REVIEW ARTICLE

Ethical reflection and psychotherapy

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Abstract

OBJECTIVE: Theories of ethics and ethical reflection may be applied to both theory and practice in psychotherapy. There is a natural affinity between ethics and psychotherapy. Psychotherapy practice is concerned with human problems, dilemmas and emotions related to both one's own and other people's values. Ethics is also concerned with dilemmas in human thinking and with how these dilemmas reflect other individuals' values. Philosophical reflection itself is not a sufficient basis for the ethics of psychotherapy but it may aid in exploring attitudes related to psychotherapy, psychiatry and health care.

METHODS: PubMed, Web of Science and Scopus databases were searched for articles containing the keywords "psychotherapy", "ethics", "therapeutic relationship" and "supervision". The search was conducted by repeating the terms in various combinations without language or time restrictions. Also included were data from monographs cited in reviews. The resulting text is a review with conclusions concerning ethical aspects of psychotherapy.

RESULTS: The ability to behave altruistically, sense for justice and reciprocity and mutual help are likely to be genetically determined as dispositions to be later developed by upbringing or to be formed or deformed by upbringing. Early experiences lead to formation of ethical attitudes which are internalized and then applied to both one's own and other people's behavior. Altruistic behavior has a strong impact on an individual's health and its acceptance may positively influence the pathophysiological mechanisms underlying numerous diseases. Ethical theory and reflection, however, may be applied to both theory and practice of psychotherapy in a conscious, targeted and thoughtful manner. In everyday practice, psychotherapists and organizations must necessarily deal with conscious conflicts between therapeutic possibilities, clients' wishes, their own as well as clients' ideas and the real world. Understanding one's own motives in therapy is one of the aims of a psychotherapist's personal therapy and a frequent goal of supervision interventions. It is a psychotherapist's ethical obligation to do no harm, maintain clear therapeutic borders, not abuse patients, undertake supervision and learn good self-reflection.

CONCLUSION: Knowledge of ethical questions and related issues as well as continuous ethical self-reflection are essential components of high-quality psychotherapeutic management. This requires both good psychotherapy training and systematic supervision.

INTRODUCTION

Theories of ethics and ethical reflection may be applied to both theory and practice in psychotherapy. There is a natural affinity between ethics and psychotherapy. Psychotherapy practice is concerned with human problems, dilemmas and emotions related to both one's own and other people's values. Ethics is also concerned with dilemmas in human thinking and with how these dilemmas reflect other individuals' values.

From time immemorial, ethical issues have been addressed by philosophy. At that time, philosophy, anthropology and psychology blended together into a "holistic study of humans", concerned with the determination of humans, their behavior toward themselves, others and the whole. Socrates and Plato's view are mainly about ethical behavior. For ethical thinking, Socrates is inspirational especially for his use of a dialogue to understand certain questions, the so-called Socratic questioning. Socrates, whose attitudes and opinions are known from works by Plato (Platón 1919, 1936, 1979, 1994) or Xenophon (Xenofón 1972), achieved mastery in conducting dialogues. His inductive questions to get to the heart of the matter made his partners gain, suddenly and unexpectedly, a new insight into the situation. Ethics requires reflection considering both one's own and other people's motives, interest of the whole and the sense of behavior with respect to values. Here, what is innate or learned is not sufficient; ethical reasoning should go beyond that. Socratic dialogues led to controlled discovery of these aspects. Similarly, the Epicureans considered ethical issues to be essential in philosophy as cosmological questions are practically of no value to a human life. Much attention to ethics was also paid by modern philosophy. For Kant, ethics was probably the most preferred discipline (Čechák *et al.* 1984). His well-known quote "the starry heavens above me and the moral law within me" suggests his desire to produce moral philosophy and elaborate human freedom issues. Rather than perceiving humans as passive products of nature, Kant viewed them as subjects of autonomous behavior and their own self-improvement. Kant considered ethics an important issue, claiming that all people are equal. In this respect, his introduction to the Critique of Pure Reason is of special importance, stating that freedom is the condition of the moral law: *Act as if the maxim of your action were to become through your will a general natural law*. As in ancient ethics, emphasis was placed on needs of the whole. However, there was a marked shift in the modern age. This is probably due to abundant resources, with an individual no longer feeling so tied to the whole. Emphasis is placed on an individual, his or her rights and freedoms, with the resulting duties to the whole being a little bit neglected.

METHODS

PubMed, Web of Science and Scopus databases were searched for articles containing the keywords "psychotherapy", "ethics", "therapeutic relationship" and "supervision". The search was conducted by repeating the terms in various combinations without language or time restrictions. The articles were collected and sorted according to their relevance to the topic. Subsequently, other key references were hand-searched. Also included were data from monographs cited in reviews. The resulting text is a review with conclusions concerning ethical aspects of psychotherapy. The outcomes were grouped into text subchapters and discussed by the authors.

ALTRUISTIC BEHAVIOR AND ITS BIOLOGICAL BASIS

The ability to behave altruistically, sense for justice and reciprocity and mutual help are likely to be genetically determined as dispositions to be later developed by upbringing or to be formed or deformed by upbringing (Bijleveld & Wijkman 2009, Berns & Atran 2012). These are likely to be of genetic origin because they allowed coexistence in a group, tribe or larger community, without which humans would not have survived because they were too weak against nature. In the process of natural selection, genes were more frequently selected that were involved in tolerance towards close others and intolerance towards strangers as this conferred selective advantages (Frisell *et al.* 2011). This important interaction between genes and the environment has been repeatedly shown in epigenetic studies carried out in the last decade. The mother-child bond is associated with both the child (innate makeup) and the mother's behavior towards the child (Bowlby 1977, Hofer 1996, Heim & Nemeroff 2001, Meaney 2001). However, the mother's ability to provide the child with enough security, acceptance and appreciation is related to both her own genetic makeup and the surrounding environment, which also needs to provide enough security, acceptance and appreciation. Social interactions have a significant impact on many aspects of an individual's physiology and behavior in the future life (Karelina and DeVries 2011, Arsenio and Lemerise 2004). Altruistic behavior is mainly associated with the capacity to empathize which is developed in people with well involved "mirror neurons" (Goldman 2006, Baird *et al.* 2011). These are grey matter cells automatically activated by other people's actions, mediating their experiences to us. Interestingly, the same brain regions are activated in both the actor and the observer (Preston & de Waal 2002, Harris 2007, Singer & Lamm 2009).

Early experiences lead to formation of ethical attitudes which are internalized and then applied to both one's own and other people's behavior (Tough *et al.* 2010, Tremblay *et al.* 2004). These may be referred to as "ethical schemas", automatically associating certain

behavior towards others with its classification as morally "right" or "wrong" (Dodge & Rabiner 2004). For instance, the "stealing is bad" attitude means that any thief is automatically considered "evil", unless a noble reason is found, such as that the property was stolen from another criminal and given to some in need.

Altruistic behavior has a strong impact on an individual's health and the acceptance may positively influence the pathophysiological mechanisms underlying numerous diseases (Rogers & Dymond 1954, Brothers 1989, Karelina & DeVries 2011). Through improved immunological events, decreased glucocorticoid levels and increased oxytocin levels, and probably through other mechanisms as well, affiliative social interaction aids in treating physical and mental health problems (Pace *et al.* 2009, O'Connor 2012). Altruistic behavior is also associated with phylogenetic development of the limbic system, with an important role being played by the amygdala (Goleman 1995, Allmen & Brothers 1994, Greene *et al.* 2004, Singer *et al.* 2004, Brzok *et al.* 2012). As any social acceptance, a therapist's empathy promotes neurotransmission of dopamine in the nucleus accumbens (a center of the brain reward system) and its co-transmitters beta-endorphins (Lahey *et al.* 2011, Trezza *et al.* 2011). Thus, the mesolimbic dopamine system modulates rewarding, motivating and stimulating behaviors (Trainor 2011).

ETHICS AS A COMPONENT OF PSYCHOTHERAPY

Ethics is concerned with what interpersonal relations should or should not involve; psychotherapy theory is concerned with what happens between people in the interpersonal space, both consciously and unconsciously, and why. Psychotherapy practice deals with experiencing, thinking and attitudes of individuals and their dilemmas using a defined relationship space (Stirman *et al.* 2010). Ethics is also about dilemmas in human relationships and about creating a space among people where different values may be reflected (Ross 1994). It seems that there is a natural connection between psychotherapy and ethics and that psychotherapy used without an ethical aspect would, in fact, no longer be psychotherapy (Holmes & Adshead 2009).

In psychotherapy, clients gradually learn to gain an insight as to what, how and why they experience in their lives and how they establish relationships with others (Moro *et al.* 2012). Through increased self-realization and deeper understanding, their autonomy is developed and changes occur, with some of them being desirable and presumed but others being just suspected. There are also changes that clients would rather forgo or would not choose at the beginning of their therapy (Voth 1972). Frequently, they are unable to predict the consequences of their changes for themselves and others, whether roles and behavior in relationships would not be redefined and whether they would not lose some of

their relationships unwillingly (Rosenbaum 2011). To a great extent, these consequences cannot be fully estimated even by therapists. Their effort, however, is to do their best to guide their clients so that their choices are autonomous, not therapist-induced (Stirmann *et al.* 2010). From the very beginning, therefore, the psychotherapeutic process may bring about numerous dilemmas that therapists should reflect and clients should be informed about. But the way the information is presented to particular clients is a dilemma. On the one hand, clients should get it; on the other hand, it may dissuade them from therapy even though it is needed. The basic problem is that although psychotherapy is classified as a treatment, frequently it is rather a dialogue leading to a client's individual development.

In psychotherapeutic theory and practice, the emphasis on ethical issues has been automatically applied for the 100-year development of psychotherapy. Explicit attention to ethical issues in psychotherapy, however, occurred relatively late; in fact, it was only in the 1990s (Holmes & Adshead 2009). Yet self-reflection is one of psychotherapists' competencies, always reflecting ethical dilemmas as well (Praško *et al.* 2012a). Ethical theory and reflection, however, may be applied to both theory and practice of psychotherapy in a conscious, targeted and thoughtful manner. In everyday practice, psychotherapists and organizations must necessarily deal with conscious conflicts between therapeutic possibilities, clients' wishes, their own as well as clients' ideas and the real world. Therapists must maintain confidentiality and should respect the need for informed consent and therapeutic contract and maintain therapy in agreed-upon and ethical boundaries (Hren *et al.* 2011). For them, it is essential to understand the nature and need of boundaries, especially those related to confidentiality and discretion, and to clarify the attitudes and behavior preventing clients from being economically, emotionally or sexually abused (Gabbard 2009, Chalmers *et al.* 2011). Important values on which bioethics is based were described by Beauchamp (1994) as "four principles" comprising autonomy, beneficence, non-maleficence and justice. These bioethical principles may also be used for ethical reflection in psychotherapy.

Ethical reflection is a process stemming from the therapist's deeper attitudes and values. Attitudes and values of an individual or a group significantly influence therapy, strategy selection and behavior towards clients, often at an unconscious, unreflected level. The therapist's basic attitudes towards others and towards oneself are typically not subjected to routine analysis in the course of therapy of a particular client unless the issue is dealt with by supervision. A typical example of such attitudes is labeling of clients. If therapists or therapy teams are convinced, for example, that personality disordered patients actually do not suffer from their symptoms and problems, exaggerating them and striving for the so-called secondary gains, they auto-

matically label, moralize and tend to trivialize anything the clients say, confront them vigorously and punish for their symptomatic behavior. Although they consider such behavior as "establishing boundaries", most frequently it is emotional abuse. The ability to realize one's own attitudes, their ethical dimension and how these influence practice is one of important tasks of responsible therapists. It must be realized, however, that numerous basic attitudes are older than therapeutic training and attitudes adopted in the profession.

Most people would agree that "helping others" is an attitude reflecting an important ethical value. However, people who decide to help others may have different motives. The reasons for choosing a helping profession are definitely not financial. In most cases, these professions are underpaid in this country. The decision itself may be based on the noble idea that helping those in need is important and right. The hidden motives, though, may be the desire for power, need for gratitude, compensation for inferiority complexes, need for tackling one's own unresolved problems etc. The motives are usually mixed and one may even be unaware of them. Understanding one's own motives in therapy is one of the aims of a psychotherapist's personal therapy and a frequent goal of supervision interventions.

Together with tendencies to create the profession of a "psychotherapist" and to pass a "psychotherapy act" seen in the last 20 years throughout the world and mainly in Europe, psychotherapy organizations have produced "ethics codes" and "ethics committee terms of reference" in order to promote ethical practice and punish its violation, for instance the Statement of Ethical Principles of the European Association for Psychotherapy (EAP 2002) or the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA 2002). The basic principles such as beneficence, honesty, justice and respect for all people apply to psychologists, psychotherapists and supervisors alike. Creating codes of ethics partly reflects the realization that psychotherapy is a powerful therapeutic tool altering human thinking, attitudes and emotion that may be both beneficial and harmful, but also a political effort through which therapists seek visibility and recognition to see that their work has social impacts. However, what supervisees need to see from their supervisors and learn is the real integration of ethics and laws into practice in a particular client. This approach strengthens internalization of ethical principles in supervisees more than any lectures or preaching (Koocher *et al.* 2008). Thus, rather than giving answers, ethical reasoning in psychotherapy teaches therapists how to ask questions in particular situations.

PSYCHOTHERAPY AND AUTONOMY

An important aspect of therapy is striving for clients' autonomy. To help with developing an autonomous mature individual is one of the most frequently quoted goals of psychotherapy (Rogers & Dymond 1954, Holmes & Adshead 2009). However, this goal is only rarely thought of by clients seeking therapy. Rather, they suffer from depression, anxiety, dissatisfaction with their lives and relationship problems. Their concern is to be helped by their therapists, not taught how to be autonomous. Primarily, they want to get rid of negative experiences and the fact that they should "mature" seems rather degrading to them (that is why the therapists do not tell them although they often think that). The clients prefer advice and instructions on what to do in their life situation; they usually do not think that they should seek their way to independence and autonomy. These results in a strange paradox – the clients themselves, freely, demand to be helped; the therapists respond to their demands by telling them to learn to help themselves.

Therapeutic relationships are based on clients' feeling secure. Well-established therapeutic relationships provide the patients with the so-called atmosphere of a secure risk. This means a space where many otherwise unacceptable things are possible. The patients do not have to fear the impacts of their thoughts on their lives and may try new behaviors, attitudes, etc. in an environment where being unsuccessful does not mean failure. Therapists work on establishing good therapeutic relationships since their first encounters with their clients. They take on a role of an expert both offering help but clearly defining cooperation. These are well-known truths of most psychotherapy schools of thought. However, clients' freedom is often illusory. The clients seeking therapy are often in a mental condition that makes free choice impossible; their choices are determined by their frustration, anxiety or helplessness. They often struggle with defining their problems and goals, requiring significant help with formulations from their therapists. Therapists aim at helping patients specify their problems as much as possible but the formulations themselves are often beyond the stressed clients' capabilities. May such problems and therapeutic goals be considered autonomous enough? To what extent are they indoctrinated with therapists' own views, conscious or unconscious wishes and needs? Therapists offer treatment strategies and steps that patients usually know very little about in advance. Rather than autonomy, trust in their therapists is important. Clients frequently know little or nothing about alternative approaches to therapy. Ethically-oriented therapists should provide them with adequate and unbiased information. Unlike in somatic medicine where the instrumental and expressive components of therapy may be separated and, for instance, a good surgeon may not necessarily be an empathetic, honest, supportive and congruent person to successfully perform surgery, it is very difficult or maybe impossible to separate the two components in psychotherapy (Gabbard 2009). Moreover, since psychotherapy requires mutual cooperation, the result depends on their mutual liking, willingness

and ability to cooperate, will and other relationship characteristics. Similarly, in the process of – especially long-term – therapy, crisis may occur in the therapeutic relationship (Holmes & Adshead 2009). To a certain extent, the character of the crisis may be predicted from the initial examination; however, these estimates are far from preventing the crisis. The initial sessions may show that the client-therapist relationship is impossible due to their personal incompatibility. The client may have paid for several sessions only to learn now that there is no use to continue. Therefore, many therapists separate the evaluation process from therapy (Mace 1995). Another option is to establish informed agreement for a few initial sessions in advance and, if it is apparent that therapy will not work, to discuss it openly together. If the client decides to discontinue the therapy no ethical problem arises; there is a problem, however, if the therapist decides to end the treatment that the client cares for. How to explain this to the client without causing iatrogenic damage?

A conflict similar to the above stems from the natural dichotomy of security – autonomy. A child's natural instinct to seek the close proximity of certain people and to feel more secure when having them around is called attachment. This instinct has been shown to exist in various animal species. Thus, attachment means both human and animal babies' tendency to seek certain individuals and feel more secure in their proximity (Bowlby 1977). Both a need for autonomy and a need for a close bond are very likely to be inborn in humans as a species, being manifested from childhood to old age. If the need for a close bond and attachment prevail in a client, may his or her choices and steps be considered autonomous? These are questions to be asked by an ethically-oriented therapist. The answers aim at as little interference with the client's process of choice as possible. The therapist's goal is to create a space that is safe enough to allow for as autonomous decisions made by the client as possible. Anytime we meet someone, we have certain thoughts and emotions elicited by that person, and vice versa. Similar thoughts and emotions have occurred in all similar relationships. This is referred to as transference or countertransference, the latter being from a therapist to a client or from a supervisor to a supervisee (Praško & Vyskočilová 2010). Both psychotherapy and supervision aim at understanding both sides and including this understanding in what they do together. If we do that, we do not think only about the others but also about ourselves and our participation in the relationship. This is called self-reflection in therapy.

PSYCHOTHERAPY AND BENEFICENCE

The principle of beneficence means an obligation to do good to clients. In the past, psychotherapy was frequently criticized for being little effective and thus of little benefit to clients. Another criticism was that

changes in attitudes as well as insight and understanding aimed at by psychotherapy are far from leading to disappearance of depressing symptoms. But studies have shown that psychotherapy is effective, being the most effective tool for help in certain conditions such as anxiety disorders, personality disorders, obsessive-compulsive disorder, hypochondriasis, substance abuse or eating disorders (Gould *et al.* 1995, Taylor 1996, Barlow *et al.* 1998, Sousa *et al.* 2006, Gava *et al.* 2007). As is the case with other therapeutic methods, however, psychotherapy must be indicated and performed so that it is beneficial to a particular patient (Praško *et al.* 2007). Some therapies may be more effective in certain problems and others may be more effective in different ones; some approaches may even be contraindicated in some problems (Roth & Fonagy 1996). The question is how ethical prolonged psychodynamic therapy is in patients with severe manifestations of obsessive-compulsive disorder, in the view of the fact that only cognitive behavioral therapy has been proven effective. Similarly, exposure to childhood traumas is likely to be a useless burden in a patient unable to adjust to a new job.

The basic requirement for a therapist is to be empathetic, warm and sincere during psychotherapy (Rogers 1967, Patterson 1984). This usually helps clients feel better immediately after sessions. In most schools of thoughts, the theory of psychotherapy assumes that such behavior of therapists is the basic tool for therapeutic change. There is usually no ethical conflict present unless the therapist naively promises unattainable goals or suggests that what is said during therapeutic sessions is sufficient for achieving change. On the other hand, some steps in psychotherapy apparently cause significant stress and in many cases, progress is impossible without stress (e.g. in exposure therapy, patients with phobia must be exposed to phobic stimuli to habituate to them gradually). Also when discussing severe childhood trauma or dealing with complicated sadness, it is practically impossible to avoid the fact that temporarily, clients feel worse or even very badly no matter how much therapists try to facilitate their processing of painful experiences. This is similar to the situation when, following orthopedic surgery, rather painful rehabilitation is necessary to recover the function of a limb. But do therapists have the right to induce painful emotions in their patients even after informing them in advance? Patients usually have no idea of how painful his experiences will be when discussing a traumatic topic. On the other hand, is it ethical not to do that if there is no other option to help patients in the long term?

A serious ethical question is whether patients may be treated using methods the effectiveness of which is not empirically evidenced (Holmes & Adshead 2009). The abilities to consider research data, expert opinions and convictions of one's own school of thoughts, to step back and to be unprejudiced – these all are compli-

cated ethical dilemmas. Problems may stem from being blinded by one's own approach and having an implicit faith that the approach may help despite research evidence showing the opposite. In severe depression, for example, electroconvulsive therapy is most effective, followed by pharmacotherapy, with psychotherapy having only a supportive role. Inadequate knowledge of the diagnostic process, unawareness of the evidence of effectiveness or absolute faith that the approach is omnipotent are serious ethical problems, often related to therapists' immaturity. This is where the ethical principle of beneficence is on the borderline with harm to the client.

PSYCHOTHERAPY AND NON-MALEFICENCE

"Primum non nocere" is a traditional medical approach. As other therapeutic methods, however, psychotherapy, if incorrectly indicated or performed, may be harmful. There are also adverse (side) effects of psychotherapy that cannot be fully estimated in advance (for instance, psychotherapy may lead to the patient's divorce). These have to be monitored and dealt with, similar to side effects in medical treatment. A serious ethical problem is when therapists leave their clients in the lurch even though, in fact, the therapists made the clients take the decisive step. Psychotherapists try not to give advice and lead clients to take full responsibility for their behavior which is essentially correct. However, the way they ask questions and things they stress or miss in the dialogue, including their non-verbal communication, may significantly influence clients' decision-making on important life issues. In these cases, the "it is up to you" approach is a concession, not an ethical act.

Patients with many mental disorders (as well as somatic diseases) may be characterized by impaired interpersonal relationships and a rigid non-adaptive system of erroneous assumptions about others. This makes cooperation more difficult but at the same time, it provides us with valuable information about the world of patients' relationships – their previous negative experiences are generalized to all people and authorities, including therapists. his is referred to as transference (Praško *et al.* 2010a,b). Therapists' task is not to take on roles into which they are sometimes manipulated by their clients but to behave authentically and yet understand some of their inadequate actions. In good psychotherapy practice, the most arduous task is to *avoid complementary behavior*, for example by not reacting to patients' aggression with counteraggression, not granting concessions to excessively loyal patients, etc. Such complementary behavior is usually dictated by countertransference (Praško & Vyskočilová 2010).

Potential harm in psychotherapy less frequently poses a direct threat to one's physical health but it may stem from an abused relationship, either consciously or unconsciously (Adshead 2004). This danger is always present if in the relationship, one of the partners is dependent on the other one, which is not uncommon in psychotherapy. To exploit someone means to use the person to achieve one's own goals rather that the other person's goals (as central to Kant's moral principle). Although for most of time, the majority of people behave in a trustworthy manner, in certain situations, many of them are able to cheat, lie, steal, use sexually, be unfaithful, hurt and damage others, just to achieve their own goals. Interpersonal exchange, without abusing others, is regulated by the rules of reciprocity, creating a sense of fairness and being explicitly formulated by laws. Many patients who seek psychotherapy were abused in their childhood or adulthood, becoming sexual objects or objects of their parents' narcissism. Their own needs were ignored, overlooked or turned against them. They have learned to live the roles of victims; for little gratification, they are willing to continue being abused, considering abuse a social norm. Similarly, some therapists were maltreated in their childhood, which they supercompensate by finding a job where they can help others, with various degrees of success (Holmes & Adshead 2009). The therapeutic relationship is based on trust – in both an individual and the organization. Together with an atmosphere of openness, intimacy and truthfulness, trust produces a milieu resembling the most confidential relationships. In the relationship, patients are often vulnerable and open, often disclosing things they have never told anyone and even have not admitted to themselves. Therefore, it may become a means of deep transformation as well as, unfortunately, abuse for the therapist's needs, especially if the patients is dependent on the therapist. Patients may be abused for boosting one's self-confidence, economic or sexual reasons (Gabbard 2009).

Patients may be harmed by therapists' silence, criticism or refusal that are not the aim of patients' change but the need for therapists' gratification (Adshead 2004). In particular insecure, anxious or extremely self-critical therapists easily get into a position allowing them to perceive patients as worse and themselves as better. This process is usually unconscious; however, it may maintain patients' feelings of failure, nonacceptance and misunderstanding. It is even more treacherous if patients feel accepted at the beginning of therapy, having confidence in their therapists who by contrast gain power over them. Gradually, the process of abuse is revealed, with criticism, harsh confrontations, reproaches, refusal, pouring out emotions to patients, etc. Patients are extremely vulnerable because of everything they confide. Thus, therapy may slowly turn into abuse that none of the participants may be aware of. This process of emotional abuse in therapy is very similar to the process of emotional abuse in the family. Patients who were abused in childhood are able to withstand such non-therapy for years. Both therapists and patients, in complementary roles, repeat their unresolved relationship problems from the past.

ETHICS AND RELATIONSHIP BOUNDARIES

Psychotherapists' ethical obligation is to maintain clear therapeutic boundaries. Since the 1990s, when studies about sexual abuse of patients were published, most professional codes have considered a violation of these boundaries as professional failure. In Canada and some of the US states, this is even considered a crime (Holmes & Adshead 2009). Sexual abuse in medicine, psychiatry and psychotherapy is a relatively common problem. As seen from studies, it may appear in 1–12% of male therapists and 0–3.1% of female therapists (Holroyd & Brodsky 1977, Pope *et al.* 1979, Pope *et al.* 1986, Akamatsu 1988, Gechtman 1989, Borys & Pope 1989). Therapists' sexual contacts with clients are unethical for several reasons. From the very beginning, the relationships are unequal because therapists have at least the advantage that their clients come for help, share their problems and are less able to understand what is happening in the relationship, while therapists are professionals who were trained to understand relationships and their activities are paid. Thus, therapists fail to provide service they have been contracted for. The main problem, however, is that therapists put their needs above the needs of their patients. Gabbard (1994, 2009) classified therapists sexually abusing their clients into four subtypes:

Psychotic disorders: Psychotherapists very rarely sexually abuse their patients as a result of their psychotic disorder. However, cases have been reported of psychotherapists who, in their manic episode, believed that they could cure their patients through sexual relations and made the idea real.

Predatory psychopathy and paraphilias: These therapists often suffer from antisocial personality disorders or severe narcissistic personality disorders. These mentally disturbed individuals abuse their power over patients without feeling guilty. Their problems stem from a severely compromised superego as manifested by other antisocial activities such as fraud or corruption in other spheres of life. This category also involves persons suffering from paraphilia who make their clients victims of their sexual urges.

Lovesickness: This category comprises several diagnostic subgroups. These therapists fall in love with their patients. They are neurotically oriented individuals, often with mild narcissistic features, or persons experiencing a personal or professional crisis. This category involves most female therapists abusing their male patients. They usually need to be loved and idealized by their patients to have their self-esteem strengthened. Frequently, specific ego functions are impaired, such as judgment, manifested by inability to anticipate consequences of one's actions, and reality testing. These therapists are often naive and inexperienced, not understanding their countertransference, with decreased ability of self-reflection. Female therapists often fall in love with clients with dissocial or narcissistic personality disorders or those who have developed substance abuse, hoping that their love will save them. Unlike predatory psychopaths usually having many victims, most cases in this category are characterized by a single failure which tends to be painful.

Masochistic surrender: These therapists take pride in treating "difficult" or "impossible" patients. In established therapeutic relationships they tend to repeat similar relationships from the past in which they were intimidated and abused by dominant partners they have met in the role of patients. Frequently, they resemble their dominant parents. They tend to sacrifice for their clients, save them from suicide, financial crisis, etc. In a typical scenario, they rapidly stop charging their clients, tolerate their irregular visits or night phone calls and give in to their demands. Gradually, the boundaries are no longer recognized and sexual contacts occur. Finally, the relationship gets to the point when dominant clients start to abuse them.

The situation may be ethically more difficult if the sexual relationship takes place after the end of treatment. In some organizations, such as the American Psychiatric Association, sexual contacts with any former patients are considered unethical. Other associations such as the American Psychological Association consider such contacts to be unethical if held less than two years after treatment. Some are convinced that when the relationship ends up in a marriage, it is difficult to talk about abuse (Appelbaum and Jorgenson 1991), but for others, marriage does not preclude abuse, also showing that transference works even years after the end of therapy (Celenza 2007).

Other types of patient abuse and boundary crossing or interference may include abuse of patient's trust or information, economic or political abuse, or abuse of relationship to pursue one's own interests. Financial abuse can happen very easily in numerous ways known from common business. Patients may be charged different amounts for their sessions. As in the market, sometimes the fees are exorbitant even if the therapist is much in demand. In such cases, however, clients know the conditions from the very beginning. But other approaches may be ethically flawed, for instance increasing the fees in the course of therapy or prolonging the duration of therapy on various pretexts (Holmes & Adshead 2009). Similarly, an improper trick is to entice the patient with short-term therapy although the problem apparently requires long-term work and to reveal later that prolongation is necessary. The client, used to a particular therapist, is unlikely to look for another one.

Therapists are also under pressure to earn enough money. Yet there are few rich clients and many poor ones. This makes some therapists turn to "Robin Hood strategy", robbing from the rich and support the poor by charging them less. It is up to everybody to conclude whether this approach is ethical. It definitely compromises the ethical maxim as working with a rich client

is hardly ever more demanding than working with a poorer one and, logically, the charges should be identical. Otherwise, rich clients are abused through fictitious "deductibles", similar to those used by health and social insurance systems. Such a policy should also be reflected from the perspective of transference and countertransference, as these are modified by higher charges. VIP clients are treated differently than others and also require a different, more privileged approach for their money, which is harmful to the process of therapeutic change. Confrontation with negative aspects of their behavior is more difficult, sometimes even impossible. Instead of an equal relationship, therapists become "paid servants". Thus, therapists may tend to classify some clients as more attractive based on their charges, appeal or prestige. This significantly modifies the treatment process.

One of the most common types of boundary crossing may be disclosing personal information by therapists (Gutheil & Gabbard 2003). Self-disclosure may have a positive effect if it moves the therapeutic process forward. On the other hand, it may be the first unconscious step towards turning therapeutic relationship into therapist abuse (Adshead 2004). Therapists may solve their personal problems by disclosing them to their clients. Initially, clients may feel more useful and self-confident. However, they are deprived of their own process which, in fact, is blocked.

PSYCHOTHERAPY AND JUSTICE

Effectiveness and price may be important ethical issues in therapy. If long-term therapy is provided to a client in whom a short-term approach would be sufficient, or if therapy has no effect and a client needs a different approach but the therapist continues treatment not to lose income, it is a serious ethical problem even if the therapist rationalizes the necessity for long-term therapy using theories of his or her psychotherapeutic school of thought (Adshead 2004). Even more sorry and ethically flawed is not referring a client to another therapist who would be more helpful, just for competitive or political reasons. Similarly, not prescribing medication to a client if there is an obviously marked risk or suffering stemming from the non-prescription is ethically problematic.

ETHICS AND SUPERVISION

Neither psychotherapy training nor experiences alone are sufficient as without continuous supervision and evaluation, the original mistakes may be reinforced by constant repetition (Yalom & Leszcz 2007, Gilbert & Leahy 2007). Humans simply cannot see some of their behavioral patterns. The most typical example is countertransference (Praško *et al.* 2010, Praško & Vyskočilová 2010). Today, a psychologist, psychotherapist or supervisor alone cannot fully perceive the

entire reality and understand it completely. The way we understand each other contains the way we have adopted the surrounding social and physical environment and its tension and made it a part of ourselves. As a results, conflicts reappear as one's own conflicts, being determined not only by personal but also others' conflict moments. These are difficult to perceive and understand for a single individual. One may get a better attitude when talking about them with others, trying to open up and discovering how to understand oneself and the world today. That is why supervision is so important (Falender and Shafranske 2008).

SELF-REFLECTION AND ETHICAL QUESTIONS

Ancient philosophers underlined the importance of self-knowledge. "Know who you are, and be it" is a direct appeal for self-reflection and maturation. Conscious understanding of one's own emotions, feelings, thoughts or attitudes at the time of their occurrence, and the ability to monitor them and realize them continuously are among the most important abilities of therapists and supervisors. Boud *et al.* (1985) consider self-reflection an intellectual and affective activity that individuals use to explore their experience in order to understand and appreciate them better. Socrates' recommendation "Know thyself" is very likely related to this basic premise of life wisdom – constant awareness of one's own feelings and openness to them. Self-realization may also be characterized as impartial, non-judging attention aimed at our internal states (Goleman 1995). Thinking about oneself and one's own bond with the world is the starting point for the attitude of searching leading to self-reflection. Self-reflection is one of the basic psychotherapist competencies (Kaslow *et al.* 2008, Praško *et al.* 2012b). Self-reflection may also open us to others, especially if we are able to express it (Shafranske & Falender 2008). It gives us an opportunity to disclose our internal reactions to others, enabling open sharing. Self-reflection means that an individual is usually not interested in oneself only as it almost always comprises interactions with others. If we are able to open that, others perceive it as care for them.

Developing reflectivity is extremely important as studies have shown that 60% of clinical psychologists continue their work even when too distressed to be effective (Pope *et al.* 1987). Training clinicians to prioritize attention to their emotions and self-reflection will likely improve their ability to recognize their personal distress and prevent the negative impact on their clients' well-being (Vasquez 1992). Conscious self-reflection contains especially three aspects: (a) self-concept; (b) self-evaluation as both a process and its results; and (c) observable behavior, or external manifestation of "I" (Hupková 2010). This type of attention impartially adopts everything passing through consciousness, as an alert observer. Self-reflection is not attention con-

trolled by emotions which in turn controls one's acts; by contrast, it is attention maintaining a neutral attitude of an "observer" able to maintain self-reflection despite one's turbulent feelings (Hoffart *et al.* 2006). Realizing one's own thought and attitude processes is referred to as meta-cognition; realizing one's own emotional processes is termed meta-mood (Wells 1997).

Self-reflection training is particularly important for beginner therapists as this skill helps to develop critical thinking and ethical decision-making (Gardner 1980, Sofaer 1995). Here is how an ethical view is disclosed during supervision:

Radek: I do not think anything can be done about the patient. She has a personality disorder. She has destroyed her family. One of her children is in a children's home. Anyone trying to take pity on her and being nice to her bitterly regretted doing so.

Supervisor: I understand, you do not feel she could be helped. She seems to destroy any place she walks into. Can this be understood? Why is she doing that? What has happened in her life?

Radek: Well, her childhood was not very good. But the same is true for many people. This is not a reason for her to destroy what is around her. From the very beginning, she has had conflicts at the ward, both with fellow patients and nurses. I think she is full of anger.

Supervisor: You may be right if that is how she is behaving. I am just thinking about what has happened to her, why she is so hostile.

Radek: Well, I do not know exactly why. She would be criticized a lot by her mother and her father was an alcoholic. But I do not know any details. Mainly, I have focused on what is happening here and now and I do not like that. I have neglected her childhood a bit. It is a shame. I really have no idea why she is the way she is. For some reason, I have not made a proper conceptualization. I think she annoys me. That's probably the main reason.

Supervisor: It sometimes happens that we are angry at patients or dislike them, preventing us from understanding them fully. But, Radek, I must say that I like your being honest and able to admit that.

Radek: You are right, I feel quite ashamed that I made an opinion on her based on the referral letter and on what she said about her husband... a preconception that she actually is evil. And I felt angry at her so I studied neither her childhood nor the causes. I just said that if my wife did to me what she did to her husband... I don't know... I would either leave her or have a nervous breakdown. So I got angry at her.

Supervisor: You seem to have projected a bit of yourself into her story. This is what sometimes happens. Do you think this somehow influences the way you understand her?

Radek: That's what I say, I completely missed her. It must be transference. I did not realize it at all. I will try to discuss her childhood with her thoroughly, looking at her without preconceptions and not projecting my own marriage into that.

Supervisor: You are amazing, I'll keep my fingers crossed for you. You have managed to admit that and stop rationalizing your attitude.

Self-reflection may be improved if we try not to suppress our emotions but to accept them (Greenberg 2007). Self-reflection cannot be achieved by an attitude in which we observe and categorize the ways of experiencing only at the level of thoughts as this means keeping distance from them without experiencing ourselves emotionally (Horowitz 1997). If we are unable to address our emotions as signalized by those around (or the supervisor) it is better to ask the following questions: do we know such feelings in a particular situation, when do similar feelings occur in our colleagues, how do they experience them, how do they evaluate them, how do they deal with them, what prevents me from having such feelings? Anxiety, sadness, helplessness and anger may help us better understand ourselves. If we suppress them, we tend to philosophize about the situation and resort to learned attitudes or accept what those around us claim (Kimmerling *et al.* 2000).

Self-reflection is constantly deepened through training and supervision. Therapists often using self-reflection in their work gradually improve their ability to self-reflect. Self-reflection is an important component of the growth of supervisees' clinical skills (Sutton *et al.* 2007). Therefore, it is important that supervisors strengthen supervisees' ability to self-reflect. Unfortunately, it is more common to see supervisors automatically turn their attention to technical components of therapy, trying to assess those and forgetting about the importance of supervisees' self-reflection. It is apparent, however, that if supervision does not pay enough attention to supervisees' self-reflection they may be trapped in not understanding their patients and therapy fails (Bernard & Goodyear 2004). Blocks in self-reflection inhibit understanding of countertransference phenomena and may limit the ability to establish good therapeutic relationships as therapists are unaware of their own role in them (Prasko *et al.* 2010a,b). All supervisees, irrespective of their training, may benefit from more focus on self-reflection (Orchowski *et al.* 2010).

CONCLUSION

Knowledge of ethical questions and related issues as well as continuous ethical self-reflection are essential components of high-quality psychotherapeutic management. This requires both good psychotherapy training and systematic supervision.

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