Therapeutic Communications from the Bench: A Psychological View

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This chapter provides a psychological conceptualisation of therapeutic communication. The chapter is in four parts. First, I describe the essential elements of therapeutic communication. Second, I discuss the types of communication strategy that one needs to build onto those basic elements in order to create therapy. Third, I discuss the central importance of motivation in therapy and why it is critical to understand the motivational structure of the individual one is trying to influence. In the final section I pose a number of questions about the relevance of therapeutic communication to court settings other than problem-solving courts.

Introduction

I am not a member of the judiciary. Nor am I a lawyer; not even a bush lawyer. I have therefore resisted the urge to use this chapter to instruct judicial officers as to how to communicate with various other persons in their courtrooms. What I provide in this chapter is an overview of the psychological understanding of what constitutes therapeutic communication and any reader who is a member of the judiciary can take this information and apply it to his or her own context and purposes. Someone cannot learn how to communicate therapeutically by reading about it, and this chapter was not designed to train the reader in communication skills. Notwithstanding the previous point, I have included some discussion of what therapeutic communication is and how it might be done, with some examples to clarify those points.

Let me begin, though, by providing a brief definition of the term therapeutic. There are hundreds of definitions in the psychological literature, most linked to theoretical models or to particular authors’ peculiar views. In essence though, something is psychologically therapeutic if it contributes to either or both of two outcomes: (1) the psychological growth and development of the recipient; (2) the resolution of some psychological or social problem, including but not limited to the correction of some psychological malfunction. In common language, one either helps the person to fulfil some natural potential or one helps the person to fix something that is not working properly. Either way, the person is happier (or at least is less distressed) and is more able to achieve his or her goals in a socially constructive and culturally appropriate manner.
The Essentials of Therapeutic Communication

Since the 1960s we have had evidence supporting what psychotherapists had intuitively known, and written about, for decades before that. Frank (1961) summarised the evidence that indicated the basic essential ingredient in psychotherapy, or in any change process, is the quality of the relationship between the helper (therapist, clergyman, neighbour, faith healer, barmaid, etc.) and the person being helped. It is not only the helper's skill in creating an impression of wisdom, concern, and hope, nor only the pain level (desperation) of the client, but it is the synergy between the two people (the mutual positive regard and shared values) that enables the two to work together in whichever helping process is undertaken. It is essential that the client trust the helper and have a sense of hope in the helping exercise. Some clients present full of trust and hope; confident that you are trustworthy and capable of helping them. However, with many clients the helper needs to earn the client's trust and instil a sense of hope. Subsequent research in the 1960s clarified the essential ingredients of the helper's communication style that enable such a therapeutic relationship to develop.

The Three Most Basic Essentials

In their groundbreaking book, Truax and Carkhuff (1967) summarised a series of studies with different types of clients in both individual and group-based counselling for various types of problem and identified three broad therapist features that consistently emerge as critical to the therapeutic relationship.

The first is warmth: a caring, concerned, manner that conveys genuine interest in the client and his or her wellbeing. The second is accurate empathy: an accurate understanding of the client's perspective and feelings (as much as is humanly possible, accepting that one can never understand another person 100%). The third is genuine positive regard: acceptance of the client and respecting his or her value as a person regardless of his or her behaviour. A distinction is drawn between accepting the person and accepting his or her behaviour, which might well be unacceptable. These basic ingredients in therapeutic communication continue to be accepted as the critical bedrock for all else that might be added (Egan, 1994; Franklin, 2002; Sommers-Flanagan & Sommers-Flanagan, 1993; Teyber, 1992). Even behaviour therapists place importance on these basic factors when interacting with clients (e.g., Goldfried & Davidson, 1976).

It sounds straightforward to say that what one needs to do to be therapeutic is be warm, show empathy, and respect the person you are trying to help. The first obstacle that some helpers face is that such things cannot be convincingly faked for any length of time. To be an effective helper one must truly care about, empathise with, and accept the person one is trying to help. The second hurdle is that one not only needs to be genuinely warm, empathic and respecting but one also needs to communicate those things to the person
being helped. It is difficult to communicate that you do care, that you do understand, and that you do respect the person when that person is feeling such heightened distress or rage that he or she is not well-placed to hear that message. The person might not just be enraged, but might be specifically angry toward figures of authority such as judges, or toward good-for-nothing, interfering know-it-all do-gooders like me. Moreover, the person might well be engaging in behaviours that are socially inappropriate or self-destructive and we need to act so as to minimise those behaviours, or at least help the person realise what he or she is doing, whilst also communicating warmth, empathy, and respect. This is a balancing act that is difficult to perform. Thankfully, there is a body of research and theory to guide us as to how one can best perform that act.

Strategies for Communicating Empathy and Respect

The two most basic skills for communicating empathy, warmth and acceptance are generally termed attending and active listening (Egan, 1994; Sommers-Flanagan & Sommers-Flanagan, 1993). The following summary of these communication skills is based on “how to do it” guidelines and theoretical discussions by Egan (1994), Goldstein (1980), and Sommers-Flanagan & Sommers-Flanagan (1993).

Attending refers to “the ways in which helpers can be with their clients, both physically and psychologically” (Egan, 1994, at 90). Egan outlines three levels of attending. The first, micro-skills, includes such behaviours as facing the client, leaning slightly forward with a relaxed open posture (not crossed arms or legs), maintaining eye contact without staring the client down and giving minimal verbal indications that one is listening and understanding (mmm, ok, I see, yes, etc.). These skills need to reflect the culture of the client, so those listed are not always the appropriate behaviours for some cultures. For example, it might not be culturally appropriate to maintain eye contact when clients from some cultures talk about personal matters or express distress.

The second level is body language. For example, it is not helpful to fidget or move about too much, which could communicate distraction, boredom, or even irritation. Moving synchronously with the client is helpful – e.g., nodding in affirmation, grimacing or other facial expressions that are in tune with the emotions expressed by the client or implicit in the events the client is describing. It is important to be natural and slightly understated. Exaggerated or manufactured postures and movements are counterproductive (Sommers-Flanagan & Sommers-Flanagan, 1993). Effective body language will come naturally to the helper who genuinely cares about, respects, and is interested in the client so long as he or she doesn’t have any mannerisms that detract from the therapeutic demeanour. Having said that, practising with someone who can provide feedback or videotaping oneself and deliberately adjusting your body language and practising the new mannerisms will improve the body language that emerges naturally (without deliberate effort) in the real situation (Pipes & Davenport, 1990; Sommers Flanagan & Sommers Flanagan, 1993).
Training and rehearsal do improve performance so long as the attitudes and feelings portrayed are real.

The third level is social-emotional presence. One's whole presentation needs to communicate one's willingness to understand and help and one's capacity to do so. This relies on a high level of self-awareness. For example, the helper asks him or herself questions such as, what are my attitudes toward this client? What distractions am I experiencing and how can I manage those? How are my emotional reactions to the client and his or her story making it difficult for me to be fully present and attentive? Obviously going off in a reverie about such matters is not what is being suggested as that would hardly facilitate an attentive presence. However, a prompt and confident response to such questions and a commitment to that type of self-monitoring are critical.

Active listening "refers to the ability of helpers to capture and understand the messages clients communicate, whether these messages are transmitted verbally or nonverbally, clearly or vaguely" (Egan, 1994, at 90). Egan outlines four aspects of listening:

- First, observing and reading the client's nonverbal behaviour - posture, facial expressions, movement, tone of voice, and the like. Second, listening to and understanding the client's verbal messages. Third, listening to the context, that is to the whole person in the context of the social settings of his or her life. Fourth, listening to sour notes; that is, things the client says that may have to be challenged. (Egan, 1994, at 94).

Clearly, none of this is possible without adequate attending. Even when the helper is listening fully at all four levels, it is critical that this is communicated to the client. At a basic level this means not interrupting the client and keeping to a minimum the verbal indications of listening that were described above in terms of attending. Other techniques that need to be added to that basic level include reflective listening (paraphrasing content and expressed or observed emotion), clarification, summarising the core issues from time to time, and staying on the client's track.

Paraphrasing is a powerful and subtle communication of listening, but it backfires when it is overused and obvious. An example follows. The client says, with a tone of ambivalence and sadness, "All my friends are into drugs and I can't be straight when I'm with them, but they are important to me. What do I do?" The helper replies, "Both things are important to you, your friends and getting clean, and you are torn between them". This reply clearly communicates that the helper has heard and understood the main message in the client's utterance, and if it was said with appropriate emotional expression it would also communicate that the feelings were noticed and understood. An example of clarification would be if the helper had also added, "You seem quite sad about facing that choice. Is that how you feel?" Clarifications communicate both what the helper has heard, and therefore that the helper
has been listening, but also the helper’s desire to fully understand the client. Summarising the core issues and themes that run through what the client has been saying communicates that the helper has understood not only each utterance but the essence of the client’s message and problem. Such summarising can also be delivered as a clarification.

Egan (1994) also describes what he calls *staying on track* and the role that plays in communicating accurate empathy. This refers to the helper responding to the client’s messages, both intentional and accidental, that the helper’s reflections and other communications are accurate and empathic. In particular, the helper needs to move at the client’s pace, or ever so slightly ahead of it once accurate empathy is established. For example, let’s suppose that the client in the exchange above responded to the clarification with the following: “Yeah, I do feel sad about it. I’ve been through a lot with some of my friends and I can’t just walk away from them. Besides, I don’t make friends easily and most straight people annoy me. Also, when I get depressed I start thinking about all the shit in my childhood and I don’t know how to switch that off. I also think I’ve done all this work and it comes to this. It makes me feel like using”.

If the helper responds to this with a superficial paraphrasing of the content, then he or she is missing the progression that the client has made. The client is at a deeper level of exploration and the helper needs to communicate that he or she has heard this. A response that would be *on-track* would be, “I can see how hard that is for you. Those are real central issues, aren’t they? Let’s look at that a bit more and then we can look at some things that you might be able to do to move on”. This communicates that the client has identified a significant problem and that we will get around to looking for a solution to it. The matter-of-fact confidence also indicates hope that a solution is findable.

On top of all that I have described thus far, several authors note that empathy and positive regard also stem from working collaboratively with clients rather than imposing agendas and goals on them (e.g., Beck, 1995; Teyber, 1992). Apart from being more respectful, clients will only work toward those goals that are meaningful and important to them regardless. Even when a powerful social entity like a court imposes goals on the therapy, clients will only work towards those goals if they are able to find them personally meaningful in some way. Otherwise, clients comply for a period of time and then revert to their previous ways of being; they do not make real psychological change. Having said that, a court imposing therapy can be the catalyst to seeing a need for change and committing to the change process (see the section below on motivation).

**Therapeutic Strategies**

In this section I give a very superficial description of some of the therapeutic strategies that might be added to the basic ingredients of a therapeutic communication. The objective here is to give the reader a sense of what
types of things might need to be done to transform the basic ingredients into effective therapy. Some of these strategies might be effective when delivered from the bench in a problem-solving court, but I am unsure how relevant they are to other courts. I would like to think that some can be delivered in various courts, particularly in civil litigation where there is plenty of room for wounded parties to be validated and respected, if not healed. Perhaps members of the judiciary who are enthusiastic proponents of therapeutic jurisprudence might be able to see how some of these strategies can be delivered from the bench. At this point in time I am a little wary of becoming too idealistic. Perhaps I am too wary.

A critical aspect of therapeutic interviewing is what has been termed probing (Egan, 1994). This refers to questions that are designed to elicit more information, usually on a specific matter that the therapist deems important: in that regard it differs from clarification as defined above. An example is, "That argument with your wife that you just mentioned sounds important to me. It sounds similar to the problems you told me you have at work. Tell me more about that argument, I can think we can learn something from looking at it more closely". This example contains more than a basic probe, it also provides the client with a link to other issues that the client has already identified as important and problematic and it also announces to the client that talking more about it might lead to a clearer sense of the solution to his problem.

Another critical aspect is goal-setting. It is important at the outset, or at least very near the beginning, that the therapist assist the client to set tangible goals for therapy. In the behavioural and cognitive-behavioural schools of therapy these goals are deliberately expressed in behavioural terms so that it is clear when the goals are reached. For example, the goal would not be phrased as "I want to feel more confident", but more as "At a party or work function I want to be able to approach people I haven't met before and start a conversation".

A further aspect is problem-solving. Clients need to leave therapy with solutions to the problems that brought them into therapy and with new strategies for daily living so as to prevent further problems of that type. Most problem-solving approaches begin with an exploration of the problem – the idea being that we need to understand the problem in order to generate an effective solution.

Another school of thought is the solution-oriented approach which works from an exploration of the client's strengths and usual problem-solving approach in order to design possible solutions to the current problem (O'Hanlon and Weiner-Davis, 1989). I don't have space here to outline problem-solving strategies, whole books are written on that topic, but the interested reader could refer to Egan (1994) and O'Hanlon and Weiner-Davis (1989).

The types of strategy just described are generic and basic to most forms of therapy and might well be appropriate types of conversation for a judicial
officer to initiate from the bench. I can see how they might be implemented in
a conciliation conference in the Family Court, for example. I can certainly see
how they could be important elements in an alternative dispute resolution
process in any court. The strategies that I briefly touch on in the following
paragraphs are those which may or may not fit into a court room scenario. I
stand to be corrected on this matter.

For many clients, part of their problem is that they either have limited
competencies in some areas (e.g. self-control strategies, regulation of
emotional arousal, assertiveness, coping skills, stress-management skills) or
they lack confidence in their ability to enact such skills. Most forms of therapy
therefore contain a skills-training component. In behavioural and cognitive­
behavioural therapies a strong emphasis is placed on learning new skills
through rehearsal, self-monitoring and self-evaluation, and giving clients
feedback on their skill-development both verbally and through video or audio
recording their performance. This often involves the therapist modelling some
of those skills.

Other techniques use conditioning schedules to shape the client's behaviour,
but these require a degree of control over the client's environment (something
which can be achieved in hospitals, prisons, schools, and other institutions).
Highly effective therapies have been developed using these learning
principles but with the client being the one who exerts control over his or her
environment (e.g., Watson & Tharp, 1993). Clients identify the aspects of
their environment that elicit problem behaviours (e.g. having the cupboard
fully stocked with chocolate biscuits and a freezer full of ice-cream when one
is trying to lose weight). Clients remove the temptations from their
environment and replace them with elements that facilitate the attainment of
the behaviour-change goals. Clients also learn how to shape their own
behaviour, for example by rewarding themselves for enacting successive
approximations of the desired behaviour (e.g. I can buy that CD I want if I eat
non-fattening lunches for a full week) and punishing problematic behaviours
(e.g. I can't watch my favourite TV programme if I eat too much dessert).

There is a large variety of psychotherapy strategies that might be termed, in
common language, fixing the broken bits. These strategies involve assisting
clients to identify and then repair psychological processes that are self­
defeating, socially unacceptable, or in some other way dysfunctional. Such
strategies are often tied to particular theoretical frameworks or schools of
therapy and are sometimes designed to treat specific disorders. For example,
in vivo exposure is a behavioural strategy for treating phobias. It involves
training the client in relaxation and other anxiety reduction techniques and
then taking the client into the feared situation. For example, a client with a lift
phobia would be taken into a lift and instructed to remain in the lift for a
specified brief period of time beyond the point at which his or her anxiety is
heightened and to use the newly learnt techniques to reduce the anxiety.
Across sessions the period of time would be extended until the person is able
to ride lifts without his or her anxiety exceeding the level at which the
techniques are effective. With further exposure to lifts the conditioned anxiety
response extinguishes and the person no longer has the phobia. As anyone with any form of phobia, or even mildly elevated fear (e.g. of heights, closed spaces, public speaking - we all have at least one) would realise, the therapist who does not communicate with warmth, empathy, respect, and hope or who does not seem trustworthy will have little success in getting the client to engage in the type of treatment strategy just outlined.

When fixing the broken bits, it is crucial that the therapist is competent at correctly diagnosing what psychological processes need fixing. These may include ways of thinking, conditioned responses, core aspects of self-concept, core beliefs about the world, social-skills deficits, core aspects of personality functioning, biochemical processes, neurological functions, regulation of emotional arousal. The therapist must also be similarly competent at implementing effective strategies for correcting those malfunctioning processes, and must understand that the limited treatments available might do more harm than good and should not be attempted in those cases. It might seem to some people without training in behaviour therapy that behaviour management approaches are straightforward and common sense for instance one simply rewards the behaviour that one wants the client to engage in and punishes (e.g. disapproving expressions, removal of previously granted rewards) or fails to reward (e.g. ignores) undesirable behaviour. Behavioural theories are more complex than that, as are people, and many behavioural management strategies are very complex and are individually designed on the basis of a functional assessment of the problem behaviour.

Similarly, cognitive therapy techniques are more complex than simply instructing the client to stop thinking particular counterproductive thoughts - for example “I can’t do this, I mess up everything I try to do” – and to replace them with more self-enhancing optimistic thoughts such as “if I keep working on this I will master it”. Even pharmacological therapies are more complex than just giving depressed people the latest antidepressant medication that seems to work on everyone. The point I am making here is that many people with complex, or even seemingly simple, psychological problems need more than just a warm, empathic counsellor who is actively listening to them, and that the ‘something more’ needs to be provided by someone with appropriate training and experience in implementing those treatments.

There are many aspects of helping people change that warm, empathic, respectful, clergymen, barmaids, hairdressers, neighbours and judges will be able to implement better than many psychologists, but the types of second-tier strategy that I have referred to in this section need to be left to those with the appropriate training. Of course, many clients would never find their way to the trained psychotherapist if not for those clergy, barmaids or judges communicating therapeutically encouraging the client to see the need for professional help.

All of the above rests on an assumption that the client possesses a genuine pro-social core, and is motivated to change those patterns of behaviour and thinking that the therapist regards as warranting change. For the most part,
this assumption is valid. Even people whose problems involve severely antisocial behaviour often have at heart a desire to bond appropriately with their fellow human beings and to operate in a manner that is of mutual benefit. Many people lack various competencies that are required to live in this socially ideal manner and therapy can help them address those deficits.

However, there are people who are so damaged by past events, or are so severely narcissistic and antisocial, that they are unlikely to respond to therapy in the way that others would like them to. It is also the case that circumstances in client's lives can sometimes conspire against the process of change. Finally, no therapist, however good he or she might be on an average day, is perfect every day and no therapeutic intervention is effective in every case regardless of the weight of evidence that shows that some therapies are much more effective than doing nothing (Barlow, 2001).

Motivation – Why Should Anyone Change?

Unless the client recognises a problem and is seeking to change his or her problematic behaviour, all the warmth and empathy in world will not lead to lasting change. What brings about an awareness that one needs to change? It is commonly said that pain is the great motivator, and the research on self-regulation (e.g., Carver & Scheier, 1990; Miller & Brown, 1991) shows that it is an awareness of our goals not being met and the negative emotions that accompany that realisation that captures out attention and prompts us to shift from automatic pilot (habit) to what psychologists call controlled processing, or deliberate planned action. In simple language: when what we are doing makes us feel bad we are motivated to change our behaviour and we start to think about, and then experiment with, different patterns of behaviour. Numerous studies with people in various forms of formal treatment for various behavioural problems led to the development of what became known as the transtheoretical approach to understanding change processes (Prochaska & DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992). Other research indicates that people who change entrenched behaviour problems without any professional help use similar processes to those that occur in therapy and other formal change programmes (Sobell, Sobell & Toneatto, 1991).

Stages of Change

The transtheoretical model outlines five stages of change that progress in a cyclical rather than linear sequence in that people typically fall back to previous stages and progress again through the cycle eventually progressing into and remaining in the final stage of maintaining the change.

The first stage is pre-contemplation. This is where the person is engaging in the problem behaviour but is unaware of the problem and is not contemplating change – or perhaps the behaviour is yet to become problematic for the person and is only problematic for others. In the second stage,
contemplation, the person is aware that the behaviour is problematic and is beginning to think about change. The third stage, preparation, is where the person is deciding what needs to change and what it might be changed to, and is planning how that change might be brought about. In the fourth stage, action, the behaviour-change plans are implemented. The final stage is maintenance, where the changes are maintained and reinforced and relapse into the old ways is prevented.

For many clients, the new skills and ways of relating to the world that emerged from the action stage are easily maintained because they are self-reinforcing due to being more effective in meeting the client's needs than the old behaviours were. For other clients, the old ways still hold some temptation and maintenance is more difficult and the person relapses into the old patterns and cycles through contemplation, preparation, and action many times before moving securely into a maintenance phase.

Most problematic behaviours hold some value to the person and have served important functions within the client's environment. The behaviour is problematic because it leads to undesirable consequences in some, perhaps most, settings. But, if it only led to negative outcomes then it would be readily discarded once alternative responses were identified and mastered. Most problem behaviours produce rewards as well as negative consequences. For that reason, the person's motivation to change varies in concert with the perceived need for those rewards, the perceived likelihood of the negative consequences, and the person's confidence in being able to master alternative behaviours to obtain those rewards.

Motivation and Motivational Interviewing

Motivation reflects the balance of incentives and disincentives. One sometimes hears therapists say that a client has no motivation. It is my view however that unless the person is in a coma it makes no scientific sense to say that he or she is unmotivated. What the therapist should say is that the client is motivated to enact different behaviours to what the therapist thinks the client should enact. For example if the person does not want to stop taking drugs it is not because he or she has no motivation, but because the balance of incentives (as perceived by that person) lies in favour of continued use rather than abstinence. The perceived benefits of drug use outweigh the perceived costs. This person will not move into the contemplation stage until, and unless, the balance of incentives shifts such that the costs outweigh the benefits. This balance shifts with changes in setting, mood, information about the consequences, and changes in the consequences that the environment delivers. For example, when I am looking at the scales, the fruit salad seems more appealing than the chocolate, but when I am feeling bored and the chocolate is right in front of me (unlike the scales) then the fruit salad is no longer relevant. We change when the costs outweigh the benefits more often than the other way around, but change has its own costs. Change requires effort and other resources, whereas habits are effortless and avoiding awareness of problems is easy.
Most therapies are designed on an assumption that the person is in the preparation stage, if not the action stage. However, many clients are referred to therapy when they are barely in the contemplation stage. Motivational interviewing was developed in the 1980s based on the trans-theoretical model just discussed. This technique is used to assist clients to become more acutely aware of the costs of their problematic behaviour and also more aware of what the benefits of it are and how those benefits might be obtained through alternative behaviours that do not carry the same degree of cost (Miller and Rollnick, 1991).

In other words, this technique can shift clients from contemplation to preparation. This technique rests on all of the therapeutic communication strategies outlined above and therefore in the context of genuine warmth, empathy, and respect, but with the therapist probing specifically for more and more detail about the perceived costs and benefits of changing and of not changing. Once the list of reasons for and against change is comprehensive, the client can make an informed and sound decision about changing and can move confidently into the preparation and action stages, or confidently decide that there is no problem to be solved and can feel more comfortable with what he or she has been doing. The more clear the person becomes as to where the balance lies, the more robust is the resolution that is made, and this not only impacts on the person’s immediate commitment to therapy but also on the capacity to maintain those changes and avoid relapse (Saunders & Allsop, 1989). The resolution is more robust because the person is more likely to remember why the decision to change was made.

Motivational interviewing is often enacted in a superficial manner, and I argue that it is more effective when the therapist examines the costs and benefits in terms of the underlying psychological needs that are important to that client. For example, one might notice that many of the costs and benefits that the client gives weight to involve his or her sense of connection to other people. Murray (1938) termed this the need for affiliation; a psychological need that we all have but that some people feel more strongly than do others. Alternatively, it might be the need for autonomy or for order that is seen in many of the costs and benefits.

This form of analysis can provide the therapist with a sense of the client’s most strongly felt needs. An important part of therapy then becomes assisting the client to develop more socially acceptable and effective methods for meeting those needs so that the problematic behaviour is no longer required. This type of analysis allows for a broader understanding of the client’s motives and can guide change processes and resolve problematic behaviours.

The caveat given at the end of the previous section still holds. There are some people who seem to be so damaged or so lacking in empathy and concern for others that no amount of motivational interviewing will get them to decide to change behaviours that we find unacceptable. They might feign such motivation in order to avoid immediate negative consequences but which they fail to commit to therapy.

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As discussed above, those problems that hold too many costs are easy to change, and those that hold benefits that can be otherwise obtained without cost, or with fewer costs, will discarded in favour of the alternative behaviours. However, when costs are only incurred by others there is little motivation to change unless one empathises with and cares about those people.

In essence, observing that one's behaviour is harming others becomes a personal cost. The motivation to change increases with that awareness. In the criminal courts in particular, we need to keep in mind that there are some people, very few thankfully, who do not feel any discomfort with the knowledge that their behaviour is upsetting or harming others. Unless some personal cost consistently follows from the behaviour that is harming others, those people will not become motivated to change.

**Therapy in the Courtroom**

I stated at the outset of this chapter that I do not feel qualified to instruct judicial officers how they may enact therapy in their court rooms. I have attempted to outline a psychological view of what therapeutic communications entail so that the judiciary may determine themselves how it might be applied. I outline in this final section some that puzzle me about therapeutic interactions in courts.

Firstly I ask why would the bench want to be therapeutic? In problem-solving courts, the whole point is to be therapeutic, otherwise how will those problems be solved? In mainstream courts, the question is more puzzling. There are many reasons why judicial officers might want to help people. At a basic human level they might be moved by the various tragedies and pain that unfold in the stories that they hear. They will naturally want to help in some way so that those tragedies do not reoccur in the lives of the people before the bench. The people the judge sees and empathises with might be victims, criminal offenders, litigants in damages claims (both plaintiffs and defendants), witnesses or children whose divorced parents are in dispute. Each of these people is in need of some form of help.

I also ask are the basics of therapeutic communication all that the bench should aspire to, or should the bench try to promote positive growth and behavioural change by enacting more advanced therapeutic strategies? Communicating with people in a warm, caring, empathic, and respectful manner will no doubt lessen the risk of psychological harm from appearing in court.

People who are distressed, but who are not suffering any specific psychological disorder or significant dysfunction, will benefit greatly from the supportive and nurturing effects of basic therapeutic communications. They will feel heard and understood - which might be all that they need from the experience - and they will experience some relief of their distress. Those with
more complex problems will at least not be further damaged by the experience. However, it is unlikely that such people will make significant behavioural change and resolve their psychological problems on the basis of empathy and respect alone.

Perhaps we can also ask should the bench engage in motivational interviewing to assist people before the court to make informed decisions about whether or not to change? Should the bench assert its own view as to whether or not the person needs to change and then simply coerce the person into the arms of the waiting therapist who can then use all of his or her skills to get the client to truly make the changes that the court requires?

Finally how might a therapeutic stance from the bench diminish other aspects of the court's role, or will it enhance those other aspects? At a pre-trial conciliation conference I can see a clear benefit to communicating with both parties to the litigation in a therapeutic manner, but how this may be maintained in a subsequent trial when the court is set the task of arbitrating in favour of one or other party is problematic. How do you tell a plaintiff, in a therapeutic manner, that you do not believe compensation is owed? How therapeutic can you be when you are telling a defendant that he will have to sell the family home to afford to pay the damages that you are awarding?

If a judicial officer actively attends to and listens to the people before the court and warmly communicates accurate empathy and respect for those people, does this have to be construed as an attempt to be therapeutic? Might we not simply regard it as human decency? Perhaps those of us who have been bullied too often by managerialism might cynically refer to such communication as customer-focussed.