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ETHICS AND PSYCHOTHERAPY

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The article deals with ethical issues that are key to the appropriate development of therapeutic relationship. The authors have related them to treatment paradigm, the ideas of health and illness, as well as the importance of the patient's autonomy and their bond with the therapist. Application of particular ethical rules has been compared with individual ethics of the therapist and the patient, as well as the relation between them.

key words: patient's autonomy in psychotherapy, patient's competence to consent to psychotherapy, ethics of therapeutic relationship

Summary: The authors express an opinion that discussion on psychotherapy should be based upon its ethical dimension. In their opinion, the source of that are the expectations of the patient and the obligations of the therapist that emerge in a therapeutic relationship. In that relationship, the ethics of psychotherapy appear and develop, and are influenced by the ethical principles of both participants of the therapy. The authors suggest referring to the medical paradigm and medical ethics when dealing with ethical decisions in psychotherapy. The article also presents ethical implications of actual or nominal handling of mental illnesses and disorders, also in relation to psychotherapy. The influence of the specific position of the therapeutic relationship's participants on the importance of ethics in this relationship is pointed out (the patient's status as both the healed and the healer, and the therapist's characteristic experience of carrying the therapy's burden). The authors also refer to the issue of the patient's autonomy in psychotherapy and investigate a related problem of the patient's conscious consent to psychotherapy and the question of medical paternalism in psychotherapy. The article points out the issue of the therapist's loyalty towards the patient, as well as possible limitations to the therapeutic dialogue determined by the psychotherapist's and patient's worldviews and ethical principles. The authors reckon that because of the relational nature of ethics, the ethical problems of a psychotherapist are different in the relationship with every single patient and in each given moment of the therapy.

Introduction

For a psychotherapist, engaging in a discussion regarding ethics of psychotherapy is identical with asking questions that, although dispersed, happen to appear during the professional practice.

For the initiation and flow of psychotherapy, a relationship between two people: the patient and the psychotherapist, is indispensable. As a consequence, reciprocal expectations and obligations, followed by ethical questions and dilemmas, emerge. As an effect of the relationship between the patient and the therapist, rules, methods, aims, as well as possible consequences of psychotherapy develop ethical features and are subject to moral evaluation from the patients, the therapist, as well as third parties' point of view. The therapeutic relationship is therefore material of psychotherapy's ethics, and the ethical dimension should be the basis of reflection upon psychotherapy.

A similar conviction about the basic meaning of ethics in psychotherapy is expressed by Tjeltveit [1], who concentrates mostly on the issue of values in psychotherapy, putting aside the relative source of ethics of psychotherapy.

The questions that we pose below concern the ethical sources of decisions taken by the psychotherapist, including those related to the perception of the patient's suffering, the influence of the therapeutic relationship's specific nature on the therapist and the patient, the possibility of obtaining the patient's conscious consent to psychotherapy, the paternalism of the therapist in the view of the patient's autonomy, the therapist's loyalty towards the patient, the influence of worldviews represented by both parties of psychotherapy during its course, as well as the possibility of taking up and continuing psychotherapy and the limitations in this regard based on ethical grounds. Let us add that these questions are posed from the position of a physician psychotherapist and psychologist psychotherapist and therefore only one of the two – besides the patient – participants of psychotherapy. We cannot speak on behalf of the patient, although what they would have to say is – if not more important – at least as important as the therapist's opinion.

Medical paradigm as the source of ethical decisions

Psychotherapy is a method and a way of curing persons that experience mental and physical suffering. The therapy, and so psychotherapy as well, concerns by its nature the health and sometimes also the life of the patient, which are of the utmost importance for almost every person. Each act of treatment takes place between at least two people: the curing (physician, therapist) and the cured (patient). The physicians/therapists that undertake treatment have been obliged to follow ethical rules, which are usually more strict than in other professions. Are the obligations of physicians towards their patients compulsory also for psychotherapists in their relationship with patients? The question might seem rhetorical, but just a few psychotherapists are at the same time physicians.

Probably it is possible to reflect upon ethical problems of psychotherapy without taking into account the tradition of medical ethics; in our opinion, however, this point of reference seems the most important among other ones, and difficult to pass over, as every other view would bear the risk of accepting ethical rules inconsistent with those accepted in medicine, or even contradictory to them or weaker at protecting the well-being of the patient. Furthermore, the physicians' ethics that was a base for developing medical ethics, dating from the Hippocrates's oath back in 5th century B.C., is the oldest professional ethics that for 2500 years has served to establish the therapist physician's duties towards the patient and has been tried and tested in solving conflicts related to therapeutic relationships.

To consider ethical problems and dilemmas that the psychotherapist faces, as well as their choices, we will therefore take into account the experiences of medical ethics.

How does the thinking of health and disease influence ethical views?

To undertake ethical decisions in medicine, and so in psychiatry, it is important how someone understands health and disease. Szewczyk's [2] questions might be repeated: is health possible to define without disease? Is disease contrary to health? Is disease an attribute of life? Is disease a way of looking at

the end of life, a way to familiarise oneself with death? Let's add one more: does life manifest itself in disease and is life possible without disease?

On what the therapist thinks of disease and health, what are therefore their views on the patient's ailments, sufferings and complaints, depends how they see the patient's treatment and recovery, as well as their share in those processes, and so relations with the patient. Things look quite similar on the patient's side. For such reasons psychotherapy as a method or way of treatment cannot be considered without taking into account how one understands health, disease, being ill, patient's suffering and their treatment.

Supporters of the reductionist view on disease, based usually on its mechanistic model, both among the physicians (therapists) and the patients, concentrate on seeking the pathogenic factors and on finding methods to remove or counteract them. More and more varied and improved medical technologies serve this aim. The above attitude favours the focus of physicians, patients and other people on the disease as a separate being, granting it an ontological nature. Such realistic understanding of disease is dominant in medicine these days.

The consequence of such attitude is leaving behind the person of the patient, but also, in a non-intentional way, stigmatization of being ill and of the patient when the disease cannot be stopped by medical technologies [2, 3]. For the same reasons, the physician therapist who "cures the disease" and not the patient, is subject to criticism when he does not succeed at the task – posed by themselves or by others – of "fighting the disease". Such a physician therapist will undertake medical interventions and interferences that will be strictly medical acts of a "monologue over the patient" character, and the therapeutic relationship will be of an extremely paternalistic kind. Moreover, physicians who see themselves in such a way, trying to prevent doubts about their power, might indulge into "medical determination", revealed by prescribing the patients more medicines and/or ways of cure when the previous ones did not help, without regard for the non-beneficial consequences and the risk that the patient runs [3].

The followers of the reductionist view of medical problems try to solve ethical dilemmas referring to ethical consequentialism (teleologism), best expressed in different variants of utilitarianism [2, 4].

Utilitarian ethics seems, however, fallible in medicine, where we touch upon issues that reach the limits, i.e. when both the curer and the cured, as well as a third party (for example, a member of the patient's family) who is not involved in the therapeutic relationship and is just observing it, state – each on their own – what is the most important goal of the treatment. Would it be the life of the patient – then all curing methods that help to rescue and support the life will be considered ethical, even if they are persistent and troublesome for the patient; if it is the patient's health – the risk is the "medical determination" mentioned before, without taking into consideration the costs and consequences for the cured [3, 4]; if the most important aim of the therapy would be diminishing the patient's pain and/or suffering, then the effect of it would be acceptance of every method that could eliminate those, and so – also euthanasia. It is not difficult to imagine possible conflicts between different people – participants of the therapy, resulting from accepting

by them varied and differing aims of the therapeutic process, which seems an inevitable consequence of accepting a utilitarian perspective for ethical decisions in medicine.

Supporters of non-reductionist approach in medicine understand being ill as an aspect and even an attribute of life and the disease as its sign. It enables them to perceive a meaning in the disease, to notice in pain, suffering, disease not something abnormal, but on the contrary, something natural, immanently bound with life. With this approach, being ill can be seen as a sign of life which defends itself from what threatens it, and, with time, makes the organism familiar with death. For those who perceive the disease in such a way, it bears only the nominal, and not the real meaning, as seen by the reductionists [5]. Gillon [5] turns attention to drawbacks and risks that could be an effect of accepting one of those approaches: the realists might concentrate on the disease and not on the ill, on the other hand, the nominalists may only see as disease what they accept as such.

Among psychiatrists and psychologists, both the supporters of realistic and those of nominal approach to mental illnesses and disorders may be found. The former ones usually focus on the illness/disorder and speak of curing psychoses, depression, addictions, anxiety disorders etc. The latter ones see the mental phenomena, related to the patient's suffering, as reflections of the patient's inner conflicts, appearing as a result of life experiences. For the nominal approach to mental diseases and disorders appeal the changes in the classification of mental disorders that reflect the changes in perceiving them. It is worth taking into consideration that stepping down by the therapist from the effort related to diagnosis, naming and prognosis, or the actions that favour making the illness or disorder "real" and that are the core of contemporary medicine – and so of psychiatry – in favour of being a witness, companion in the patient's suffering, on the one hand expose the therapist to the patient's pain, the sources of which are unknown and if learnt – always ambiguous, on the other hand – this is the very base of the therapeutic relationship [3].

Non-reductionist approach in medicine does not relate directly to any particular ethical views, however, teleological theories would be difficult to use by a physician therapist, supporter of such views on being ill. What seems more appropriate in such a case, are the deontological theories (*deon* – duty), i.e. theories of rights and duties that describe the ethics of duty. They are usually based on religious values systems [2].

A modern extension of deontological theories are ethical concepts that find the base of morality in being responsible for another person [6] or in caring for such a person [2]. It could be repeated after Szewczyk [2] that unconditional imperative of care for the patient should be the distinguishing feature and attribute of a therapist physician's professional ethics.

Therapists that see the phenomena related to health and disease in the nominal aspect gain freedom that enables them to undertake a therapeutic dialogue with the patient to establish the aims, scope and methods of treatment. The essence of such dialogue is the participation therein of both parties: the patient and the therapist. Because of that, the paternalism that is common in medicine, is usually not useful in such a

dialogue. The support for the curer and for the patient alike is then their reciprocal relationship that is being developed between two subjects that undertake autonomous, mutually agreed, respected decisions. Such a situation is also the essence of psychotherapy.

Treatment and psychotherapy

Psychotherapy is a method, but also a way of treatment (*therapei*). One of its participants is the patient, and the other is the psychotherapist, who – unlike in other methods of treatment used in medicine – engages in it and takes part in it, experiencing it by him- or herself. This personal engagement of the therapist in the therapy, being also an important burden for them, seems to be an indispensable factor that enables the patient's healing.

In this respect, it is an exceptional curing situation, because the curer (the psychotherapist) and the cured, who is also curing themselves (the patient) both take part in the healing process of the latter one, both experience and feel the emotional burden related to it. In other curing methods there is a substantial difference between taking part in the curing and the burden resulting from it for the curer and the cured (curing oneself). Experiencing the therapy's burden by the psychotherapist makes their experiences influence the attitude to the patient, manifested by different phenomena experienced by the therapist (thoughts, feelings, will). The personal engagement of the therapists and their experiences resulting from it – indispensable for the psychotherapeutic process – are the particularity of the therapist–patient relationship. On the other hand, sometimes this might lead to a conflict between the benefit of the therapist and the benefit of the patient, and as a consequence to an impossibility of supporting the patient's benefit by the therapist. The above feature of the therapist–patient relationship is one of the factors influencing the importance of the ethical aspect in psychotherapy.

Also the patients' status and what they are responsible for during the course of psychotherapy differ from other treatment situations. The difference may best be seen by two epithets of a patient – being healed and healing oneself. Healing or curing patients is the physicians' domain, whether they use medicaments, medical interventions or other methods. Between the curer (physician therapist) and the cured (patient) a therapeutic relationship develops. In psychotherapeutic process, as we understand it, the patient is both cured – being healed – and the curer – healing oneself, thus bearing a greater effort, burden and emotional cost, but also gaining a greater role in the therapeutic process.

Because of such a status of psychotherapy participants, the therapist is on the one hand responsible for the patient's healing and therefore should care for the person whom they cure and who at the same time is curing him- or herself, and on the other hand the therapist must also not forget about care for him- or herself. Also, the patient takes responsibility and care for his/her cure. They both participate in the therapy; they both are responsible for it. Both for the psychotherapist and the patient this might be difficult. It could be the fear of not being capable to meet such requirements that restrains some therapists and some patients from undertaking psychotherapy, or induces them to desist from it after some attempts.

With reference to the above it should be underlined that within all the medicine the previous arrangements considering relations between physicians (therapists) and patients are being re-evaluated. The patients are, and want to be, less and less the cured ones, they want to be the curing ones more and more. This changes the traditional therapeutic relationship, based on medical paternalism, to a relationship based on the dialogue of two individuals, whose opinions are equivalent. Because such situations have been characteristic of psychotherapy, the experiences of psychotherapists and their patients can probably be used to widen and deepen the discussion concerning medical relations, also in their ethical aspect.

Is the patient's consent to psychotherapy a conscious one?

The consent of the adequately informed patient to the treatment has been a rule accepted generally in relations between physicians and patients in the Western culture in the last several decades [5, 7, 8, 9]. Assuming that the therapy is a method – a way of treatment, it cannot be undertaken without the conscious consent of the patient.

The therapist, asking for consent to psychotherapy, faces two problems: is the patient, due to his or her mental disposition, able to give the consent, and is he or she aware what the consent is about, what is the subject of the consent. Let's take a look at those two aspects of the patient's consent to psychotherapy in ethical context.

Accepting the conscious consent rule is based on an assumption that the patient is competent to give or not to give such consent, which requires him or her to dispose of adequate and sufficient autonomy at the time.

The autonomy of a person relates to thinking, will and action and is not identical with freedom. It is a disposition and an ability of a person and it can be seen, in each of those aspects or as a whole, at a continuum from minimum to maximum [5]. Limitations in thinking, will or action result in limitations of a person's autonomy. They might concern many mentally suffering persons, and so those undertaking psychotherapy as well.

The question, who and on what basis should determine the minimal level of autonomy needed to acknowledge the patient's competence as sufficient to express consent to the suggested therapeutic proceedings, is important in many medical situations resulting in ethical dilemmas. This problem is rarely referred to in case of psychotherapy patients, maybe being omitted or unnoticed. It happens so even though, as we mentioned earlier, some mentally suffering persons may experience limitations of their autonomy (for example, in strong anxiety, discouragement, mental breakdown or psychotic experiences). Limitations of autonomy might also occur in the course of and in relation to psychotherapy, as well as in relationship with the psychotherapist as a result of various transference reactions. Such circumstances should be taken into consideration.

Based on the professional practice, as well as on the research on the question of conscious consent to treatment, it is known that the curers (physicians, therapists) usually overestimate the patients' competence

to give such consent when they accept the suggested treatment methods, and to underestimate them when they do not agree with the suggested methods [5]. One might suppose that it is similar when psychotherapists evaluate their patients' competence to express consent to psychotherapy. The psychotherapist should therefore take into consideration that – if both he or she and the patient consider psychotherapy as an adequate treatment method – it is possible that he or she might evaluate this person's competence to give consent to this therapy not critically enough, not noticing that the patient's decision is not autonomous enough [9, 10].

Having this in mind, it can be acknowledged that the patient's competence to express conscious consent to psychotherapy should be at least such as in the case of considering his or her ability to give consent to psychiatric pharmacotherapy. If we decide that somebody's consent to pharmacological treatment with regard to that person's mental health would be accepted, then at the same time we should also accept this person's competence to give consent to psychotherapy, as possible effects (including side effects) of the treatment do not differ significantly in terms of risk for the patient, as well as in terms of possible benefits or the risk related to not undertaking the treatment by the patient.

Another problem faced by the therapist (and the patient) is the consent to psychotherapy. The significant difficulty in expressing a conscious consent to psychotherapy by the patient is that the scope of the treatment, the cost and effort as well as the results of it are not and cannot be known nor to the patient, nor to the psychotherapists, although the latter, basing on their and other therapists' experience might be the source of information for the patient about the hypothetical, possible or even expected circumstances of the treatment and of potential change in the patient's health. The task and duty of the therapist is to inform the patient that the aims (set by the patient, not the therapist) and methods are just the framework of the therapy, related to uncertainty and obscurity of what awaits the patient and the therapist during and at the end of the therapy [11]. The psychotherapist does not know the patient better than he or she knows him- or herself, he or she is not an expert nor a specialist of the patient's mental problems, although he or she has general knowledge about human mental problems. He or she usually also disposes of better or worse skills of supporting the patient at pursuing ways that could facilitate his or her healing. This is also the assurance that can be given to the patient.

Holmes and Adshead [12] in a discussion concerning the patient's consent to psychotherapy, the effect of which is often difficult to specify, and during which additional suffering might appear, compare the psychotherapy to orthopaedic therapy that temporarily limits the patient, causes discomfort, but with time makes the patient feel better in comparison to the state before the therapy [12].

Giving a conscious consent by the patient to psychotherapy is difficult not only because of the uncertainty felt on their side, but also because of their uncertainty relating to the psychotherapist. The psychotherapist is for the patient an alien and unknown person. And so the psychotherapy begins for the patient with uncertainty relating to themselves, to the therapist and to the results of the process. The task of

the therapist is to help the patient realize those areas of uncertainty, which can be the ground for the conscious consent to psychotherapy.

Taking into consideration the above circumstances that significantly limit both the objective and subjective possibilities of giving consent by the patient, the consent should be preceded by a conversation regarding those circumstances and uncertainties relating to the therapy, therapist and the patient.

The consent of the patient to psychotherapy is at the same time an invitation to the therapist to a common search of ways out of a difficult situation for the former. There might exist many of such ways or none at all. If they do exist, they might be found, but just as well they might not be discovered in the course of psychotherapy. The therapist is therefore a person invited by the patients (usually also chosen by themselves) and let step by step into their intimate matters.

Another problem is worth noticing at this point, that is usually not touched upon in discussions concerning consent to treatment, including psychotherapy, and that is significant for therapeutic relationship, and so for the ethics of such relation. Because of the status of both participants of psychotherapy, considering the consent to therapy (treatment), both the patient and the psychotherapist should be taken into consideration. As it comes to the patients, it is important if they are able to give consent to the therapy (if they have the factual and formal competence to do so, resulting from their autonomy), and if they are able to take up and benefit from psychotherapy as a persons who are being cured and who cure themselves. On the other hand, the psychotherapist should have the ability (competence) to run the therapy of a patient, who at the same time will be cured and will be curing him- or herself. Such a complication of issues related to therapeutic relationship impacts the complication of such relationship's ethics.

Paternalism and patient's autonomy in psychotherapy

As we consider the patient's status in psychotherapy as the cured and curing themselves, we touch upon the issue of their autonomy. During the process of psychotherapy it might fluctuate due to the patient's mental condition. Having the patient informed of the possibility of such situation and foreseeing it is the duty of the psychotherapist before undertaking the treatment. Increasing the patient's autonomy seems an obvious, although rarely mentioned by the therapists and the patients themselves, effect of psychotherapy [11]. In most therapeutic approaches it is accepted that the therapist is obliged to respect the patient's autonomy.

At the same time, many therapists think that psychotherapy should take into account the patient's autonomy to a larger degree than other treatment methods. This approach can be expressed, for example, by undertaking or continuing psychotherapy of patients who express suicidal thoughts, commit acts of self-aggression or have thoughts and desires of aggressive actions towards other people [7, 13].

On the other hand, in every therapeutic relationship, including psychotherapy, a desire to appeal to medical paternalism appears both in the therapist and in the patient. In medicine, the paternalist tradition is still strong and it might seem – particularly for the patient – something natural that they experienced before

with benefit for the treatment. The temptation to create a paternalistic relationship between the therapist and the patient for each of them might appear during the therapy also because – surfacing during the course of therapy – the patients return to reactions appropriate for earlier development phases (regression) and his or her need for dependence.

So, if and when should or might the psychotherapist appeal to paternalistic rules in psychotherapeutic relationship, thus limiting the patient's autonomy? Paternalism, accepted and useful in medicine, sometimes indispensable for the treatment [7, 8] remains in conflict with psychotherapy if it threatens the patient's autonomy (that they dispose of at the current stage of therapy, or are ready for) and leads to its limitation. It might happen, though, that as the patients' health worsens their autonomy significantly diminishes during therapy. If the therapist doesn't take that into consideration, this might actually harm the patient. In such a situation, the psychotherapist may either continue the therapy, appealing temporarily in relationship with the patient to paternalism (so-called soft paternalism would be best), or – if he or she finds it impossible – adopt a "harder" paternalistic attitude and suggest to the patient a change in the curing method, and at the same time – the curing person. In other words, if the therapist comes to the conclusion that without appealing to paternalism in a longer run curing the patient is impossible, it means that also psychotherapy as a method of curing this patient should be changed for another. A similar decision can be taken by the patient, when he or she is unable to remain in the psychotherapeutic relationship without demanding a paternalistic attitude from the therapist, and might mean resigning of psychotherapy (and changing it for another treatment method).

From patient's trust to therapist's loyalty

When a patient undertakes psychotherapy, he or she is ready to share their secrets with the therapist, and counting on help in his/her suffering, puts confidence in the therapist. The latter should be ready to meet those requirements and not to let the patient's trust down. It seems that a therapist that is not ready to accept the confidence, for example not feeling friendly towards the patient, should not undertake or continue the therapy with that person, informing him/her of the barriers on the therapist side that make it impossible to accept that role.

The patient's trust to the therapist is mostly about the therapist in a dialogue with the patient being able to hear the patient's words, accept them whatever they are and sometimes to respond to them. The patients also count on the therapist not to hurt them, not betray, not disappoint them, because the relationship between the patient and the psychotherapist, as with a physician, is of a trusting kind. The patients entrust their health, suffering, secrets and other goods to the therapist. The confidence is based upon the loyalty of the therapist and trust of the patient [14]. The importance and meaning assigned to the confidence in therapeutic relationship is the duty of professional of medical secret that the therapist is bound by.

The therapist's ability to become the patient's confidant depends on what experiences the patient excites in them. They do appear, as in any other relationship between two people, even more in a psychotherapeutic relationship as it touches upon the patient's intimate matters. Regardless of the kind of

those experiences (thoughts, emotions or feelings), a condition to undertake or continue psychotherapy is the possibility to maintain the psychotherapeutic relationship by both its participants, i.e. entrusting their matters by the patient and accepting them by the therapist-confidant. If anyone of them does not dispose of such a possibility, the psychotherapy becomes de facto impossible.

The confident characteristics of the therapeutic relationship are based upon the psychotherapist's loyalty towards the patient. On the other hand the therapist's loyalty towards the patient, in our opinion indispensable in psychotherapy, rules out their neutrality. The theoretical, but also factual impossibility of remaining neutral as a psychotherapist in relationship with the patient was described by us elsewhere [14]. Here, we would like to take into consideration the ethical aspect of the fact that both the psychotherapist and the patient have their own worldviews and moralities, usually mutually unknown at the beginning of the therapy. The psychotherapist's worldview, as well as his or her ethical principles, remains partially unknown for the patient, although he or she tries to learn them, asks about them, fantasises about them or suspects what they are, checks them in many ways or challenges them. The patient's worldview and ethical principles are revealed to the psychotherapist to a smaller or larger degree as they uncover them in the treatment process.

Some psychotherapists – those that accept the theses of utilitarian ethics and advocates of reductionism with paternalistic attitude – think that in the therapy process the psychotherapist has the right to influence the patient to change their worldview, if according to the therapist it poses a barrier to their recovery [15]. The supporters of this view assume that the therapist knows better what is a larger, more important benefit for the patient, putting the patient's health in the foreground, not taking into account or ignoring other goods that might be important for the patient. It makes an impression that the patient's mental problems are treated in an engineering way and that psychotherapy, understood as a treatment technology, is used to its means. It also shows that such psychotherapists act by the rule that the responsibility to define the means to achieve the goal, as well as the goal itself, is on the therapist's side and the patient's rights in this regard are diminished accordingly [15].

What is forgotten with this approach is that the patients, as they entrust the psychotherapist with their secrets in the course of psychotherapy, expect the therapist's loyalty towards them, regardless of the therapist's perception and experience of the patients, their life, worldview and actions. It is a difficult challenge for the therapist and even more so as "being loyal towards the patient relates to a person that we are only just getting to know, and knowing them goes completely beyond the horizon of our possible perception" [14]. Uncovering themselves in the course of therapy, the patient checks this loyalty, counting on it and expecting it on the therapist's side. The psychotherapists' loyalty towards the patient means that they will not criticise the patient, his or her choices and decisions, but will remain the patient's confidant, looking alongside him or her for ways to diminish the suffering regardless of their choices and decisions. In our opinion, this is the essence of psychotherapy. Psychotherapy can continue as long as the psychotherapist

is and can be loyal towards the patient. If remaining loyal goes beyond the psychotherapists' possibilities, they should end the therapy, having the patient informed about the limitation.

It could be argued that the limits of psychotherapeutic dialogue are set on the one side by the worldview and ethical principles of the psychotherapist and on the other – by the worldview and ethical principles of the patient. Within that realm, the treatment process – that of healing the patient – may occur.

Ethics of therapeutic relationship and ethical principles of the therapist

Assuming that the possibilities of applying and using psychotherapy are determined by the worldviews and ethical principles of both participants, we can consider what a psychotherapist might/should do in situations of moral conflict resulting from their therapeutic relationship with the patient.

A question could be posed, what should psychotherapists do when they experience a conflict between the professional duty towards the patient and general ethical principles that they respect?

As the ethics of a person performing the profession of a psychotherapist is inferior to their ethical-professional duties, application of specific particular norms in professional issues is limited by the possibility of fulfilling them to the degree to which they do not disturb the general ethical principles of such a person. Applying any professional norm against one's worldview and accepted ethical principles would be unethical for the therapist. Professional norms are possible to use and demanded only when they do not collide with the ethical norm of a given person. Otherwise, the therapists would breach their ethical principles, which cannot be demanded nor expected. A similar limitation to the use of psychotherapy could be described if ethical principles of a patient collided with any ethical principles of psychotherapy.

Also if the psychotherapists were obliged to continue the patient's therapy or continued it of their free will in spite of conflict between their ethical principles and those of the patient, the therapists would be doing something that would feel immoral or they would stop being loyal towards the patient, becoming a critic of their actions and choices, or even a person that pursues a change in the patient's worldview or ethical values. Taking into consideration discontinuation of psychotherapy in such a situation would be a solution resulting from taking by the therapist into account their ethical principles and from respecting the ethical principles and worldview of the patient. It would therefore protect the patient on one side and the therapist on the other. What can be noticed here is an analogy to the so called "conscience clause" that allows physicians not to undertake specific medical interventions if they do not convene their moral or religious beliefs. In case of conflicting ethical principles, the therapists could maintain the therapeutic relationship only if they would be able to remain loyal towards the patient without running the risk of feeling immoral with themselves.

Another kind of ethical conflict can be experienced by the psychotherapist because of limitations in access to psychotherapeutic services for the people who need it, as a result of providing such services to a specific patient. It is one of typical conflicts within the professional ethics of a therapist and concerns the hierarchy of "the benefit of a given patient – my patient", "the benefit of my other patients" or "the benefit

of potential patients” [2]. Such a conflict can be considered from the justice, as one of the ethical principles, point of view. In this case, this is justice in access to health services. Such a situation happens when legal and administrative rules that concern distribution and access to psychotherapy do not settle the case. It is the psychotherapist who is burdened with the responsibility of action in case of conflict in access to therapy of different people. In such a case, the existing relationship with a patient remaining in therapy should determine taking into account the benefit of such a person in the first place. In other case, a patient undertaking psychotherapy could not count on the therapist’s loyalty that would enable them to continue and complete it, which would breach the rule of trust towards the therapist and towards psychotherapy as a treatment method. On the other hand, the possibility of continuing therapy of a patient or ending it is sometimes considered by the therapist on the grounds of the patient’s actual health, the improvement that they have achieved, as well as other people waiting for therapy and their state of health. Balancing by the therapist the needs of the patient in therapy and the needs of patients waiting for therapy might be a condition to suggest completing the therapy.

Thinking about the mutual relation between the ethics of the person performing the profession of a psychotherapist and the ethics of psychotherapeutic relationship, it could be said that the former is challenged in face of dilemmas appearing during the therapeutic relationship with the patient, what makes the latter appear and take shape at the same time. It is similar when it comes to the patient’s ethics. Therefore, the ethical problems of a psychotherapist vary in every relationship with a patient, as well as ethical problems of a patient vary in relationship with different therapists. At any time during a therapeutic relationship, both its participants may face new ethical dilemmas. The therapists on their side should settle them to the patient’s benefit, to which they are obliged by professional codes. If this is impossible due to their ethical principles, along with the patient they should consider putting an end to the therapy.

If ethical dilemmas that appear in psychotherapy are considered in the context of relationship that its participants are bound by – relationship that is, to say it again, ambiguous in its very nature – then the requirement of supervision that psychotherapists face amounts to their basic duty (*deon*). Without it, fulfilling responsibly the obligation to act to the benefit of the patient seems not possible at all. What is the supervisor’s share in a psychotherapeutic relationship, and particularly in facing ethical dilemmas that accompany psychotherapy, will be considered elsewhere, thus joining a discussion already undertaken in these columns [17]. Let us note here just one more reflection: ethical dilemmas that appear in a given psychotherapeutic relationship are not dilemmas of the supervisors, but they must become theirs, if they treat their task as an obligation towards all the participants of psychotherapy.

Recapitulation

It is the patient and the psychotherapist that take part in psychotherapy. The subject of ethics in relation to psychotherapy cannot be considered in detachment of those two people, who both have a share in a therapeutic act characterised by dialogue, but who differ in terms of responsibility, as it is something else

that the curing and the cured/curing oneself are responsible for. Creation of therapeutic relationship results in ethical consequences for both its participants, as ethical issues are of a personal type and concern a relationship between two specific people, in this case both the participants of psychotherapy. Let us repeat here what was earlier expressed and described in more detail – that there is no ethics outside the relationship, and in the relationship it may remain only an obligation of the therapist towards the patient, with whom they try to establish this relationship, and as long as the relationship lasts, the ethical problems cannot be solved [16]. The relational nature of ethics implies that obligations and demands relating to the course of therapy do not end abruptly at the same time when therapy ends, as a therapeutic relationship between the psychotherapist and the patient does not end with the end of last session. It is difficult to determine whether it even ends with the end of their lives.

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