almost always motivated among other things by the desire to be respected and honoured for his generosity. His philanthropy is in no way less valuable for that. Similarly a social worker strongly prompted by power motives may nevertheless make decisions helpful to his client. But there is a great danger that the more the case worker pretends to himself that he is operating only from selfless motives, the more influential his power shadow will become until it finally betrays him into making some very questionable decisions."

We are exhorted to consider our own motives, our shadows, because the therapist's only tool is himself. The therapist must rely on his/her personhood for what happens in therapy, because that is his/her only tool (Sussman, 1992). Strupp (Sussman, 1992, p. 6) argues that "the therapist's personal influence outweighs the effects of particular techniques on treatment outcome".

Acknowledging the way in which his training, books he has read, workshops, seminars and

supervisions attended, have been instrumental in the shaping of the way he functions as a professional therapist, Kottler (1995, p. 3) acknowledges that, "however the essence of what I know, what I have written about and taught others, comes not only from these formal learning experiences, but also from surviving, even flourishing, after a childhood in which I felt so down-trodden that I never gave myself a chance to succeed in life".

It is no surprise that one of the tenets of the psychoanalytic tradition has been to encourage the analytic therapist to work out his/her unconscious motives. Basic to this tradition has been a need to alert one to the dangers of allowing one's countertransferent tendencies to encroach into the therapy (Corey, 1991). Supporting this, Hammer (Sussman, 1992) speaks of the need for therapists to explore their shadows, their hidden motives for wanting to do the work, so as to be able to prevent those needs from inappropriately affecting their work.

What I find useful for me, is the remark that, brought to the fore, one's shadows can enrich his/her set of resources that can be effectively utilised for the benefit of the client. I am struck by the shift in thinking from seeing the therapist as the blank screen objectively reflecting on the client's issues. A shift in thinking that now shies away from discarding those shadows to actually utilising them for the benefit of therapy, from assuming that the therapist can leave his/her personhood at the door, to encouraging him/her to take it along into therapy.

With this, we can no longer hide behind the pretence of omnipotence. When we not only tag along but also become aware of our own shadows, it makes it possible for us to transform them to become invaluable assets in therapy.

Gone are the days of the invulnerable therapist, the objective shutting out of the personal from the professional, the all-knowing therapist. We need to be aware of the dangers in which our shadows creep into our therapies in subtle ways. Until this is done therapists will continue to inflict a lot of harm on the client, both conscious and unconscious.

The discussion so far has provided enough ground for me to lead you into my shadows as a person and in learning to be a therapist. The discussion has looked at and discussed what I call the shadows, that is, the personal aspects of the therapist that can serve as both a positive

facilitator and a hindrance for the therapist to gauge where the client is. The discussion has also raised the importance of each therapist reflecting on how he/she impacts on the therapeutic relationship in both obvious and non-obvious ways, because of the shadows that he/she carries. Because this represents a personal account of the themes colouring my life, I cannot find a way of doing it without the trepidation of not knowing how to do it best.

I find myself being deeply touched by the quote from Kottler (1995, p. 15) that, "as I journey back in time, leaving the beauty of my present surroundings for the bleakness of the past, I wonder how I ended up where I am now. How and why I ever became a therapist and not an entrepreneur like my brothers, a salesman like my father, or a printer like my grandfather".

Hopefully I will be able to tease out the shadows in such a way that my journey of ethics in training and therapy will become clear to you, the reader.

Who is this Traveller?

Overcoming The Not Enough And The Fear For Failure

It has not been clear what it was in those early years of growing up. It is through reflecting on it now that I can start to gain some faint glimpse of what the propelling forces were and what it looked like at that time. A scourge and a blessing at the same time. A scourge because it highlights the one-eyedness, one-leggedness in me. A blessing because it propels me into bettering myself in a way that always heralds a sense of "there is something better at the end of the tunnel".

Epitomising high spiritedness and exuding a sense of perfectionism, it never occurred in my nature that I should settle for any second best outcome in all I wanted. I never imagined this as throwing myself into the deep end, of losing touch of my real self.

In what looked like burning the midnight oil, I became the hard worker, never sparing a second for a rest - which I still do. My being in this training is partly a testimony to that. I studied at night and worked during the day.

I was a paragon of hard work, people really admired me for what I was achieving, but could not be reached out to because of the pain I was carrying inside. I enjoyed being independent and self-sufficient but deprived myself of the natural care that the self needed.

Brought up to be self-reliant and stoic, I would never let anyone see my vulnerability, the neediness or any emotions that would signify weakness. Being the strong one, the rescuer, I became adept at expressing anger easily, at those I found inflicting harm on others.

Looking at the many milestones of my life and other themes that emerged, those of not being enough, fear of failure and being unsure of the self, are the most pervasive and basic.

A black male with a rural background, I was brought up in a big extended family from 1969. Brought up a step-son myself, I am now a step-father. The strict Christian upbringing coloured my personality and those of others then; in what was to be a mode of suspiciousness concerning engaging with others later in life. A religious service was forcibly attended twice a day. All was according to the Bible. Interaction with others was restricted except at school. Whoever did not belong to this family and religious group was openly called a "heathen".

I keep asking my mother why I am not religious now, and she says that I have always hated the church, even before I went to school at the age of seven in 1976.

My sister, a year older than me, and I grew up looking like twins, but I have always resisted being treated as the younger one. I considered myself a lot wiser and more responsible.

Growing up with a father who deserted us before we could go to school was hard and confusing for my little, growing mind then. A sense of shame was instilled by always overhearing other elders badmouthing us and our mother by assuming that I was too young to hear and understand.

As if to aggravate my embarrassment, my substandard A teacher would ask us about our father's names, which other kids could confidently say. I felt mocked for not knowing my father or challenged that I was lying and that I did not have a father. I blamed and hated my teacher for

having created those shameful moments. Coming home I would keep a lot to myself, knowing that I would be shouted at and then be told that my father is 'a tree'.

A Difficulty Rejoicing Over One's Success Set In

Come Christmas and Good Friday, when everyone received presents. I expected to get nothing, or to receive second hand clothes because my mother was working as either a domestic or farm worker. I was still younger than 9 years of age, but I expected others to shout at me, to hurt me, and I really received what I expected. I did get shoved around, shouted at. I wondered why I was treated differently from every kid, even from my own sister. I realised how unnecessary it was to waste time complaining. I physically arranged for myself to take the back seat, for example, when being given presents. Many therapists-to-be are characterised by this brooding nature, the sinking into the desperation of theirs and others' pain.

The frustration I carried came from realising that the ill treatment was from family members and not outsiders. Fending for us, mother was most of the time not around.

Shattered Hopes

When my mother married my step-father, it brought many hopes that life would be better. The period was 1979 - 1980. I looked forward to this as a retreat from not having had a father for too long, with hopes of having a parent in full-time employment. I expected it to bring a new identity, but not the one I got.

We finally moved to the new home village in 1982, but before this the two of us and a younger brother went to stay with relatives, my mother's sister.

What a living hell it was. Being 11, my sister 12, and a younger brother, 5, we were left alone most of the time. Neighbours in that village knew that we were without a father, beggars, eating a lot. I still don't know how we survived. I could have dropped school and started stealing. We learned to just look at each other, to be quiet when things went rough, to just assume that everyone was feeling it, but not to share it among ourselves.

Settling into the new village in 1982, my mother had given birth to twin brothers. The other twin brother died when he was a year old. Two younger sisters were born in later years. Being the breadwinner of an extended family, my step-father lost his job in the same year. Again I still don't know how we survived because for all my schooling years there was no one working at home, except for my mother sometimes working at nearby white-owned farms.

As a black person, you are made to grow up with shame and guilt for not being a blood family member. You walk around and see people disregarding you for being a step son. I felt half-human and as if I did not belong.

Except for the unexpressed disappointment and hurt inside, I felt ashamed when my elder sister fell pregnant in 1984, the year I went to the circumcision school. I hurt because it increased the burden of responsibility on my parents' needy position. I felt ashamed at having to stand the whispering about the incident in the community.

As if this was not enough, to cap it all, a younger sister nearly died of what the nurses called malnutrition. I recall being told by my mother that a nurse mocked them about my younger sister's condition. This reminds me of hearing some extended family members saying that they were wondering how my mother was going to feed us if she was so concerned about making babies. I was really hurt to hear people regard my family as not good enough. We still have extended family members who never visit us and tell others not to because we are poor.

Being a step-son brought up some painful challenges too. There has always been some tension between me and my step father, which most of the time I interpreted as unfair singling out. No one knows that I was told by him several times to leave the family. Leaving then would have been the end of my life. I still shudder at the thought of it because I had no place to go to, besides the fact that I was between 12 and 16 years of age.

I cried many times alone. I would look for a secret physical space to do my crying. I do not remember myself crying openly, until the death of the only surviving twin brother, in 1991. We were all at home, except my step father, when he was struck by lightning. We could not save his life.

Never Thought of Myself as Deserving any Care

Instead of attending to the pain of loss, I found myself standing up stoically to prevent further harm to the family. Wishing it were my own death, I started my journey of self-sacrifice. There were the police who wanted to stop the funeral and other relatives who claimed that because my mother violated the known customs of marriage, we could not bury my brother at home. I single handedly warded off all these and the funeral went on at home.

Developing an Exaggerated Sense of Responsibility to Save Everyone

I saw myself as carrying the burden of everyone at home; going out of my way to force myself to forget about my own pain and neediness in order to shield others. I chose the most convenient way of not exposing my own vulnerability for fear that others would not come to me for help. I still can't ask for help. I did not realise how this was making me alienated from my real self, bottling up a lot of hurt, hatred, sadness, etcetera, in me.

Always wanting to help others, I thought I was doing it for them, not aware that I was only rescuing myself from seeing others in pain. Their pain reminded me of my own pain.

For many years I did not speak about the pain of losing a brother, being deserted by a father, etcetera, thinking that I was saving everyone from hurt. I never spoke about the pain of growing up, for fear of causing old wounds in others.

In the process I felt much pain because no one really saw how I felt. I paid a very grievous price. I developed very severe abdominal pains, headaches, nose bleeding, etcetera. I have come to understand these illnesses as metaphors of bottled up feelings pushing themselves out for release.

I now understand the workaholic in me as the trying to deal with the sense of not being sufficient. I made it difficult for others to reach out to my 'not being enough side', to offer me assistance, because I never accepted this side as part of me. Having grown up in a family that begged for everything, I wanted to steer clear of that experience.

It would be belittling to acknowledge the not being recognised and not being enough in me. I found it very comforting to identify with the part of me that strove for the best, working hard. Realising the hardship my family endured, I opted for an ascetic lifestyle, postponing self-indulgement sounded very logical.

Loneliness Creeping In

With the growing impatience in me, I was sliding into the deep end of solitary childhood and adolescence. I never had a friend, still do not. This cutoffness took its roots from home, finding it more difficult to relate to both my siblings and parents. Amazingly I developed a knack of being there for others when they are in need - responding very quickly and spontaneously to traumatic situations.

I did not realise then that I have a deep fear of being hurt by rejection. First, my particular nature looked like a well calculated plan which sparkled rare intelligence, not knowing the havoc it was to usher into my life. I belonged to several associations by just being physically there, sometimes feeling misunderstood or forced to belong.

Harbouring hurt and anger disguised in silence towards my elder sister, mother, biological father and relatives on my mother's side for over twenty eight years (1969-1998), I blamed everyone for denying me the life that I so much imagined could have been.

When stress took its toll on me, causing severe nose bleeding and abdominal pains, the obvious way out was to go to medical doctors, faith healers and inyangas. My many speculations around these saw me going to places I have never been to, doing things I would never have done, from being told that I was bewitched, that I should go back to the church, to coming just short of being medically operated on.

The silence around my biological father broke after 28 years when I located him. It was a relief experience to find out about the pain and hurt both my mother and elder sister had carried through this conspiracy of silence. For reasons I do not know, I also felt relieved from the psychosomatic pains I carried all the time. I am still being haunted by the feeling of wanting to save others, to

sacrifice myself. I still ache at the thought of knowing that my step father lost a son through lightning. Going home now and seeing him being in such an ailing physical condition, not working, the many years he spent not working, makes me forgive him for our tough relationship when I was growing up. I can't afford to see him go through more than what he has had to endure now. A fear of facing conflict situations, being the peacemaker who always steers clear of hurtful situations.

The Emergence of a Personal Ethic in Therapy

I start the discussion by reflecting back on how I was moulded into adopting my particular personal ethic in therapy as will be shown from here onwards; by casting another view backwards onto the salient aspects of my upbringing as shown in the above discussion, and in terms of what the literature says.

The stoicism, self-sacrifice and thought of thinking that I do not deserve any care, are explained by Goldberg (1986) as a result of being exposed to others' sufferings that evoked pain in the self. Here Goldberg (1986, p. 56) tells of a story of a man who grew up to be a physician, whose mother, when he was growing up, "spent half her life in hospital. She regularly had severe asthma attacks, and as the eldest son in the family - he would call for ambulances or hail taxis to rush his mother to the hospital".

The development of my exaggerated sense of responsibility to save everyone is linked to a realisation that, as observers and not-participants in the family and social situations, therapists-to-be develop an acute sense of other people's situations. They become drawn to wanting to cure other people's pains (Goldberg, 1986). One of the reasons they become cast as nurturers in the family, is the chaotic family life that they grew up in. Reasons range from "a missing or psychologically unavailable parent, a psychologically disabled parent(s) by whom they were induced to try to heal and comfort as best they could at an early age at which they had neither the maturity nor skill to do so effectively" (Goldberg, 1986, p. 55). The tenacious determination to do the healing work in one's growing up, sets one well on the road to practice as a therapist.

As for the ascetic lifestyle, postponement of self-indulgence, Goldberg (1986) believes that

people who grow up to be therapists are characterised by early lives of loneliness. Having learned to retreat into their own worlds of self-exploration, such people have not only been tolerating long periods of solitude, but deliberately sought it too. Carl Rogers is quoted in Goldberg (1986, p. 54) as saying that "I remember no social life at all. I was not too lonely, however, because I spent the long evenings with my new books - I realized that I lived in a world of my own created by these books".

Emphasising the loneliness of retreating into self-exploration, Goldberg (1986) further quotes Burton who says that "it is not that therapists are uncomfortable with the social scene but that their inner life is so much richer than the often ritualized allegro which passes for social life. The words introvertive or schizoid do not describe this creative state of being - these are pejorative terms - for it is voluntarily elected, and some people require more incubation of their creativity than do others. This inner dialogue with parts of the self, or with the temporarily and spatially juxtaposed, satisfies the interpersonal's self-other need but also provides an epiphenomenal feeling of being separated or special" (Goldberg, 1986, p. 54).

Looking back at the development of my own physical ailments, for example, abdominal pains, Goldberg (1986, p. 57) refers to many renowned therapists who were affected with serious physical ailments in their growing up. "Rudolph Ekstein, with a chronic ear condition, which later developed into partial deafness, and Arthur Burton with pulmonary asthma". It is in going through such pain that the therapist to be is sensitised early in life to the pain of life that his/her clients will be bringing to him/her in his/her practice.

Goldberg (1986) brings me to grappling with the question: "Where does the journey to be a therapist begin?" Therapists bring their own woundedness into the practice, which serves as an anchoring motivation to stay on. Having looked at the childhood lives of many therapists, Goldberg (1986) asserts that they were moulded over a long period in their families of origin into fostering "an exquisite sense of the inner life of others, which becomes the hallmark of the therapist's calling" (p. 58).

With the help of the literature consulted in this chapter, I hope that I have tried to show that my own upbringing in life testifies to that moulding as hinted at by Goldberg. I have also tried

to indicate that the many hurdles and bumps I have had represent my shadows.

In his talk about the intricate relationship between the personal and the professional practice of the therapist, Goldberg (1986) emphasises the fact that therapists are impelled by their own inner wounds to want to heal those of the client.

Exhorting therapists to inquire for themselves into their motives to wanting to do the work of healing, I find both Goldberg (1986) and Sussman (1992; 1995) asking me to inquire into my own.

Unless we are prepared to risk this excruciating self-searching questioning, we will continue to do therapy because of the deep-seated guilt and compassion for others that we are also denying for ourselves (Goldberg, 1986). We continue needing our clients to help us repair our own wounds and to confirm our nurturing roles (Goldberg, 1986).

We risk being trapped in an ethical dilemma hinted at by Pope and Vasquez (1991), by meeting our own unmet needs, areas of our unfinished business, through our clients.

The following quote from Burton is mentioned in Goldberg (1986, p. 48). *"We can distinguish between repair needs and growth needs. Repair needs come into play when the therapist realises he needs his patients in order that he can be confirmed as a therapist. He thus becomes aware that his self-esteem depends on his seeing his patients thrive ... as a mother feels confirmed by seeing her child thrive. Winnicott has specifically made this point. He emphasised that a doctor usually embarks on a life-long career of doing repair work ... because of his own psychological needs. Obviously, he could not do this repair work without recruiting a patient ... In addition to becoming confirmed as a parent and doctor, the therapist needs his patient in order to realize his growth potential. There growth needs, rather than repair needs, seem important. Thus a deeply anxious schizophrenic patient may bring the therapist into closer touch with areas of disassociation, disintegrative anxiety which the therapist can now experience ... and allow to contribute to his growth. Yet when we reflect ... we find we have to steer a narrow and precarious path from which we can stray in either of two directions. Either we can need our patients too much, keeping them dependent and needy or we can need our patients too little and*

lack motivation for getting ourselves deeper into it". Corey (1996) makes a similar point.

Both Sussman (1992; 1995) and Goldberg (1986) would quickly rush to caution us against the ethics of conducting this kind of therapy with any client.

It is the extent to which therapists are willing to recognise this that will cause them to carefully, knowing that they are not mechanics relating to the client in an impersonal way. We do not just relate to the client as an entity out there, but use our own inner pain (as in our shadows) to be responsive to the pain of the client.

I am finding the journey to be a risky road, along which I could harm my clients. I thus need to take little stops along the way and hearing the sage advice of Goldberg (1986, p. 13) to realise that my own illness, pain or shadows "can thus become a vehicle for attaining a higher level of consciousness, if the traveller has kept his inner fires ignited and utilized them as a means to direct his life. These inner fires, originating from the fierce passion of combat with illness, may be employed to inspire others, as well".

The way we are, our whole personhood, including our shadows, facilitates or impedes a way of looking at the self in relation to others. It leads us to relate in therapy using a particular way of ethics far beyond that which is prescribed by the professional bodies.

The discussion in the next chapter is geared towards indicating that, having come into the training and the practice of therapy in my own unique way, I have had to be faced with and grapple with ethical issues in an unique way. I have also been influenced by my personhood and shadows to adopt a constructivist posture as I have found this to be best expressing my struggle of wanting to bring about fairness in the world.

In answering the question: "Where did my journey begin?", I align myself with Goldberg (1986), thinking that I was coming into the training moulded in a particular way to be attuned to the pain of living. It is through this attunement that a particular way of ethical behaviour has been provoked in me, as indicated in the next chapter.

I believe that in coming into training, I already had the ethical traits of humility, respect, humbleness and responsibility entrenched in me. It is through this way of being, as moulded through the various life milestones shown in this chapter, that I came to find constructivism as a comfortable, healthy way of expressing conduct in therapy, as I mentioned in the previous chapter.

Helping me to embrace the core ethical principles of conduct in therapy as articulated by Koocher (*et al.*, 1998), coming into the training with this particular ethical stance, has encouraged me to draw strength from my shadows, to constantly reflect on my own conduct. Using my own shadows, pain and personhood has encouraged me to find ethical conduct in therapy as not just a mere rule following of the obligatory moral conduct stipulated by professional bodies. I have tried to come up with a way of merging a personal way of being with the prescribed professional conduct to enrich my own ethical therapy conduct.

The next chapter aims at showing the practical confluence between the professional and the person in ethics that kept guiding me along the way. It focuses on how I came into the training and the practice of therapy, and how the choice of the constructivist lens influenced my interpretation of the professional codes of ethics into evolving a personal style of ethics.

CHAPTER 5

GRAPPLING WITH ETHICAL DILEMMAS

Preview to the Chapter

While the previous chapter unravelled the shadows that I carry into therapy, this chapter looks at how I come to interact personally because of the shadows I carry. Taking a constant self-reflective stance, it looks at both the positive and negative impact that the shadows of the therapist bring to therapy. Hinged on the premise of the inevitability of the fusion between the personal and the professional, the chapter looks at the therapist's grappling with the inherent ethical dilemmas the therapist faces in therapy, by using my own experiences as an example. It carries a critical inquiry into the taken for granted ethical conduct of the therapist. It does not aim at arriving at finite answers, but at a creation of dialogue about ethical dilemmas by remaining constantly self-reflective. To do this I start by looking at the positive side of therapy as guided by my own shadows, which are my gauge of where the client is. A literature review is used to support this. It ends with the opening up of the void, but also the creation of higher order ethical sensitivity by criticising the very conduct I earlier justified as providing holding and healing. This approach helps to create and not to stunt the dialogue about ethical dilemmas, which are always there. To this end the following quote explains the situation:

"Those who feel they need psychotherapy tend to be the very people who are most easily exploited: the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed, whose depression is often such that they are willing to do and pay anything for some improvement of their condition" (Forster, in Holmes & Lindley, 1998, p. 155).

This quote shows some of the inherent ethical dilemmas in being and learning to be a therapist. Although therapists are schooled by the professional codes of ethics, not to harm clients, this knowledge being further instilled by the many years of experience in their work, they still remain fallible beings who can harm clients in their practice or during training. This is illustrative of the dilemmas of dichotomising professional codes of ethics and personal ethics.

The Ethics of Holding

The above quote indicates some of the troubling experiences clients bring to therapy. It shows the delicate balance that we walk in creating a healing human encounter. With the possibilities of client exploitation ever hovering above our heads, our priority is that of facilitating a healing space for the intense emotional wounds which the client brings to our encounter. With objectivism and its master craftsmanship gone, the lens of constructivism leaves us with only ourselves in this human encounter. Since the only way to go is to be human with the other, we need to fully position ourselves inside the therapy with the person we are (Gerson, 1996).

We can only use our own shadows if we want to identify with the client's. Using the shadows in us will allow us to be empathic, compassionate and able to perceive the client's emotional field as reflected in ours (Symington, 1996; Stevens, 1996). It is through that empathic and compassionate meeting with the other, that a healing human bridge connecting the client and therapist is formed(Stevens, 1996): an ethical way of being respectful, human and humble, through using our own shadows to reach out and create a healing human experience with the client.

It is this particular encounter of ourselves with the client that I have come to call "holding in therapy".

Blotzer and Ruth (1995) call us to consider the much avowed dictum of "not knowing", of sitting with and tolerating uncertainty in therapy, as highlighted in the writings of Goolishian and Winderman (1988) and Hoffman (1988).

Coming closer to what Sussman (1995) calls the shrinking away from our inherent ability to be humane with the other, Inger and Inger (1994) have spoken about the therapist's tendency to intellectualise and rationalise his/her experiences and those of the client. They saw this to emerge as a result of deluding oneself about being an objective expert, acting as a blank screen.

The distance between the client and the therapist consequently increases without realising the impact that each person brings to the therapy process. This is because of regarding oneself as the

knowing, the expert therapist who can and should maintain a neutral stance. It leads to the therapist acting impersonally in a personal encounter. Unlike objectivism, constructivism helps to realise and avoid falling into such a trap.

Putting much emphasis on the learning of techniques to be the expert, objectivism with its master-craftsmanship rang some irritating bells in my head. I needed a relational style that would incorporate both the humane and the technical for the benefit of the client. To do this I found myself benefiting in a useful way from the many techniques taught to us in the training, by drawing on the self (of me) I was bringing into the training. This is what I have been calling the juxtaposing of the personal with the professional, or realising the confluence between the two. The therapist's wisdom lies in keeping the balance between the two. Sole reliance on only one aspect and disregarding the bigger picture in which the two co-exist and guide each other, is to deny what in ourselves is an inherent reality widely espoused by the constructivist lens.

The reliance of the therapist on his/her expertness, leads to the sole use of techniques. His/her ability to act in an intuitive way, responding to what comes naturally, is curtailed. Such a stilted way of acting and responding does not allow the therapist to be spontaneous because that would be equated with being unprofessional. It is ironic that Minuchin and Fishman (1981) came to title their book "Family Therapy Techniques", and to call the first chapter in that book "Spontaneity". I say ironic because they describe an ethical way of *being* for the therapist as I am describing it here, in a book that is about the *techniques* that one should use.

Journeying through the spontaneity of being a therapist (Minuchin & Fishman, 1981), I have become transformed into learning and cherishing the techniques instilled in me during training and letting those flow with my humanness. I have come to realise that one does not have to know beforehand how to manoeuvre his relating in therapy until that real human contact with the other (client), is actually occurring.

This is where the ethics of being respectful, humble and humane comes to the fore. This has not been an easy intellectual experience as I write about it here. It entailed embracing both my denied emotionality and my spirituality, that I never before figured would feature in the journey to be a therapist. The journey so far traveled has involved many frustrations as matched against

my earlier expectations - frustrations that made it worth staying in, though.

Having to be spontaneous with objectivism in parenthesis, I took the risky, lonely adventure into the excruciating realisation that doing therapy is about engaging the other person (client) regarding issues that cause them inner pain. It is about walking with the client through his/her shadows. What other better ways to journey through these than by tagging my own shadows along?

The struggle of maintaining the balance between being spontaneous and using techniques, enriching the feedback between professional codes of ethics and the personal stance of ethics, encouraging the fusion of the personal and the professional conduct of the therapist, is crucial. I realised how my conduct in therapy becomes shoddy and harmful for the client, as said by Blotzer and Ruth (1995), when I put a highly valued primacy on techniques. I have come to loathe such a sole adherence on my being the expert. This is with the help of Blotzer and Ruth's (1995) comment that attempting to take the client through those pain evoking issues, would be bound to be abortive if I did not allow myself to journey through such an experience: touching down on the underworld experience of being there (Tick, 1995), and acknowledging that I cannot engage the other from without.

A failure or denial to do this would be tantamount to hiding behind the professional role thinking that the client cannot see me (Corey, Corey & Callanan, 1988). Citing the case of a client with special needs, Blotzer and Ruth (1995, p. 3) say that "All of these behaviours are forms of escape from the reality of disability experience. And when people - especially therapists and other service providers - ignore the reality of disability experience, we compromise our ability to think. Not thinking is particularly dangerous for therapists, because our job is not simply to understand, but to develop understanding sufficiently deep, accurate, and attuned to transformative potentials so that we can help people change. Without insight, we may use an approach that fails to help or that even hurts".

It is this attunement to others' experiences that leads to transformative healing. Attunement and healing, that we find in being human with ourselves and others, by connecting with them through our own shadows, by staying in the present with them.

My own shadow of not feeling adequate, wanting to be acknowledged, has spurred me on to make up for this by garnering more knowledge, with the thought that this is what I needed to survive in what I grew up experiencing as demeaning social relationships. The learning of more techniques, as in the pursuance of higher academic qualifications, is one of those attempts.

The provocative experiences in therapy have necessitated me taking a back seat to re-look into myself. I have experienced how I can engulf myself with the huge image of omniscience as embodied in the many technical languages of theory. Using Symington's (1996) words, I noticed how the healing work of therapy needs one to refrain from being embroiled in asserting oneself and down- treading the client by keeping him/her in a dwarfed position of dependence.

The constructivist lens has shifted me into self-scrutiny, becoming aware that my therapeutic power lies in making myself an instrument of the client's cure, locating the cure within myself (Symington, 1996; Sussman, 1992); that a compassionate way of perceiving the client in his/her situation needs drawing on my shadows in such a way that the client will gain hope and healing (Symington, 1996).

The holding back of my own judgments, being the expert in the not understanding too quickly (Goolishian & Winderman, 1988), has been an invaluable ingredient for me to meet those clients with the emotional conditions they have been coping with. The concept that it is not just the books I read, but also the painful experiences of having had to endure the brunt of a younger brother being struck by lightning, have brought to light a sense of being a humane and feeling person in therapy (Kottler, 1995), and made more sense as I kept on grappling with the many ethical dilemmas.

I could not be convinced beyond Fairbairn's words (Symington, 1995, p. 11) that "emotional contact is what people most deeply yearn for and what fundamentally gives meaning to a person's life. Men and women derive their deepest satisfactions - in their work, hobbies, domestic life, and guiding aspirations - when they tap into the reservoir of emotional contact. Such contact, however, is only effectively made through a signal emitted from the true self of another. I therefore contend that the only interpretations that are effective are those that proceed from the true self of the psychotherapist".

Embracing the saying that I need my own personhood as an ethics tool in therapy, I came to realise that sometimes staying quiet is more helpful than holding on relentlessly to the assumption that my intervention is making any sense. I have come to be sensitised to the many covert ways of harming the client, ways that are always couched in the disguise of healing: the disguise that most of the time makes us think that if the client is not benefiting, it is because of his/her own resistance and not a reflection on what we, the therapists, have done.

Suspending the discussion on the necessity of providing "holding" for the client for a while, the next section takes us to a real situation in therapy in which I grappled with being technical and/or spontaneous. It is an example of how the impossibility of acting personally allowed me to use my own shadows - my own inner feelers, as shown in the previous chapter to provide "holding" for the client.

Going Through the Case

What follows is a fictitious therapy case based on my experiences in both the training and therapy. The client does not exist in reality, but only as I create him here. The events around the case are not based on one particular case I have had, but on various experiences with different clients in the process of training. It should be realised that although the client does not exist in reality, the specific experiences are very real, and so are my responses and reflections throughout. I chose my interactions from various points in the time of therapy and training and with various clients. I think that this way of presenting the case provides personal protection for the clients by not giving out information that will in any way lead to an infringement of their privacy. The personal nature of my comments and reflections, as said earlier, maintains the real crux of the dissertation by exposing the ethical dilemmas that I personally grappled/am grappling with, in journeying to be a therapist. It is a testimony for me that one cannot learn to be professional without learning to be personal and real in therapy. I have given the client the name of Molahlegi.

The case starts as a conversational extract by the client, which then leads to me reflecting on the therapeutic interaction, interspersed with relevant aspects from review of the literature.

Client: *You are the first person I have ever known who can relate to me with true*

humanity. Mine is a crowded living space of forced connections and belongings. A stifling environment that is devoid of the humanness I have ever longed for at heart. A living space in which I have had to helplessly watch the dwindling of my personal needs in the pursuance of the ideas of fake group support. I have heard people commenting about how communal our life is out here, but have also been touched at heart by how the individual can be lost in such circumstances. I have always considered myself a wounded animal who is limping and crying in a faint voice that can never reach the other side for rescue.

You wake up each day to endure the emotional brutality of being alive. You always find yourself dealt a deadly blow by life's ruthless unforgivings. Watching what counts the most for my dear life being snatched away from my sight, I always felt left with wanting to give up.

You go to bed wishing the next day will bring some positive difference only to be greeted by the glowing bitterness of what the next day sinks one into.

Therapist: It is very flattering and yet humbling to be confided in fully like this by someone. You realise the seriousness that being in the work demands. You also realise the risks of being too "close to see a flame that burns within the sorrow of each client we see" (Kottler, 1993, p. 46).

It is experiences like these that necessitate a re-evaluation of our ethical stance. An awakening call that warrants an ever alertness because ethics is what we start and end with. Being ever fully present with the client.

Client: *Fragile as it looks, it is in those tender years of growing up that a child relies heavily on his human environment for nurturing and support. When other kids have the fortune of both biological parents to carry the burden of growing up with them, mine was not to be. When other kids get spurred on by the jubilating faces of their parents over their little yet meaningfully profound achievements, I could not get that parental resounding back.*

I watched from the sideline the downward rocketing of my childhood. Inner sadness became my second nature. Trust-mistrust issue became a big issue for me. I learned the well calculated way of not showing the inside as a way of protecting the fragile self. Slowly gravitating towards a reclusive life style. Amusingly, lonely careers became appealing for me. When you cannot fully take part in the present, you either resort to fantasy or want to leave the field. Choosing the latter, suicide has always been a reasonable way out for me.

It started with the disappearance of my father, as I heard, with me ending up with my mother. When I recall, my late mother's ailing health must have been due to having single handedly been there for both myself and herself in that impoverished upbringing of mine. A paragon of my need to go on, she exemplified a lioness that always fought the turf for its little cub. Her leaving the space took away my zeal to go on.

Therapist: There is a strongly held belief in the Sepedi folklore that a person lives up to his name. Molahlegi's case is significant testimony to that. The name itself means "one who is lost". There is a clear resemblance to feeling lost as shown by the theme of wanting to give up in the case. One of the explanations the Pedis would give is that the man was cast into the perpetual curse of the name from the moment it was given to him.

This brief, tearful interlude in this man's life immediately took me into my own shadow of inner pain through which I was starting to identify with him. As if asking myself the question I have always been asked, and knowing what the answer was already, I hesitated to ask him the question that I also knew would be difficult to answer. Difficult not because the words were not there, but due to the kind of memories and response it would make one recall.

Client: *It happened forty six years ago when I was six years old. My mother had by this time borne a daughter and a son after me, by my stepfather who was also staying with us.*

The door of our rented room was locked. My mother had to rip the chain and lock on the door for us to be able to get inside.

Drunk on his arrival, he fumed with anger when he found out what she had done to enable us to get inside. A deafening argument ensued. Into the dark night she had to run for cover as he was chasing behind her with a knife in hand.

Staying behind, the three of us cuddled against each other, though I also followed them into the dark night. Whatever happened there in the chasing is not known, except the indelible painful memory of the swearing I heard, the picture of a mother I saw lying there, who later died at the hospital with a broken knife stuck in her spinal cord.

Therapist: As if having stirred up inner emotional fires, I could not resist tears falling down my cheeks, as he also let his fall. In a true union of human souls, I sank into deep humbleness. I started comparing his memories to what I have always reckoned to be the severe traumatic experiences of my life, and realised how mine were not that severe. In the lens of constructivism, I radiated respect for him, for the person he is.

The values and shadows we bring to therapy guide in subtle and unnoticed ways, the manner in which the nature of our therapies unfolds. It is through listening to this underworld side of our nature that a healing human experience can be facilitated, in which the client can be held.

I must be fortunate to have grown up with a mother who although destitute, looked after me. I fully stand by Gerson's wisdom (1996) that it is by positioning oneself within the therapy, by responding and relating to the other with the full person we are, that we can enrich the therapy relationship with empathy. You respond to your own inner shattered hopes of early childhood so as to walk through the client's life of doom and darkness. I hear the silent and sidelined child in the client as long as I allow my shadow of my own lonely childhood to guide me: the emotional orphanage in the other that is up against the "not being enough", ever trying to rise against all odds to keep its head up.

You offer the client the other side of the obvious, of being seen as a social failure, by reflecting on that experience as related through each other's shadows. The ethics of getting in touch with our shadows, allows us to realise that we are not required much to intellectualise, we need to respond spontaneously in an intuitive humane way that is respectful of the client's human soul - the bedrock of healing that therapy is hinged on.

Client: *I do not know the exact particulars of my therapist's life, but just merely being there with him offered me a sense of having the otherness of mine in him.*

He never assumed a persona of value neutrality, of an estranged relationship between me and him. He gave me a true sense of immersing himself into my interests and concerns as a person (Fairbairn & Fairbairn, 1987).

At forty six, unmarried, Molahlegi stays with his extended family. He has never been able to hold down a permanent job in his life. Not having a stable relationship at the moment, his relationship life has been a difficulty for him, with both sexual partners and friends being few. Besides his difficulties of relating to others, he is also being accused by his family of smoking dagga, stealing from neighbours, attempting car-hijacking and not wanting to work so that he need not contribute financially at home. The untimely passing away of his mother saw him growing up immaturely into continuous relocation from one relative to the other - starting to struggle with the issue of belonging. On the basis of the aftermath of this, I picked several themes as stated in the conversation between me and him in the therapy.

Feeling such humbleness, humanness and respect for the man in front of me, I dug into my own shadow of silence and, thinking that no one would understand how I felt, joined him (Minuchin & Fishman, 1981; Becvar & Becvar, 1996; Minuchin, 1974), in a way that was more of an attitude than a technique (Minuchin & Fishman, 1981; Symington, 1996).

It must have been healing potentials of the union of souls that Molahlegi felt in our connecting, that moved him to feeling safe to open up (Symington, 1996). I do not believe that the shift that he made in opening up about his struggles in life, for the first time, had anything to do with the use of any skilled techniques which others in his social life could not use. I attributed the shift to

the humane way of relating to the client, that Shainberg (1993) sees as providing the client with a mirror image of themselves in terms of where they are, so that they can heal. This does not have to do with being the expert, applying outlandish ideas of cure.

To support this, Shainberg (1993) talks of her experience with her own therapist, of what has facilitated moments of completeness and happiness as leading to healing for her. She picks out the relational attributes of being respected, treated with kindness, humour, being clear, and a lack of rigidity between the therapist and the client. Saying that she was treated with empathy, she could start the healing process of going deep into experiencing her struggles with clarity. It is the open heartedness of making the other feel his/her worth as a person that helps them to transcend their life struggles.

When we do not imbue ourselves with the illusion of having grand ideas, we can draw respect, humility and being human, from our own shadows, to see our clients as having the strength and healing potential that we do not have, and to become aware that we, as therapists, may have some limitations that our clients do not have (Sussman, 1995).

Taking serious decisions came out, for me, as the central theme engendered in Molahlegi's life. From the moment of his mother's death, he never consulted anyone on any decisions regarding his life. After being taken with his two siblings to stay with an aunt, he left two years later to stay with his biological father's family, where he is still living now.

Client: *I recall how my big extended family always subjected me to the brunt of being called horrible names. I was the singled out one, the only one ever to be sent for errands when playing, eating, relaxing or woken up from sleeping. I was given little food and pocket money for school as compared to the other kids in the household.*

Therapist: I connected with him through my own denied experiences of being treated badly by extended family members in the years of growing up at relatives' homes. Such a genuine connecting with Molahlegi allowed me to be real and reflect back the experiences to him: the experiences of not just being trapped in a mechanical role

and being alienated from myself. Talking about the necessary disclosures that the therapist needs to use to facilitate this realness with the other, Corey (*et al.*, 1988) indicate that self-disclosures by the therapist need not be verbal only. Non-verbal disclosures as gestured in the encounter will do.

Client: *After many years of enduring the harshness of life there, I decided alone to leave and go to stay with my great-grandmother's family on the late mother's side. That happened after breaking the silence of hurt to my father who responded by just slamming the door behind me and not saying a single word. Feeling disowned by my own father, I headed for the family that I am in now.*

I listened with helplessness to this man's determination. I sensed the deep hurt from seeing him cry bitterly, but also the deep strength that he had to be taking such bold decisions. I commented about his determination.

Understanding people and their situations can be hampered by listening and using only our minds as in using theories. We need to shift beyond this. To not resort to theorising, understanding people's situations too easily. To do this, Shainberg (1993) suggests a way of staying with the other by calming down our tendencies to intellectualise. This will enable the therapist to be compassionate with the client, to open him-/herself for the latter's healing.

I still do not know exactly what one did to facilitate the experiencing of those feelings by Molahlegi. I remember him talking about the physical anger he was being accused of, as a way for him to take his mind off the vivid images of how his mother was brutally stabbed to death. Even the thefts are a way to avoid such thoughts, a way of keeping himself busy at something different.

Connecting with Molahlegi through my own shadow of keeping the pain inside, not wanting, or being scared, to show how emotionally deserted I am, he went on to struck me amazingly with his daring nature and the gift of being exposed to so much, so soon in life.

With tears falling down his cheeks, he spoke about the pain of not having had any close contact

with his two siblings to talk about their troubled life, about how he would have wished to, and about how constantly this had driven him into thinking about committing suicide. In a detailed plan locating a spot in the nearby hill to do it, he would find himself stopping these thoughts whenever he thought about his two siblings. With that ambivalence of vacillating between self-determination for the self and self-sacrifice for others, I was made to relate deep inside of me to what I do in my own life, to recall how much I have had my childhood sacrificed very early in life when everything was to be taken very seriously, when survival for both myself and others existed as a priority for me.

The human connectedness created in this therapy was very humbling for me. I respected him for the person he is. I was moved to connect with him and his pain through my own pain. I managed to provide the holding that made him feel valued. Using my own shadow of inner pain, I allowed myself to sink into the emotional crisis he was bringing and to provide him with the emotional field of forces that at the same time were facilitating healing for him (Symington, 1996).

Meeting him with the person I was, I used my role as a therapist to listen from the heart. I see myself as having refrained from the intellectualising that would have distanced me from the emotional impact of the stories Molahlegi told me. I risked using myself, by opening up to my shadows, to interact authentically with Molahlegi, in ways that Inger and Inger (1994) regard as being ethically and truly a meeting with the other.

At this point, my journey in ethics looks well taken as I feel I provided enough holding for the client's healing space. Looking further, deep in myself, to check whether the professional codes of ethics were not applied technically, I also ask myself about the ethics of having done what I did with Molahlegi. To do this I look at the ethics of when holding can be anti-therapeutic, not healing for the client.

I do not aim at disqualifying the positive effect of what holding brings. Respect, humanness and being humble allow one to hold the client not to be tempted to feel like grinding the client emotionally. Using one's shadows helps one to gauge of where the client could be emotionally, without using any outside feelers. I was able to relate to Molahlegi the way I would have liked to be related to had I been in his position.

Although the conversation, comments and reflections interposed with the literature review end, I continue with a critical look now at and scrutiny of my own therapeutic conduct in the above discussion. This is in line with the constructivist lens of not believing in myself as the expert, a belief that ethics cannot be resolved by arriving at hard and fast rules in a unilinear way. One needs to be always sensitive to the hidden dilemmas and pitfalls inherent in one's conduct in therapy because the only way a therapist can conduct him-/herself is personally too. The "mastercraftmanship" of being the expert who can remain neutral and objectively detached from the therapy is gone. This way one's ethical behaviour is sharpened, by engaging ourselves in a critical dialogue about our own conduct. I continue in this kind of dialogue by looking at the dilemmas and pitfalls inherent in the therapeutic conduct of holding, if it is taken for granted, by looking at the motives and shadows behind doing so. This is possible only if one remains constantly self-reflective and inquiring about what may seem appropriate motives.

When Holding can be Anti-therapeutic and Unethical

"Paul, I see you are connecting deeply here in therapy. You do really reach out to the client by using yourself. I just wonder if that is not the opposite of what you are doing in the other spheres of your life". These were the words of one of my supervisors in my training.

I still carry these sage words for my own inner dialogue, about what I do in therapy, all the time. These days I have come to own them as mine, playing them back as if talking to myself. When I do that, I ask myself as to whose needs am I pursuing in therapy. Those of the client or mine?

I find this to be taking me to a higher order level of the ethics of being respectful, humane and humble. I not only dig deep into my own shadows as a guide to my ethical conduct in therapy, but also use self-questioning to look at how my own shadows can lead me to be unethical: a constant struggle of being self-critical. I sometimes wonder if I can ever be truly ethical. I am scared of ethical complacency. I feel that continuous self-questioning is essential.

I believe that it is at the level at which I have been entangled in the ethical dilemmas, the frustrations they have brought in me, that a higher level of ethical awakening has been raised in

me. I do not regard myself as having resolved those dilemmas inasmuch as I have, rather, facilitated higher level dilemmas and shifting experiences of awareness at ethics. *It is this thinking as I carry it that defines the stage I am at in the journey now.* I am scared of the hubris of complacency when I think that I can resolve ethical dilemmas unscathed.

Having been sensitised to the otherness, the struggles of living through my own pain, I am now taking a moment to reflect on how this personal way of responding to the client's pain could facilitate either healing or harm for the client. I become aware that my own sensitivity to inner pain is a bias. It carries an illusion that therapy is only for the client.

If only I had known that holding, provided to the extreme, leads to being unethical. Stevens (1996) mentions how too much identification and empathy create a situation of submerged differences and conflict, where it is difficult to differentiate one's needs from those of the client.

Too much sensitivity and holding can result in the therapist being always on duty (Kottler, 1993). It leads to the illusion of doing the work without ever questioning ourselves as therapists about how we do it, always telling ourselves that it is motivated by just motives, for the client's benefit.

Kottler (1993) says that he does not worry much about the times when he catches himself meeting his own needs at the expense of the client, but much more when he fails to catch himself doing so. My personal stance is that I need to always worry, whether I catch myself or not. I need to be aware of how my personal and professional selves are infused, because this is the ethics of being a therapist.

I needed (still need) a way of personally involving myself in this adventure - far beyond what I could technically do. I needed not only my own humanness, respect and humility, but a higher sense of them. *Neither was the strict rule following of the professional codes of ethics helpful.* Reflecting on the anti-therapeutic and unethical nature of holding, I continue to raise two self-critical questions which are for when therapists vicariously attend to their own needs through those of the client, and whether therapists ever need clients too much more than clients need them. As in line with the self-reflective stance, I see a bigger sensitivity and wisdom as being inherent

in the asking of the questions themselves,, than in just rushing to give answers, hence stalling the dialogue about our own therapeutic conduct.

Vicariously Nursing my Own Pain Through the Client's?

If therapy is about engaging the other about issues that cause him or her inner pain so that they can acquire experiences of shifting in order to heal, how much holding and challenging does the therapist need to provide in therapy?

I did provide a sacred holding space for Molahlegi by identifying with his struggles through my own pain. I used my own aloneness, inner soul orphanage, etcetera, to provide empathy and compassion towards him. At that time I found my conduct being ethically sound, becoming fully respectful of his autonomy and strength, not imposing my values on him (Koocher, *et al.*, 1998).

Considering the client's welfare a first priority, I became cautious and reluctant to ask too much from him, in line with Ivey (*et al.*, 1997) that the therapy session should not be used to delve into the life of the client. One can do this if he/she becomes willing to acknowledge his/her own limitations as a person, accepting the shadows that make him/her human. Some therapists may use therapy as a way of expanding their knowledge base without caring about how the client feels (Ivey & Simek-Downing, 1980). If one considers his/her own shadows, this may be avoided. Therapy is "for the client's gain, not for the therapist's expansion of information" (Ivey & Simek-Downing, 1980, p. 12).

When I first let my own tears fall when listening to the client telling his painful stories, I also learned to challenge myself for doing that. Recalling that one of my shadows has been to offer help always, rescuing others because their sufferings remind me of my own, I asked myself as to whether those tears were for him or for myself. How genuine were those tear drops for the other?

It is through considering one's shadows that one becomes sensitised to the vulnerability and possibility for exploitation the client is in, owing to what Pope and Vasques (1991) consider to be the powerful invasiveness of therapy ,that makes it look like surgery.

For the first time in my life I allowed my own concealed vulnerability to come to light. For the first time I allowed my own humanness to be seen by the other in its neediness. I really exulted at this human connectedness at the end of the sessions, coming out feeling as though I had contributed towards the client's healing.

I realised how in my own fallible nature I harbour many areas of unfinished business that, if not knowingly brought to the fore, end up being shadowy spots contributing to a harmful therapy practice (Corey, 1996). Those shadows kept creeping in, in subtle ways. I asked myself how value-free my own practice of therapy was (Tjeiveit, 1999; Vesper & Brock, 1991; Pope & Vasquez, 1991).

Sensitive to the ethics of doing no harm to the client (Ivey & Simek-Downing, 1980), realising the vulnerability of the client and the need to walk with tact (Gibson & Mitchel, 1990), I embraced principles of non-maleficence, beneficence (Corey, 1996; Koocher, *et al.*, 1998), I offered him the ethics of being (Inger & Inger, 1994) in my humility, humanness and respect towards him.

I could not challenge the client for fear of challenging myself - but I was not aware of it then. I remember meeting with the client for those secluded sessions, where he could open up away from his own extended family. Lost in the nursing of the hurt of my own young boy, I saw how my own shadow was constricting the healing community that the client would have benefited from.

I am ducking my head in the shame of recalling a supervision session that made me realise that one's shadows can make the client's therapy harmful. A reclusive loner myself, rich with the experience of feeling alone in a big extended family and adept at not connecting, was I offering holding for Molahlegi to value healing alone? How much of the therapy outcome was prescribed in ways that were a replica of my own life style?

It is through my shunning of objectivism that I can ask myself how much of myself (my shadows) plays a role in directing therapy in ways that are comfortable for me and not the client - objectivism blinds me from being aware that I do contribute to therapy failure. It makes one

attribute failure to the client only.

How ethical would I have been if I had asked the client to venture in expanding his social connections? Would that not have been asking him to do something that I personally fail to do? How much pleasure would I have gained if he were to either succeed or fail in this?

I do not have answers to these questions and neither do I hope to offer any in the future. I find a high level of ethical sensitivity in asking myself the questions rather than shrugging them aside. This offers me a way of offering an account of my conduct in relation with others in therapy: the ethics of responsibility that the constructivist lens aspires to. The ethics of being humane and humble with another human being: the client.

I cannot excuse myself from personally accounting for myself in therapy by shifting ethical responsibility to an outside body that should judge my conduct as either ethical or unethical.

Aligning my constructivist lens with what Corey and Corey (1998) say, I realise that ethical awakening entails a process of constant self-reflection, reiterating a point mentioned in the previous chapter, that tagging along one's shadow with one is a helpful thing to do.

Reflecting in retrospect, being made aware of not occupying the client's healing space in the training was very insightful and has left an indelible ethical mark on me. Corey (*et al.*, 1988) reflect on this when they discuss the therapist's use of self-disclosure. How much of the therapy attention did I take to myself with those tears in the presence of the client? How much of that was an ethical gesture of my humanness? Again, I hope that my being ethical is defined by making it possible for these questions to be asked. When this is done, I can clearly see myself in relation to the other (the client), which leads to being ethical (Inger & Inger, 1994).

Needing the Client too Much?

It is by allowing ourselves to ask this question that we can see ourselves as not different from what Guggenbuhl-Craig in Sussman (1992) argues for. What we do is not only due to our pure and just motives. Our work is like sculpting as a sublimation of the wish to play with faces

(Sussman, 1992), having chosen the work of therapy to pursue our concealed needs that we have failed to meet somewhere.

Praising myself and using Blotzer and Ruth's (1995) words in working with special needs clients, to realise the multi-faceted nature of such work, I did a home visit to Molahlegi. Perhaps it was due to feeling that I could not do only one thing to help. I feel that playing with many roles was ethically as long as I was aware of which hat I was wearing, taking on the welfare role here. I cannot just excuse myself by justifying my ethical conduct on the basis that the client (Molahlegi) later commented about how that had benefited him, making him feel acknowledged.

I keep asking myself as to how much of my exaggerated sense of responsibility to save everyone did contribute to this immense reaching out to the client in his pain. Corey (1996, p. 74) says that "some counselors reach out physically not to meet the needs of their clients but to comfort themselves, because they are distressed by the pain their clients are expressing". Having orchestrated such a pattern in other spheres of my life, I wonder how much of it was played out again between myself and the client? How much of my emotional hunger and need to be psychologically fed, turned me into being a helper in more need of the helpee, than *vice versa* (Corey, 1996)?

Corey (1996) argues that ethical issues need to be periodically examined so as to enrich our professional conduct. I believe that this ideal can never be reached if we forget about inquiring into the impact that our own shadows make. It will not help if we just examine professional ethical codes as rules only, without intermingling this with the contribution that the self (shadows) of the therapist makes. Corey (1996, p. 53) alludes to this when he says that "ethical practice demands that the counselor recognise the central importance of continuously evaluating in which direction their personality might influence clients - for progress or for stagnation". When one does not see himself/herself as an expert, he/she can see how his/her shadows keep influencing his/her therapy conduct, how he/she can never apply himself/herself as a constant (Kottler, 1993). This is a difficult situation to be in, but it allows one to be aware of his/her constantly changing self in relation to the client in various circumstances.

How much of the void created by my wasted childhood and youth impelled me into reaching

out to Molahlegi? What at first looks like a humane gesture towards the client could end up being stifling for him/her. I do not need a model based solely on an objectivist stance to monitor my conduct, because that is hinged on the denial that the subjective or personal can influence the professional. From my own personal experiences and the writings of the analytic theory, I can draw some examples that show how denial and suppression end up leading to harm to both ourselves and those we live with. Suppressed or denied needs build up an untold energy that creates massive destruction. We end up seeking recognition and reparation in subtle ways that are taxing on the victim. If this happens in therapy, it will have adverse implications on the client's life.

The injunction that this holds for ethics in therapy is for us to avoid being the wolf clad in a sheepskin (Golann, 1988), parading the holiness of our practice and not highlighting its sinister side, calling it a selfless offering for the client, not mentioning how the self is not always that altruistic.

Having indicated that to be in therapy is to be in ethics (Efran, *et al.*, 1988), I also see that to be a therapist necessitates a need to sharpen one's ethical sensitivity. To do so is to engage both the self and the professional in a constant critique of the therapeutic conduct. It is not about resolving the conflict in the confluence between the self and the professional in the conduct, but about being aware of how each informs the other in both healing and harming. It is about staying alive in the present. It is not about choosing either one of the professional codes of ethics or the personal style of ethics, as the best route. Choosing only the first, we either do therapy purely and solely for the client or for ourselves, as is the case with choosing the personal style of ethics.

The journey needs one to look back, to be in the present so that a forward look can be charted. To be present with the client one needs to inquire about his/her motives in practising therapy.

CHAPTER 6

NOW AND BEYOND - REFLECTIONS ON THE JOURNEY

Preview of the Chapter

As the writing of this dissertation nears its end, I keep contemplating about how to conclude it without detracting from the main thrust embodied throughout it, and the main journey.

Similar to this is another contemplation about how to walk into this last lap of the journey still engulfed and guided by the same humbling, human and constant self-reflective spirit with which I flowed from the middle, towards the end, of the previous chapter.

Self-reflection has been a major hallmark of the journey. As for the title of this chapter, preferring 'now and beyond' over 'the conclusion', is an apt portrayal of being self-critical. A depiction of the need to maintain dialogue with ourselves, constantly evolving oneself and staying with ethical dilemmas. An epitome of one of the tenets of the constructivist lens, encouraging further inquiry, conversation about ourselves and others, participation and not closure, the title I chose here is a representation for me of the ideal I cherish, that the journey to be a therapist is a journey about ethics which entails perpetual inquiry about our own conduct in the present and into the future. An ideal that the journey to be a therapist, about ethics, is ongoing.

With the journey to be a therapist and the learning about ethics being inextricably linked, I found myself grappling with answering a number of questions, such as: "Where did the journey to be a therapist begin? Does the journey to be a therapist end?"

Pondering on a higher level about the reflections I have had on the journey, this chapter shifts to look at what those reflections have meant for me, what the process of writing this dissertation has meant for me. To arrive at this point, it draws first on the main themes upheld in the dissertation and their implications for being a therapist and ethical also. These include the fusion of the personal and the professional, the self-reflective journey; self-reflectivity as not an end in itself, and ethics, therapy and the journey. These lead onto a reflection about implications for

training, before a description of embarking on what the writing has meant for me.

The Fusion of the Personal and the Professional

Many ethical problems are created when, as therapists, we allow our personal being to encroach on our professional conduct.

We become unethical when we allow our own values to sneak into the therapy sessions. As the lenses through which one views the world, our values, which also represent our biased attunement and perception to reality, should, according to the objectivist science, be kept outside of the therapy.

Objectivist science stresses the need to shut out the personal values (the self) of each of us as a therapist, as they represent the most dangerous aspects of ourselves, contributing to unethical conduct.

Placing such a high premium on the expert, objective, well-functioning professional therapist, objectivist science equates being ethical with being able not to let the personal (subjective) aspects of our being, influence us. This has been echoed by Corey and Corey (1998) when they say that a part of becoming a professional therapist entails one's ability to apply ethical codes of conduct. Numerous ethical codes and principles of conduct were developed for us to follow in our journey(ies) to being therapists and we were shown ethical ways of guarding against the personal from tainting the professional.

I found the part of the journey taken so far as being bigger than, and sometimes contrary to this preoccupation with ethical codes. It has been characterised by the impossibility of not being influenced by the subjective (personal) self. The much glamourised and aspired for objectivity went by the wayside as I watched how my own personal biases and values influenced my conduct in therapy.

I noticed how, in my own self-referential way, I constructed and gave meaning, in a way constrained by my own experiences and attunement to life, and its struggles. Moving from

aspiring to being objective to embracing the reality of being a subjective being, I noticed how I cannot personally impact each client's life in therapy. It has been with the help of the constructivist lens as highlighted in the previous chapters that I have come to realise the impossibility of shutting out the personal from the professional therapy session. Having given up the expert role of the objectivist scientist, now embracing my own subjective perceptions and owning my own senses in ways that can enrich my conduct with the client, I have realised how the therapy cure is located within my personal self. Responding to the client with the person that I am, I could only use my own shadows as a gauge of where the client was both emotionally and mentally.

I see my journey to being a professional therapist as necessitating the tagging along with the personal side of who I am. In understanding, appreciating and therefore being of any therapeutic help to Molahlegi and the many clients that I met along the way, I could not assume the persona of neutrality and anonymity. I saw myself drawing upon my own personality, subjectivity and shadows in my work of therapy.

For me, and for the clients, drawing upon my past experiences prior to embarking on the training, and those experiences outside the therapy and training at the moment, was much more useful than what the training has taught me what to do and how.

I can see that my sensitivity to the stories the clients told me has to do with the particular attunement to my life pain and the struggles which I brought with me into the training. Like Stevens (1996), who notices that she is able to use her own experiences to listen to and hear about sexual violation from her clients, I am also aware of how my own particular attunement to life's pain contributes to the process and affects the way I offer therapy treatment. The fact that I am personally impacting on the nature of the unfolding process of therapy, shows how value-laden therapy is. It shows that the professional will always be inextricably infused with the personal, the objective with the subjective. Attempts at keeping the personal outside the therapy have failed. According to the constructivist lens that I have espoused throughout, such an attempt is tantamount to becoming 'shrinks', shrinking our humanity away and presenting ourselves in a stale, unfeeling encounter with the other in which therapy becomes inhuman. The constructivist lens and the literature consulted have brought to my awareness the need and requirement of

always acknowledging how I come to affect the nature of the events unfolding in therapy, through the shadows of the person I am. In showing me that I am not a value-free person, they sensitised me about how I subjectively intervene in what I thought to be an objective practice.

Shown in the case study of my therapy with Molahlegi as presented here, one can see the practical evidence of the ideas enshrined in the literature and seen through the constructivist lens. I can start to see the actual impossibility of my own life experiences and circumstances not intruding in the work of therapy. I notice how my own life experiences have coloured the values that I cherish, hence how I sense the client's situation using my own biases and attunement to having been there. I was able to hold, or at least sense the need in Molahlegi to be held, as testimony to the constructivist lens that things are not what they are until we come to intervene and see them that way by using our own inner feelers: a proof that Molahlegi's reality did not just exist independently, but through both of us construing it as we perceived it.

It was through my own experience of lostness and inner orphanage that I could sense and know about his (Molahlegi's) lostness and know how to walk with him through it (Fisher, 1991).

I used the parts of me (in my shadows), from my own experiences of living with people of substance abuse, to start appreciating and acknowledging what the man from Alcoholics Anonymous was going through before I could dare to assume any expert knowledge of his situation and start reforming him.

When I listen retrospectively to how many therapists have been driven by experiences of growing up in their lives, how they were initiated into the healing work of therapy long before they entered into the official training, I start to wonder, but also come to see that the journey to be a therapist precedes the training itself. It is those experiences both outside and inside the training and therapy that mould us. My own stumblings and fallings with how to do therapy carry a wealth of evidence about this. I have had to use my own subjectivity, shadows, personal experiences before my training, in order to learn to walk the journey of doing and being a therapist.

The Self-Reflective Journey

Acknowledging the value-ladenness of therapy, how the personal and the professional are fused, Dryden (1987) asks herself whether she has any right to impose her own moral values on her clients, whether she is in the business of character building for her clients, like a traditional boarding-school headmaster. It is a reflective stance like this that makes me reiterate the importance of acknowledging the impact of experiences preceding the training and those outside of therapy: that the therapist needs to constantly reflect on how those experiences (shadows) influence therapy, hence the client's life, in both direct and indirect ways.

The journey needs embracing humility so as to be humane and respectful, something which becomes possible when espousing constructivism.

By not denying the impact that we subjectively bring forth, we learn to account for our own influence on the system that we are a part of and are influencing, however small that may be. Giving up the objectivist stance of being an expert probing the client, the therapist learns to ask himself/herself the same questions he/she asks of the client and to avery the motives for doing so.

When I hesitated to ask Molahlegi the question: "What happened ... ?", it initially looked like an ingenious gesture of being empathic to the client. It was only after reflecting on this later that I realised that much of myself (shadows) was contributing to this particular scenario. Yes, it was due to my being sensitive, but was that sensitivity helpful for the client? Was it necessary for him? It is when questions like these are asked that I learn not to impose my own needs on the client.

I have noticed that each time I engage in therapy unique ethical dilemmas are faced which I can only notice if I allow myself to stay with this self-reflective attitude.

The constructivist lens means that I should not regard myself as an objective expert , thus I do not consider any therapy encounter objectively except as a process that I and the client both bring forth. Always taking cognisance of the visual other (client), it is not just what I do that counts, but also the relationship context I am in with the client, that guides me.

Because each therapy encounter brings with it unique ethical dilemmas, it helps to be continuously self-reflective, not to apply oneself as a constant. I have learned to monitor myself by inquiring about my own therapy conduct, by acknowledging and inquiring about how I personally impact on the therapy process through my own shadows.

My fear and inability to face my own pain showed up when I could not stand seeing Molahlegi cry. Added to the need to be ever responsible and take care of others - saving myself through them - I could see how these needs become shadow aspects that may dangerously stay unquestioned.

I say dangerous because Guggenbuhl-Graig (Sussman, 1992) has argued that those who pretend (do not want to inquire into their own motives) to act in a purely selfless way to help others, end up making questionable decisions when those concealed needs run away and need to be compensated for. It was through this constant self critiquing that I could see how my shadowy need to be needed might keep the client in a dwarfed position and patronised, robbed of his/her autonomy (Corey, 1996).

The words of my trainer, congratulating and challenging me on connecting deeply in therapy, have brought to me a realisation that too much closeness or identification makes it difficult to differentiate between one's own and the client's needs. Sometimes this leads to vicariously meeting one's needs at the expense of the client, with the therapist being always on duty because he/she needs the client much more than the latter needs him/her.

Ethical codes are helpful in prescribing the normative behaviour the therapist is expected to exhibit in his/her practice. They describe and sensitise us to what right and wrong behaviour in therapeutic conduct. However, this does not specify exactly how the expected behaviour will or should unfold, given a specific case with a client.

We need to move to the stage of not just merely applying ethical codes as rules and reducing the therapist's conduct to sterile rule - following behaviour, oblivious of the actual interactional ecology of therapy, and should guard against reducing ourselves to unfeeling robots and our conduct to a sterile inhumanity.

Noting that self-monitoring, as it derives from being self-reflective, is a better route for therapists to take than being policed by outside agencies, Corey (1996) further enjoins each therapist to constantly reflect, recognise and evaluate the direction in which he/she personally influences the client through his/her shadows, for both progress or stagnation.

It is through the meeting with the other that our shadows are cast in front of us; however, they are invisible to our awareness. It is the context, the process of being with the client far beyond the prescriptive rules of codes of ethics, that brings us to a higher ethical awakening. This is because our personal selves are always infused with the professional we are or strive to be.

When Corey (1996) said that ethical issues need to be periodically examined so as to enrich our professional conduct, he must have been referring to the need for self-reflection on the part of the therapist: a reflection on how one's shadows, values and hidden motives and in wanting to be therapists inappropriately affect our therapy work.

It is only through self-reflection that we can realise how the self constantly changes in relation to the client(s) in various situations. In cautiously monitoring when we catch (or fail to catch) ourselves meeting our own needs at the expense of the client (Kottler, 1993), each therapist learns that ethical responsibility lies in each one of us and not just in the policing professional boards.

However hard it may be to swallow the realisation that ethical responsibility cannot be learned in a cut and dried way, this also teaches us to be humane, respectful and humble.

When we do not constantly self-reflect on our shadows we assume the elusive omniscient attitude of the expert objectivist therapist. We fail to see how our personal and professional selves interchangeably nourish on each other. We lose the sense of our self in a relational ecology of the other, of the client. We reduce ourselves to mere robots controlled from the outside by rules. We see the client being harmed but cannot do anything to avoid this because we do not see ourselves as responsible - as objective experts we are not personally responsible.

It was only after I had given up the shackles of objectivism and welcomed constructivism, that I incorporated constant self-reflection, to see the self of me which is not always so altruistic. I

have learned not only to hold clients, to identify with their pain, but also to critically question myself as to why do I do this, why I sometimes hold and identify with others, and push and challenge clients at other times.

Self-Reflectivity as not an End in Itself

Being aware of how my personal self is intermingled with the professional, knowing the value-ladenness of what I do, and being self-reflective is not to cast doubt on the professional codes of ethics. My personal leaning towards a preference for being self-reflective is due to the realisation that I cannot substitute my ethical responsibility by a mindless following of rules (Corey & Corey, 1998; Pope & Vasquez, 1991). The route of being self-reflective is chosen because professional codes, while useful, can be misleading in being too general and not addressing the specific ethical issues one encounters regularly (Corey & Corey, 1998; Pope & Vasquez, 1991).

Realising that one's feelings, thinking and responding cannot be rested upon ethical codes, I note the challenge that the self-monitoring brought about by being self-reflective allows one to be attuned to the specifics of each client session at its particular time and in its context. This allows me to never be swayed off the track of acknowledging how I come to personally impact on the client's situation through my shadows.

I eschew the sole reliance on the self-monitoring that arises from being self-reflective, as much as I refrain from the sole reliance on rules which arises from adhering to professional codes of ethics.

I try to keep an unsteady balance between being self-reflective and tip-toeing though professional codes of ethics. I have been brought to realise that acquiring a sense of professional and ethical responsibility as a therapist is a journey that is never completely finished (Corey & Corey, 1998). While my scale is tilted a little to the side of preferring a self-reflective stance, I am also aware of the danger of dislocating elements of a recursive loop.

A sole reliance on professional codes could be like a blind walk in a dark valley, not conscious of the journey itself, of the context in which the journey is taken, which includes the traveller

himself, those he or she meets on the way, and the impact each has on the other.

Had it not been for the awareness that my ethical stance of being self-reflective does not excuse me from taking note that I should not practise therapy outside the confines of the professional codes of the major ethical bodies, such a stance could have just been mere self-indulgence (Ivey & Simek-Downing, 1980).

Sensitive to the fusion of the personal with the professional, I did not just admit and assume the self to be self-less when the client was provided with a space that was holding. Inquiring and challenging into my own shadows for doing so, this self-reflective stance allowed me to incorporate into my practice such core ethical principles as justice, beneficence, and autonomy. It was with this higher order stance of being self-reflectively monitoring one's conduct that my practice could be in line with the principles of concern for the client's welfare, respect for his/her rights and dignity, etcetera.

Professional codes led to self-reflectivity, to professional codes, to self-reflectivity, to professional codes, into a circle of events that complement each other.

Because of a constant self-reflectivity, I could maintain dialogue between the two. Acknowledging the fusion of the personal and the professional while being self-reflective, I have learned to monitor myself objectively while being subjective, to be humble, respectful and humane while playing the expert, to use my shadows as a gauge and the self as a therapeutic tool while incorporating professional standards of conduct.

According to constructivism each view is self-referential and valid only within its given context. Each view carries by its side a space for the other, which because of the self-referential and limited nature of each view, needs to be listened to. An ability to listen to the other, to keep the dialogue alive, should keep us from a monologue that would stunt any relational life.

This ethical dialogue has for me been maintained by my own higher order constant self-reflectivity.

Ethics, Therapy and the Journey

Being involved in therapy implies an involvement in ethics. We inevitably use our subjective selves. Whenever one takes part in therapy he/she is involved in an excruciating struggle to maintain the use of the self as a healing instrument rather than one of harming the client. One needs to keep a constant dialogue between the self as we see it, the expert, and the shadows of the self that we mostly deny or are unaware of.

Learning to be a therapist entails being initiated into walking this journey: a constant journey into self-reflectivity, of not separating the objective from the subjective but encouraging a dialogue between the two for the benefit of the client.

Each client we meet is unique. Each moment in therapy brings with it new experiences and dilemmas, that is, challenges to the therapist. This implies that becoming a therapist is not a destination that can be arrived at with certainty. It becomes an unending journey that can never be completed. To think that we can finish it is to choose either the professional codes of ethics or the self-reflective stance - the objective or the subjective, and to lose sight of the bigger whole of which the two are parts, to be trapped in a monolithic view.

Implications for Training

I believe in training's potential to establish in the trainee, the habit of being self-reflective. However, I need to say this with caution, realising that it is not just any training context which will encourage the trainee to see that the journey to be a therapist is not a pre-packed, one way walk to a specified end.

Putting complacency aside, I need to realise that the three years I have taken at the university, are just a part of the bigger ecology of the journey. I acknowledge that I have not yet arrived and that by the end of the three years I will still not have arrived. I am becoming used to the discomfort of knowing that every moment is a challenge for new experiences and therefore for learning, which makes me humane, humble and respectful to every client I see.

It is through an acknowledgment of this intrinsic fallibility in me that I allow myself to be constantly self-reflective so that I can learn and grow with the clients.

I agree with Blokland's (1993) portrayal of the training as having elements that make it similar to therapy. In this case the trainee, just like the client, stands a chance of both growth or harm. This then creates questions of how to train someone ethically.

Just as the client learns, albeit unawares, to utilise his/her experiences in therapy, it is the unfolding of the interactional events between the trainer and the trainee that will seriously impact on the therapeutic style the latter will take. This again raises the question of how to train someone to be ethical.

The sole leaning on the scientific credibility of the trainer as an objectivist leads to a training in ethics and about the being (of) a therapist that puts less emphasis on interpersonal and professional values.

As the expert, the trainer hands down ethics as rules to be learned and abided by. As a novice, and initiate, with no history of being an expert, the trainee depends on the trainer who leads him/her. Nothing comes close to the high expectations according to which the trainee is supposed to perform. There is not only paucity of dialogue between the trainer and the trainee, but fear too is instilled in the latter.

I recall from my two years at the university when, as the only Black trainee in the group, I was put under much emotional strain to satisfy my trainer's expectations. After many attempts to draw attention to the hardship, most of which were effectively not considered, the trainer accepted and acknowledged that the pressure I was put under was personally beneficial for him. My emotional pain was his source of growth.

From another angle this sounds like sour grapes, an unfairness utterly discriminative on many grounds and not worthy of forgiveness. However, one also notices the courageous step (although belated) taken by the trainer to admit how his personal needs were confused with the professional in his conduct. I wonder how many trainers of therapy constantly apply this self-questioning to

themselves, how many stay on this road of being constantly self-reflective? How many poor trainees endure the emotional strains of being put under the pressure of having to prove themselves in the training and to their trainers? Like a therapist who takes the client's healing space, vicariously meeting his own needs through the client, needing the client too much and always being on duty, the trainer runs the risk of holding the trainee's training hostage. Being constantly self-reflective not only makes the trainer sensitive to the fusion of his/her personal issues with the professional, but also makes his conduct and the training ethical.

A Concluding Personal Comment

Often times therapists ask their clients about how they experienced therapy. Therapists rarely inquire or reflect as to how they experienced the therapy. They do this because the assumption widely held is that therapy is for the client. As expert healers, they offer help to clients, who are the sick ones. Therapists are only there to offer a service. The only side of themselves that they bring is that of the professional helping expert.

I disagree with the above assumption. I see myself as a fallible human being who has personal complexities. This is because I ascribe to the notion of the fusion of the personal and the professional, the subjective and the objective. A major part of becoming a therapist and ethical professional, implies not only acknowledging my own personal complexities in my shadows, but also owning and using them for the benefit of the clients so that I do not harm them. I rely on myself as a therapeutic tool that can be both harming and healing, and I need to acknowledge both sides. I need to monitor it (myself) closely; however, I first need to explore it. This is only possible if I keep on being self-reflective. How can I monitor something that I do not know or refuse to acknowledge?

The writing of this dissertation has not only been intended for you the reader, but has also been personally rewarding for me. If I had not involved myself in this excruciating self-exploratory writing here, how would I do it in therapy? If I did not want to admit and write about my staunchly held notion of the fusion of the personal and the professional, how would I acknowledge it in therapy?

I consider the value of this dissertation to lie not only in the mere act of writing, but also in its having engendered in me the spirit of being self-reflective. It was through the writing that I started to fully reflect on my whole process of training and therapy. It has been like monitoring myself, similar to what I have suggested elsewhere in this dissertation, that each therapist should locate self-monitoring within the self. I hope, then, that this dissertation will encourage each one of us to learn to focus and be self-reflective, not as a self-indulgent activity, before we assume that we can help others. This will help us to have respect and humility in our work.

I further realised that learning to be ethical equals learning to be a therapist. This cannot be fully understood within the limited context of the official training to be a clinical psychologist.

The training is neither the beginning nor the end of learning about ethics and becoming a therapist. It does, however, serve as a significant point in the journey to be an ethical therapist. The writing of this dissertation has helped me to realise that there are other, equally important events preceding the training which also need to be considered so that one can appreciate the journey to be a therapist. I do have areas of my own unmet needs that constantly impact on my therapeutic interactions. These bring a tone of their own to my ethical conduct as a therapist. They bring humanness to the professional.

The training carries no responsibility to make me aware of those aspects in me. It is incumbent upon me, the trainee, to bring them out and acknowledge their impact on my conduct in therapy. After the training finishes I will still continue to grapple with ethical dilemmas in the work of therapy and will hopefully continue to grow in blending the professional and personal.

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