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ETHICS IN THERAPY: MOVING FROM THE MIND TO THE HEART

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Ethical practices in therapy have evolved in response to the dilemmas inherent in a field of practice that deals with the complexities of human interaction. Initially, ethics was established to guide practitioners, protect clients, safeguard the autonomy of professional workers, and enhance the status of the profession (Mappes, Robb, & Engels, 1985). Codes of ethics sought to establish both universal rules (principle ethics) and acts that involve the actual qualities of the professional (virtue ethics). The former asks the question, "What shall I do?" while the latter is concerned with, "Who shall I be?" (Huber, 1987, p. 4). This was an early recognition of the dual aspects of ethics, but it did not yet include the client's preferences or opinions.

Codes alone do not ensure good judgment and reasoning (Welfel & Lipsitz, 1984). The impact of the therapist's individual biases, experience, discipline, personality, and values profoundly influences the process of ethical decision-making (Keith-Spiegel & Koosher, 1985). Social Constructionist thought has elevated the role of the client in the decision-making process to an equal level with the therapist.

This paper will suggest that it is right and proper to include more room for the client's voice in negotiating what is or is not ethical. Lewis Thomas, a noted field biologist and author, will be used as an example of how an individual in a field of study loosely connected to our own was able to approximate a social constructionist stance in observing, categorizing, and understanding systems in an objective and subjective manner. This will serve as an example of how to move into the world of a system with both a strong code of ethical conduct and a gentle, more compassionate heart.

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THOMAS'S VISION: ETHICS OF HEART

The late Lewis Thomas was fascinated with the exploration and description of microorganisms, insects, mammals, and sea life. His writings marvel at their complex and beautiful ways of living with a kindness and wonder reminiscent of Gregory Bateson and Harry Goolishian. In one breath, he might be talking about the life of a germ, then compare it to the culture of a large city. Above all, he made room in his heart for the smallest of things: insects, bacteria, and so on, revealing a deep interest in including the voice of the observed in the observation:

> Termites are even more extraordinary in the way they seem to accumulate intelligence as they gather together. Two or three termites in a chamber will begin to pick up pellets and move them from place to place, but nothing comes of it: nothing is built. As more join in, they seem to reach a critical mass, a quorum, and the thinking begins. They place pellets atop pellets, then throw up columns and beautiful, curving, symmetrical arches, and the crystalline architecture of vaulted chambers is created. (Thomas, 1978, p. 13)

In this segment, Lewis is both a scientist and a poet. He moves deeper to capture the voice, desires, and subtle nuances of something as small as a termite even as he follows rules of scientific observation. His own ethical code allows for observation, imagination, subjective speculation, and elevating the voice of the organism. Observations are interwoven with kindness, humor, and childlike curiosity. What if this were more a part of our field's description of virtue ethics?

Webster defines ethics as "standards of conduct and moral judgment . . . of a particular philosophy, religion, or group." (Webster, 1999). In the field of mental health, it has come to mean the basic rules of therapy; those that involve what we should not do with and to our clients. Codes of ethics are meant to protect against certain risks inherent in therapy, establish a climate of basic justice, and ensure the autonomy of the client. These ideas are reflected in rules of confidentiality and duty to warn. Harry Goolishian argued that, despite the importance of these rules, damage could be done in therapy and in psychiatric facilities even when each is followed to the letter. People can be misunderstood, labeled as "sick," or have their wishes ignored as the result of therapeutic interventions that follow the letter but not the spirit of good ethics (Goolishian, 1991). Ethics must not just guide what should and should not be done in therapy (content ethics), but rather be broadened to encompass our deepest intentions, beliefs, and aspirations as they pertain to the therapy relationship (process ethics). This requires that a therapist openly participate with the client in the creation of ideas that are benevolent, immediate, uncensored, and always elevate the wishes and ideas of the client (Ray & Swim, 1999).

Thomas beautifully illustrates the union of content and process ethics by demonstrating that we are always both participant and observer when seeking to

understand anything (Thomas, 1978, p. 67). He stands out as an example of what happens when ethics encompass both one's mind and one's heart.

RELATIONAL ETHICS

T. Andersen suggests that therapists learn and benefit the most from practical conversations with others and experiences with clients, rather than from training and theoretical readings, because the former occurs in a relationship (Andersen, 1997). When a conversation springs from mutual respect, intent interest, and the willingness to abandon the urge to favor one idea over another, amazing things can happen. This shift can occur when care is taken in building a relationship between therapist and client (Andersen, 1997); when we honor people where we find them (Hoffman, 1991), and when we make space for as many ideas as possible (Anderson & Goolishian, 1988). These beliefs are at the core of process ethics.

H. Anderson has said that the goal of therapy is to "help" someone (Anderson, 1999), and yet I believe many models supercede this goal with an overemphasis on describing and understanding underlying pathology. Attention is paid to content ethics, but this is not sufficient. It is not humane. Process ethics embraces the proficiency-based philosophy and a respect for the voice of the client espoused by post-modern thought (Goolishian, 1991, Hoffman, 1991).

As a supervisor, I notice that students often seem to dilute their sense of humanity and intuition when learning the techniques of a given model. Instead of being encouraged to emphasize compassion and immediacy with the client, they become preoccupied with an idea or potential direction, and the client's pain is not adequately "heard." It is my opinion that this kind of therapy covers "mandatory ethics" but fails to go further into "aspirational ethics" (Corey, Corey, & Callanan, 1993, p. 5). Like Thomas, we must go inside the termite hill and be immersed in what we see as both participant and observer. Instead of asking, "What is the problem, what must change, and what is the goal?," one should ask: "How would I want to be treated right now, if I were they?" The following cases will demonstrate three principles that embody process ethics while honoring current ethical codes of conduct.

OPENHEARTEDNESS

Openheartedness results when there is a conscientious forfeiting of the belief that we are different from our clients. Instead of using a therapy model or technique to control or choreograph an interview, the therapist steps into the other person's world. Openheartedness does not mean there is no direction in therapy, but rather that defining and categorizing problems must never precede a kind, uncensored human connection.

Stepping into Another's World: Lucinda and I Learn about Each Other

Lucinda sat upright on the edge of her seat in my waiting room. She told me that she was looking for a new therapist. In previous sessions, she had been told she was codependent and needed to address her lack of boundaries with others because she frequently let her family take advantage of her. Thus far, she had been unsuccessful. She was frequently overwhelmed and sometimes suicidal. She further explained that the therapist was often late for session, and Lucinda felt this was rude. Her immediate demeanor seemed confrontational and difficult.

While considering all this, I felt that momentary red flag that forewarns a tough case. In response, I could either put up my own guard (accept the label that she would be difficult), or adopt a more open response to her. It was evident that she had brought these problems up because she wanted to be sure I was the right person to help her and that she wished to be more of an informed consumer.

I worried (out loud) that I might also be late occasionally, since one of my three kids is frequently creating an emergency just as I am getting ready for work. I wanted to make sure, in case I was a little late, that she understood that it was not intentional. When asked if she was okay with this, she gave a warm laugh and seemed to relax. "How many kids do you have?" she asked. "Three," I replied, "but they can seem like thirty."

For a moment, we discussed how hard it is to raise kids and work—the normal kind of conversation that could happen between two mothers. My decision to self-disclose so early is not accidental, but happens spontaneously when a stance of open-heartedness is assumed. It is a natural outcome of refusing to adopt the philosophy that therapists must guard themselves from being too familiar with clients. In this stance, it is neither comfortable nor natural to hold back honest feelings, even in the earliest moments of contact. The less of myself I bring to the conversation, the less the connection. These early moments of being human can clear the way for the mutual creation of process ethics by establishing a code of openness and immediacy.

She was glad that I was honest about my kids and that I recognized the commitment one has to her family often leads to doing things one otherwise might not do (like be late or seem "codependent"). In our first meeting, I asked her to tell me about her life. I listened with my whole self (which means carefully, slowly, and with an open mind). "Anyone will become weak," she explained, "when love is lost." If she had wanted to discuss "co-dependency," that would have been okay, but on this day, this was not how her story unfolded. She said that when she got married, it had been forever. Then when she adopted her alcoholic sister's abandoned five-year-old daughter, it was with the utmost hope that she could save her. Through a complicated set of circumstances, the marriage began to fail and her (now) teenaged daughter's behavior began to get out of control. Her husband left her for another woman and her daughter twice became pregnant. She bailed them out and repeatedly forgave. She described herself as a real "sucker," and said it

was "not in her" to give up on them. Her therapist was clearly tired of her weakness too, and advised that she divorce the husband and stop bailing out the daughter by sending her money. Lucinda felt too weak to comply.

As we talked, my intention to believe in her lead me not toward her weakness (we already knew that part of her story), but instead toward her tenacity and unbending sense of commitment. This was *not* just a positive reframe. I did not construct it, and then weave it back into the conversation. I felt it honestly and wholeheartedly because it came from my intention to see the good in her. Others had scolded her for being so weak, but in exploring her motivations in an openhearted manner, it became clear that she took life-long commitment seriously. This was an admirable quality. As I shared these observations with her, the conversation began to move toward understandings that explored both her weaknesses and her tenacity, willfulness, and foolhardy (yet wonderful) optimism. Our conversation did not move rapidly toward a goal, but took many detours into her philosophy of life, religion, and family. Under her direction, we discovered that she felt ordained to be a nurturer—someone with a calling to help others. This resonated with her as we talked. As she talked about her hero, Mother Theresa, and how poignant her life story and accomplishments had been, there was an electric energy in the room.

Thomas observes that when organisms (read: people) communicate and connect ideas and finally reach a critical mass, a serge of energy occurs, and real thinking begins (Thomas, 1978, pp.11–13). In therapy, when a pivotal theme emerges in an immediate and spontaneous way, sudden and dramatic shifts in understanding can occur with a noticeable burst that is experienced by all involved.

She began to embrace this new understanding of having a calling to help others as a worthy rather than shameful trait. However, the dilemma of her own pain remained. I asked why she could not take her other therapist's advice and try something different with her estranged husband and daughter. I decided to ask because it had been on my mind and I did not want to hold back those ideas with which she might not agree. She surprised me by saying, "It's not quite time to stop trying." When I asked why now was not the right time, she replied, "If I gave up on love that easily, it wouldn't be real love, would it?" This made sense to me because I was now a part of her world of understanding. It became incumbent on the two of us to explore ways to nurture and hope without burning out. She did finally divorce her husband "when she knew it was time," but still sends her daughter money. In the end, she decided it was not time to give up on her child.

Openheartedness helped establish process ethics by (1) using early self-disclosure to establish immediacy and warmth, (2) enthusiastically considering that there were honorable reasons for her to behave in the manner she had described, and (3) suspending the need to fix the problem.

I called to check in after writing this and she said she was still supporting her daughter and was now involved in a volunteer program holding and rocking HIV and AIDS babies for a local hospital. She had found this project on her own and at last had evolved a meaningful purpose for her nature.

IDENTIFICATION

As ideas and meanings unfold, by the act of being completely present with the client, a sense of increased identification develops. Thoughts often move to one's own life experiences in a more animated way. There is a strong sense of knowing what it must feel like to be in a client's shoes. Identification marries empathy with immediacy and willingness to feel. One may become incensed, choked with grief, or overwhelmed as stories are shared. Everyone's voice is heard, boundaries of helping are fluid, and each person becomes completely a part of what is created.

There are several refreshing discoveries that frequently result. First, sessions are rarely boring. As common ground is found, barriers brought on by training and personal prejudices are chipped away. Ideas are shared in an undiluted manner, filtered only by beliefs that are local (such as those defined between oneself and the client) as opposed to those filtered through various models of therapy. Differing perspectives occur, but there are fewer circumstances under which consensus cannot be found. Rather than seeking to simply describe or analogue their "world," there is total immersion in it.

Another effect of assuming this position is that the therapist's agenda (such as the urge to fix the problem or the need for a single goal) diminishes. While there is much collaboration around exploring ideas in a multipartial manner (Anderson & Goolishian, 1988), emphasis on colonizing preferred ideas is minimized.

Finding Common Ground: Tim Finds Healing through Atonement

Tim came on his own to the counseling center where he was to be seen by me and a team of five practicum students. At 28 years old, he was unemployed and living with his father because he had lost several jobs in the past three years. On the phone, he said he had to do something about his anger because it was "destroying his life." In session, he sat, legs apart, hands clasped tightly, and head bowed low that first day.

In pre-session, someone said they were worried because his intake indicated a history of violence. They worried that we might not be the best place for him to seek help; that our backgrounds might be too different. Tim agreed to a team meeting after hearing that the purpose of the team was to generate as many ideas as possible and also give students hands-on training. He liked the idea that he could help someone become a better therapist.

Tim was a streetwise young man, very intense and shy. He said he was the black sheep in his family because he had been singled out for severe spankings by his father and had difficulties due to dyslexia. Tim had been in gangs and had a long, violent history. He admitted (with difficulty) that he had done many

things that were very wrong and for which he felt ashamed. He confessed that he had beaten his mother and father, tried to kill rival gang members, and systematically failed every job anyone was able to get for him. Tim told us that he wanted therapy to resolve, once and for all, his uncontrollable temper that was so damaging to everyone around him. He warned us several times that while he detested his inability to control his anger, once incited, the victim of his rage was no longer human in his eyes and he lost all sense of reason and compassion. Even someone whom he loved, like his parents, would be his target. He said he was terribly ashamed of himself and wanted to make amends to the people he had hurt. This was all that kept him going.

Identification requires actively looking for common ground even when differences seem insurmountable. The team could only overcome their fear and thus achieve real immediacy and connection with Tim if they felt both identification and openheartedness. The presence of this tension was palpable in the room as we began to share our thoughts and impressions with Tim.

When an awkward silence ensued, I brought out the suggestion that Tim's story was poignant and scary. I fancied that this was one of the most difficult cases most of these young therapists had ever heard. A reminder was given that Tim deserved candor and frankness. Tim eagerly agreed and asked the team to tell him what they thought. The ideas that were shared were spontaneous and emotional but not particularly clinical in nature. Some commented on their sadness and concern for his parents, others asked questions about his anger and what he had tried to do to control it. One student said that Tim reminded her of a good friend in high school who had made so many wrong choices that he was now totally alone. We all agreed that his story made us want to make amends to others we had ever hurt. I told him I hoped that his having shame was a sign that his conscience was still alive and salvageable.

Tim had kept his word and had considered our ideas. At our next meeting, he began the session by saying he appreciated our ideas but warned us that his anger was not romantic or far removed. It was real and ever present. He was worried that we could not completely understand what this was like for him, since we were so different. He said that he had realized, after we talked last time, that he did have a conscience, even when he was totally out of control with rage. Deep down, he knew he was doing something wrong, and that he would need to atone for what he was doing. This realization caused him hope and frustration. He brought up the analogy of killers not being able to look into the eyes of their victims, lest they weaken in their resolve to commit the act. He also began to talk about his relationship with his only brother, two years younger, who was a doctor. He said he loved him fiercely, and would do anything to see that his life is happy. He had protected him growing up, and had taken additional punishment from his father gladly in order to keep his brother safe. He seemed to take real pleasure in his brother's accomplishments. He was

beginning to see himself as a person capable of love and conscience. As the team wondered out loud what his first step toward change might be, he replied immediately, "to be able to look into the eyes of the people I hurt."

Reflections from the team were quite familiar and personal. (This is often the case when identification is occurring.) One person commented that they wanted to meet his little brother. Another person shared what it was like to apologize to her parents for something she did years back, and Tim listened carefully as she shared her experience. Lastly, the student who had said that Tim reminded her of a friend in high school, commented that this was no longer so. Tim was trying to change, and her old school friend would never have the strength of character to do that.

It is evident that these conversations do not look like therapy. Conversations center not just on Tim and his "problem," but also on a process of self-disclosure, puzzling over human weakness, and a mutual exchange of meaning. There was a goal. We were there to connect, understand, give our ideas, and identify with him. What is difficult to convey is the kindness and mutual respect that flowed back and forth between Tim and us. He was immensely patient and polite, and we stayed fully connected with him, even when some of what he said was hard to hear. The team began to identify so much with his story that it dominated our discussions after he left. The thrust of therapy gradually shifted, through the ebb and flow of our conversation, from a theme of controlling anger toward a theme of atonement.

Four sessions later, Tim was in a different place. He had not had any angry outbursts since the day he announced he planned to "look into the eyes of his victims." He was settling into a job with moderate success and felt he was beginning to atone for his mistakes. He had identified strongly with something he had read about Vietnam Vets and how they are always "combat ready" and able to detach from their enemies in order to fight and kill. This detachment from conscience could last long after they returned to the U.S. He said he had decided it was like that for him. The key to controlling his anger was simply to force himself to see that the other person was a human being (to reattach). Once he acknowledged this, it was impossible for him to stay so mad. At follow-up, Tim said that he was doing very well. He was working and in school, but his greatest pride came from knowing he had finally atoned for his mistakes and continued with life.

Identification in this case served to enhance process ethics by using the reflecting team format to (1) entertain different ideas simultaneously and (2) share immediate reactions and feelings of commonality.

RELATIONAL HONESTY

The final element of therapy that contributes to the creation of process ethics is relational honesty. As with openness and the willingness to identify, honesty is

an integral part of every conversation with clients. Relational honesty is the legitimate product of a genuine relationship between my client and myself. It develops gradually as meanings and understandings are explored. While the client continues to determine the overall direction of conversations, the therapist may become increasingly candid and uncensored. These ideas continue to be presented in a warm and immediate manner, but can be quite directive and appear less collaborative.

Ideas are powerful. I believe that ideas withheld intentionally because we have decided that the client does not need to know what we think is unethical. After all, it is our ideas and thoughts that we are being paid to share. It is what we build. When is it appropriate to be really direct and does this conflict with a not-knowing stance? Does offering ideas that exceed what has been introduced by the client constitute a dilution of self-agency? These are perhaps some of the most difficult questions to consider.

Relational honesty must spring forth from, and be a part of, a fully present, impartial exchange of ideas the client and myself have mutually created. As the professional, it is incumbent on me to be aware of and control my intentions, to see that as many ideas as possible emerge from conversations, work toward the imperative that the client's voice be heard above all others, and participate in a process that ensures that every idea be given full consideration.

Offering Uninvited Ideas: Meg Acquires a New Backbone

Meg was one of those people who seemed like she did not belong in therapy. She was very cheerful and attractive and a bright young mother of three. She was coming to therapy because she felt moments of being overwhelmed and the sense of being smothered by everyone around her, especially her husband and kids. She was a stay-at-home mom and loved being with her children. Despite her husband being terrific, she never felt quite close to him or satisfied in the marriage. She was sharp-witted and strong-willed, to the point where she admitted that she knew she kept her husband at a distance much of the time. Dread was a central theme in her life. She said she had been molested by her grandfather and felt she was constantly running from the subsequent pain. She physically shook as she told me how her mother ignored her pleas and made her stay all summer with her grandparents, and how incredible it seems to her now that no one saw what was happening. She described how he stalked and pursued her and how she finally fought back and made him stop when she was 15 years old by standing up to him.

She married her current husband when she was only 18 years old. The grandfather died two years later. She said that her marriage was very secure and she took great pride in being a stay-at-home mother who protected and nurtured her children in a way she was not, but that she wanted to stop feeling pursued by the memories and fears of her youth. I told her I was proud of her as a mother,

how she made sure her children were safe with her and that was a good first step. She admitted she was very protective and said she was also proud of picking someone as healthy and normal as her husband.

Despite the positive tenor of the first meeting, Meg was much worse when I next saw her. She said she had lost control during her five-year-old daughter's temper tantrum and had locked herself in the bathroom, yelling through the door to her husband and daughter that she wanted out; she wanted away from all of them. She realized how it reminded her of how she would lock herself in the bathroom anytime grandmother would leave for an errand, in hopes that grandfather would not find her. He always did. She said she knew the feelings of wanting to be gone were really about him, but this did not help. They seemed unstoppable. No amount of logic on her part or love and support from her husband seemed to help. She kept repeating that she did not want to hurt her kids. Maybe she should just leave them. I spent several sessions listening to her carefully as she tried to put her past in perspective and get back to being the person she wanted to be—a mother and wife. It was her deepest desire. Sometimes it takes more than listening, being completely present, understanding, and voicing ideas in a collaborative way. She needed something more from me. I spoke several times with her husband, continued to see them together and apart, and tried to work from her strengths. There were often stretches of several months when things would be fine, and I would not hear from her. Then suddenly she would call, in crisis, desperate and feeling an urgent need to leave. Initially, I did not try to talk her out of leaving, in fact I tried to stay focused on simply hearing her and helping her understand and make sense of her urge to leave. This was useful in that she became more confident that her instincts and intuitions were healthy and normal. She grew closer to her husband and seemed to be improving.

After several months of erratic shifts, she once again came in upset with her daughter, who she stated was pulling away from her. She said she knew she was pushing her daughter away, too, but she couldn't seem to stop herself. I was puzzled by this and told her so. I was troubled and terribly sad for her. She admitted to telling her daughter that she did not want to be a mom anymore. I expressed that I did not want her to hurt her child in this way, and yet I believed in her enough to know there had to be more to this that I could see. She disclosed that Marie (5) was now the same age she had been when Meg was first molested. She described how much they looked alike at that age and how innocent she was. She was pushing Marie away just as she felt her mother push her away. It was too hard to be close. Marie was responding with angry indignation and hurt, just as Meg had to her mother so many years ago. Their relationship had never been mended. "There is one crucial difference," I told her, "Marie hasn't really yet been hurt." I went on to tell her that I simply could not sit passively by being empathetic while she hurt her child in the way she had been hurt. I voiced my own dilemma. While I had total faith that eventually she would find her away out of these "woods," I could not give her permission to

her push Marie away. The stakes were too high. I assured her that I would not let her hurt Marie, and that this was not even a choice if she continued to work with me. Meg relaxed and gave a deep sigh. I could tell she was responding to my suddenly assuming a directive stance. We then shifted gears and began a discussion of how to deal with Marie. I took a leadership role in this conversation for the first time, with her expressed permission.

The decision to be so directive at that moment was based on my comfort level in our evolving relationship. She told me later that she had needed someone who would hold her to her own standards of conduct, someone who would give her a dose of backbone. Later, I asked her what she had done about Marie and she told me that she had decided the only thing she could do was the one thing no one ever did for her; she started snatching her up whenever a temper fit ensued, and cuddled her until it passed. She admitted she still occasionally had fantasies of running away, but she decided she could not indulge herself in them anymore. Her daughter was too important. It would have been easy, she admitted, to take the easy way out, but she knew her own values would not permit that she take that path.

Relational honesty furthered process ethics with Meg by (1) using honest reactions to underscore the existing complexities so they could be mutually explored and (2) assertively advancing Meg's own goals of therapy through gentle and honest confrontation.

CONCLUDING THOUGHTS

People come to therapy for as many different reasons as there are thumbprints. As a friend of mine has said, "We don't meet people on their best days." They come to us angry, sad, discouraged, and terribly vulnerable. Expanding current ethical codes of conduct to include a more personal, honest connection will make therapeutic conversations more potent. It is a move toward a philosophy of helping that acknowledges our unique ability to provide comfort and humanity as well as justice, beneficence, and autonomy.

In conclusion, Lewis Thomas again comes to mind. He might say that a therapist's intentions resemble the organism yeast. It is all around us; in everything we touch and smell and taste. It is in our bodies and in the air we breathe. Depending on one's intention, the yeast of conversation may bear fruit as bread (nourishing, satisfying, and fulfilling), or become pathologic (irritating, foreign, destructive). I know this is true of therapy. My own intention is absolutely critical to the creation of an environment that helps.

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