Academic Article

Egalitarianism in Therapeutic Dialogue: A Catalyst for Client Autonomy

By Maurice Kinsella

Introduction

Autonomy sits at the epicentre of counselling and psychotherapy. As a client capacity that practitioners have a duty to uphold and as a destination that they actively pursue with clients, autonomy pervades the ethical concerns that underscore therapeutic principles and practices. Engagement in "dialogue" (i.e. each person being responsively attuned to what emerges within the therapeutic encounter) is a catalyst in fostering such autonomy. Dialogue is most fully realised when it emerges within an "egalitarian" dyad grounded in a recognition of clients' nascent autonomy and their ability to operate as a co-directive force in their therapeutic journey.

Implementing an egalitarian dialogue can be challenging – in particular in scenarios where a client's autonomy may have been previously undermined. In this case, they may benefit from a greater use of "paternalistic" interventions e.g. in early-stage addiction rehabilitation. Nevertheless, dialogue is foundational to both the establishment of a robust therapeutic alliance and to the joint-achievement of therapeutic goals. Building on insights from the field of "relational autonomy", this paper makes four recommendations that can act as a useful reflective device for practitioners seeking to foster egalitarian dialogue.

Dialogical Personhood and the Therapeutic Alliance

People are inherently dialogical. Interpersonal relationships are a prime agent in facilitating the ongoing process of psychological maturation – helping to mould the clay of who we are and the attributes that we possess. The ever-evolving social matrix within which we live our lives is internalised over time, profoundly and pervasively influencing facets of personal identity such as beliefs, desires, and goals.

Building on the belief that "... we define our identity always in dialogue with, sometimes in struggle against, the things our significant others want to see in us" (Taylor, 1992, p. 33) , interpersonal relationships can be a means through which our autonomous capacities are either affirmed or undermined. As Catriona MacKenzie (2008) discusses, the

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experience of trust we have in our inner resources has both "first-personal" and "relational" aspects and is navigated within a pattern of *call-and-response* with others. There are few places in which this process is more apparent than in counselling and psychotherapy, wherein the therapeutic alliance can enable clients to attain greater psychological health and to achieve the aligned ability to exercise positive changes in their life. This alliance can be understood as the client and counsellor's subjective experience of working together towards psychotherapeutic goals, including the experience of an interpersonal bond (Duff & Bedi, 2010). It is characterized by experiences such as "mutual trust, respect and understanding" (Christman, 2013, p. 378).

A prime catalyst engendering the transformative power of this alliance is the establishment of dialogue. Therapeutic dialogue represents a process of mutual exchange and understanding: expressing "me" and internalising "you", so that "we" may responsively negotiate the shared meaning of the encounter. The concept of "catalysed" (developed from insights within Self-Determination Theory) conveys the stance that autonomy is not necessarily *created* by the experience of interpersonal recognition within dialogue, but rather – as an inherent capacity – is *fostered* by this experience.

The distinctly therapeutic nature of this dialogue is that it occurs to facilitate clients' healthy psychological development. It therefore calls on practitioners to be mindful of the nuances of their interactions in a manner that may be more demanding than other dialogues they encounter in their lives. Given the elevated vulnerabilities with which clients may present, they can be especially perceptive of interpersonal dynamics that occur within the therapeutic dyad and sensitive to them. Practitioners will, here, be familiar with the three core therapeutic conditions that underscore Carl Rogers' "Person-centred Therapy" (1995 (1961)) – namely empathy, congruence and unconditional positive regard.

Autonomy within Counselling: A Relational Perspective

Autonomy is understood within philosophical literature as "self-law" (*auto-nomos*): the iteratively realised capacity to govern one's life in accordance with justifications and motivations that are authentically one's own, rather than the product of external forces deemed manipulative or distorting (Christman, 2015). The value of autonomy in terms of one's psychological wellbeing is attested to within numerous contemporary clinical orientations, including Motivational Interviewing (MI) and Self-Determination Theory (SDT). Here, SDT provides a further definition of autonomy as the "self-endorsement of one's behaviour and the accompanying sense of volition or willingness" (Ryan & Deci, 2008, pp. 186-187). Engagement in counselling and psychotherapy enables clients to more fully recognise the presence of their autonomous capacities and to exercise such capacities in how they choose to live their life. It is, consequently, no surprise that autonomy is positioned as a prominent conceptual pillar within bioethical literature. Here, it is vital in defining the rights of clients and the attendant responsibilities of practitioners to uphold such rights, as well as in articulating the broader mission of the therapeutic journey.

Codes of ethics within contemporary healthcare are increasingly supportive of professional encounters being more firmly grounded in a "person-to-person" dialogical alliance. These run counter to "practitioner-to-patient" prescriptive monologues that discard discussion and deliberation in place of paternalistic directedness. The rationale behind this movement (within a therapeutic context) is that although the skill-set possessed by a practitioner (rooted for example in their knowledge base or experiential insights) is a necessary feature of their professional competency, it may not be *sufficient*. Instead – as within the Humanistic paradigm – it is argued that the success of one's strategies derives from one's interactional style. This brings the therapeutic bond into completion. In a study undertaken by Jack De Stefano and colleagues (2010), it was reported that clients' attentiveness to practitioners' technical skills was significantly superseded by the value they placed on their "relational persona as the embodiment of desirable human qualities and facilitative communicational skills" (De Stefano, Mann-Feder, Gazzola, 2010, p. 144). Similarly, for Carlton Duff and Robinder Bedi (2010, p. 91), the experience of an "alliance"

was considered among the most "consistent and robust" predictors of counselling outcomes.

As Carolyn Ells and colleagues (2011) note, the broader bioethical literature is increasingly explicit about recognising and being receptive towards patients' decisional and volitional capacities – as within Tom Beauchamp and James Childress' (2009) analysis. Dissatisfied with models that appear to equate autonomy with independence from others – "the right to make one's own decisions, protected from outside interference" (Kim, 2013, p. 183) – clinical discourse has moved towards alternative encounter models. In particular, the concept of autonomy has been revisited to more fully articulate our social nature and accommodate healthy embeddedness. Here, "embeddedness" can be understood, from a sociological perspective, as "a multidimensional construct relating generally to the importance of social networks for action" (Moody & White, 2003, p. 4). This calls for an ethic of *actively fostering* autonomy through the nature and tone of one's interactions (i.e. upholding clients' "positive" right to a supportive environment), rather than simply passively upholding clients' "negative" right to non-interference.

This movement has emerged alongside the ascendency of "relational" models of autonomy which assert that there is a correlation between the nature of the environments within which people are embedded, and the development and utilisation of their autonomous capacities. Relational perspectives are broadly aligned in the conviction that "persons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting

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social determinants" (MacKenzie & Stoljar, 2000, p. 4). Within a wider healthcare context, as Vikki Entwistle and colleagues (2010, p. 744) note, "all communication with patients" is rendered "potentially significant for their autonomy" . The communication style adopted by the practitioner has consequences both for the interpersonal client-counsellor relationship, and the client's own relationship with themselves.

While the goal of personal therapy may be *individual* autonomy-growth, a dialogical position enables us to more firmly appreciate the extent to which this process is most fully facilitated through a healthy therapeutic *relationship* grounded in the practitioner's recognition of the client's capacity for autonomy. Fostering autonomy should not be regarded as an individualistic endeavour, but as a co-journeying, where "…part of the mechanism for achieving such a renewed self-understanding is aid and understanding from significant others and social agencies" (Christman, 2013, p.378). As Stefaan Cuypers (2001, p. 55) argues, individualistic models of autonomy are "directly at odds with our intuitive, common sense conception of the nature of persons".

Both MI and SDT have attempted to empirically validate this perspective, in particular within the field of addiction rehabilitative practice. These approaches argue that the greater the degree to which clients' actions are rooted in an experience of autonomous choice, the more likely clients are to both commence and persevere through rehabilitation (DiClemente, Bellino & Neavins, 1999; Ryan, Lynch, Vansteenkist & Deci, 2011). Practitioners are therefore encouraged to provide "autonomy support ", defined as the extent to which clients feel supported in their ability to function autonomously and make decisions congruent with their sense of self (Kasser & Ryan, 1999). Building on this relational stance, SDT contends that the individual's inherent tendencies towards personal growth and integrated functioning require a nurturing environment (Deci, 1975; Deci & Vansteenkiste, 2004; Ryan & Deci, 2000). A crucial means of mobilising clients' intrinsic values and stimulating behaviour change (Miller, Moyers, Ernst & Amrhein, 2008) is therefore through establishing a collaborative dynamic. This reduces the power-disparity that may undermine clients' commitment to and cooperation with the therapeutic journey. In such instances, therapeutic interactions are designed to facilitate clients' understanding of the therapeutic process , their role within it, and how best to take ownership of it.

Therapeutic Egalitarianism and its Dialogical Rootedness

The therapeutic alliance emerges when both parties come together to create and achieve common therapeutic goals. But what attributes should rightly constitute this alliance? As discussed, paternalistic stances may perpetuate an image of practitioners as the *sole* causal agent of change, therefore

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undermining clients' self-directedness. In their place, we are offered models that are premised on supporting an egalitarian form of clinical interaction (Caplan, 2008). At the heart of this move is the belief that, when possible, clients' decisional and volitional capacities should be both recognised and encouraged as being a directive force in their therapeutic journey. This imbues a more authentic and efficacious engagement.

Calls for the therapeutic alliance to be grounded in such equality require us to ask "equality of *what*?". At first glance, there are a number of indications that inequalities pervade the relationship. The fact that counselling and psychotherapy exists as a profession, with its evidence-based strategies, insights and ethics, attests to this. Alongside this, practitioners are called to display ongoing attentiveness to their emotional and psychological wellbeing, for example to "monitor their own personal functioning and seek help when their personal resources are sufficiently depleted to require such action" (IACP, 2011, 4.1.2). The inference here is that practitioners are often more attuned to the client's psychological needs, and how best to fulfil them, than the clients themselves might be.

This highlights how practitioners operate from a place of an immediate differential, which, in turn, may support the *need* for them to occupy a directive stance within the relationship. Indeed, awareness of such differences is often the key motivator in clients' decisions to seek clinical intervention in the first place. Many codes of ethics e.g. the IACP Code (2011, 4.3.1.) do in fact explicitly acknowledge this disparity, holding that ethical counsellors are "acutely aware of the power dynamics of the practitioner/client relationship and shall not exploit clients in any way, either during the relationship or after its conclusion".

Power differentials are a lived reality of therapeutic encounters that shape peoples' approach to the dyad and the role they occupy within it. Consequently, they should not be disavowed out of hand *per se*, but respected as a defining feature of the relationship to be navigated with cautious consideration. Establishing an egalitarian dialogue is therefore not so much about the denial of practitioners' capacity (and often professional responsibility) to operate in a directive light, but rather about the discretionary use of such direction in a *dialogical* context, so as not to undercut the self-determining capacities of those seeking their professional guidance. The essence of the therapeutic alliance is that it is a collaborative relationship, with both client and practitioner participating, *if in distinct ways*.

Here, we can distinguish between two forms of equality. The first, "ontological equality" (operating in an ethical sphere), affirms each person's rights and the attendant responsibilities to uphold such rights in one's interpersonal interactions. Such equality is a foundational attribute endowed by our shared humanity and exists irrespective of the particular characteristics a person may possess. It is not synonymous with sameness or homogeny, which may undercut our appreciation of each person's individuality, and so it is useful to consider a second form of "discrete equality" (operating in a cognitive/physiological sphere), which affirms the distinctiveness of the attributes each person possesses and allows us to recognise difference in such attributes. Equality in one's rights and dignity does not equate to equality in one's abilities, needs, and vulnerabilities.

Egalitarian dialogue therefore serves a dual function. Firstly, it helps open the door to acknowledging and accommodating the contribution that clients can make to the trajectory of the therapeutic relationship – grounded in the belief that "since clients hold almost all the information about their past and current thoughts, feelings and experiences, it is essential that clients actively participate in the joint search for greater understanding" (Nelson-Jones, 2002, p. 59). Secondly, it serves the role of fostering clients' recognition of *themselves* as a resource in overcoming the challenges they face. Inter-personal recognition of one's autonomous capacities fosters an attendant sense of intra-personal recognition. Susan Sherwin's discussion on "negative stereotypes" explores a corollary of this argument, holding that experiencing "diminished expectations" can develop into "diminished capacities" (McLeod & Sherwin, 2000, p. 79).

It is difficult to sustain the argument that clients can exercise a requisite degree of ownership over their lives following the cessation of therapy, if it is not

preceded by an invitation to develop an acquaintance with whom it is that will exercise such ownership i.e. oneself. Egalitarian encounters thus motivate clients to reflexively endorse their personhood and appreciate themselves beyond the mere moniker of "patient" or "presenting problem", and to utilise this intra-personal insight in a directive capacity within the therapeutic alliance. A clients' phenomenal frame of reference is thus an important resource in helping shape therapy as an endeavour that is at once both more authentic, and attainable.

Differentiating between "ontological" and "discrete" forms of equality helps to maintain a mindfulness that each member of the alliance brings with them a unique set of attributes and occupies a distinctive role within the dyad.

Egalitarianism in Therapeutic Dialogue

Facilitating an egalitarian dialogue between client and practitioner is a challenging process that requires the ability to make use of one's therapeutic toolkit while accommodating a clients' co-directive role within the dyad. The practitioner's stance influences whether clients will come to understand themselves as either simply submitting to information and instruction (potentially fostering dependence), or as actively collaborating in formulating therapeutic strategies (fostering autonomy). Drawing on clinical insights into therapeutic approaches, in line with Sue Eusden's (2011, p. 112) call for practitioners to become aware and actively foster "the intersubjective, bidirectional nature of the therapeutic alliance", we make four recommendations to assist practitioners in establishing an egalitarian dialogue.

- Differentiating between "ontological" and "discrete" forms of equality helps to maintain a mindfulness that each member of the alliance brings with them a unique set of attributes and occupies a distinctive role within the dyad. This recognition is balanced against an acknowledgement that, irrespective of such differentials, both parties possess an innate dignity that should be respected.

- Disavowing unreflective practice ensures that the process of coming to know, understand and empathise with the *person* at the heart of the alliance is not bypassed in favour of engaging with the particular *problem* they are exhibiting. Full appreciation for the issues that clients may present with is attained when they are contextualised within the broader ambit of their own lived experience and their wider life circumstances. This most fully occurs through attentive interpersonal interaction.

- Deliberating on the formulation and realisation of therapeutic goals ensures that clients remain a collaborative participant in the process, someone whose phenomenal frame of reference should be called upon to act as a co-directive force in the trajectory of therapy. This is vital so that the client may look *on* themselves as capable of active participation in the therapeutic encounter and look *to* themselves in scoping the direction of the therapeutic narrative – in particular so that they may continue to grow autonomously following the cessation of therapy.

- Using directive strategies in a discretionary way (in a manner that most suitably addresses clients' needs) is still useful at times. Clients' vulnerabilities may manifest themselves in an inability (perceived or otherwise) to exercise their autonomous capacities, and here, counsellors must occupy a more explicitly paternalistic stance. However, such discretion allows for the use of directive interventions at appropriate times and ensures that clients' own capacities are not habitually crowded-out.

Conclusion

Dialogue lies at the heart of the therapeutic alliance. It is a "two-way communication for good or ill . . . [where] . . . counsellors and clients are in a continuous process of sending, receiving, evaluating and interpreting verbal, vocal and bodily communication" (Nelson-Jones, 2002, p. 53). The process of therapeutic engagement *must* be grounded in an attentiveness to and facilitation of dialogue, given that it has the power to catalyse a client's autonomous capacities. This is what an egalitarian ethic most fully accommodates. It requires an acute mindfulness that the nature and tone of one's interactions can be internalised by clients and cause repercussions throughout their self-system. It obliges practitioners to be aware that power differentials (real

or perceived) exist between client and practitioner, and the quality of the therapeutic encounter depends on how the differentials are handled. Egalitarian dialogue is rooted in the belief that the narrative unfolding in the therapeutic alliance is given its fullest expression through a process of co-authorship between client and practitioner, where both are actively and authentically collaborating .

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