

ORIGINAL ARTICLE

# Ethical questions and dilemmas in psychotherapy

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## Abstract

**BACKGROUND:** The authors emphasize the importance of regular questioning of ethical dilemmas in psychotherapy, because of the special status of psychological treatment as a potentially hazardous field in practice, and because of substantial relationship between client and therapist with a thin border and potential use of power or abuse. Although professional codes indicate guidance on highest possible standards of function, they do not always give clear answers; hence, clinicians must be able to critically weigh up and understand these codes in relation to everyday practice.

**ETHICAL DILEMMAS IN PSYCHOTHERAPY:** There is no distinct answer to the various, complex and multilevel ethical questions that therapists may be exposed to during treatment of their clients. Such dilemmas are nuanced, contextual, dynamic, and highly complex. The most frequently cited ethical concerns in psychotherapy are related to professionalism, therapeutic boundaries and confidentiality. Beliefs and attitudes intermediate the relationship between legal arguments and rule-violating behavior and moral reasoning can predict rule-breaking behaviors directly as well as indirectly. Ethically oriented therapists serve the well-being of their clients above all other benefits or obligations. Principle-based medical ethics is a valuable tool for resolving ethical dilemmas in psychotherapy in that the therapeutic aspects of ethical dilemmas can be better expressed than in other methods. The main four principles of bioethics, i.e. autonomy, beneficence, non-maleficence and justice, may be adapted for ethics in psychotherapy. However, the context must be reflected because of exceptions in the use of this general concept. On the other side, a client in psychotherapy can be abused economically, sexually and emotionally. This process may be intentional as well as unintentional. Another important dilemma is the dual role in psychotherapy. This dilemma is linked to the tension between psychiatrists' obligations of beneficence towards their clients and conflicting obligations to the society, third parties, other health care colleagues or the continuation of knowledge in the field. The issue of confidentiality often causes ethical dilemmas for the psychotherapist. Since confidentiality is essential for clients to engage in therapy, it is important to protect psychotherapy notes. On the other hand, there is a difference between confidentiality and legal right; how, why and when it can be broken. And the reasons for doing so are not well understood by many therapists. Superficially, confidentiality might seem to be an elementary idea to apply in therapeutic practice. In fact, it is quite complex and filled with exceptions that frequently differ from situation to situation and from country to country.

**CONCLUSIONS:** Ethical question is an important part of psychotherapeutic practice. There exist many dilemmas in these issues which must be reflected by ethical therapists and many of them are in connection with self-reflection and supervision.

## INTRODUCTION

The psychotherapy practice gives rise to various ethical dilemmas. Ethics in modern psychotherapy, as well as in medicine and psychology in general, is based on two main traditions of ethics: deontological and teleological (Filaković & Pozgain 2008). Deontological ethics is the normative ethical position that judges the morality of an action based on the action's adherence to rules and choices that cannot be justified by their consequences. What makes a choice right is its agreement with moral norms. Teleological ethics says that the rightness of an act is determined by its end. An optimal ethical decision in psychotherapy takes into consideration both traditions, and is preceded by ethical dilemmas to offer the best achievable therapy to the client in that moment and make ethical challenges before they occur (Barnett 2008). The most frequently cited ethical concerns in psychotherapy are related to professionalism, therapeutic boundaries and confidentiality (Jain & Roberts 2009).

## PHILOSOPHICAL AND SOCIOLOGICAL ROOTS

Once ancient people began to live in larger communities, it was necessary to establish basic rules for behavior to make coexistence possible. Basic instincts were not served enough, because they had been formed by natural selection over thousands of years in tribal coexistence. Therefore, a part of every main religion was a set of rules – commandments, a type of an original code of ethics that deals with the required behavior and defines undesirable behavior. Ethical issues started to be one of the first questions of ancient philosophy. Philosophical conclusions of Socrates and Plato relate mainly to ethical behavior.

Ethics, a crucial philosophic discipline, is the study of values and related behaviors of an individual or a group of people. It contains the exploration and utilization of concepts such as justice, right, wrong and right, and responsibility. Ethical principles in Ancient Greece predetermine broader philosophical ideas. The fundamental ethical category for the Ancient Greeks was arete or virtue, which described a certain strength or ability. The sophist Protagoras first formulated the relativism in Western thought by saying that man is the extent of all things. But the history of practical ethics starts with Socrates. For the first time, Socrates regarded arete as the rational part of the human mind. Socrates was inspirational mainly for his use of forms of dispute or discussion for clarification of certain issues, the so-called Socratic questioning (Vyskocilova & Prasko 2012). Philosophy in the Socratic view is not speculative exploration of nature, but learning about how to live (Platon 1919, 1936, 1994). The main subject of Socratic dialogues was questions of ethics (Xenofon 1972). Similarly, Epicures assumed that ethical issues are essential because cosmological questions have virtually no meaning for human life.

From a psychotherapeutic point of view, modern philosophy has the main significance for ethical questioning. Jaspers' work can contribute to both ethics and psychotherapy, especially with the concepts of limit situations, transcendence and pluralism (Ghaemi 2007). Limit situations mean the fact that an individual life is characterized by existential circumstances, or crises, which appear to opportunities for authentic existence. Transcendence means that freedom is an essential aspect of human existence. It cannot be explained only by technical knowledge or involved in any solely rationalistic scheme of thinking. Pluralism is perhaps Jaspers' most innovative idea, which still fails to be adequately recognized by the psychiatric profession. The innovation in his work is in that he says that science means understanding the methods used to gain knowledge, along with the axioms and limits of those methods (Cohn *et al* 2010).

The intention to respect the self-esteem of each subject is essential to the philosophy of respect-for-persons ethics and postulates that autonomy, as freedom of the moral manager, is a moral obligation. Implied reality of liberty is in a practical effect, critical to being a rational actor who can thereby apply knowledgeable alternative. The moral law, principle of freedom, involves the autonomy of the will and an essential ending to which all effort is aimed at (Boyd 2000).

Legal socialization theory says that beliefs and attitudes intermediate the relationship between legal arguments and rule-violating behavior (Cohn & White 1990). Moral development theory submits that moral reasoning can predict rule-breaking behaviors directly as well as indirectly (Blasi 1980). Cohn *et al* (2010) presented a combined rule-violating behavior model drawing on both theories. Structural equation models point out that while ethical and legal arguments are directly and indirectly related to rule-violating behavior, legal reasoning bears no direct connection to rule-violating behavior.

## BIOLOGICAL CONTRIBUTIONS

Morality is among the most advanced features of human judgments, behavior and, ultimately, minds. A person who acts immorally may violate human rights and ethical rules, and can intimidate others' individual liberty, sometimes becoming aggressive (Fumagalli & Priori 2012). The ability of altruistic behavior, sense of fairness, reciprocity and mutual help are probably genetically determined as a predisposition, which may further develop through family care and education, or may be deformed by the same sources. These are genetically determined, probably because they allow coexistence in a group, tribe or larger community; without them, humans would not survive because they would be too weak against the nature.

In recent years, neuroscience has generated more interest in human ethics and morality and has increased our understanding of the neuronal, emotional and cog-

nitive processes incorporated in moral decisions, their neuroanatomical localizations and neurology of abnormal moral behavior. Although research into this area is just beginning, the initial results suggest that this finding may make sense. Ethical thinking and behavior are a complex multilevel process and therefore some of the brain areas involved share their neural circuits with areas controlling other behavioral processes, such as emotions, cognitions and others. The “moral brain” consists of a large operating system including cortical and subcortical neuroanatomical regions (Fumagalli & Priori 2012). The neuroanatomical regions involved in ethical processes are the prefrontal, temporal and cingulate cortices. The prefrontal cortex controls the action in subcortical emotional regions, planning, cooperating and supervising ethical verdicts. A disturbance in its function can lead to impulsivity. The temporal lobe is implicated in theory of mind, and its malfunction is connected with violent dissocial behavior. The cingulate cortex intermediates the conflict between the emotional and analytical components of moral reasoning (Fumagalli & Priori 2012). Other prominent structures contributing to moral reaction include the subcortical circumscribed regions such as the basal ganglia, amygdala and hippocampus. Brain circuits and areas participating in ethical processes can also be guided by hereditary (inborn), neurotransmitter, hormonal, contextual and environmental influences. Hormonal factors can alter moral functioning through their action on the brain receptors in various neurotransmitter systems. Finally, genetic polymorphisms can determine aggressiveness and violence, suggesting a genetically based tendency to moral reactivity. So altruistic behavior as well as criminal behavior are largely genetically determined and transmitted from generation to generation. (Frisell *et al* 2011; Bijleveld & Wijkman 2009). Because abnormal moral actions can arise from both structural and functional brain abnormalities that should be assessed and treated, the neurobiology of moral operations has potential implications for practice and raises ethical concerns.

Without good empathy, ethical questioning is difficult because ethical decision typically examines the experience of the other side (Harris 2011). The human mirror neuron system in the brain can play an integral role in mediating experiencing of the empathy (Baird *et al* 2011). But there has been limited understanding of different forms of empathy, including cognitive, emotional and motor empathy.

The idea of personhood linked close to mind is, therefore, understood as reinforcing an individual to choose among different actions, to define directions in life, and to give priority to different values and ethical themes, which originate in moral hermeneutics (Boyd 2000). Existentially done background and conditions, narrow decision in unexpected manners, such that the predicted value of autonomy is fragile to misinterpretation or abuse. Neuroscience gives attention to better

understanding of the role of emotion and cognitive processes in ethical reasoning by finding which brain activity and circuits are affected by emotion-triggering stimuli (Fumagalli & Priori 2012). Not only psychotherapists’ decision, but also jurors’ decision-making is affected by emotion, actual context, elicited from potentially disturbing evidence which can cause more punitive judgments (Salerno & Bottoms 2009). Neuroimaging evidence showed that emotionally relevant stimuli triggered heightened emotion and decreased high order cognitive processing crucial to understanding jurors’ enlarged punitiveness after being exposed to emotionally strong evidence (Boyd 2000).

## ETHICAL QUESTIONING

There is no distinct answer to the various, complex and multilevel ethical questions that therapists may be exposed to during treatment of the clients. Such dilemmas are nuanced, contextual, dynamic and highly complex (Jain & Roberts 2009). Although professional codes indicate guidance on highest possible standards of function, they do not always give clear answers; hence, clinicians must be able to critically weigh up and understand these codes in relation to everyday practice. A contemporary clinician continues to face modern dilemmas in the dynamic 21st century practice setting. Ethically oriented therapists serve the well-being of their clients above all other benefits or obligations. Clinicians paying particular attention to the professional obligations they have can adopt some strategies to increase their ethical competence, such as constantly self-reflecting their thoughts, emotions, behavior and attitudes, in addition to those of their clients, and developing expertise in ethical issues, having a solid understanding of relevant professional codes of conduct, and showing openness to supervision.

Following Jaspers, Schlimme *et al* (2012) attempted to answer the question: What are the limits of psychotherapeutic approaches with respect to issues of life conduct? The most influential limit is the unbreakable connection between the style of person’s life conduct and the experienceable or transpersonal sense of life that cannot be disrupted by means of any justifiable belief or falsifiable knowledge. This existential connection is the starting point of numerous psychotherapeutic strategies.

## PRINCIPLES OF BIOETHICS AND PSYCHOTHERAPY

Principle-based medical ethics is a valuable tool for resolving ethical dilemmas in psychotherapy in that the therapeutic aspects of ethical dilemmas can be better expressed than in other methods (Robertson *et al* 2007). Psychotherapists can best apply a principle-based approach to ethical dilemmas, when combined with a degree of critical self-reflection in the context

of other ethical theories as well as careful clinical and social context of an ethical dilemma. The main four principles of bioethics, as formulated by Beauchamp (1994) are following:

#### *Psychotherapy and autonomy*

An important aspect of psychotherapy is a direction towards client self-reliance and autonomy. Support to the development of an autonomous mature individual belongs to the most cited aims of psychotherapy (Holmes & Adshead 2009). But what is general may not be true in some special conditions. For instance, psychotherapy with a client in a dying process helps the client to feel autonomously. Nevertheless, in case of the client's dependency the therapist typically allows it. Also in some difficult clients we can speak only about partial autonomy. Clients with mental retardation, dementia or chronic psychoses are actually dependent on the therapist or team and need this dependence for many years or sometimes to the end of their lives. Also, psychotherapy with little children allows only limited space.

#### *Psychotherapy and beneficence*

As other treatment methods, psychotherapy must be indicated and practiced to help the concrete client (Prasko *et al* 2012). Historically, psychotherapy has been developed in sick people and is applied in the arrangement treating the disorder. Healthy people without symptoms of the disorder are only in exceptional cases the subject of psychotherapeutic exploration as to their experiences and behavior (Leitner & Schuch 2004). The empirical findings provided cover areas of life which show impairment and in which psychotherapy can produce positive changes. The public versus individual benefit of psychotherapy is questioned especially in the scenario where many psychotherapeutic approaches were not test to their effectiveness in scientifically done research. On the other side, even if there was evidence of effectiveness for an intervention, it did not mean that it was necessarily an acceptable addition to the treatment system (Sinclair *et al* 2011). For instance, whilst the evidence base from randomized controlled trials for the role of contingency management as a strategy in substance misuse programs is compelling (Dutra *et al* 2008; National Institute for Health and Clinical Excellence 2007; Pilling *et al* 2007) the uptake into clinical practice has been less scrupulous (McGovern *et al* 2004; Kirby *et al* 2006; Petry 2006). Who was the real beneficiary of this kind of intervention – the service users themselves or the public at large? Was this policy being driven by political motivation rather than the evidence base? These discussions articulated concerns of moral principle and personal belief, which were not evidence-dependent, were not changeable within the group discussion or remediable by research or policy clarifications (Sinclair *et al* 2011).

#### *Psychotherapy and non-maleficence*

The possible harm in psychotherapy is less obvious in acute jeopardy of somatic health but can grow from the exploitation of therapeutic relation consciously or unconsciously (Adshead 2004). The client can be exploited to confirm therapist self-confidence, because of economical or sexual reasons (Gabbard 2009). The client in psychotherapy can be abused economically, sexually and emotionally. This process may be intentional as well as unintentional.

#### *Psychotherapy and justice*

Efficacy and price could be a serious ethical problem in therapy. If the therapy is prolonged and in fact a short-term therapeutic approach has the same efficacy, or if the therapy is without results and another therapeutic approach could be helpful, but the therapist needs his/her income and continues the therapy because of this reason, it is a serious ethical problem. Nevertheless, the therapist rationalizes the necessity of long therapy by the theory of his/her therapeutic school (Adshead 2004). A more abstract discussion can be held about the general concepts of using the client's or public money, within a health system that offers universal coverage, to incentivize people to change their behavior.

### **DUAL-ROLE DILEMMA IN PSYCHOTHERAPY**

In psychiatric ethics, the dilemma of dual-role is linked to the tension between psychiatrists' obligations of beneficence towards their clients and conflicting obligations to the society, third parties, other health care colleagues or the continuation of knowledge in the field (Robertson & Walter 2008). The psychotherapist faces the same dilemma in many cases. The ethical status of specialized boundaries and the ethical character of dual and various overlapping relationships in modern psychotherapy practice remain constant dilemmas in all health care disciplines (Crowden 2008). These contradictory obligations exceed a conflict of interest in that the expectations of the psychotherapist, other than the client's best interests, are so critical. This stress illustrates how the discourse in psychotherapeutic ethics is found in the cultural and social context of the situation. It appears that as cultural changes in the view to the philosophy of liberal autonomy and the "societal good", psychotherapists may also need to change.

Crowden (2008) identified some commonly occurring situations where overlapping relationships in psychotherapy are expected. A case study from a rural area where size, isolation and community expectations strongly influence the capacity of a therapist to follow distinctly defined professional therapeutic relationship boundaries was analyzed. The rural case is relevant. A virtue ethics perspective moves some step toward helping perceptions about the features of dual relationships that add to long-term uncommunicativeness amongst psychotherapists to practice in countryside settings.

Clearly, if a dual relationship involves exploitation then relationship is a boundary interference that should accurately be categorized as a boundary violation, which is abusive and improper. However, some dual relationships may include boundary interference that is not automatically boundary violation. Despite their general prohibition by codes of ethics relevant to the psychotherapy, Crowden (2008) argued that in special situations, if the therapist behaves with professional integrity from the obvious professional role-related qualities and/or regulative principles that guarantee the goals of psychotherapy (to increase independence and psychological health) are met, then a dual relationship in psychotherapy will be ethical.

Very rarely, the therapist acts as both a psychologist and forensic evaluator in the same case (Strasburger *et al* 1997). Although circumstances sometimes require a practitioner to recognize the dual role of a therapist and forensic observer, the problems involved in this practice suggest that it should preferably be avoided. Attempts to treat and evaluate the same subject usually create an antagonistic role conflict. This role inconsistency manifests itself in different concepts of truth and causation, different forms of relation, assessment, and different ethical procedures.

#### **CONFIDENTIALITY IN PSYCHOTHERAPY**

Confidentiality is the secret-keeping obligation that arises from the organization of the professionals which was developed with the clients (Younggren & Harris 2008). Confidentiality is essential for clients to engage in therapy; therefore, it is necessary to protect psychotherapy notes (Clemens 2012). Mental health information is especially sensitive and potentially harmful if privacy is breached, which makes clients reluctant to seek therapy if they cannot be guaranteed confidentiality. This obligation, created by the therapeutic relationship, is set forth in the European Psychotherapeutic Association Ethical Codex, American Psychological Association's (2002) Ethical Principles of Psychologists and Code of Conduct, and codified by various state regulations in most western countries. On the other hand, there is a difference between confidentiality and legal right; how, why and when it can be broken. And the reasons for doing so are not well understood by many therapists. Superficially, confidentiality might seem to be an elementary idea to apply in therapeutic practice. In fact, it is quite complex and filled with exceptions that frequently differ from situation to situation and from country to country. A lack of reverence for and a lack of understanding of the importance of these exceptions could have serious ethical consequences.

The issue of confidentiality often causes ethical dilemmas for the psychotherapist. Fennig *et al* (2000) searched whether psychotherapists have ethical approach to confidentiality and boundaries that are unique to their specialized group compared with

lay professionals and whether gender or professional uniqueness are linked with these attitudes. Clinical cases illustrating ethical dilemmas about confidentiality and boundaries were displayed to 93 therapists (professional group) and 55 employees and students from the area of law and the humanities (lay group). In general, the lay persons demonstrated a greater tendency to preserve confidentiality than the professional group. Concerning boundaries, the greater part of psychotherapists were against having any sexual contact with current clients, former clients, supervisees or students; the differences between professional groups were statistically significant. Most therapists (96.7%) refused to accept payment in advance in comparison with only 54.4% of the second group. Analysis of the therapists according to their professional background discovered that in the greater part of cases, there was no difference in view to confidentiality and boundaries between social workers, psychologists, and psychiatrists. This study showed that psychotherapists have different ethical approaches in comparison with non-therapists concerning the issues of boundaries and the therapeutic contract. Psychotherapists are more rigorous than non-therapists on the topic of issues of boundaries but less stringent concerning problems of confidentiality.

Fennig *et al* (2004) studied if psychotherapists are unvarying in their approach to confidentiality or weigh up each situation on its own merit. A survey consisting of a sequence of clinical cases representing diverse ethical problems in confidentiality in psychotherapy was completed by 93 psychotherapists of different backgrounds and 55 students from the fields of law and humanities as controls. Participants in both groups were not consistent in their approach to confidentiality in two-thirds of vignettes, and most of the subjects based their decisions on the unique history and background of each case.

Building privacy and security protections into health information technology systems will bolster confidence in such systems and extend their implementation. The privacy question can be resolved through a comprehensive structure that implements core privacy principles, adopts safety network design characteristics, and establishes supervision and responsibility (McGraw *et al* 2009). The public policy challenges of implementing this strategy in a complex and developing environment will require improvements to existing laws, new rules for entities outside the public health facilities, a more nuanced approach to the role of consent, and stronger enforcement mechanisms.

#### **INFORMED CONSENTS IN PSYCHOTHERAPY**

Well-implemented informed consent procedures substantiate therapists' respect for clients' right to autonomy and can create meaningful contributions to therapy through strengthening reciprocal trust, constituting therapeutic relation, and facilitating a sense of

ownership (Fisher & Oransky 2008). Key components of informed consent to psychotherapy are related to real-world psychotherapy scenarios. Therapists could present information on client-therapist debates of the character and process of treatment, fees, involvement of third parties, confidentiality issues, and new and untested treatments.

### **ETHICAL DILEMMAS IN PSYCHOTHERAPY WITH SUICIDAL CLIENTS**

A client's suicide is a source of considerable worries for psychotherapists (Sudak *et al* 2008). It is experienced by a significant number of therapists and has a considerable emotional impact. A study of 105 therapists forms the basis for the Menninger (1991) report on the frequency of client suicide and its impact on psychotherapists, according to the phases of their response. Strategies of coping with a client's suicide, particularly group support and training that predict such an event are described. Of particular note are some survey respondents' remarks on lessons they have learned from a client's suicide.

### **ETHICAL ISSUES IN CLIENTS WITH SEVERE PERSONALITY DISORDER**

Most psychotherapists are unenthusiastic to work with clients with severe personality disorders because they think there is nothing that psychotherapy can provide (Glen 2005). Severe personality disorder also signals problems which are complicated morally. Various previous commentators have remarked upon the implications for applying of supposed negative feelings among care staff (Wright *et al* 2007). Social constructionist approaches are drawn on to offer insights into public and therapists' discussion and the potential effects on therapeutic interaction. The presented discourse constructs subjects with a diagnosis of personality disorder as fundamentally different from other population. Moral philosophy has not found a satisfactory way of dealing with personality disorders. The ethical question is: What makes a subject morally responsible for his/her behavior and what is an acceptable attenuating aspect? How do psychotherapists working with these clients recognize the immoral issues some clients do? Which concepts do they need if they are to know how to make clear and how to behave? It is suggested that complicated personality disorder is best regarded as a moral category, framed in terms of goodness, badness, obligation and other moral concepts. It seems plausible that in essential ways, the severe personality disordered client does not recognize morality or understands it in a different way. The atypical position of the complicated personality disordered client in our system of social responsibility stems from his/her obvious inability to feel and recognize the importance of the interests of others. Might it be more beneficial to

consider personality disordered clients as children or adolescents, i.e. partially but not wholly responsible for their actions? Might we consider the complicated personality disordered client responsible for those behaviors which he/she evidently understands, such as causing another person physical pain, but not for those behaviors with which the client is only superficially understood, such as causing emotional distress? The complicated personality disordered person does not fit without difficulty into any conventional moral category, and therefore an analysis of his/her moral responsibility must take into thoughtfulness his/her particular situation (Glen 2005). Deep understanding of frequently traumatized childhood and lack of fulfillment of basic children needs help the therapist understand the client's behavior. Psychotherapy and staff training are likely to be more successful if such dialogue is challenged, and attempts are made in therapeutic encounters to identify shared characteristics and positive attributes as much as perceived difference and negative attributes (Wright *et al* 2007).

### **ETHICAL ISSUES IN THERAPIST-CLIENT BOUNDARIES**

The existing "slippery slope" model in boundary dilemmas is associated with a rule-based view to ethical decision-making (Martinez 2000). A graded-risk approach for boundary dilemmas is introduced to provide a "process" approach to ethical resolution in boundary dilemmas. This approach divides boundary crossings into six variables: (a) the potential harm for the client, (b) the potential benefit for the client, (c) the presence or absence of compulsory and abusive factors in the boundary crossing, (d) the expert's intentions and motives, (e) the expert's wishing for professional ethics, and (f) the circumstances of the boundary crossing.

Nonsexual boundary crossings can weaken the therapy, disrupt the therapist-client alliance, and cause harm to clients. But rarely it can augment psychotherapy, provide the treatment plan, and reinforce the therapist-client working relationship (Pope & Keith-Spiegel 2008). Building on Gutheil and Gabbard's (1993) conceptualization of boundary crossings and boundary violations, therapists can provide practical steps in deciding whether to cross a boundary, discuss common cognitive errors in boundary decision making, and give realistic corrective steps to acquire when a boundary cross has negative effects.

Fennig *et al* (2005) investigated whether the attitudes of clients in psychotherapy to boundaries and confidentiality are similar or dissimilar to attitudes of therapists and lay persons. Clinical cases describing ethical dilemmas of boundaries and confidentiality were presented to 103 clients undergoing psychotherapy (client group), 93 therapists of different professional backgrounds (professional group), and 55 staff and students from the fields of law and humanities (lay group). The clients

were asked how they think psychotherapists should behave in the circumstances presented, and psychotherapists were asked how they should act in these situations. The client group displayed a larger inclination to view psychotherapists as breaching confidentiality than the therapists and lay groups. Concerning boundaries, most therapists were against having any sexual contact with current clients, former clients, students or supervisees, whereas both clients and lay persons described a less rigorous view; these differences were statistically significant. The majority of psychotherapists (96.7%) disapproved of accepting payment in advance compared to 31.1% of the clients and 54.4% of the lay persons. Analysis of the clients group by gender did not reveal any significant relationships. The authors concluded that (1) clients have different ethical norms from therapists and lay persons regarding the issues of confidentiality and (2) clients and lay persons are less stringent than psychotherapists concerning issues of boundaries.

Self-neglect is more common than currently recognized (Lauder *et al* 2005). The problem of self-neglect and the associated ethical values and judgments related with it is serious. A multidisciplinary framework for managing self-neglect is needed.

#### **ETHICAL ISSUES IN THERAPIST-CLIENT SEXUAL RELATIONSHIP**

It is a psychotherapist's ethical obligation 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 (Holmes & Adshed 2009). Sexual abuse in medicine, psychiatry and psychotherapy is a relatively common problem. It can 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). A therapist's sexual contact with a client is unethical for several reasons. The relationship is unequal from the beginning because the therapist has at least the advantage that the client comes for help, shares his/her problems and many intimate issues and is less able to understand what happened in the relation, while the therapist is a professional who was educated to understand relationships and his/her activities are paid. The main problem, however, is that the therapist puts his/her needs above the needs of the patient.

The situation may be ethically difficult if the sexual relationship took 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 contact to be unethical if held less than two years after treatment. Some are convinced that when it comes to marriage, it is difficult to talk about abuse (Appelbaum

and Jorgenson 1991), but for other marriage does not preclude abuse, also showing that the transference works even years after the end of therapy (Celenza 2007).

#### **CONCLUSIONS**

Ethical questions are an essential part of psychotherapeutic practice. There exist many dilemmas in these issues which must be reflected by ethical therapists. Many of them are related to self-reflection and supervision. Clinicians who are paying particular attention to the professional obligations they have can adopt some strategies to increase their ethical competence, including constantly self-reflecting their thoughts, emotions, behavior and attitudes, in addition to those of their clients, and developing expertise in ethical issues, having a solid understanding of relevant professional codes of conduct, and showing openness to supervision.

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