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Paradigms and Epistemologies in the Promotion of Therapeutic Change: A Synoptic Re-Examination

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Abstract

Although psychological clinicians in Africa and the wider world are usually exposed to several paradigms and epistemologies for promoting therapeutic change in clients, not many of these clinicians tend to look back and draw their clinical guidance from most of those therapeutic approaches and philosophies. Rather a vast majority of practising clinicians tend to adopt only one of those existing therapeutic paradigms or epistemologies, ignoring others, influenced by the conviction that psychological problems originate from one single master cause which when discovered and dealt with will lead to the amelioration of the challenge presented. This article argues that this tendency to adopt a single assumption theory of aetiology of human psychological problems is mistaken and needs to be reconsidered as problems which many clients present for psychological attention often do originate from multiple sources or factors. Against this background, the major objective of this article is to encourage practising clinicians to form the habit of looking back and drawing clinical insights from important variety of paradigms and epistemologies that promote effective therapeutic change which they were exposed to in the course of their training. Through such a strategy they will avoid the regrettable error of continuing to neglect important clinical approaches that they have routinely ignored but which may merit a second chance of attention in promoting their practice.

Keywords: *Paradigms and Epistemologies; Psychological practice; Promotion of Therapeutic Change; Human Psychological Problems; Traditions and Approaches of Therapeutic Practice*

Introduction

One of the major contributions of the learning theory tradition is the view that learning is a lifelong process and that transformative and progressive learnings are a product of relearning. As the present

author sees it, the current culture of demanding for regular professional 'recharging' of psychological practitioners appears to be grounded on such a learning theory tradition; namely, the need for the promotion of their habit of relearning.

Against this background, the primary aim of this article is not so much to teach the reader old tricks of clinical practice as to promote in him or her, the habit of craving for a re-engagement with some of the fundamental ideas and taken-for-granted knowledges they have inadvertently tended to neglect in the course of their attempt to enhance their professional practice. In making this observation, the specific objective of the article is to re-present to the practising psychological clinicians a number of salient philosophical traditions that influence effective habits of thought and actions in professional psychological practice. Here, when reference is made to the existence of some important philosophical traditions or paradigms for influencing successful therapeutic change in clients, the mind usually runs to the view credited to Karl Tomm (as cited in Carr, 1997, 2000), that until quite recently, all approaches to understanding and solving psychological problems had tended to rest on one single core assumption or paradigmatic perspective. Understood in this way, part of the aim of this article is to review and identify what these core assumptions or epistemological traditions for improved psychological practice made reference to by Karl Tomm, are by name.

To achieve this goal, it is deemed appropriate to begin with the task of defining the notion of Paradigm in psychological practice; to which we now turn.

The Notion of Paradigm in Psychological Practice

In the context of this presentation, the term paradigm can be taken to refer to a 'theoretical tradition for explaining the origin of something' that has gone amiss; or 'a conceptual framework' for understanding something that has gone wrong in order to facilitate the process of dealing with it decisively. Applied to the field of psychopathology, for instance, the term paradigm is used in this article to refer to the existing conceptual frameworks or theoretical assumptions about psychopathology and how it originates and what can be done to alleviate it. In this regard, whichever paradigm that is adopted influences how abnormal behaviour or a given mental illness is assessed, measured, interpreted and classified by the practitioner guided by it (the said paradigm). Hence, according to Karl Tomm (See Carr, 1997, 2000) different paradigms for abnormality do exist and have different assumptions about what creates human sufferings, and what can be done to alleviate them. And so the question will now come; what are those existing paradigms that Karl Tomm was talking about? Given below is an attempt to respond to this question.

Paradigms and Traditions of Therapeutic Change

A careful review of the professional literature easily reveals that there are several paradigms or theoretical traditions for understanding the conditions of possibility for the emergence of psychological or emotional disturbances in human beings and the techniques to be taken to effect their remediation. Among such paradigms/traditions the following appear to stand out:

1. The Biomedical Tradition

The Biomedical tradition operates from the core assumption that whenever there is a psychological disturbance, an underlying disease process is the problem (Barney, 1994; Kleinman, 1980; Chodoff, 2002). Clinicians who go by this tradition or understanding engage in Mental Status Examination (MSE) of the emotional problems of a client in search of the conditions and circumstances involved in their origination and the procedures to be followed to effect a cure.

2. The Psychoanalytic Tradition

In contrast, in the psychoanalytic tradition, the second of the exiting therapeutic paradigms, the core assumption is that the patient's developmental history is the source of the problem and the core underlying difficulty (e.g. Bateman & Holmes, 1995; Kaner & Prelinger, 2007). For this reason, the notion of history-taking is highly regarded in clinical psychological practice under the psychoanalytic persuasion.

3. Behavioral/Learning Theory Tradition

The Behaviourists (influenced by the learning theorists) in their own case, take the view that reinforcement contingencies are the central difficulty (e.g., Falloon, 1988) in psychological disturbance. According to this tradition or paradigm, to understand a client's problem we need to, first, understand the context in which s/he was born and raised and the human models or influences around him or her.

4. The Sociological Perspective

From a sociological paradigm, family dysfunction, not the individual's developmental history, is the core problem to be attended (e.g., Gelles, 1995). That is to say, it is the family dysfunction or instability that creates the problem for the individual that manifests in the form of psychological disturbance.

5. Anthropological/Cultural Theory Tradition

Anthropologists/cultural theorists, on the other hand, emphasize the view that cultural practices underpin most human difficulties (e.g. Krause, 1993; Kleinman, 1980: Mead, 1930; Geertz, 1973, 1984, 1988). Hence, for them, certain psychological illnesses (like amafufunyane, in the South African context) are culture-bound illnesses. This means that they are found only in particular cultures but not in others; and so the role of culture in instigation and understanding of psychological disturbance must be taken into account.

6. The Hermeneutic/ Interpretive Tradition

According to this paradigm or conceptual framework of mental illness, most of the time people are psychologically disturbed by the negative stories they tell about themselves; if those stories change or are successfully challenged, their views about themselves will change; and their psychological problems will dissolve (Frankl, 1987). Therapists influenced by this paradigm give particular attention to the power of narrative therapy as an intervention of choice in psychological practice (Anderson, 1997; 2007a, b; Anderson & Gehart, 2007; deShazer,1985; Beck, 1976; Gehart, 2007).

7. The Family Therapy Tradition

Within the family therapy tradition, a core assumption is that some aspect of the family system or the therapeutic system formed by the family and the therapist underpins the problem. However, different theorists make unique assumptions about which precise aspect of the family or the therapeutic system is problematic. These variations are clarified below:

- The Structural Family Therapy Tradition:

Within the structural family therapy tradition Salvador Minuchin (1974; Minuchin, et al. (1967, 1978) was of the view that maladaptive family structures underpin clients' problems (Colapinto, 1991). For example, lack of boundaries between the parental and the child subsystems of the family is said to be often the source of the problem.

- The Strategic Family Therapy Tradition

Within the strategic family therapy tradition Jay Haley's (1959, 1973, 1976a, 1978) core assumption is that a poorly aligned power hierarchy leads to the development and maintenance of interpersonal difficulties in human families (Madanes, 1991). He proposes, for example, that in some family situations, the parental subsystem may not be acting from a united front; which fact often negatively affects the two parents' ability to work together in managing the children; with this resulting in chaos and distress for members.

- Family Communications Theory Tradition

Virginia Satir (1967), whose approach to family therapy evolved out of the human potential movement, emphasized the importance of adequate family communications, and took the view that poor communications within the family as well as low self-esteem among members was the core difficulty for most clients seeking therapy.

- The Trans-Generational Family Therapy Tradition

Murray Bowen, who highlighted the centrality of the trans-generational issues in psychological problem development, worked from the assumption that most difficulties arise from a lack of differentiation and achievement of psychological independence from the respective parent's family of origin (Friedman, 1991). This encourages the need for construction of family trees (genealogies) to know whether the problem is of an intergenerational origin.

- The Constructivist Family Therapy Tradition

The constructivist tradition typified, for example, by Ben Furman's approach, involves the view that the client's explanation or assumptions for his or her difficulties is the core problem, as these assumptions can be wrong when looked at closely (Furman & Ahola, 1992; Maturana,1980, 1988; Maturana & Varela, 1980). To effect a remediation, the starting point is to ask the client to offer his or her own view (or personal theory) of the origin of the problem.

- The Solution-Focused Family Therapy Tradition

de Shazer's (1985,1988, 1989; Nichols, 1984) solution-focused viewpoint rests on the idea that the client's focus on the problem/limitations is the core problem. In his view, client's focus should be made to shift from problems/limitations (e.g., ugliness or undesirable personal appearance, low self-esteem, shortness in height, and family poverty) to resources and possibilities possessed by the client.

- Karl Tomm's Bring-forthist Perspective

In contrast to these other theoretical positions or paradigms for understanding abnormal behaviour in human beings, Karl Tomm, of the Family Therapy Program of the University of Calgary, Canada, teaches that his core assumption is that the way the problem is interpreted or constructed is always the central problem. His theory, therefore, shares a common ground with the constructivists on the origin of psychological problems.

He, Karl Tomm, however termed his viewpoint a *bring-forthist* perspective. The core assumption of the bring-forthist perspective is that all clinical practice and interviewing process in particular involves helping clients to co-create different views and perspectives with respect to the problem through co-creating different interpretations of the problem; or looking at the problem from a different perspective (Tomm and Gover, 2007; Tomm, 1987, 1988b,c; Strong & Tomm, 2007; Tomm, & Action, 2011),

Now, one thing that is common to all these paradigms or conceptual frameworks for understanding the basis for psychological disturbances in human beings and what can be done to relieve them is their tendency to promote a single assumptive theory of mental disturbance; or the belief that in psychological

disturbance there is only one single mechanism or an underlying disease that needs to be identified and dealt with for there to be a cure.

This, however, is where the major problem lies; for in real life, psychological problems can originate from multiple sources or conditions, or factors. And handling any one of them alone may not give a lasting solution to the problem presented. Consequently, in most cases the best practice is to search for multiple sources for the origin of the problem under attention.

Modernist and Postmodernist Epistemologies in Psychotherapeutic Practice

Against the background of the single assumption theory of aetiology of human psychological problems that determine much of what professional psychologists do in their day to day practice, it is important to draw attention to two major ways of highlighting the controversies that exist in the literature of psychotherapy practice in this regard. Among these are *the Modernist vs the Postmodernist Epistemologies* (Hansen & Scholl, 2018) and *the Cartesian vs the systemic or post-Cartesian (both-and) perspectives*.

Achieving familiarity with the key tenets and assumptions of these sets of philosophical traditions in the field of psychotherapy is an essential prerequisite for progressive professional psychological practice in the South and other regions of Africa and the wider world. Consequently, some space and time must be devoted to clarifying the essential import of these sets of themes.

To open up the discussion along this line, the following questions come to mind:

- What does it mean to conduct one's psychological intervention from the perspective of the modernist epistemology? For example, what systematic procedures are called for in the context of psychological practice using the modernist epistemology?

- In contrast, what does it imply to organize psychological intervention from the postmodernist epistemology (Hansen & Scholl 2018) or from the alternative model of collaborative/ narrative approach? For instance, what is the place of assessment under the collaborative intervention model?

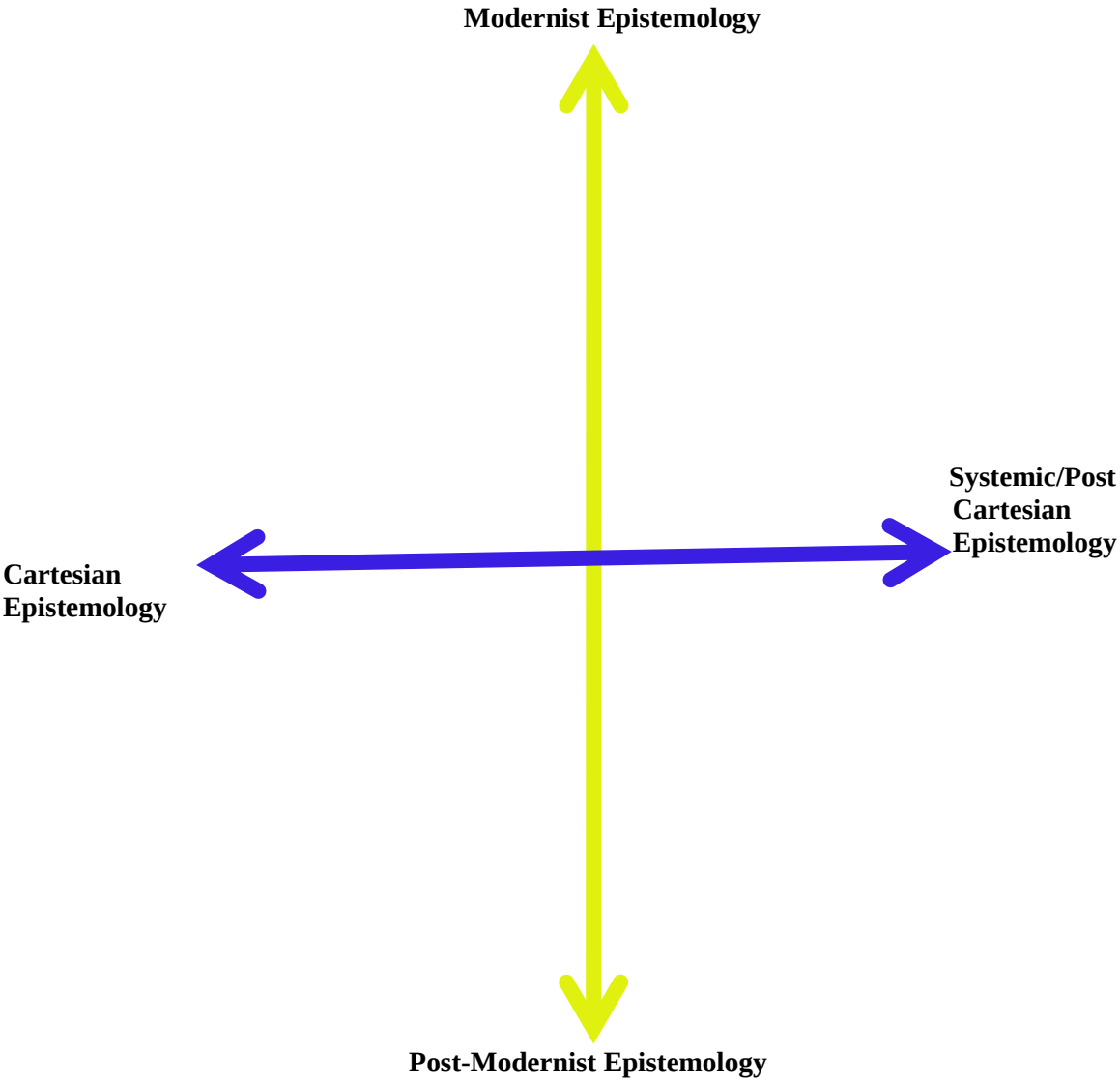
- If instrumental (scales) diagnostic or psychological assessment is not emphasized, what is emphasized, instead? Stated differently, what are the key assumptions of the modernist epistemology in psychological practice?

- On the other hand, what are the basic tenets and assumptions of the postmodernist epistemology? Which of the two epistemological positions - modernism vs postmodernism - goes with which model of psychological intervention practice?

- What is the essential tenet of the Cartesian or the Individuocentric or Intrapsychic approach to psychological healing? E.g., with regard to the role of the therapist?

- What is implied in the paradigm shift from individuocentric/intrapsychic approach to the dialogical/conversational paradigm?

The major aim for the discussion that follows is to offer some summary response to these questions; using the aid of the following illustrative diagram below:



1. Presented above is a Quadrant Diagrammatic Illustration of the Opposition in Perspective between the Modernist and Postmodernist and the Cartesian vs Systemic/Post Cartesian Approaches to Therapeutic Practice.

In doing this, these questions will be taken one by one in the order in which they have been mentioned above**.** This means that we will first and foremost, explore the principal tenets/assumptions of the modernist epistemology? This will help us to get to know how one can get to know when one is using the modernist paradigm/epistemology to psychological healing. Or put another way, what does it mean for one to conduct one's psychological intervention from the point of view of the modernist epistemology? For example, what systematic procedures are called for in this regard, in the context of psychological practice?

Tenets and Assumptions of the Modernist or the Biopsychosocial Model

The modernist paradigm is practiced through the biopsychosocial approach to healing developed at Rochester in the United States some decades ago by Drs. George Engel and John Romano. While the traditional biomedical model of clinical medicine focuses only on pathophysiology and other biological approaches to disease etiology, the biopsychosocial (BPS) model emphasizes the importance of understanding human health and illness in their three-dimensional contexts.

Following this understanding, the biopsychosocial approach operates as a framework for understanding the multidimensional sources of affliction in human beings: biological, psychological, and social factors and their complex interactions. To apply the modernist/ biopsychosocial approach to clinical practice, in other words, the clinician is expected to be the one that occupies a position of authority in comparison to the client. Yet the therapist under this model also recognizes that therapist-client relationships are central to providing successful health care. However, because, on the whole, the therapist in this model is looked up to as the one in the know about how to discover what is ailing the client, s/he is expected, in using this paradigm, to conduct a diagnosis, including in some cases, a Mental Status Examination (MSE), as a guide to initiating a comprehensive treatment plan against the problem presented.

In proceeding in this way, s/he, the clinician, is expected to take the patient's history, conduct his or her mental status examination, and provide a psychological hypothesis or explanation (or formulation) as regards the predisposing, the precipitating, the maintenance, and the ameliorative factors associated with the client's problem. Again, following this modernist model the therapist is expected to be the one, rather than the client, to single-handedly decide which aspects of the client's biological (physical), psychological, and social history are to be examined for understanding and promoting client's recovery; essentially by providing a multidimensional treatment.

The above indications imply that using the modernist approach to psychological intervention there is emphasis on determining the sources of a client's problem by looking into the client's biological (e.g., chemical imbalances and abnormalities); or the state of his/her psychological systems (cognition, affect, and behaviours); and social contexts (e.g., work environments). For the African psychologist what is not right when using the modernist approach to psychological healing is its lack of attention to the possible cultural and spiritual origins of the problem presented.

Some other distinguishing characteristics of the modernist paradigm to therapeutic change include its emphasis on the use of instrumental diagnosis as a means of achieving understanding of what is ailing the client, and the idea of the therapist as the expert for helping the client to understand his or her problem and to achieve a cure. In other words, within the modernist epistemology to psychological treatment, the therapist is fully invested in as the sole conductor of the orchestra directing the psychological intervention operations while the client is seen as somebody in a rather passive/uninformed position, bewildered by his/her presenting problem, and present in the therapeutic relationship merely to receive attention from the clinician and respond to questions or test batteries put to him or her in the course of this process; not to co-construct the basis for his or her problem or the means for his or her cure.

Tenets/Assumptions of the Postmodernist or Collaborative Therapy Model

In contrast, the postmodernist paradigm to psychological treatment is propagated under the collaborative therapy model currently championed by Harlene Anderson and colleagues from the United States. The postmodernist model operates as a direct opposite of the model of the client as a passive agent within the therapeutic relationship associated with the modernist or the biopsychosocial perspective (Hansen & Scholl, 2018). In a book she co-edited with Diane Gehart published in 2007, entitled "Collaborative Therapy: Relationships and Conversations that make a Difference", Harlene Anderson

highlighted her collaborative theory of the elements of psychotherapeutic change; a summary outline of which is offered below drawing from one of the chapters in her book with Gehart. In the Chapter under reference, Harlene Anderson delineated what she believed to be the eight major propositions for characterizing the therapeutic relationship as a collaborative or participatory partnership within the postmodernist perspective.

Four of those eight propositions, are paraphrased and presented below as follows, namely that:

1. In the collaborative model of the therapeutic relationship within the postmodernist epistemology, the client and the therapist are understood as conversational partners.

In Anderson's (2007, p. 45) own words, the participatory nature of the therapeutic relationship "is of primary significance. ….It requires: (a) meeting and greeting a client in a manner that communicates they are welcomed and respected, (b) the collaborative nature of the relationship, shows that you are interested in engaging with clients and learning about them as they choose to present themselves, and (c) *entering the relationship as a learner who listens and responds by trying to understand the client from their perspective and in their language."*

Following this frame of reference, "clients along with their agenda and story, take centre stage, particularly as regards what they want the therapist to know about them, what they want to talk about, and what story they want to tell and how." (p. 45).

In that case, the therapist is seen as if s/he "is a host who meets and greets the client, as a guest while simultaneously the therapist is a guest in the client's life." (p. 45).

It is this very point that Anderson was underscoring when she observes that given credit to the client as the expert on his/her life and story …does not mean that the therapist's knowledge is not valued; it simply means that the therapist is not considered the expert on the client's life: the client is. Instead of being an expert on the client (including their problem, resources, preferred solutions, etc.,) the therapist's competence or expertise is in establishing and fostering an environment and condition that naturally invites collaborative relationships and generative conversational processes.

2. In the collaborative model of psychotherapy within the postmodernist paradigm, both the client and the therapist are adjudged as experts in their own rights.

The above statement implies that as seen by Anderson (2007) and her colleagues, in the postmodernist paradigm to psychological intervention, both the client and the therapist are experts in their own rights: the client is seen as an expert on his or her life; and as far as that expertise goes should be understood as the therapist's teacher. Consequently, according to Anderson, within the collaborative model of the therapeutic relationship in line with the postmodernist epistemology, the therapist should respect, honour, privilege and take the client's reality (e.g., words, beliefs, and story) seriously; and thus deliberately seeks for the client's opinion on the source of the problem under attention.

This means that under the postmodernist or the collaborative therapy process, "the therapist trusts that clients know themselves best, made richer by their own personal epistemology (or hidden aspects of their lives that nobody except themselves know about) may possess an educated guess about the origin of their problem and will talk about what is important to them – as well as when and how" to do so (Anderson, 2007, p.47). At the same time within this same frame of reference, the therapist's expertise as a clinician who is well trained for organizing transforming meetings with clients is never in doubt; it is indeed taken for granted even as s/he operates in the collaborative roles highlighted above.

It is this very point that Anderson was underscoring when she observes that "giving credit to the client as the expert on his/her life and story, …does not mean that the therapist's knowledge is not valued; it simply means that the therapist is not considered the expert on the client's life: the client is. Instead of being an expert on the client (including their problem, resources, preferred solutions, etc.,) the therapist's competence or expertise is in establishing and fostering an environment and condition that naturally invites collaborative relationships and generative conversational processes. (See also Tomm, 2022, 2023, 2025; Guanaes-Lorenzi, et al. 2025).

3. In the collaborative/postmodernist paradigm of psychotherapy, the "client and therapist join in a mutual inquiry"

According to Anderson, within the context of psychotherapy as collaborative partnership, the therapist's operational stance "invites the client into a mutual or shared inquiry about the issues or tasks at hand." In Anderson's view too, "this inquiry is initiated by the therapist entering the relationship as a learner ….and the client as the therapist's teacher."

This is said to be so because "the therapist wants to learn and understand the client from the client's perspective and preferences. The therapist wants to learn the client's lived experience, and the meanings and understandings associated with it" (p.47).

4. In the context of psychotherapy as a collaborative partnership within the postmodernist paradigm, the therapist comes to the meeting with a "not-knowing approach to knowledge."

This means that under the collaborative/postmodernist paradigm of therapeutic change influenced by the postmodernist epistemology, the therapist does not come into the interaction with a pre-knowing stance regarding the issue at hand or what is ailing the client. S/he enters the relationship free of prejudices and biases about the client's life and situation.

These indications mean that under the collaborative model of therapeutic change drawing from the postmodernist epistemology, the therapist does not come into the therapist-client relationship with the belief that s/he can know the client or the client's story or circumstance in advance of the meeting or better than the client knows himself or herself through the indirect method of tests/psychological assessments. And neither can s/he know the outcome of any therapy process ahead of time. S/he comes into the meeting with the open-minded attitude to work towards learning about the client from the client, not indirectly like in the modernist approach through the use of tests and other standardized assessment batteries.

This also means that the therapist's knowledge whatever its form – questions, comments, opinions, or suggestions –presented in the course of the therapy process, "is offered as food for thought and dialogue, as a way of participating in the conversation. It is not offered with the intent of being unquestionable, objective, or instructive." Which means that under the collaborative paradigm of therapeutic change, drawing from the postmodernist epistemology, "therapists honor, make room for, and give authority to the client's voice and do not over-shadow, divert, or subjugate it with their own knowing" (p. 49).

Now, one important implication of these observations is that working from the notion of psychological treatment as collaborative partnership, the client occupies an active (not a passive) role of co-constructor of processes of importance in the promotion of change. S/he (the client) is presented as one in a strategic position to guide the therapist's vision towards understanding the case as from one with a privileged background concerning the case; while the therapist, essentially, creates the context through which both of them can learn and draw from one another in the service of the case.

Given the above, one may then be tempted to ask, what is the major difference between the modernist versus the postmodernist approach to psychological healing? In response, the main difference between the collaborative/postmodernist paradigm, *vis-a-vis* the modernist/biopsychosocial model of psychological treatment is that unlike the latter, the former deemphasizes the use of instrumental assessment (particularly tests and other indirect diagnostic instruments) as an aid to treatment. In contrast, the collaborative perspective depends on the resources of the narrative or conversational dialogue with the client in getting to know the details about the client's problem situation, including its genealogy, predisposing conditions, and factors responsible for its maintenance and escalation.

Operating from this frame of reference, collaborative therapists, influenced by the postmodernist epistemology, believe that we can help clients better by collaboratively helping them to acquire new meanings on their problems through mutual inquiry; a process that should replace the therapist as objective expert who stands apart from the client and his or her problems or challenges, and attempts to manipulate their interactions from the outside (or as the sole expert in-charge).

These indications mean that clinicians who work from the postmodernist epistemological bent do not claim to have the answers to the client's problems. On the contrary, their efforts are directed at working in partnership with the client to challenge their (clients') old assumptions and to co-construct new narratives or realities that are less saturated with past failed solutions that colonize their (clients') lives. Apart from Harlene Anderson, another influential authority who supports the collaborative paradigm to psychological practice is Karl Tomm earlier mentioned.

The Cartesian and the Post-Cartesian or Systemic Paradigms

Another major paradigm shifts in the field of therapeutic change that is worth mentioning in this discussion is the shift from Western individuocentricity to the systemic complexity model of understanding human psychological problems. This shift demands that to understand and treat individuals, couples, families and larger groups with some relational disquiet effectively, we need to conceptualize cases within the system in which they exist (within the context and the meanings attributed to the context), assess the salient factors in the system, and intervene at identified points within the system (Tomm, 2022, 2023). In line with this shift, the Cartesian or the intrapsychic or individuocentric paradigm of psychological treatment breaks down and there is room for the systemic paradigm. In this way, even when a clinician elects to work exclusively with individuals in clinical practice, the approach will be different as he or she will operate from the idea of the system (including not only the family but also the school) within which the person lives and interacts, in order to get a multidimensional bearing on the case for promotion of effective clinical action on it (the case) from a systemic thinking.

Given these indications it will be easy to see that many psychological intervention models (e.g., the psychodynamic model and the CBT) available in the literature and lined up for study in many clinical and counselling training programs in universities in the South and other regions of Africa, work from the perspective of the intrapsychic paradigm and the modernist epistemology. But the current climate in psychological practice in Canada and the United States and Australia, and even from clinicians over here in Africa, suggest that this more common focus is no longer ideal if not outright entrapment in the old dispensation, and needs to be reconsidered.

Critical Reflections: Importance of Context in Therapeutic Change

Having said all this, the time now appears ripe for conducting a critical reflection on the importance of context in therapeutic change. In taking up such a task the point to be developed is the view that even when one effectively masters and understands the major paradigms and epistemologies (whether

modernist or postmodernist) to therapeutic change we have reviewed earlier on in this presentation, one still needs to take into account what is typically referred to, in the professional literature, as the contextual factors that can affect positively or negatively, the practice of psychotherapy.

Among these factors only the following three can be mentioned and commented on in this discussion, at least, for illustrative purposes:

1. The cultural background and context of the client under attention

2. The Linguistic context/ communication difficulties and,

3. The frame or the quality and lay out of the Therapy Room

A brief reflection on each one of these is given below.

The notion of cultural context in therapeutic practice

Under this heading the focus is on understanding the extent to which the problem which the client has brought up for attention is influenced by the cultural background of his/her community and upbringing. Within this framework psychological practitioners in Africa are understood as culturally competent when they are able to see certain aspects of the client's culture reflected in the story of distress reported by the client.

Another angle in which the notion of culture becomes important in psychotherapeutic process is as regards the crisis of cultural mistrust that at times arise when a client is paired with a therapist from a culture that is different from his or hers. Where this scenario is the case, the problem to be faced is the possible spirit of hesitancy the client may develop which may make him or her unable to be honest and lay bare his or her mind to a therapist from a different culture; a culture which, perhaps, up to the time of the meeting is accused by the members of the culture where the client comes from, as the basis for the distress in society of which the client is a part.

In some cases, this phenomenon of cultural mistrust may be mutual and the therapy process, in that case, cannot proceed successfully unless the therapist is able to do something special to win the confidence of the client, and thus be able to build trust where none exists and establish a solid working alliance before requesting the client to tell his or her story. Where this technique is not forthcoming, or the therapist is unable to clear this hurdle, the therapist is advised to resort to the use of the referral process to find a therapist from the client's culture, to take over the case, to match the client's cultural expectations and trust and readiness to open up.

The Linguistic Context and Communication Difficulties

Given that the postmodernist therapist emphasizes the notion of the therapy system as a linguistic system, or a conversational practice the critical issue will then be the problem of language and/or communication barriers that can arise between the therapist and the client to be served. Problems in this regard often arise from a natural situation of things, such as happens when a therapist finds himself/herself presented with a case involving a client who speaks an indigenous language that s/he (the clinician) does not understand.

This problem is often compounded in a situation where no common languages, such as the English or Zulu or Afrikaans (in the South African context) serve to bring the two of them together. An

impediment of this nature can present a near insurmountable obstacle where the story, which the client may like to share with the clinician, is not the type that can allow the presence and assistance of a committed but neutral interpreter.

In that case, the lesson to take home from this discussion is that with psychological treatment being understood as a linguistic enterprise, one accumulates advantage the more the number of languages one can speak and understand. In that way trainees who can speak more than two or three languages will be placed in a position of advantage in the practice of psychotherapy in a country such as South Africa compared to their mates with just one international language to boast of, without any indigenous language as a back-up.

The Physical Context of the Therapy Room

The psychological literature suggests that the therapy room as the physical context of the psychotherapeutic relationship can only become a successful healing environment where the following elements are taken into consideration:

- *Relevant furniture availability*.

Commenting on this theme, Lemma (2003) and Kaner & Prelinger (2007) agree that the room in which counseling or psychotherapy is to be undertaken should be furnished as follows:

1. *There should be a comfortable chair in which the client can sit and feel comfortable*

Although it is true that many clients will be so tensed up at first that they will be unable to make proper use of such a chair; but one hopes that as therapy progresses they will increasingly be able to do so.

2. *There should be a table behind which is a desk for the clinician but the furniture is to be so arranged that the client is not immediately opposite him or her.*

Commenting in this regard, Kaner & Prelinger (2005, 2007, p. 104) observe that "chairs can be positioned either facing one another or at an angle. Some therapists prefer the former, there being something open and direct about face to face contact. Placement at an angle, on the other hand, allows the patient the opportunity to face away from the therapist with greater ease should he wish to do so."

Not having a table to break the space between the clinician and the client is considered ill-advised. For, although it is often said that psychotherapy involves a 'meeting of minds', we also know that it involves a meeting with embodied clients; and therefore 'a meeting of people with bodies.' In that way, without the table, a lot of the lower region of the body of the client may become too exposed to the therapist. This can cause distraction or discomfort to both parties.

Additionally, professional experience suggests that it is useful to have one or two extra chairs easily available in case it may be necessary to see relatives together with the client. For, although, in one-to-one counselling and psychotherapy, interviews will normally be confined to the initial meeting with one specific client but it is to be prepared to seat one or two more people if needed.

- *Decoration of the room*

In many instances, the counselor/clinician, especially when s/he is on internship, will have little or no choice in how the room is decorated or in what other furniture may be there. When possible, however,

what is called for is to decorate the room in such a way that it is able to give the impression of warmth and friendliness. Where the counselor/clinician could exercise their own choice, they may well like to hang some pictures on the walls, and fill the bookshelves (if there are any) with their books and those provided by the institution where they are employed.

However, professional experience suggests that the room should not contain anything which too strongly asserts the clinician's taste or which is likely to reveal a great deal of his/her personal life and values. Devout Catholics employed in public schools or colleges may, for example, need to avoid displaying the crucifix, or the chaplet or the rosary, so as not to alienate non-Catholics, including non-Christians such as Muslim clients; and vice versa.

Similarly, according to Lemma (2003, p.106) "the choice of the art we display in the consulting room will require some thought." In that way, while many practitioners may like to bring reminders of home into their offices by displaying photographs of their wives/husbands and children. Most authorities including Lemma (2003) and Kraner and Prelinger (2007) suggest that it is unwise for clinicians to do this as they represent intrusions into the patient's space. For example, "if we have a penchant for nudes this is not appropriate"

Besides, a photograph of the clinician's wife or husband and children is likely to act as a constant reminder of his or her successful and happy family life and may generate envy or jealously and lack of concentration on the part of some of the clients. For example, female clients may compare themselves favorably or unfavorably, with the woman depicted as wife in the photographs; and this may cause more distraction and resentment directed at the clinician than would be the case if the client's idea of his wife and children was based only on speculation.

Again, it is important that if possible, the room should be quiet. Extraneous noise is not only disturbing in itself but also gives rise to anxiety on the part of the client. For if noise from without can come into the room, it is to be presumed that sounds from within can be heard outside it. And nothing is more inimical to frank disclosures, than the belief or suspicion that people outside the room may overhear one. Hence "the physical environment of therapy requires careful planning. Its most important feature is the extent to which it enables us to ensure confidentiality and minimize interruptions by others" (Lemma, 2003, p.106).

In line with the above, the clinician is to avoid using the telephone while counseling/psychotherapy is going on. Hence, one can say that a viable therapy room is one with a calm ambience; capable of putting the client at ease and making the context of the meeting to look professional, appealing and reassuring; different from the ordinary locations familiar to the client.

Conclusion

To conclude, let me share the following comment made by Larner (1997) that although the modernist (biomedical) and the postmodernist (narrative or collaborative) paradigms as highlighted in this discussion appear to present themselves as an *'either or'* stances, Glenn Larner's (1994) para-modernist approach recommends that both epistemologies hold something valuable in their respective perspectives and should skillfully be drawn upon by any practitioner, in the service of clients. No wonder, the same Dr. Glenn Larner (1994, p. 11), Senior Clinical Psychologist and Editor, *Australian and New Zealand Journal of Family Therapy*, citing the perspective of the French philosopher, Jacques Derrida, went on to note that family therapy, in particular, is neither modern nor postmodern, but both/and these alternatives, that is, para-modern".

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