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Ethics Commentary

The Psychotherapeutic Relationship

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Immanuel Kant once observed, "We are not gentleman volunteers; we are conscripts in the army of moral law" (Murdoch 1992, p. 35). We recognize that many individuals act primarily, perhaps exclusively, in self-interest. But Kant's observation that there is a moral imperative—what he called a "categorical imperative"—is indeed compelling. We cannot ignore the fact that moral demands are placed upon us by virtue of our living in a social order with other human beings.

Physicians and health professionals in particular live in a moral order, with obligations incumbent on them by virtue of the needs of those who seek their help. Acknowledging that there are scoundrels among professionals, those motivated solely by self-interest and not in the service of others, we recognize that there are certain demands that health professionals cannot escape. Specific moral obligations are imposed on them by virtue of their relationship with patients or clients. This relationship is shaped by the clinician's promise and expertise to heal and by the imbalance that naturally exists between a person in need and a person who seeks to provide treatment, answers, and comfort in relation to that need. Whether one understands those obligations as allegiance to conscience, allegiance to God, allegiance to society, or a more direct allegiance to the patient or client, the obligations are present.

Professionalism in the psychotherapeutic relationship

The relationship of clinician and patient is sometimes spoken of as a sacred trust. That bond deserves further reflection and careful understanding. A fiduciary relationship means a relationship of trust. Law understands fiduciary differently from medicine and other clinical fields. In law a fiduciary, or trustee, may act on behalf of the client. In the health professions, the trust derives from the relationship and must be earned again and again in every moment. The clinician acts with the patient in true partnership.

In the early years when bioethics began to emerge as a discipline distinct from medical ethics, a question was often posed, "Is there anything distinct about medical ethics, or is it just everyday ethics applied to medical situations?" (Clouser 1974). The more mature discipline of *biomedical ethics* recognizes multiple perspectives (physician/professional, patient/client, and society) on what goes on in this very special and personal encounter. These diverse perspectives offer valuable insights into the relationship.

Since the early 1980s, many professionals have spoken of this relationship as a relationship with a client, suggesting a more explicit, business-oriented contract with a more or less coequal autonomous person. Such a relationship implies more responsibility for the client, consistent with more

contemporary notions of autonomy, but no less responsibility for the professional. And whereas physicians once understood their obligations almost exclusively in terms of a principle of beneficence, and still do, it would never be permissible to act with a disregard for the patient's wishes and needs, although those may at times be in conflict.

Over the past 24 centuries, the Hippocratic writings (Oath, Corpus, Aphorisms) have placed special obligations on physicians that were not incumbent on members of society in general. For example, the proscription against sex with patients ("mischief") applied to physicians in a unique way in ancient Greek society. As an itinerant healer, the physician might spend extended periods in a particular household. It would not be unusual in that society for the master of the house to provide sexual companions to a guest. Physicians, followers of the Oath, set themselves apart from this practice, no doubt with a sense that their function in the household was not as a recipient of hospitality and with recognition that indulging in their own comforts would compromise their effectiveness.

Much of the understanding and misunderstanding about the therapeutic relationship involves the recognition of a sexual or sexualized tension between therapist and patient/client. Even when sex does not occur, there may be sexualized feelings and fantasies. Distinctions are important, and subtleties are important. The clinician comes into contact with people at a time of vulnerability imposed by the illness. In order for the clinician to be able to understand the patient's illness, the patient must subject him- or herself to a degree of scrutiny not encountered elsewhere in life. The patient must be examined physically and psychologically—exposed, unclothed, naked, vulnerable. The patient, a person seeking care, must disclose the most personal information imaginable—indeed, information that one might not readily imagine as possible to discuss with another. Ancient traditions (Hippocrates as the most ready example) recognized the imperative that such information be kept confidential, private, and secret within the relationship ("not noised abroad"). Professionals have vigorously stood by this principle for millennia, holding that therapeutic work could not take place without the guarantee of that privacy. Certain situations are recognized in which it may be permissible or even mandatory to violate this secrecy, such as when child abuse is suspected or the risk of violence is present. Even when such disclosures may be mandated by the state (i.e., government, court, or law), however, they are never made without regard for confidentiality—the confidence and trust of the patient.

Confidentiality, understood as trust, is a value that is gradually being eroded in modern health care. Medical information is shared between practitioners only with the explicit consent of the patient/client. However, insurance companies freely share pooled information about every claim, provider encounter, diagnosis, and treatment. This is done under a blanket consent, which everyone signs when applying for insurance. Although the consent is tacitly recognized, it is really a coerced consent. One could not use insurance without giving consent for review of records. Perhaps most disturbing in this trend is the recent federal privacy guidelines, which eliminate formal requirements for patients to consent specifically and prospectively to the use of their medical information. Indeed, under the new guidelines, personal medical information no longer belongs to the patient.

Psychotherapists are the first to sound the alarm and cry "foul." True therapy cannot occur without the assurance of privacy. One could not feel free to talk to a therapist (and certainly not about personal matters) if it were known or suspected that such information might be shared with others. Such information could be misused by employers or might be used at some future time to prevent employment or discriminate against the consumer—for example, in obtaining health insurance. Ethics in such considerations is not just a matter of personal conscience for the provider; it is also a matter of social policy, law, and respect for and protection of individual rights.

The solely commercial understanding of the patient undermines the understanding professional relationship as an ethical commitment to the suffering person. Commercial expediency cannot be good for our society. Healing calls upon a more universal good. It invokes the sacred. It invokes the ability to appeal to another in a community with the trust that such an appeal will bring needed help. The healer understands that appeal not just as a participant in a commercial transaction, but also as a member of a caring community.

THE NATURE OF THE PSYCHOTHERAPEUTIC ENCOUNTER

In this commercial era, the therapeutic encounter is often thought of as an exchange of commodity—a pill, a procedure. More basically, the therapeutic encounter encompasses all that transpires between doctor and patient (professional–client), including especially talking, listening, telling one's story, biography, medical "history," examination (often including a physical exam), evaluation, counseling, treatment planning, follow-up, reconsideration,

recommendations, and more follow-up. Many ancient and contemporary traditions view the medical practitioner as a shamanistic healer—someone who has magical powers, someone who can harmonize the spirits; the person to whom a sick person turns for help is someone who can be believed in because of the powers he or she commands. This is no different today in our society, when the powers believed in are understood to be medical technologies, a complex body of information, much of which is arcane, most of which is believed and hoped to be useful.

The relationship between the sick and the healer has received the most scrutiny in the psychoanalytic tradition—psychoanalysis and the derivative psychotherapies. The therapeutic relationship is best understood in this encounter, which is essentially little different from the encounter with the stereotyped brusque surgeon or with the mysterious shaman—except for the scrutiny given to the relationship itself.

It was Sigmund Freud's particular genius to recognize that when two people spend time together, they develop feelings that derive from other significant relationships in their prior experience. Significantly, the patient develops feelings for the physician that repeat feelings held for parents. Freud called this phenomenon *transference* and recognized that it could be a vehicle for understanding past experience. It is beyond the scope of this book to assess the place of Freudian theory in psychotherapy, but an appreciation of the concept of transference is essential for understanding the ethics of the therapeutic relationship.

Psychotherapists structure a frame within which the reflective process can occur. They agree to meet at a certain time at a certain place for a certain duration at a certain frequency for a certain purpose. These are the boundaries of the frame and the boundaries of the therapeutic relationship. Development of a therapeutic alliance is part of the therapy in which the patient allies with the clinician to get better. More specifically, the part of the patient that wants to get better allies with the therapist to understand the part of the patient that wants to repeat maladaptive behavior patterns. This repetition is called *resistance.* In the early years of psychoanalysis, resistance was seen as an obstacle that needed to be overcome before analysis could be successful. Today, resistance is appreciated more sympathetically as part of a defense structure that must be accepted and understood. Too-rigid adherence to the boundaries places the therapist at risk of appearing uncaring and of increasing the patient's defenses. Disregard of the boundaries compromises the therapist's chances of creating a situation in which reflection can occur. The therapist walks a delicate tightrope, demonstrating concern and empathy yet insisting on scrutinizing what takes place between clinician and patient as a possible transference clue that needs to be understood.

The case examples that follow illustrate everyday dilemmas that can be problematic as matters of technique, judgment, and ethics.

CASE 1

A woman approached therapy eagerly and with energy. She was polite, easygoing, and friendly. She was interested in the therapist, curious about the therapists' personal life, and, in a social way, asked ordinary but persistent questions, such as "Did you have a nice vacation? Where did you go?" The therapist recognized these questions as a departure from the therapeutic stance, but he felt that it would be too much work to keep inquiring about the curiosity behind the questions, when in fact they were innocent enough.

This ordinary situation is one that every therapist encounters. How is the frame established? Should the therapeutic frame be set when the patient is met in the waiting room, when the door to the consulting room is closed, or when the patient settles down and begins to work? How should chance encounters be handled? What if patient and therapist are thrown together in some community activity, as is especially likely to happen in small communities? The Exploitation Index, an educational tool developed by Epstein and Simon (1990; Epstein et al. 1992) for use in examining therapeutic boundary issues, provides an opportunity to consider some of the situations in which boundary crossings or frank transgressions may be an unrecognized issue.

Most therapists encounter such situations, which can be quite awkward and which require a certain discipline to remind the patient that therapy is different from a social relationship and to hold the therapeutic frame.

CASE 2

A young woman consulted a psychiatrist for help with anxiety and disappointment with relationships with men. She was open, energetic, talkative, and highly successful in her profession. The psychiatrist considered himself a "medical psychopharmacologist" and prescribed an appropriate medication for this patient. He was in fact skeptical of psychotherapeutic approaches to dealing with problems he knew could respond quickly to medication. He saw nothing wrong with an extraprofessional relationship that did not involve dating or physical intimacy, so he accepted the patient's invitations to her pool parties. Although he considered this just being sociable, the patient felt that more was involved and understood.

Although this clinician had not crossed the boundary into a sexual relationship, he failed to appreciate the boundary that he should have recognized between a professional relationship and a social relationship.

Case 3

A young man sought therapy because of disappointments in his life. He felt that his therapist was someone who understood and cared for him, and he looked forward to their sessions. When he became particularly distressed, the therapist would schedule him as the last appointment of the day and sometimes would extend the sessions. The therapist felt that supportive therapy was indicated and that the patient needed support to face the difficulties in his life. When the therapist later began to limit the time in the sessions, the patient became hurt and angry and decided to end the treatment, because he felt it was no longer working.

These cases share ordinariness; they are common situations in therapy that offer dilemmas and raise questions of values. They are matters of technique and judgment. No deliberate harm was done, although opportunities for good might have been missed. Often, therapists will say that they do not deal with the transference; that is an issue for psychoanalysis. But as these mundane examples illustrate, transference feelings can arise in all kinds of therapy.

Clear boundary violations, such as sex with a patient or failure to maintain confidentiality, are obviously unethical and can be devastating for the patient as a personal violation of trust. The proscription against sex with a patient is clear and unambiguous in the codes of ethics of all professions. The American Psychiatric Association's (2001) *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* explicitly state that sexual activity with a patient is unethical.

Case 4

A medical student was threatened with expulsion from medical school when it was discovered that he had had sex with a patient on the service where he was rotating. When the matter was brought to administrative attention, the student stated in his own defense that the sex was "consensual" and that he had not realized that there was anything wrong with it: "It wasn't like it happened on the psychiatry rotation, or anything like that."

Sexual relations with patients (and former patients) receives the closest scrutiny in psychiatry and in psychotherapeutic relations, but the same transferential concerns of trust, dependency, and idealization occur in other professional relationships as well.

What about sex with a former patient? Is that ever permissible? Are the expectations different for a relationship with a patient who is seen once on a consultative basis and a patient who is involved in a psychotherapeutic relationship? Might it be possible after a specified period of time—say, 1 or 2 years—to engage in a personal, intimate, sexual relationship with a person who was formerly a patient? And if so, how could it be determined what the appropriate "cooling off" period should be? The American Psychiatric Association has taken an increasingly austere stance on this issue. Whereas the statement in the 1973 version of *The Principles of Medical Ethics* read, "Sex with a current patient is unethical. Sex with a former patient is almost always unethical" (American Psychiatric Association 1973, p. 4), that annotation was revised in 1993, and in all iterations published since then, the statement is absolutely unequivocal: "Sexual activity with a current or former patient is unethical" (American Psychiatric Association 2001, Section 2, Annotation 1). It is possible that a physician and a patient could truly fall in love and commit themselves to each other forever. But should the relationship subsequently turn sour, the patient (or former patient) could always claim exploitation on the part of the physician.

We have spoken of boundary violations as transgressions primarily in the frame of the psychotherapeutic relationship. This is the easiest way to grasp the concept of boundaries, but in fact boundaries are more complicated in everyday life. The boundary that the therapist must respect is the boundary between self and other, between therapist and patient. That is a complicated boundary because, like other relationships, it has a transference component. The extent to which a patient may wish to please (or to rebel against) the therapist may be a repetition of feelings developed in childhood in relationship to significant others. Parents who used their children to gratify their own wishes probably left those children vulnerable to exploitation by others. Such children are said to have been used as narcissistic extensions of their parents. In the extreme form of this problem, the boundary between parent and child is not established, and the exploitation may be perverse. But the successful student or athlete may be working for the pride of the parent rather than a sense of personal accomplishment, a pride that may be inadvertently exploited by a teacher or coach with the best of intentions. The effective and ethical therapist works to establish and maintain a boundary that—despite often appearing artificial at first—eventually provides the emotional distance for

the patient to develop an autonomous sense of self. This sense of self expands the philosophical concept of autonomy that is so important to bioethics.

With an appreciation of the transference dynamics of the boundary between therapist and patient, self and other, and of the practical ethical consequences of this boundary's violation, it is possible to look at the question of a relationship with a former patient in a new light. From the standpoint of an enduring commitment, we may recognize marriage as the possible exception to the "never" rule. With the recognition of transference feelings, however, we caution therapists that the partner may later claim that the feelings once understood as love were in actuality a transference that was exploited in therapy. It would be very difficult indeed to defend oneself against such a claim.

Several considerations can help clarify the understanding of boundaries:

- *Nonsexual boundary violations*—Sexual boundaries and boundary violations receive the most attention because their violations are the most devastating. But if the violations are understood to represent a transgression of self and other, there are also other aspects of the relationship that can be transgressed—for example, business, financial, religious, and social.
- *Boundary crossings*—Sometimes a therapist will experience an internal sense of discomfort at having allowed him- or herself or the patient to cross a certain boundary. The transgressions may be minor self-disclosures (e.g., talking about vacations or one's personal life), extratherapeutic social encounters, or just a sense that one is not holding the therapeutic frame. Although unlikely to result in formal ethics complaints, such boundary crossings may undermine the clinician's ability to do effective therapy. Recognition of a boundary transgression should prompt the therapist to seek consultation or supervision or to reflect on his or her motives in personal therapy. If the therapist is a trainee, it is the task of the supervisor to create an environment in which such self-awareness can occur and to help the trainee come to an appropriate resolution. Sometimes boundary crossings can illuminate the transference–countertransference dynamic and thereby further therapeutic understanding.
- *Divided loyalties*—Situations occur in therapy when the therapist experiences divided loyalties—allegiance to the patient as well as allegiance to some other interest (Knight 1995). These situations have traditionally been spoken of as the "dual agent" problem. A physician or therapist is a dual agent, for example, if he or she owes an allegiance to his or her employer as well as to the patient. A classic example of this dilemma is the psychiatrist or psychologist working for the military or for a state or federal institution. Increasing numbers of physicians and other providers are now working for large organizations, such as health maintenance organizations or managed care companies, rather than in independent practices. Subtler issues involving overlapping and divided loyalty arise for small-community clinicians, who must serve not only their individual patients but also their patients' families, who are neighbors and friends. More globally, clinicians increasingly recognize an allegiance to society, which makes it increasingly difficult to buffer a unique concern for each individual patient.

Case Scenarios

A psychology intern completing a rotation in the rape crisis clinic notices a classmate from her training program in the waiting room; the classmate is coming in for crisis evaluation and treatment after an assault the night before.

The chair of psychiatry at an academic medical center receives a call from the CEO of the university hospital, requesting mental health treatment for her mother-in-law.

A psychotherapist attending a small dinner party discovers that one of the other dinner guests is a client of his.

A psychiatrist routinely encounters one of his patients at a coffee shop near his office. The patient appears to be waiting for him there and often tries to engage him in conversations that are intensely personal.

A young, married psychiatry resident begins caring for a patient who has many sexual partners. He finds himself becoming very curious about the new sexual liaisons of the patient and very much looks forward to each therapy session with this patient.

A consultation-liaison psychiatrist with duties at a community hospital receives a psychiatric referral for a patient who was recently diagnosed with testicular cancer. She has known the patient for several years, and they went on a "casual date" 4 years ago.

More extreme cases put the more mundane cases into perspective. Psychiatrists in the former Soviet Union, as well as in other Eastern European countries and in the People's Republic of China, have come under scrutiny for hospitalizing political dissidents and labeling them mentally ill or "psychiatrically impaired" (Lifton 1976). Physicians in the military governments in Latin American and in several African nations have (perhaps

under coercion themselves) cooperated with torture of political prisoners. Nazi physicians conducted experiments in concentration camps, which would previously have been unimaginable and which have given rise to many safeguards in human research (Lifton 1986).

From a moral perspective, most double-agent situations are best seen as cases of conflicting loyalty or clashing duties. The clinician must choose one duty over another (Macklin 1982). Perhaps most problematic are situations in which the patient assumes (because of the weight of the professions' patient-centered ethic) that the clinician is working exclusively for the patient's best interests and well-being. Thus, a psychiatrist conducting a prearraignment examination might be able to elicit more information than a police interrogator simply by projecting a trustworthy demeanor. But if the message is not "I am here to help you," then the purpose of the examination should be directly stated. A therapist conducting an administrative evaluation in a student health service should clearly state, "You are being evaluated at the request of the Dean, who will receive a report of my findings." A mental health professional should not convey the impression that everything discussed will be confidential if that is not the case. In clinical research, the issue of dual agency ("the therapeutic misconception") has become recognized as a key ethical consideration.

Furthermore, review and examination of double-agent issues should be a continuing obligation of mental health professionals, for such scrutiny is the only way to prevent such issues from disrupting the clinician–client relationship. These are issues that often come before professional ethics committees and serve as reminders of the ethical principles kept alive through education, codes, and professional discipline.

When a conflict of interest arises, the health care professional should make his or her allegiance to the patient/client primary and should fully inform the patient/client of the conflict of interest. The goal of maintaining trust is essential to the therapeutic relationship, and anything that erodes that goal diminishes not only the therapy, but also the therapist and the profession he or she represents.

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