ETHICS AND PSYCHOTHERAPY: A SOCIO-CULTURAL PERSPECTIVE

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Abstract

The main aim of this paper is to understand ethics in psychotherapy from a socio-cultural perspective. To fulfill this aim, psychotherapy, as a social healing practice, is related to the socio-cultural issues underlying it. This perspective could offer therapists some ethical reflections about what (and why) is appropriate/inappropriate to be done in the psychotherapy field. Exemplifying and deconstructing such issues could facilitate therapists' training, and could fulfill an ethical need for more critical thinkers. This paper works toward these aims by first placing psychotherapy in a socio-cultural context and exemplifying the bidirectional influence between psychotherapy and society. This will be related to an ethics perspective because it implies what therapists and clients are entitled to do and how appropriate psychotherapy aims and means are socially constructed. Second, it focuses on the three main ethical challenges in psychotherapy; i.e., trust, caring and power. These three issues are closely related and cannot be properly understood and developed unless they are placed in a socially constructed practice context.

Keywords*: ethics, psychotherapy, socio-cultural perspective*

Resumen

La meta principal de este trabajo busca comprender la ética en psicoterapia desde una perspectiva sociocultural. Para conseguirla, la psicoterapia, al ser una práctica social de cura, se relacionará con los elementos socioculturales a su base. Esta perspectiva permite ofrecer a los terapeutas algunas reflexiones éticas sobre qué (y por qué) es correcto hacer, o no, en el campo de la psicoterapia. Ejemplificar y deconstruir tales elementos facilita la formación de los terapeutas, al igual que nos permite lograr la necesidad ética de pensadores más críticos. Este artículo desarrolla estas metas, situando, en primer lugar, a la psicoterapia en un contexto sociocultural y ejemplificando la influencia bidireccional entre psicoterapia y sociedad. Esto se relacionará con una perspectiva ética puesto que determina qué se permite hacer a terapeutas y clientes y cómo se construyen, socialmente, las metas y los medios adecuados de la psicoterapia. En segundo lugar, el trabajo se centrará en los tres desafíos éticos principales de la psicoterapia, es decir, confianza, cuidado y poder. Existe una gran relación entre estos tres elementos y no se pueden comprender ni desarrollar adecuadamente a menos que se sitúen en el contexto de una práctica socialmente construida.

Palabras clave*: ética, psicoterapia, perspectiva sociocultural*

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Introduction: ethics, values and psychotherapy

Ethics is a key element at the core of therapeutic practice. As Clarkson (2005) defined it:

> *"Ethics is that branch of philosophy devoted to the study of good and bad. Also used to describe a set of rules that a group of people have between them agreed on about what is better or worse about how to behave"* (p. 102).

Ethical guidelines are of much interest. They are regulated by different codes and in distinct cultures and contexts to provide therapists with norms about what is appropriate to be done what should not be done, or what should be avoided (Colegio Oficial de Psicólogos, COP, 2010; Gabriel, 2005; Jenkins, 2002; Koocher, 2007; Pope & Vasquez, 2011; Zur, 2007).

All these guidelines are important and have helped to understand and define the phenomena of properly conducted practice. It is noteworthy that psychotherapy practice reflects certain ethical assumptions, which are mostly hidden from our views (Tjeltveit, 2004). At the same time, if, according to McLeod (2001), psychotherapists are not trained, but socialized to particular therapeutic approaches and research types, it could be considered an ethical responsibility to facilitate future psychotherapists with some reflections about their profession, and about the main elements underlying it. Therefore, it is very important for psychotherapists to be aware of the philosophical and theoretical assumptions that lie at the heart of the methods they use for treating clients and for studying psychotherapy (Elliott, 2008; Slife & Williams, 1995).

If it could be assumed that psychotherapy is a social healing practice (Wampold & Imel, 2015), it would be important to delineate and track the socio-cultural origin of therapeutic practice and to use it to understand what is appropriate to be done in the ethics context. Deconstructing and exemplifying such relationships are the main aims of this paper.

For example, if ethics answers the question of what is right or wrong to be done in a particular psychotherapeutic context, some ethical issues appear in an ongoing way in the in-session interaction of therapy participants. This refers to what is agreed on by therapists and clients as being appropriate for each role, and what is the basis that facilitates the establishment of conjoint therapeutic practice.

First, the answer could obviously differ depending on the therapeutic model. However, this answer does not come unexpectedly. In an attempt to fulfill the main aim of this paper, we need to relate this answer as being deeply ingrained in a particular zeitgeist or socio-cultural moment. Psychotherapy could be anything but apolitical (Cushman, 1992). This means that, depending on the specific socio-cultural moment, clients tend to demand a specific behavior of their therapists, while assuming a specific role. Likewise, therapists assume a specific role and provide their clients with a specific context based on several constructed therapeutic assumptions. How clients and therapists resolve their conjoint work is deeply

ingrained in the values, assumptions, feelings, attitudes, etc., that pertain to a particular historic moment (Caro Gabalda, 1995a, 1999).

The issue of values is important for psychology (Prilleltensky, 1997). Practitioners tend to use their knowledge wrongly most of the time, as if psychotherapy were a neutral application of this knowledge. In this case, psychotherapy is converted into an applied science or a psychotechnology with a predominant objectivist view (Woolfolk & Richardson, 2008). This perspective on psychotherapy is not only reflected in the aims and means of change, but also in the ways to measure change.

For instance, reliance on the tendency to empirically support treatments, a gold standard (albeit controversial; Consumer Reports, 1995; Elliott, 1998; Seligman, 1995) for many researches has important connections to ethics. Indeed, it is related to answering questions such as whether therapy does any good, what good it does and what the aims in relation to that good should be (Smith, 2009). In this context, therapy research has more to do with socio-economical and cultural forces than with academic debates.

For example, as Woolfolk and Richardson (2008) stated, cognitive-behavioral therapy conceived its methods as a psychotechnology by standardizing manuals, and by applying treatments as if applying a drug. This allowed cognitive-behavioral treatments to enter randomized controlled trials (Roth & Fonagy, 1996; David, Cristea, & Hofmann, 2018). This is merely an example of psychotherapy immersed in a practice guided by market values. Let's develop *"ever-faster and more efficient brief therapy practice, more concrete and specific DSM categories, and more quantifiable therapeutic outcomes, all in order to better technicize and industrialize therapeutic practices*" (Cushman, 2002, pp. 103-104).

Obviously, this does not justify that "anything goes". Quite the reverse. We can suggest that the training of a future researcher should not focus exclusively on research methods, and on mental health conceptualizations, techniques, etc., but, also, on theoretical reflections on the attitudes and values behind these clinical and research strategies. That is, reflect on what is "good" or "bad" to be done. For instance, that therapy could be fully manualized; that it is appropriate to establish therapeutic "horse races"; that all the subjects in an experimental group, for example, do change and do so to the same extent, etc. (Elliott, 1998; Henry, 1998; Wampold, 1997).

Therefore, if we frame psychotherapy within a conceptual, socio-cultural context, different questions and answers arise, and a close connection with the field of ethics is maintained. That is, each model, as it is historically situated, regulates what is good or bad, what to focus on, or how therapists and clients put their therapeutic roles into practice. Psychotherapy occurs in a socio-cultural context that implies various disguised ideologies (Woolfolk, 1992).

Psychotherapy and the socio-cultural context

Offering a general definition of psychotherapy is difficult because it is better defined in specific perspectives. Frank's classic definition of psychotherapy established that psychotherapy could be considered a kind of personal influence that requires a healing agent, a sufferer who seeks relief from this healing agent, and a healing relationship. That is, more or less structured contacts between the healing and the sufferer exercised primarily by words, acts, rituals, etc. (Frank & Frank, 1991). In any case, a "*form of rhetoric that relies on the methods of hermeneutics*" (Frank & Frank, 1991, p. 73).

Hence, in psychotherapy, there is a tendency to focus on and analyze clients' problems from specific therapeutic approaches, which facilitates both the therapist and client to interpret and to frame clients' needs. Once these problems are understood and framed, different techniques and strategies are applied in the context of a different kind of therapeutic relationship. Each historic moment offers a specific way of understanding different clinical phenomena and the relationships among them. Aims of psychotherapy, its procedures and its focus are agreed on by a particular zeitgeist.

More specifically, from a hermeneutic perspective, the substance of all our beliefs, experiences, practices, or our very identity, is mediated through culture, language and self-understanding (Richardson, 2012).

As Berger and Luckmann (1966) established from a social constructionist perspective, society was a human product, and an objective reality; and, in addition, the human being was a social product. Therefore, their analysis could be applied to therapy as a human product. For these authors, what is relevant is the conceptual aspect of therapy. In this sense, and following Berger and Luckmann (1966):

> "*Since therapy must concern itself with deviations from the 'official' definitions of reality, it must develop a conceptual machinery to account for such deviations and to maintain the realities thus challenged. This requires a body of knowledge that includes a theory of deviance, a diagnostic apparatus, and a conceptual system for the 'cure of souls'* "(pp. 130-131).

Moreover,

> "*When psychological theories attain a high degree of intellectual complexity they are likely to be administered by personnel specially trained in this body of knowledge……The psychological theories then serve to legitimate the identity-maintenance and identity-repair procedures established in the society, providing the theoretical linkage between identity and world, as these are both socially defined and subjectively appropriated*" (p. 197).

Understanding psychotherapy from these perspectives allows us to assume the bidirectional influence between psychotherapy and society. Woolfolk and Murphy (2004) described that, some time ago, human beings' definitions were framed within theological, moral or political conceptualizations. However, with time, the

relevance of these influences have diminished and, thus:

> "*...the explanation of human nature has come to rely more and more on the kind of interpretation provided by psychotherapists and behavioral scientists. Psychotherapy in this manner achieves a cultural impact that extends beyond its immediate effects on clients. The institution of psychotherapy becomes an important source of customs, values and worldviews. It is also a sensitive indicator of those very customs, values and worldviews. The relation between psychotherapy and culture is one of reciprocal influence. Psychotherapy absorbs and reflects the culture of which it is a part while, at the same time, it places its own distinctive imprint on that culture. Psychotherapy influences society directly, through its effects on literature, art, the mass media, and the manifold social institutions of which psychology and psychiatry are integral features. The institution of psychotherapy and its underlying disciplines respond to the needs that secularized societies have for directive structures by providing "scientifically based" cognitive frameworks for ordering, rationalizing, and norming the social world. The normative order of psychotherapy is one in which fact and value are intertwined, sometimes to the degree of being conflated*" (Woolfolk & Richardson, 2004, p. 179).

The appearance of mindfulness could be an example of this mutual influence. This tendency can be used to describe a different psychological and therapeutic perspective. First, it should be acknowledged that as a scientific discipline, psychology formed part of a modernist tradition (Gergen, 1991; Kvale, 1992). Therefore, psychotherapy could be considered a project of modernity and a Western project. On the contrary, the tendency toward mindfulness reflects the appearance of an Eastern perspective (Kabat-Zinn, 1990). This tradition has appeared in a postmodern world, a global world with an inclusive view on different cultures. At the same time, the self is fragmented and saturated (Gergen, 1991).

Very briefly, when the Western subject attempted to control thoughts and emotions, the 'mindful' subject welcomed them. The subject embedded in this tradition has developed his/her possibilities for living in the here and now and being self-conscious and mindful of what (s)he is experiencing. So according to Kabat-Zinn (1999), there is a change from what is wrong for this kind of subject to what is fine for it. The therapist, from a modernist tradition, knows what is wrong; e.g., distorted or irrational thinking. However, from an Eastern tradition, the power to connect with what is wrong or with what is desirable and healthy relies on clients. This tendency toward mindfulness is inherited from a society that turns to new ways of behaving (and, therefore, to what is good to be done in therapy) based on different/new valued traditions and cultures (e.g. Buddhist philosophy). What it has begun in, for example, the field of cognitive therapy (Segal, Teasdale, & Williams, 2002) and behavior therapy (Hayes, 2004), as a different way of approaching and dealing with human problems, has spread worldwide. In the present decade, the

practice of mindfulness is used in many areas, from hospitals to therapeutic institutions, businesses, Internet big corporations, etc. (Brandsma, 2017). There is a wide variety of 'mindful……' possibilities. Mindfulness is all around, not only in academic contexts, but also in media. Working on mindfulness is very fashionable. A new society is spreading mindfulness and mindfulness contributes differently to that society; for instance, a different understanding of therapists' ethical guidelines.

Hence, there are huge differences between what can be considered ethical guidelines from a Western *vs.* an Eastern perspective. Following Morgan (2013), a therapist should follow certain precepts that have to do more with moral action than with ethics, as previously defined. In this sense, a therapist should follow precepts, such as do not kill (behave compassionately and live a reverence life); do not steal (be more worried about equity and generosity); do not exercise improper sexual behavior (the ability to deal with sexual energy); do not lie (use skilful sincere talk); finally, do not take drugs/pills, etc. (be aware of such uses).

A second example comes from emphasizing that the mindfulness practice, based on Buddhist psychology, does not differentiate between "good" and "bad" actions because they are merely social conventions. If the general aim of mindful practice is to stop suffering (Segovia, 2017) then, and following Germer (2013), a difference appears between 'wholesome' actions (those that reduce our suffering) and 'unwholesome' actions (those that increase our suffering). This doubtlessly reflects a different perspective about any psychotherapeutic aim in different ethical requirements.

Any socio-cultural account should take into account not only the main societal elements of each historical period, but also a reflection on the kind of subject who develops and arises in this society. Therefore, any person who applies and receives therapy has very specific characteristics. Each model has a specific human being image at its core (Pilgrim, 1997; Rychlak, 2003), just as any taxonomical system has, like DSM (Cushman, 2002).

For instance, if we continue with our previous example, the human being behind mindful practice is very different from the human image in a Western psychotherapeutic practice. A therapist practicing mindfulness should understand the assumption that there is a possibility of addressing his/her work to a different kind of subject; e.g., one who does not exert control (as in mindful practice in acceptance and commitment therapy; Hayes, 2004), vs. one who does and must do (as in classic cognitive therapy work, for example).

However, let's assume that how this tendency has arisen, is being sustained and what it defends as being appropriate for a particular client in a particular context, lacks, basically, a proper specific reflection, especially about values, perspectives, kinds of implicit subjects, etc. Undoubtedly, it should be acknowledged that this oversimplified dichotomy would be unable to reflect the many diverse characteristics of practicing psychotherapy based on Western *vs.* Eastern tradition. It is used here only to explain purposes, and merely as a brief example of how we cannot avoid

ethics (based on our definition at the beginning) in the psychotherapeutic field, and how ethical guidelines depend on psychotherapy as a socio-cultural product.

To conclude, it can be assumed that therapeutic approaches integrate explicit and implicit socially constructed assumptions on what the aims and means of psychotherapy are, and what is right to be done. All this offers a context to negotiate therapeutic roles and how the inherent differential power is resolved through the therapeutic relationship. In addition, it facilitates to know what the psychotherapy focus could be, and how the conjoint client and therapist work is organized. This deeply resonates with ethics, and should, therefore, be a relevant core of therapists' training.

The three ethical challenges in psychotherapy

Pope and Vasquez (2011) have emphasized that the greatest ethical challenges that psychologists face are related to trust, power and caring. These three challenges are interconnected. For instance, trust is fundamental and must provide clients with a context in which to explore their complaints by justifying and accepting the therapist's intrusiveness into their problems. As a regulated profession, therapy depends on society, just as society relies on therapists to take care of clients' problems. "*In return for assuming a role in which the safety, welfare, and ultimate benefit of clients is to be held as a sacred trust, therapists are entitled to the roles, privileges, and power due professionals*" (Pope & Vasquez, 1991, p. 34).

Therefore, therapists gain power from the trust that clients and society place in them, which must match therapists' caring of clients and their only aim: to enhance clients' well-being.

It is important to point out that a differential power exists in therapy. Although many therapeutic approaches have emphasized an egalitarian perspective, which can be seen in different ways in the therapeutic relationship, the issue of power (above all as an ethical concern) goes far beyond this relationship (Pope & Vasquez, 1991, cit.). For instance, the therapeutic relationship in client-centered therapy (Rogers, 1957) can be designed from an egalitarian perspective. However, power is, or differences in power are, still inherent in therapy. Someone is considered the therapist and someone else the client who pays, or who does not (depending on the context), for the treatment received in a professional context. Therefore, "*a defining attribute of the professional is the recognition, understanding, and careful handling of the considerable power—and the personal responsibility for that power—inherent in the role*" (Pope & Vasquez, 2011, p. 39).

Trust in psychotherapy

Why are therapists entitled to their roles and privileges as mental health professionals? Why do clients rely on them to solve their problems? First, because psychotherapy is a regulated profession (e.g., see a review on European regulations, Van Broeck & Lietaer, 2008). Ever since its beginning, psychotherapy has been

socially sanctioned because universities, institutions, professional societies, journals, etc., have used their efforts to establish what the rules are for proper practice. From the very first attempts made, e.g., Freud's interest in stopping the "wild analysis" or the regulations after the Boulder Model, ongoing interest has been shown in training and establishing who and by what means a psychotherapist can be considered as such. This is fundamental for ethical practice as training cannot escape from providing an answer to what is good or wrong to do in the field.

The training issue can be seen in all kinds of therapeutic approaches. For instance, cognitive psychotherapy has devoted considerable efforts to articulate what the best characteristics of a cognitive therapist could be (e.g., Newman, 2010; Rodolfa et al., 2005) and how to apply cognitive therapy at its best. These works have regulated the proper way of conducting cognitive therapy, and have undoubtedly influenced clients' trust in their cognitive psychotherapists. In this cognitive context, the proper training issue has been important since the beginning and is becoming increasingly more relevant (Bennett-Levy, 2006).

Second, the assumption about the proper way of being a professional therapist has been inherited from Modernism (McNamee & Shawver, 2004). Through modernist characteristics, such as industrialization, urbanization and secularization, and according to Cushman (1992), a new interest was shown in the physical world, humanities, science, commerce and rationality. Therefore, the State developed ways to control a new type of subject, based always on change and development, and one being less regulated and constrained by the role of tradition and religion, and, therefore, less predictable. This new self was a more isolated, less communal and more individualistic self, and one more confused about what was good or wrong, about what was ethical or unethical, and one who required the development of a new kind of expert, the *modern philosopher* who, with time, would become a *social scientist* who developed techniques to observe, measure, predict and control subjects' behavior (Foucault, 1975).

Psychotherapists are this figure, a socially created one that has become an integral part of the modernist tradition. As McLeod stated (1997), "*psychotherapy is a cultural form or arena in which people are given permission to tell their personal stories of troubles, in the presence and with the assistance of another person with special skills and status in relation to this task*" (p. 20).

According to Berger and Luckmann (1966):

> "*Therapy entails the application of conceptual machinery to ensure that actual or potential deviants stay within the institutionalized definitions of reality, or, in other words, to prevent the 'inhabitants' of a given universe from 'emigrating'. It does this by applying the legitimating apparatus to individual 'cases'. Since, as we have seen, every society faces the danger of individual deviance, we may assume that therapy in one form or another is a global social phenomenon. Its specific institutional arrangements, from exorcism to psycho-analysis, from pastoral care to personnel*

counselling programmes, belong, of course, under the category of social control" (p. 130).

By translating this view in the psychotherapy field, this modernist background has contributed to build a corpus of worldwide spread knowledge that provides society and prospective psychotherapy users with guidelines to know what they should demand, and where and how to find a therapist. Therapy has become globalized. Millions of people in Western industrial nations and societies have some knowledge about what a psychologist or a therapist could do for them. These more or less general or specific notions come from school, TV, magazines, films, etc. (McLeod, 1997). These socially constructed guidelines and knowledge about therapy help clients to rely on their therapists because there is a social background that confers the therapist the power to heal. Therefore, clients trust this socially regulated profession. That is, society depends on therapists "to fulfill the trust for the benefit of their clients as well as the social order" (Pope & Vasquez, 2011, p. 34).

As Howe (1993) emphasized, "*there is a 'centre', an individual subject who has privileged access to the truth, who holds the key which alone can unlock the contents of the client's experience*" (p. 185). Therefore, a prospective psychotherapist should know that (s)he, as the keeper of this key, has great ethical responsibility.

Therapists are socially sanctioned in their roles, as well as their clients. That is, trust might be an ethical issue, but in two ways. For instance, both clients and therapists have expectations in therapy about change and about what to obtain from this process.

For example, clients may expect that their therapists will fulfill their expectations, an interesting issue that could be related to therapeutic outcome (Bohart & Greaves Wade, 2013), or psychotherapists could have expectations related to outcome (Connor & Callahan, 2015). According to Feltham (2017), "*... attention from a socially sanctioned healer in a sanctioned setting plays a large part in setting positive expectations. People are often reassured by appropriate settings, a professional manner, qualifications, and an explicit rationale for therapy*" (pp. 151-152). That is, any therapy requires providing clients with a sense of hope, of being helped (Frank, 1974). Obviously, this does not mean that all clients (or therapists) attend psychotherapy with the same degree of expectations. Some clients could have a positive faith in the outcome, some could be ambivalent about it, and others could show lack of confidence in the therapeutic outcome (Glass, Arknoff, & Shapiro, 2001).

Although many prospective clients may consider that they do not need a psychotherapist and non psychotherapeutic practices have been described or could be anticipated (Gergen, 200; Parker, Georgaca, Harper, McLaughin, & Stowell-Smith, 1995), most have obtained some degree of information that could form the basis for their decisions about whether to choose one kind of therapeutic approach or another. If clients are educated about what to expect from therapy and about what sustains the whole therapeutic device, they would probably make more informed

choices and better match their therapists (Glass, Arnkoff, & Shapiro, 2001). It has been noted that clients attend psychotherapy with knowledge, provided by the Internet and self-help books, which could imply that psychotherapists are mere consultants and not the authority figures as they were in the last century (Strong & Sutherland, 2007). Hence, the evolution of society implies different demands and attitudes for these "social scientists".

As McLeod (2012) stated:

> " *.... members of Western societies are exposed to a range of discourses and practices around how to make sense of, and resolve, emotional, behavioural and relationship difficulties. It is probable, therefore, that when a person enters therapy, he or she is likely to be influenced by several of these discourses and practices, in relation to his or her general sense of what will be helpful in therapy. In addition, he or she is likely to hold some preferences around the value of certain therapy ideas and methods and will regard other approaches as lacking in credibility*" (pp. 23-24).

However, therapists could base their therapeutic decisions on what to demand of their clients because clients' role is socially sanctioned. Clients trust their therapists and enter therapy to be able to talk about things that they will not tell anyone and allow their therapist to ask any kind of intrusive questions (Pope & Vasquez, 2011). Why do therapists do that? Why is it correct to intrude into clients' deeper and more personal areas?

First because psychotherapy has inherited the modernist idea of the need for a social scientist who plays a fundamental role. The Panopticum metaphor, established by Foucault (1975), could be the perfect symbol (according to Cushman, 1992) of the new order that the modernist tradition required, as described above. The Panopticum was a prison designed by Bentham in the 18th century. It had a specific characteristic as the prisoner could see him/herself, but could never see the guards. The Panopticum metaphor describes how prisoners increase a) their tolerance to be observed; b) their tendency and ability to observe themselves; c) pressure to be normal; d) attempts to practice self-observation and the conscious behavioral change.

In relation to this metaphor, there is a clear description of what kind of subject is required for the new social scientist. This kind of subject could justify, whenever appropriate, the therapist's intrusion in clients' personal areas. In order to practice psychotherapy, we need an individual who is able to be *self-conscious,* with the capacity for *introspection* (Caro Gabalda, 2015). Therefore, any proper practice should facilitate access to the private world, to a kind of subject who expects to be observed (Cushman, 1992). Individuals are able to observe themselves, wonder what they are, think about what they hide or reveal, and speculate about their true characteristics and identity.

Therapists address their work to such subjects, independently of the therapeutic approach. Differences can be established between approaches, but they require

a therapist who relies on clients' possibilities for self-consciousness, self-exploring, etc. Thus, this is a requirement for the therapist to be able to enter clients' world. Clients trust their therapists to behave accordingly.

Caring in psychotherapy

It is an ethical responsibility to use the power and trust offered to therapists for the only aim of enhancing clients' well-being. Caring is the foundation of therapists' responsibilities (Pope & Vasquez, 2011). That is, psychotherapists base their role on benefiting others. For this reason, this aim is included in psychologists' Codes of Conduct. To benefit others is a logical demand and is, therefore, an important ethical principle (Tjeltveit, 2006).

Following Howe (1993), clients tell a story about their therapeutic experiences characterized by three main themes. *Accept me; understand me; and talk with me*. Moreover, clients describe a "nice" therapist in relation to six main themes: Comfort; good therapists are real people; the quality of the relationship; liking and being liked; truth and honesty; and support and being there (Howe, 1993, p. 21). Therefore, prospective psychotherapists should be aware that they should fulfill these clients' expectations. However, this is no easy task. Psychotherapists should guide their practice by careful thinking and carefully planning what to do in psychotherapy. Their responsibility is not only to be properly trained as a justification for trust and caring. Caring cannot be developed without sensitive and responsive attunement (Stiles, Honos-Webb, & Surko, 1998) to clients' demands. Such work cannot proceed without some pain and suffering or without clients feeling worse before feeling better (Stiles, Osatuke, Glick, & McKay, 2004). Thus, therapists should provide such caring by carefully considering its consequences.

Therefore, we may assume that a good therapist is able to go into clients' needs in-depth and to handle them properly. However, this means that clients need to experience comfort in therapy and need to trust their therapists as a way to justify them profoundly examining their suffering (or feeling worse before feeling better). This would open a door to the complexity of their lives (Messer, 2006). Only when this door opens will the ethical requirement of caring be fulfilled.

What clients need should be carefully handled in psychotherapy because the individuals attending therapy are in a vulnerability state or, as Frank (1974) stated, are *demoralized*. This vulnerability has to do with not only describing the client as being "broken", a "puzzle", "empty", etc., or as a "fragmented soul" that needs to be helped and carefully guided (Caro Gabalda, 2018). It has to do with such important issues in relation to the ethics context that should be carefully handled. Clients are the entrusting part that presents the problem by revealing confidential information, idealizing their therapists, and experiencing stress by the treatment process (Gutheil, Jorgenson, & Sutherland, 1992).

Although therapists are entitled to go more deeply into the human soul, clients' well-being has various definitions from any perspective. This means that each

therapeutic focus will be differentially constructed from specific models.

For instance, let's compare differences as to how reason and emotion are resolved in the field of cognitive psychotherapies. Traditional modernist cognitive therapies tend to favor reason over emotion, while their constructivist counterparts favor emotion over reason (Caro Gabalda, 1995b; Mahoney, 1991). That is, the Romantic philosophical tradition, where emotions should be the focus of respect and concern, clashes with the Enlightenment tradition, which considers that emotions should be regulated (Fowers, 2005). This could also be related to how emotions and thoughts are dealt with in classic therapeutic practices ("Let's control them!") *versus* how they are dealt, as stated above, in mindfulness and contextual approaches, or in constructivism where emotions are considered primitive and powerful knowing processes (Mahoney, 1991). Once again, we find a different focus that is appropriate or inappropriate in a specific approach.

Those differences in reason *versus* emotion can be understood from an ethics perspective by implying, at the same time, a vision about a different kind of person. Following Richardson's (2012) reflections on virtue ethics, as established by Fowers (2005), this dichotomy should be transcended. For Richardson (2012):

> "*It holds that emotions reveal "the kind of person one is" (Fowers, 2005, p. 44) and reflect the current state of one's 'character strengths' (p. 9) or excellences of living. Character development involves non judgmentally and non coercively schooling one's emotions "so that they are consistent with acting well" and make up an important part of the experience of what one takes to be the best kind of life. The person who has cultivated such character excellences can act "with concordance of emotion, thought, and action," which enables a degree of "continuity, wholeness, and cumulativeness" (p. 66) in one's life over time*" (p. 28).

Finally, we ought not to forget that any therapy is a theory. Briefly, this means that it is related to important socio-cultural issues about human beings. As a theory about human beings (Robinson, 1997; Rychlak, 2003), therapy provides us with reflections about what kind of life human beings should live; what the "best" kind of living is for them; what kind of identity we should look for and enact; what means some persons are allowed or entitled to use to influence others' lives and, finally, what good therapy aims could be. Nevertheless, this issue of what is good or bad has received diverse answers but, from our perspective, it is based on an important underlying assumption. Therefore, therapy is more than the treatment of clients' symptoms or disorders (González Pardo & Pérez Álvarez, 2007; Smith, 2009). Hence, implicit philosophical and theoretical questions should be clarified, instead of being taken for granted (Pérez Álvarez & García Montes, 2017; Woolfolk & Richardson, 2008). What is good, what is bad, what psychotherapists' obligations, virtues, etc., for clients 'caring are all core elements of the psychotherapeutic practice (Tjeltveit, 2004).

Power in psychotherapy

Therapists, as they are defined in the sections above, are entitled to their role, and are treated as professionals whose suggestions, directions or guidelines should be followed. Therapists have got advanced degrees with specific training and a professional license that enhance their credibility and authority, and offer them the chance to serve as agents of behavioral change (Foote, 2011).

Therapists should use their power carefully by caring for clients and being responsible for the trust that clients and society place in them (Pope & Vasquez, 2011). This is especially relevant when *"... the therapist is being styled and perceived as the one who is qualified, who knows, who embodies super-sanity, whose powers may apparently border on telepathy, and who may hold the key to an exit from misery"* (Feltham, 2017, p. 150).

Clients can, therefore, see their therapists as having a considerable amount of power. This power can be observed in different areas. The power to name and define, or the power to attach diagnostic labels, is particularly important. As Cushman (1992) described,

> "*each society or era could be studied according to historical judgments pertaining to, a) the predominant configuration of self, b) the illnesses with which each self was characteristically afflicted, c) the institutions or officials most responsible for healing those illnesses, and d) the technologies that particular institutions or practitioners have used in order to heal the self's characteristic illnesses*" (p. 24).

That is, what is the cause or the explanation for human problems, and how to evaluate and overcome those problems, are the basis of both therapeutic theories and therapeutic decisions (Gergen & Kaye, 1992). Thus, the power to attach diagnostic labels should be used based on profound ethical reflection which, from the perspective defended herein, can be better developed by placing the comprehension of psychotherapeutic decisions in a socio- cultural context.

For instance, according to social class, kleptomania was considered a mental disorder when a woman had a high social status, but robbery when a woman had a low social status. The way of solving the same situation was differentially constructed in relation to social class (Parker, et al., 1995). The history of psychopathology and psychotherapy is full of such examples (e.g., see Woolfolk & Murphy, 2004; Woolfolk & Richardson, 2008).

Following Higginbotham, West and Forsyth (1988), any illness or any set of psychological symptoms form part of the human experience, and become objects of human action only when human beings attach a meaning to them through language. Second, each illness is based on a particular point of view about the world, an epistemology and a set of values. Thus, each illness category is a cultural product based on theories and meaning networks, used to interpret and communicate specific symptoms. Finally, each clinical practice will be an interpretation. Each therapist, no matter what therapeutic approach (s)he follows, understands and

frames clients' symptoms, experiences, behaviors, etc. The therapist focuses on some issues. Some will be considered central, some marginal, and others less relevant. Abstractions will be made and the therapist will be involved in an ongoing translation process through different meaning systems. This completely depends on a particular historical moment, as the history of psychotherapy shows (Robinson, 1976). This is not only a therapist's task, but also a client's one. Clients interpret the meanings that therapists offer about their problems, which help them to construe new meanings about what is happening to them.

Hence, psychotherapeutic practice cannot be separated from a context of negotiated meanings. Codes of ethics show this. For instance, from the *conversational ethics* perspective (Strong & Sutherland, 2007), clients and therapists' conversations, dialogs and conjoint therapeutic work should be sensitively attuned. In other words, ethical practice does not only imply using our professional knowledge, but doing this, as Stiles et al. (1998) defined, in *responsiveness* terms. This cannot be separated from language. That is, psychotherapeutic practice is associated with a *content ethics* (what should or should not be done; i.e., breaking confidentiality) and with a *conversational ethics* (i.e., practical reasoning and situation-specific ways of talking with clients). Then, "*... psychologists practice in relationally and contextually responsive ways informed by their ethics and knowledge…. Psychologists face ethical tensions when balancing their professional knowledge and intentions with clients' intentions and preferences in professional interactions*" (Strong & Sutherland, 2007, p. 95).

Therefore, therapists should acknowledge that their power implies naming, defining and selecting the best ways to handle clients' problems. This means that therapists have the power of knowledge or of what factors affect human beings, and the best ways to produce changes in them (Pope & Vasquez, 2011).

Conclusion

Therapists, according to Owen (1992), relate with their clients from their theoretical explanations, which offer an implicit and taken-for-granted or justified context for their practice. As theories, psychological and psychotherapeutic theories are not perfect. If the problems in these theories are not acknowledged, they will, therefore, remain unquestioned.

In addition, the power socially entitled to therapists helps them to enter therapy as experts, as those who know what to do. Accordingly, the therapist is the strong person and the client is the weak one (Avia Aranda, 2018; Gergen & Kaye, 1992). This assumption could bias therapeutic work and strongly influence how therapists dwell on the power they have and how they justify their practice with the only aim to provide a trusting context and to pursue clients' well-being and profound care.

Many psychotherapeutic theories may fail when there is not critical reflection on therapists' actions on their clients' lives. Many therapists may also fail when they do not make this reflection. Interestingly, therapists do not tend to reflect on their

theories and how they are constructed when, most of the time, they request clients to change their own.

The answer to the question about how a therapist is entitled to speak from an authority perspective is because knowledge is a social product. That is, just as the history and evolution of what is mental health and the way to address these problems have taught and reminded practitioners, scientific representations are a consequence of the scientific community, which negotiates, competes or conspires, and agrees. Our therapeutic maps should not be taken for granted.

Therapists' proper training is one of the main ethical responsibilities of all those involved in it. In a few words, this training should encompass both the technical and theoretical parts, or theories about their work, about how to apply their knowledge. Nevertheless, there should be a higher level of abstraction and reflection about the content and context of this training. Therapists should reflect on their background, or on the historic and socio-cultural origins of their work that justify and facilitate their practice, and have explicit and implicit consequences. There is an ethical need for more critical thinkers.

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