The idea of including a philosophical perspective in a book about psychotherapy may seem strange. Americans are not used to seeing philosophy joined with psychotherapy. And yet the two are intimately related. At the very beginnings of Western philosophy, in fact, there was a concern with psychotherapy. Philosophy could not ignore psychotherapy because philosophical themes are taken from the culture, and Greek culture was intensely interested in the use of the word in the healing process. Although it did not remain at center stage of philosophical reflection, concern about psychotherapy was never completely absent from the history of philosophy.

Homer's epic poem may be understood as a testimony to the power of words to touch men's hearts. There are frequent allusions in both the Iliad and the Odyssey to uses of words to cure (Lain Entralgo, 1970). Homer spoke of the therapeutic benefits of prayers and charms, but he also referred to what we might call supportive therapy when he spoke of suggestive and cheering speech (terpnoi logos). Nestor and Patroclus use cheering speech to quiet the souls of their patients (The Iliad, 1950).

Because of its impressive effectiveness, philosophers in post-Homeric Greece could not ignore the use of words to cure. Plato took up this theme and attempted a rational explanation of the mysterious effectiveness of the therapeutic word which he referred to as charm (epode). He thought that therapeutic effectiveness was related to beauty. The beauty of the word produces wisdom or temperance (sophrosyne), a rightful order in the psyche. In Plato the word harmonizes beliefs, feelings, and impulses with knowledge, thought, and value judgments. A new axis is created in the soul by the beautiful word (logos kalos) in the form of new beliefs around which the many elements of the self are organized. Plato called this reorganizing and enlightening process katharsis, and in working out the details of its effectiveness, he gave us a rigorous, technical, and non-magical theory of psychotherapy (The Dialogues of Plato, 1931).

Aristotle also addressed the issue. Effective use of the word to cure was in his time obviously a common experience, and interest in explaining the phenomenon was more than a passing curiosity. Like Plato,
Aristotle used the term catharsis to discuss the effectiveness of the therapeutic word. But he defined catharsis as purgation. For Aristotle, words produce change in a person by relieving unconscious and hidden pressures. Besides reordering critical and central beliefs, therapeutic change also occurs by release of pent-up emotion.

According to Aristotle, the words of the tragic poem enter the ears and the mind of the spectator, but have their effect on the humors of the body as well. The therapeutic effect on the body is brought about not by a physical purgative, but by the airy, invisible, and immaterial reality of the poetic word. The word brings about a more balanced, more pleasurable, indeed a healthier state. It effects a reordering of body and soul, the physical, spiritual, and affective dimensions of man. Catharsis for Aristotle was both purgative and purifying.

In effect, Aristotle replied quasi-psychoanalytically to Plato's condemnation of poetry for stirring up the emotions at the expense of the rational parts of the soul. He saw that Plato was in fact espousing repression of the emotions and Aristotle argued for the naturalness and usefulness of the irrational impulses. Excess, he agreed, was harmful, but by the vicarious experiencing of another's emotions, a harmless discharge occurred which brought about a new and healthier measure. But the conclusion of Aristotle's doctrine of catharsis is in effect the same as Plato's: the therapeutic word in either form permits the soul to recover a good order among its parts (The Basic Works of Aristotle, 1941).

Aristotle also stressed the role of kairos, the notion that the therapeutic word must be spoken at the right time, and diathesis, the accommodation of the word to the situation of the hearer. Both Plato and Aristotle insist on a particular relationship between the speaker and hearer of the word (paraschésis). And finally a great deal was said by both about ethos, the inner being or character of the person who pronounces the therapeutic word. A confluence of all the many above-mentioned elements explains the therapeutic power of the word.

Nothing then is clearer than the fact that philosophy and psychotherapy and the arts were linked (at least since antiquity). Since the Greeks, however, the first two disciplines have grown apart. Psychotherapy in its modern form is more identified with science and medicine. As is the case with most separations, both sides have suffered a loss. Modern clinicians could profit from familiarity with the classic and contemporary philosophical texts on the human condition. And modern philosophers certainly have much to gain from insights into that same condition which have come from the contact of sensitive and intelligent clinicians with human beings in distress. There is evidence that this mutual advantage is beginning to be recognized.

In this century a rapprochement has begun between the two disciplines. Philosophers in the existential and phenomenological movement have rejoined the Greek tradition by explicitly preoccupying themselves with the ancient questions of how human beings become disturbed and how they are cured by talking. The work of Karl Jaspers (1963), for example, a philosopher and psychiatrist, reflects the concerns of both fields. Sartre wrote books on the emotions (1948) and on psychoanalysis (1953). Paul Ricoeur (1970) and Alphonse DeWaelehs (1978) are also examples of philosophers with an interest in psychopathology and psychotherapy. Peter Koestenbaum (1978) and William Richardson (1978), both philosophers, are doing research and actually working in therapy. The long, unnatural, professional separation shows many signs of being overcome.

It is not only philosophers who are concerning themselves with psychotherapy; the traffic runs in the opposite direction as well. The great innovators in psychotherapy of necessity preoccupied themselves with philosophical thought in the form of personality theory which was applied in therapy. Freud is a good example of the psychotherapist/philosopher. Lecan (1978) is another. In the work of the major theoreticians the connection is obvious, but it is verified as well in every serious reflective clinician.

Even those therapists who claim to confine themselves to symptoms relief, in fact, assume a philosophical stance. If philosophy is a concern with reality beyond appearances, there is in all psychotherapy a more substantial level of personal existence assumed to lie beyond the observable. Behaviorists differ from psychoanalysts only as to the depth to which they are willing to pursue this "underlying" reality. Psychological ailments are assumed to have an underlying core and so too the human person. It is impossible for the psychotherapist to avoid being a philosopher in the sense of one who holds explicit beliefs about the nature of man, the nature of illness, and the distinction between appearance and reality.

Psychotherapy is philosophical in yet another way. Associated with a more or less conscious assumption about the nature of human beings is a more or less conscious assumption about the way human beings ought to behave, ought to feel, and ought to live. Speaking in philosophical jargon, where there is an ontology, there is always an ethics. Beliefs about morals follow beliefs about man's nature, and one tries to make the two consistent. Psychotherapists, like philosophers and priests, work with a model of what is desirable and good for human beings, how they should behave toward themselves, others, and society. Altruism, for example, is considered healthier than narcissism, peacefulness better than aggression and hostility. Certain forms of psychic organization or character are considered deficit both by standards of normality and morality. The psychotherapist then is a philosopher in the sense of ethicist malgré lui.

If the therapist is by profession involved with ontological and ethical
beliefs, he is also assumed to be an ethical person. Both Aristotle and Plato called attention to the importance of the character (ethos) of the person who pronounces the therapeutic word. And their insight is not lost on training centers for psychotherapists. Where concern about the ethics of candidates is not in evidence, it is either hiding under some other conceptual categories or someone is not doing his job. Directors of psychoanalytic institutes, for example, are rightly concerned with more than intellectual proficiency in their candidates. Many ethical attributes are recognized as essential for functioning as a psychoanalyst. Honesty and concern for others are only the most obvious (Ramzy, 1965).

Ethics, too, in the more traditional sense of evaluation of acts, is never absent even from the most objective and scientific kinds of psychotherapies. There is no way for the therapist to avoid ethical judgments about the patient’s life strategies, just as he cannot avoid working with ethical issues which are part of the pathology. The conscience of the patient may be the root of the patient’s conflict, and at some point the most neutral analyst sides with sobriety rather than drunkenness, or tolerance rather than prejudice. If ethics is so widely recognized as intimately involved in the hard sciences, it can hardly be ignored in the applied and much more obviously human sciences like psychotherapy (Erikson, 1964; Veatch, 1976).

The ideal of neutrality in “scientific” psychotherapies is real, but it is never absolute. There is a schedule of moral values which the therapist tries to promote in some patients and a strong preference for some values which are closely allied to the therapist’s philosophy of life. Karl Menninger (1958) says it most clearly: “What a psychoanalyst believes, what he lives for, what he loves, what he considers to be good and what he considers to be evil, become known to the patient and influence him enormously not as suggestion but as inspiration” (p. 94).

But if philosophy, ethics, and psychotherapy are so closely connected, why has there not been an ongoing awareness of the relationship? Why are books like this one needed to arouse the sensitivity of professional practitioners to this dimension of their work? The answer is not difficult to find.

There are counterpressures in the scientific tradition which tend to “bracket” ethical concerns. Allied with the scientific part of the medical tradition, modern psychotherapy sometimes assumes that science is value free; that is, that it has nothing to do with ethics. The therapist in this understanding treats the patient without reference to ethics or considerations of moral worthiness. Whatever the therapy being administered, it focuses on the patient’s needs alone. The psychotherapist may very well have been advised during his training years not to become involved with the ethical, political, philosophical, or religious beliefs of the patient. The implication is that the “business” of psychotherapy, like that of physical medicine, is “nothing but” the relief of suffering. If ethics enters this mindset at all, it is in the form of a gross oversimplification: “Ethical psychotherapy is competent psychotherapy.” If only things were that simple!

Still, it must be granted that although the scientific, value-free, amoral stance of the tradition is not altogether accurate, it has nevertheless been very beneficial. It has contributed considerably to the development of an objective perspective in the understanding of mental illness, moving the profession away from superficial moralistic diagnoses and treatments. Prior to the modern period, ill-advised use of ethical categories in the explanation of pathology undoubtedly played a role in the divorce of modern techniques from ethics. Modern psychotherapy was developed so that it could be learned very much as the physician learns his skills, and could then be conducted independently of ethical considerations.

As beneficial as the presupposition of ethical neutrality has been to the profession, it corresponds in fact more to research than to clinical practice. In the day-to-day therapeutic relationship, ethics and values abound both on the side of the therapist and on the side of the patient as well. Ethical concerns, for example, can hardly be ignored when the patient’s problem is pedophilia, or when the diagnosis is a character disorder (like Narcissism) with its massive moral deficiencies. But even the more prosaic problems tend to center in what bothers the patient’s conscience or interferes with relationships to which he feels an obligation. Work, home, family, and the ethical conflicts associated with them are common themes in clinical practice. Simply stated, it is unrealistic to expect that treatment of such disorders may be carried out by the application of technical principles alone.

Psychotherapy is closely intertwined with ethics, and yet communication between the philosopher/ethicist and the psychotherapist has not been good. The training of the physician/therapist, for example, tends to be very different from that of the philosopher. There is usually a strong science identification in the former which is not always shared by the ethicist. They speak different languages and write in different styles. The clinician tends not to be interested in the “mystical” concern of the philosopher. And to the philosopher, what the clinician wants to discuss under the topic of ethics sounds more like issues of etiquette. This background difference may express itself in an antiscientific or antitechnological bias on the part of the ethicist. But the most serious communication barrier derives from a sense that the writings of ethicists are really instances of mischief making by people who have little or no experience with clinical practice (Callahan, 1975).

Lack of rapport and misapprehensions can sometimes be the result
of insecurity. It is easy for an ethicist to stress what he knows (the humanities) and play down or not adequately appreciate what he does not know as well (scientific and technological aspects of clinical practice). It is equally easy for the clinician who has long enjoyed a privileged social position to resent any comment on his behavior from outside sources. Counterpressures, then, to active concern with philosophical ethics on the part of clinicians are real and ongoing.

And yet, since there is no way of avoiding ethics in psychotherapy, the only question is whether the psychotherapist will "do ethics" in a professional way. To do ethics is to engage in a disciplined rational exercise. It means making rationally defensible judgments about morals and values. Given the complexity of clinical practice, doing ethics competently cannot be a matter of following a few norms or the example of a teacher. It requires tough-minded analyses of problems and high-level reflection on psychotherapeutic tradition and principles. In effect, it requires of the therapist a new form of philosophical literacy.

It is my hope that as a result of an identification with both fields, I can provide some assistance to the therapist without adopting either a holier-than-thou or an accusatory attitude. When one professional talks with another, there is no higher station from which one may condescend to treat the other. A dialogue between ethicists and psychotherapists can only be carried out as an exchange of perspectives. All the philosopher can do is offer to share the symbols and categories of his tradition for whatever benefit they may have for the clinician. Anything more is too much.

My goal, then, has nothing to do with telling someone what to do. Rather, I would like to provide a format or intellectual structure in which the psychotherapist can do his own reflection and come to his own decisions. Ethical choices in situations of conflict are difficult enough in themselves. Often, however, the ethical task is unnecessarily complicated by confusion about the different levels of ethical discourse (Aiken, 1952). In the absence of a methodology which keeps the levels of ethical discourse separate, discussion vacillates among many different levels, thereby compounding confusion. Decisions wind up being made by instinct, because efforts to sort things out more intelligently meet with frustration. Methodology is as important in doing ethics as it is in doing psychotherapy.

**Level 1—The Existential: Values and Context**

The human being is born into an already established set of meanings and values which we call the cultural world. Even for the child, this world quickly evolves from an amorphous unitary experience into separate objects which have names (meanings) and qualities experienced as pleasurable (values). The smallest child can sense the ethical tone of a parent's voice, and parents appeal to this sensitivity in their attempts to establish guidelines for a safe and healthy life. Besides external object relations, one's own person can be experienced as good or bad. There is no purely physical or value-free reality for the human person except after radical scientific abstraction.

The cultural world, in the sense of the immediate environment in which mature man finds himself, is symbolic; that is, it both bears meaning and is value-laden. And common sense is the term used to refer to the way human beings handle this world, relate to it, use it, and manage to get along in it. Common sense tells us not only what certain things mean, but that certain things are agreeable or disagreeable, healthy or unhealthy, noble or vulgar, beautiful or ugly, just or unjust. For man, then, the world has both a cognitive and a value dimension. It is both something known and something appreciated.

Culture orders both man's meanings and his values. Accepted meanings as well as value judgment become institutionalized within a culture. Parents transmit this reality which precedes every person's birth and persists, usually with only slight modification, throughout his life (unless one happens to live in an age of "future shock"). The world in which the human being comes to be has a culturally enshrined meaning as well as a pre-given ethical structure. It is full of goods and bads, dos and don'ts, which become part of the human person before he is able to form his own mature judgments. One of Freud's many enduring contributions traces the early development of the superego. And continued research into the origins of ethics has pushed superego formation back to the very beginnings of life (Klein, 1957; Guntrip, 1961).

Ethics then, in the philosophical sense of reasoning about the right and wrong of actions, does not begin in the ethereal world of philosophical abstraction, but rather is rooted in man's concrete being in the world. Ethics as a philosophical discipline does not come down from a world of pure forms, but rather comes up from the practical world in which the human person finds himself immersed. The human world is one of values and correspondingly of claims, demands, punishment, approval, obligations, rights, and responsibilities. The discipline called "Ethics" attempts to clarify this world, but it does not create it. Rather, ethics always starts with the buzzing confusion of man's existential condition, and ultimately its theoretical formulations will be verified or falsified in terms of their adequacy or inadequacy for interpreting his lived experience. This is true of ethics generally, as well as of the narrower concerns of professional ethics.

If the human condition is ethical at its core, we can hardly expect psychotherapy not to be so. Ethics in fact permeates every aspect of
Psychotherapy. It is implicated in the diagnosis, the pathology, the transference, and finally in the goals of treatment. The context of psychotherapy is interlaced with ethical concerns, and the therapist cannot avoid being immersed in ethics (London, 1964; Rieff, 1959).

Diagnosis involves symbols and meanings organized into a coherent system. This type of high-level understanding is an ethical activity in the sense that it involves the choice of one system of symbols and the rejection of others. Either the psychotherapist devises his own or adopts one of the already developed frameworks for understanding his patient. If clinical experience is meaningful, it is because of the meaningful structures which are used to organize it. But such organizational frameworks are not part of nature. They are chosen. The very concepts and categories by which health is distinguished from illness and normality from abnormality are ethical both in the sense that they are matters of choice and in the sense that the diagnostic model itself incorporates a system of evaluation. One model values adjustment, another productivity, a third the maximization of personal satisfaction (Macklin, 1973).

The theoretical model or conceptual system in light of which clinical experience is sorted out and made meaningful is not a tool which the therapist uses, but becomes part of the therapist's person through identification and commitment. The diagnostic symbol system then tends to order the subjective experience of the therapist as well. But where there is such choice and commitment to basic ideas, there is ethics. Ethics, in the sense of ethos, refers to those life-constituting personal choices and commitments to meaning which create a vision of reality and color man's way of responding to it. We will consider this in more detail in the fourth level of ethical discourse.

The sickness diagnosed with the aid of symbols also has an ethical dimension. It is not, as in other branches of medicine, a bacterium or a tumor, but rather ideas, memories, feelings, and sometimes behaviors which either the patient or society considers shameful. Ethical concerns then are often the very sources of anxiety and unhappiness which produce symptoms and bring people to treatment. Try as he may to imitate the mechanic and repair only that part of the mechanism that is functioning badly, the psychotherapist is inevitably pulled into the ethical aspects of a person's pathology.

And the therapist cannot evade the ethical dimension of his work by concentrating exclusively on abstractions like dynamics, structure, or the unconscious. The flesh-and-blood person who is being treated is a philosophical, religious, social, and ethical being, and one has no alternative but to work with the whole complex of this living reality. Especially today, when so many patients suffer from character pathology, superego deficiencies abound. Like it or not, the therapist is up to his neck in ethics and pedagogy. It is a short step from psychological deficiencies to ethical deficiencies in the diagnosis of pathology and the assignment of its etiology (Kohlberg, 1971; Piaget, 1966).

The close connection between ethics and pathology is obvious in situations where the presenting problem is overtly moral or legal—stealing, promiscuity, cruelty to children, exploitation, sexual perversion. If the patient is Catholic, Protestant, Jewish, or of whatever religious persuasion, there is the added dimension of the part played in the problem by the norms and values of a religious tradition. When ethical concerns constitute the overt area of conflict, how can the therapist not be involved? Approaching such problems in an objective and technical way means probing the origins and dynamics of the symptoms as well as examining the functional dimension of a behavior. But it is impossible to keep these approaches separate from the value considerations. The therapist may work toward autonomous value choices by the patient, but there is never a total indifference to the values and behaviors chosen. In fact, therapy in such cases inevitably involves some ethical direction (Abroms, 1978).

The therapeutic relationship is ethical too because the therapist is a person with his own ethical formation rather than a pure cogito or a tabula rasa. He has a personal history, professional training, religious and philosophical beliefs, cultural formation, and ethnic background, all of which influence the way he determines the good and the right. If the therapist were a priest or a rabbi, his ethical formation might be up front and obvious, but a secular person is not necessarily an ethical neutral. His own ethical formation, interacting with that of his patient, gives a distinctive ethical flavor to the transference and counter-transference patterns.

The therapist's ethics is inevitably transmitted in therapy, and the good therapist is usually aware of this influence. Skillful practitioners are aware of the ethics which informs their practice, and do not confuse it with technical expertise or science. They know that their approval and disapproval count. On one occasion the patient may be gently guided toward better ways. At other times ethical standards are set out explicitly and continuation of treatment is made contingent upon conformity. Paradoxically, the therapist who is aware of his ethics and its operation in therapy is less apt to impose his values. It is the one who is unaware of or denies any ethical component that is most in danger. Ignorance and self-deception easily become the channels of ethical assault (Buhler, 1962).

If ethics permeates both the diagnostic and interpersonal dimensions of therapy, it is even more prominent in therapeutic goal setting. Ethical language, in fact, seems very appropriate for articulating the mutually sought-after alterations in the patient's life. The hysterical patient, for
example, looks forward to a gain in self-knowledge; the obsessive patient needs to become more trusting and generous; the antisocial personality must develop a conscience and more sensitivity for other people.

Personality theory itself provides an ethical ideal toward which persons ought to strive, and as such sets out the goal of therapy. One meaning schema proposes the goal of a genital personality, another that of optimal self-actualization. Will to meaning, personal responsibility, creativity, and release of constructive tendencies are other stated ideals. In every instance the personality theory which may have set out to be purely descriptive or even scientific, becomes normative and dictates the goals of therapy.

The giants of psychotherapy all seemed to be aware of the involvement of ethics in treatment. Freud (1949), for example, spoke explicitly of the necessity of superego alteration for effective psychoanalytic therapy, and orthodox analysts work toward "autonomy" and "productivity." In other instances the goals of intended change are expressed in overtly ethical terms. Adler's and Karen Horney's followers, for example, quite openly stress the development of "social responsibility." The success of every modality will be judged to some extent by the patient's increased capacity to develop a personal value system and to act on it. Physical treatment may be considered value free, but even drug and behavioral therapies have their implied values and strong ethical components. Some endorse psychedelic values for patients and society (feeling good), while others abhor drugs and promote more puritanical virtues.

It is one thing to recognize the all-pervasive ethical dimensions of therapy and another to develop a consistent way of handling the ethics. For some persons, training and expertise in medicine and psychology will be considered the equivalent of training in ethics (Veatch, 1976). Rather than moving from recognition of the value aspects of therapy to more reflective considerations of ethical phenomena, there are therapists who consider themselves already competent to make all the ethical judgments they are called upon to face. Somehow their life experience and education suffices to turn them into ethical guides and judges (Drane, 1978). Such persons tend to rely on instinct and intuition. In ethical literature they would be referred to as situationists (Fletcher, 1966).

Others deny any intuition of the right ethical response in therapy, but still see no reason for ethical education. They in fact consider ethics nothing more than a matter of emotion or feeling. Since each person and each group has its own preferences, and since there is no objective standard, further reflection is pointless. In their crudest forms, these positions are conformist and conservative because there is little basis for challenging the status quo. In fact, taken to their logical extreme, these positions would find therapy itself difficult to defend.

As a professional, the therapist must be ethical in a more reflective way because adherence to rules, norms, and principles is what constitutes him as a professional person. And then, while some of the cases he carries do not warrant much ethical analysis, others force the therapist into ethical considerations. His alternatives are often such that he has no immediate feeling or intuition of the proper course to take. To be an ethical therapist in such circumstances requires recourse to the higher levels of ethical discourse to which we now turn.

Level 2—The Legal: Rules and Norms

Human beings are not only existentially ethical, but are existentially reflective as well. Man is a questioning animal. His drive for reasons can be compared with his drive for sexual satisfaction. Consequently, the human being ordinarily does not remain on the first level of immediate ethical evaluation. Man also inquires into why he feels this is right or that is good. He asks why society endorses certain behaviors and sanctions others. He seeks reasons not only for his own spontaneous evaluations, but for the evaluations of institutions and cultures as well. People try to make sense of ethical feelings and judgments by reference to past experience crystallized in ethical rules. This type of ethical activity requires greater intellectual and personal maturity as it progresses to values in more reasoned propositional forms.

If the first level of ethics is existential in the sense that it concerns the immediate response of a person to the value dimensions of reality, the second level involves a move away from immediacy toward distance, delay, and reflection, but not so far away as to lose contact with the evaluated concrete situation. We speak of the certainty and conviction of people with a third-grade education, because they never move away from felt responses which tend to be very persuasive when subjected to neither analysis nor criticism. The second level of ethics asks why a specific behavior is felt to be good or bad, right or wrong, healthy or unhealthy. Why should I be repelled by one action, and applaud another? Should I really feel this way? Are there guidelines by which my feelings about right and wrong can be tested? What are actually the facts in this case?

Reasons and qualifications are asked for and given first in the form
of concrete directives called moral rules. Justification for this or that evaluation is made by recourse to directives which prescribe or proscribe certain acts. This attitude is typical of the earliest stages of growth (when there is little understanding on the part of the child of why following mother’s rules makes his behavior good), as well as at more mature periods when rules provide a rationale for behavior. Rules and norms are values set down in propositional form and strengthened by a sanction.

Justification may also come in the form of an argument which explains why “X” is good and “Y” is bad. Here reason enters the ethical project in a more formal way. There is a cognitive dimension to the immediate value judgment, but now this dimension becomes explicit. Now ethics attempts both to specify the structure of the action under consideration with more precision and to argue its justification. Second-level ethical discourse (a) more precisely describes the structure of behaviors; (b) enunciates norms or justifying reasons which cover the case under consideration; and (c) justifies the application of one rule rather than another to a particular circumstance.

Sometimes behavior X or action Y is clear enough and needs little additional attention. In other cases great effort must be expended to find out what is actually happening before judgment is made about what ought to be. In questions of social ethics, for example (war, racial discrimination, distribution of medical resources, and the like), without a clarification of the situation and the proposed action, ethics flounders in gut responses guaranteed to be bad.

Ethics at this second level is essential for psychotherapy. Before deciding on the evaluation of a particular course in psychotherapy, the objective dimensions of the professional action must be accurately analyzed. Just what are behavior control, confidentiality, patient’s rights? What does patient care mean in this circumstance? Given this situation, is the action I propose a benefit to the patient or an intervention on behalf of the staff? Is my attitude toward this patient really kindness or do I act upon some felt need for personal gratification? Am I as a therapist acting as an agent of society, or of the patient? Which values are operating in the particular therapy I am delivering? What is the ethical issue in this particular case—patient rights, right to treat, informed consent? If the facts of the situation and the character of the professional behavior are sufficiently clear, then level 2 can concern itself with the development of explanatory reasons or the application of relevant rules.

There are occasions when the rules and justifying reasons are so clear as to require little attention. Kant (1956), for example, assumed the operation of the Ten Commandments in people’s lives when he insisted only upon the higher-order principle—“Do your duty.” He assumed that people knew the rules and agreed upon what duty entailed.
his practice. Some philosophers would like to downplay this second level in favor of spontaneous and immediate response to the situation in which a person finds himself (Sartre 1956; de Beauvoir 1949). This option, however, is difficult for a professional person. In addition, the question “Why?” is always on the horizon, and articulation of reasons is inevitable for rational man. Experience too tends to speak back telling us that some responses are good and others bad, and this experience inevitably becomes crystallized in rules and codes. The civil law and court judgments also supply guidelines for professional behavior.

But most important are the rules of professional codes which govern the actions, attitudes, and judgments of everyday practice. Besides providing guidance and justification for action, laws and codes are supported by sanctions which produce painful consequences when the roles are violated. They constitute a strong rationale for ethical behavior in psychotherapy.

Codes constitute an important dimension of professional ethics, and their influence on the ethical substance of the helping professions has been and continues to be considerable. The Hippocratic oath, for example, with its origins in the Pythagorean cult and its many subsequent revisions, continues to have its impact on the medical profession. This code created a fraternal spirit among medical practitioners and regulated the conduct of members in their relationship to one another and to their patients. Precise guidelines were laid down in it about sexual conduct, confidentiality, suicide. Specific rules of professional etiquette were established, and standards of decorum were set down.

It would be difficult to exaggerate the ethical impact of this one simple set of professional rules. It contributed more than any other influence to the moral tone of the medical profession and to the strength of the ethical tradition in medicine. And yet it is obvious to everyone that the Hippocratic code cannot meet the ethical requirements of the profession today. Because it was not supported by legal sanctions, heavy religious appeals for personal honor and virtue were made which sound archaic to modern secular practitioners. And neither its specific rules nor its general principles begin to cover the many areas of conflict and concern in contemporary practice.

What is true of the Hippocratic code is true even of the more contemporary sets of rules. Some might say that the professional codes, as they stand, raise more philosophical problems than they solve. Because of their limitations, do they increase or decrease the sensitivity of the practitioner to the ethical dimensions of treatment? Does a code designed to safeguard the needs of a particular profession adequately cover responsibility to patients and to society? What does it mean to uphold or violate the honor of the profession? What is the relationship between duty to the individual patient, the profession, the society? Can a profession devising its own rules of ethical conduct adequately enforce discipline? What is the relationship between the directives of a professional code and the more universal rules of ethical conduct?

And there are problems of ambiguity in professional codes, caused by a lack of concern with system and conceptual clarity. Little or no effort is made to separate out principles with their broad general applicability (see the next section) from rules which specify narrow particular behaviors. These two different forms of ethical discourse with very different ethical functions may be lumped together with “religious” exhortation to live a virtuous life which constitutes still another way of speaking in ethics. The code, in effect, is a grab bag of disparate elements.

The inherent ambiguity of the professional code is compounded by the many different codes under which a particular therapist might function. And different codes frequently establish different standards for the same professional behavior. If we imagine the psychotherapist in the Tarasoff case seeking guidance in professional codes, he would not find clear direction. The old AMA code read, “The physician may not reveal the confidence entrusted to him in the course of medical attendance or any of the deficiencies he may observe in the character of his patients, unless required to do so by law, or unless it becomes necessary to protect the welfare of the individual or of society.” Did the welfare of society require breaking confidence? To whom should the confidential material be revealed? If the patient’s welfare is paramount, then presumably to the police. But what of the welfare of the victim? And does society’s welfare require consideration when violence is only threatened? According to this code, breaking confidentiality would seem to be permissible, but it is legitimate to ask whether its direction is really right.

The new (1980) AMA code reads: “The physician shall respect the right of patients, of colleagues and of other health professionals and shall safeguard the patient’s confidences within the constraints of the law.”

The safeguarding of confidences in this new formulation of the code is situated in the context of a statement on the rights of patients (and other health professionals). Does this make the requirement of confidence safeguarding a duty which corresponds to a patient’s right? If so, what is the status of the patient’s right? Certainly it is not absolute because the law is mentioned as a constraining factor. But if the law sets up legitimate constraints on the extent of a patient claim, then presumably the law is expressing the interests of society over that of the individual. The law may constitutionalize the patient’s right, but in most cases it attempts to balance an individual interest against a public one. The Tarasoff decision, as a matter of fact, modifies the patient’s interest in safeguarding confidentiality by supporting the counterclaim of the victim for revelation and warning rather than confidentiality.

The World Medical Association code, however, is different: “The
doctor owes to his patient absolute secrecy of all which has been confided to him or which he knows because of confidence entrusted to him." And similarly, in the Declaration of Geneva: "I will respect the secrets which are confided to me." By these codes there would be a professional obligation not to break confidence. The same therapist, in the same case, adopting a course of action dictated by one code, would be in violation of another to which he may be equally bound.

Because the codes are historical documents, they condense different experience and incorporate different perspectives. Individualism may be the underlying presupposition in one, paternalism in another, egalitarianism in a third. The Hippocratic oath, for example, presupposes a philanthropic model in which the patient is the beneficiary of the great virtues and sacrifices of the physician. It assumes the indebtedness of the patient to the physician who comes across as a hieratic figure. In many instances, underlying perspectives incorporated into a code have more influence than its specific directives or admonitions on the ethics of the profession.

Finally, it is not at all rare that different elements in the same code are in conflict. A specific directive not to reveal confidences may conflict with a proscription against harm. Nothing in the code itself provides for the mediation of such a conflict. In such cases the very legitimacy of some element of the code comes into question. Further reflection is unavoidable. The same questioning and reflection which moves a person from the existential to the legal level of ethics now pushes him beyond the latter. In the next section, we look into the higher-order ethical categories by which even the directives of a professional code are judged.

Before discussing level 3, however, a few comments are in order on contracts, which are being suggested as substitutes for the professional codes (May, 1975). Behavioral therapists especially prefer contracts to codes and call for substitution of individually negotiated personalized terms for each therapeutic encounter. They prefer to use a legal/commercial model rather than the older professional model for psychotherapy. In it the patient becomes a client/consumer who purchases services under terms negotiated with the supplier. Such an arrangement, it is argued, constitutes an ethical advance because it gives maximum power and dignity to the consumer. Freedom replaces trust as the ethical cornerstone of therapy. The contract which the bourgeoisie popularized in economics, free churchmen employed in religion, and feminists use to define marriage is offered now as the most ethical paradigm for psychotherapy.¹⁰

The idea of psychotherapy as a contract is not new. In fact, a contractual dimension to the therapeutic relationship has always been recognized (Freud, 1949). The terms of the contract, however, have been implied rather than overtly specified. It is implied that the patient who comes for treatment "contracts" to pay the bill and follow therapeutic directions (Menninger, 1958). That the therapist will work for the patient's improvement, maintain his professional skill, and keep confidence is also implied. A violation of the terms of the implied contract leaves the therapist open to the charge of ethical misconduct or malpractice. What is new, then, is not an insistence upon a contract model, but the substitution of the contract model for the code. Both models have traditionally been used.

Such a substitution does not seem indicated. There is no doubt that certain ethical advances would accompany the switch. More information would be required for the patient to give legal consent to the treatment. But this advance in voluntariness would not offset the loss of professional trust and loyalty promoted by the code. With the contractual arrangement, the client presumably can "shop around" for the best deal, but such increased freedom has little "cash value" when the item is psychiatric services. Seeking relief from tragedies of human existence is different from buying an appliance. Admittedly, there would be more specificity to the obligations assumed by the therapist, but without the functioning of higher-level standards of justice and fairness, how would compliance be evaluated? The contract also cannot supply many of the important ethical elements provided by the code. But whether the specific directives originate in a code or a contract, they require interaction with the higher-level standards discussed next.

Level 3—The Formal: Principles and Virtues

Inquiry into the reasons for this or that ethical response may take the form of a skeptical stance toward moral rules. Is this rule really the basis for right action, or should it be disobeyed in this situation? Serious reservations may also develop about the validity of justifying arguments. Questioning is transcendent in the sense that human beings can move beyond any acquisition by asking yet another question.

Such questioning may emerge subjectively from man's innate capacity for reflective thought. It may also result from a painful objective conflict over what to do in a particular situation in which rules are in conflict or contradict one another. Sometimes changing conditions may throw a longstanding moral norm into doubt. A suddenly overcrowded world, for example, changed almost everyone's mind about traditional rules against artificial birth prevention.

Questions about the validity of practical rules of morality may be decided by reference to higher-level norms called principles. Principles are ethical values in verbal or propositional form which either have or presume to have universal applicability. If a rule can be shown to violate
a higher-level principle like justice, then the rule loses its force. Rules can and should be doubted, but it is not at all commonplace to doubt general principles. Because of their close association with the very fabric of human community and the essential structure of human existence, principles generate greater certainty. It is, for example, much easier to question a particular rule about a just wage than it is to question the validity of the principle of justice.11

Principles are enunciations of the prerequisites for a decent human life, regardless of the culture. They represent a high-level distillation of human moral experience in every age, and presume to provide both illumination and direction in the conduct of good life everywhere. Universalizability is an important characteristic of principles, meaning that their mandate remains even if all qualifying objectives and personal pronouns are removed. Principles provide a basis for judging both rules and immediate existential responses. They connect a specialized professional code with the broader human community and give some of its norms real force, though they may weaken others. For all these reasons, principles supply an important, indeed an essential function in ethics.

What are these principles? How many are there? One-word formulation of principles would include life, justice, love, freedom, equality, reasonableness, loyalty, autonomy, truth, care, and beneficence. But it would be difficult to make a definitive list.

Generativity in Erikson's sense of responsibility for the future does not commonly appear on the list of principles, but it should certainly be included. Shared human life is the foundation of ethics, and since life is transgenerational, caring for another generation is basic. Trying to construct the perfect list or to justify every entry would take us too far off course. For our purpose, it is sufficient to show what is meant by a principle, and how principles operate in ethics.

Important as principles are, it is a mistake to identify ethics with principles. Ethics is much more complex than the application of principles to conduct. Principles certainly are related to conduct, but they are more likely to help us determine what is unacceptable (because it is unjust or untruthful) than to provide a positive answer to the question: what shall I do in this situation? It is one thing to subscribe to justice, love, freedom, or respect as ideals, and another thing entirely to know what is the just thing to do, or the loving, respectful, autonomous, truthful response in a particular situation. The relationship of principle to conduct is such that a great deal of freedom intervenes between the principle and the concrete response required by a particular situation. I might fully ascribe to the principle of care or beneficence, but get very little specific direction from that principle for the resolution of my question: what does care require for my patient who is hyperactive or demanding, or about to embark on a homosexual lifestyle?

Because principles are abstract, the person who acts on them requires a considerable amount of creativity. Imagination, intuition, and sensitivity are all required in order to move from principle to concrete behavior. What does justice, love, or care require of me in this situation? Ethical activity, like the ethical self, is one of the supreme acts of human creativity. Only saints carry off the ethical project with a high rate of success. And oddly enough, whatever good they manage to do is experienced by them more as a gift than as a result of their personal efforts.

Principles, however, do play a role in forming the truly ethical therapist. More than rules, principles point toward interiorization. As such, they contribute more directly to the formation of character. Codes and rules establish professional standards and regularities of procedures, but alone they are not enough to constitute the ethical psychotherapist. The ethical psychotherapist must be more than outwardly correct. It is not sufficient that he be a practitioner of good etiquette. The codes, rules, or standards are crucial, but they make up only the outer wall of the complete ethical structure. The inner structure is made up of interiorized principles or virtues. In addition to the guidance they supply and the standards they establish for specific norms, principles, unlike rules, influence character formation and tend to inspire thought and action.

The processes by which principles are interiorized constitutes the core of advanced moral education (Kohlberg, 1969, 1971). Once interiorized, principles become joined with personal attitudes, thereby modifying inherited dispositions and at times readjusting one's views or rules. In this way principles incline the person toward certain consistent behaviors called virtues. Benefice is close to benevolence, truth obviously linked to honesty, trust to trustworthiness, justice to fairness. The former are principles, the latter virtues or states of character. Kohlberg (1969), Piaget (1966), and Erikson (1964) have all called attention to the interrelationship between the development of ethical character and a schedule of interiorized principles.

Principles, then, are an important ingredient of ethical life. Anyone who takes the ethical task seriously must make an effort to clarify the principles by which he lives. The more the principles are assimilated, the more autonomous and authentic will be a person's ethical behavior. Principles function like anchors and compasses in an inevitably turbulent life. At crossroads and in the midst of forced life choices, when we sense that the next move will have a serious effect on our lives, we can and should have recourse to general principles. Without them, man finds himself not only without criteria for judging rules, but also without personal light and goals. Obviously, they have a crucial role in a professional ethic for psychotherapists.

One thing which strikes us immediately about principles is that they
are vague and formal. Rules tend to be specific because they are closer to the concrete situations in which one is called upon to act. Principles are more abstract than rules, and yet they have a certain content. We know something of what truth means although the term is very general. The same is true for freedom and justice. The third level of ethical discourse cannot be confused with the second. Principles do apply to real-life situations, but they do not function as specific directives.

Principles are more stable than rules, and yet there are situations in which they too come into conflict. A conflict between two principles most often stands behind the ethical crises faced by a society and the personal dilemma faced by every person sometime in the course of his life. When the choice is not between a good and an evil, but rather between two goods, or when the realization of one good means the loss of the other, and the choice is such that it will greatly affect the life of the chooser, then we have a tragic situation in ethics.12

The best that can be done sometimes in tragic situations is to clarify the dilemma and provide a perspective from which to begin to wrestle with it (see the next section). Our point here is that principles are more stable, formal, abstract, and therefore less arguable than specific rules; and yet, they frequently come into conflict with one another. John Kennedy, who was neither a formal philosopher nor a great ethical thinker, made the astute observation that the tough decisions are not between right and wrong, but between different rights, or different wrongs. And what is true of politics is equally or even more true in psychotherapy.

Since principles are part of ethics in general, they are also part of a professional ethics for psychotherapists. Are there, however, principles which have special force in psychotherapy? Does the role of the therapist or the peculiarity of the therapeutic relationship force certain principles to the fore? After all we have said about principles and universalizability, it sounds contradictory to hear of principles specific to the profession of psychotherapy; yet it is a fact that some principles are more frequently referred to than others in codes for psychotherapists. Whether or not the therapist is a physician, the Hippocratic principles of beneficence and nonmaleficence, for example, will figure prominently in his code, and even more prominently in the profession’s tradition of caring behavior and commitment to persons in need. When faced with doubt, conflict, or ambiguity about certain rules, the professional decides by recourse to a principle such as beneficence. He asks what is best for the patient and follows the course of action indicated by this overriding principle.

The peculiarity of beneficence in medical ethics generally and the practice of psychotherapy in particular is its limitation to one’s own patient. The professional therapist today, like the ancient physician, is expected to consider the patient’s good his first priority and to reflect trust and care in his personal character. But beneficence can and often does conflict with the principle of justice in the sense of fairness to all.

Beneficence is closely linked to the principle of reasonableness or prudence which may be so important in codes governing psychotherapists as to be assumed rather than specifically articulated. To help and care for a patient, the therapist needs to have a thorough understanding of the patient’s situation and to exercise prudence in applying means to ends. The professional who does not cultivate the virtue of prudence or pattern his behavior by the principle of reasonableness is incompetent as well as unethical. Reasonableness figures both as a cornerstone of professional ethics and as an implied criterion for judging pathology.

Although the basic principles usually figure in professional oaths and codes in one form or another, some are given much greater prominence than others. There was a time, for example, when equality figured prominently in medical codes. For example, a Chinese code, the Canon of Medicine, from the Han Dynasty (200 B.C.-200 A.D.), pledged the physician to relieve suffering among all classes. It committed him to a radical equality in which “aristocrat or commoner, poor or rich, aged or young, beautiful or ugly, enemy or friend, native or foreigner, and educated or uneducated are all to be treated equally.” Another oath considered to be the work of Maimonides gave the same emphasis to equality. But more modern codes, like the principles of the AMA, following the tradition of the Hippocratic oath, do not mention this principle (Bok, 1977).

Social justice, which is not altogether dissimilar to equality, is another principle which does not receive great attention in professional codes. The principles of medical ethics generally and psychotherapeutic ethics in particular have been primarily individualistic, stressing the relationship of practitioner and patient, and leaving the larger issues of social justice, like allocation of resources, unaddressed. But pressure is being generated from inside and outside the helping professions for more attention to this principle. The ideas of John Rawls (1971) on this topic are commonly considered a good starting place for thinking about this form of justice. Rawls provided criteria by which a particular type of inequity (e.g., in the distribution of psychiatric services) may be judged actually unjust or justified as better than possible alternatives.13

Only rarely in history was there any mention of truth in the professional codes, or of the obligation to inform patients truthfully of diagnosis and prognosis. Plato believed that lies told to the patient for his own good, in the professional’s judgment, are ethically acceptable, and this belief seems to have been common within the profession. But now there is a concern about loss of trust in helping professions traceable to this habitual “benevolent” untruthfulness, and more attention is being given to the place of truth in professional communications. The re-
requirements of informed consent reinforce the need for truthful communication and demand a more prominent place for this principle in professional ethics.

The principles of autonomy and freedom were historically prominent in codes, but they tended to be limited in their application to the freedom and autonomy of the professional. Awareness of the one-sidedness of these principles has contributed to the formulation of "countercodes," such as the Patient's Bill of Rights. Now, however, contemporary ethical codes of psychiatry and psychoanalysis recognize patient freedom and autonomy in the requirement of free and informed consent. Prudence and reasonableness again are assumed to operate in assessing the level of information and the degree of voluntariness possible in any particular case.

One could actually say that freedom and autonomy are stressed in modern codes. It is the recognized vulnerability of the mental patient and the ease with which coercion might be camouflaged as beneficence that gave rise to more emphasis on respect for patients' rights. The good of the patient (beneficence), however, is often in conflict with the patient's control over his own destiny (freedom). The autonomy of the professional, on the other hand, easily comes into conflict with the requirements of a just distribution of health services. (In fact, some argue that equality or just distribution of services and freedom for the professional are mutually exclusive principles.) The choice of acting in accordance with one principle may mean abandonment of the other.

The operative principles in ethical psychotherapy, however, like the principles of ethics in general, are not the whole of ethics. Because there are many different principles, there is a problem arranging them in hierarchical order. By what principle are the principles themselves ordered? The "many" is always a problem, and one solution is to reduce multiplicity to one key principle. Kant's categorical imperative is one such key principle. But the difficulty is not disposed of so easily. Principles are multiple and they inevitably come into conflict.

One classical example, a version of which may be found in Plato, describes a person who leaves his weapon with a friend who promises to return it upon call. The weapon owner arrives agitated and hostile, demanding the weapon for the express purpose of killing his wife. Truth and fidelity require that the weapon be returned; beneficence demands that it be withheld. The case illustrates a conflict of principles and the situation in which opting for one means a violation of the other. In fact, this particular conflict is not so difficult to resolve because under these circumstances, the principles of beneficence and respect for life would in most people's view take precedence over truth and loyalty.

The more common type of conflict faced by a psychotherapist involves principles related to his professional duty on the one hand and universal principles on the other. Doing good (beneficence), and not doing harm (nonmaleficence) may conflict with a promise made to the patient, or truth, or the patient's freedom. These dilemmas are not as easy to resolve as the dilemma described above. There is no evident way to determine which principles should take precedence over which others. In such painful dilemmas the psychotherapist simply does the best he can.

"Doing one's best," however, means making a decision in light of beliefs about life that constitute the fourth and final level of ethical discourse. It means considering basic personal beliefs and the kind of person the therapist wants to be. Some may question the way a particular therapist resolves such a dilemma. Others may disagree with the direction provided by his basic beliefs. But to do so is to employ a different set of beliefs and a different vision of the good life (ethics at the fourth level). But before we move to this next level, one last consideration of principles is in order.

Existential philosophers have identified one unacceptable solution to ethical dilemmas that involve conflicts of principles. It is to avoid the issue, to act as if this conflict is not happening in one's life, or to act in one way rather than another without allowing oneself to be aware of what is actually taking place. Sartre (1956) calls these "non-solutions," or bad faith. They are pseudo-solutions based on pretense. The person who acts in bad faith pretends that no decision is called for, or that the decision is being made by others, or that outside forces make it impossible for him to act otherwise. In contrast, good faith requires a recognition of the ethical dilemma as one's own, and then a conscious effort to come to the best possible decision. Avoiding the decision is itself a decision—the worst one. Making such a decision, however, even for an atheist, involves a "leap of faith" to higher-level ethical phenomena.

We might finish this section by reminding ourselves that each of the different levels of ethical discourse has a degree of autonomy, and yet each is connected to the other up and down the line. Third-level principles are not completely abstract, though they are more so than are rules. Ultimately, they emerge out of a reflection on our human condition in the world, including conditions engendered by the existence of rules and codes. They are linked to human experience and to the lessons human beings have learned about the consequences of human action. Rules are the result of reflection on the task of constructing responses to concrete situations. Principles incorporate a slightly more abstract degree of reflection on the same task. Ultimately, however, the principles themselves have to be grounded and justified, and this enterprise moves us to the fourth and final level of ethical discourse.

The fourth level, philosophical/theological, is in one sense even more abstract, but in another sense it is a reconsideration of primitive, lived
experience at the existential level. The ultimate intellectual ground of ethics comes in the form of a philosophy or theology of human existence. Such principles as justice, love, or freedom are justified by rooting them in the structure of human existence. In providing such a justification, an explanation is also provided for man finding himself in an ethical universe in the first place. The first and fourth levels, thus, are closely related.

**Level 4—The Philosophical: Visions and Beliefs**

If man is the being who can always ask a further question, there is no reason to think that values in the form of ethical principles are excluded from this quest. In more philosophical moments, man asks radical questions. Why love? Why justice? Why freedom? When beneficence? What makes right acts right? What are the essential features of right and wrong acts? What is the meaning of good? Does it make sense to try to be ethical? Is there anything about the human reality which makes ethical striving a necessity for mental health and satisfaction?

All these questions throw ethics into a different mode and announce a new level of ethical discourse. The answers to such questions are a matter either of philosophical theory or religious belief. Closely associated with the way a person feels and acts (first level) are beliefs originating in philosophy or religion, and the deepest convictions anchored in early childhood experience about what is of value (fourth level).

Ethics is about concrete acts and choices, but it is also a matter of theory and beliefs. Man's behavior is linked to his ideas about reality, and he strives to conform his behavior to his reality beliefs. It is typical of man that he forms beliefs about reality and attempts to think through his ethical choices in order to make them consistent with his belief system. Even persons who resist contact with philosophical inquiry are sometimes forced into these more treacherous waters by existential conflicts and dilemmas. This situation frequently arises in clinical practice.

Conflicts force a person to ask not only "what shall I do," but also "what sort of person should I be, what is most valuable to me as a person?" Value considerations eventually move from a focus on actions to a focus on character. Sartre (1946) cites the case of a young man who has to choose either to care for his aged mother or to go abroad to join the resistance; he demonstrates that this conflict is really about the choice of a certain type of self. This kind of dilemma pushes ethics into the arena of self-creation and character choice. Sartre's point is that there is no way of doing ethics and avoiding what we have chosen to call the fourth level of ethical discourse. Ethics is more than concrete situations and judgments based on rules and principles. When I choose one principle as dominant for me, or decide that love, freedom, justice, or truth are important for my life, or commit myself to a course of action I think right, I do so in light of a belief about the way human reality is or about the type of person I should be.

Paradoxically, this most abstract level of ethical discourse is simultaneously the farthest removed from the concrete ethical situation with which we began our discussion and the closest to our starting point. Rather than ascending in a straight vertical fashion, the levels of ethics curve downward, so that abstract philosophical beliefs about life and reality connect with immediate feeling responses. Even our perception of values is a function of our way of being which is in turn a function of basic beliefs.

One way of speaking about this level of ethics is to refer to it as "vision" (Hauwertas, 1974). At some point, ethics is about our vision, and an ethical question pushed to its final point represents a search for vision. This vision of life and reality may be expressed either in philosophical or in religious language. In the former we use the categories and concepts of metaphysics or ontology. In the latter we use the language of story or myth.

Ethics, then, is involved in every aspect of life, and for the human being this includes the level of ultimate meaning. It makes sense to ask questions such as: Why be just? Why be ethical? What is real for the human being? What is the reality of my relationship to nature? What is my calling? What is the reality of my personal relations? Who am I? What is my purpose, function, destiny? These questions are not only not nonsensical; they are all closely interrelated. These ultimate questions frequently appear as part of psychiatric pathology, and when a healthy person finds himself in an ethical dilemma in which he must decide in favor of one value over another, then these questions force themselves into consciousness.

The relation between vision and behavior is well known to psychotherapists. Some indeed prefer to understand mental illness as false vision, or as preference for illusion and unreality. Contact with reality requires a true vision of the real. Where vision is sufficiently faulty, not only is reality denied but so too is freedom. Faulty vision creates twisted lives, and psychotherapy (especially an expressive psychotherapy like psychoanalysis) is in part a methodology for vision correction.

If vision, healthy or unhealthy, is diagnostically related to behavior, it is ethically related as well, in the sense of being good or bad. Ethics is first about immediate value choice, then about values in propositional forms of rules and principles, and finally, it is value theory in the sense of vision of what is real, good, and right for man. The vision that a person adopts...
comes through in the value judgments he makes and in his value preferences. Vision is involved in all the basic ethical factors: intention, disposition, motive, character, the grounding of value, the purpose of life, and value hierarchies. People differ according to their different ethical standards, but more basically, they differ in the different visions according to which they choose to see the world. "Doing ethics," then, is inevitably involved with religious and philosophical beliefs.

Judeo-Christian Vision

The best examples of how vision affects moral lives and ethical choices come from religion. The religious vision, communicated in story or narrative, provides a view of reality as touched by God, and the way in which the believer experiences reality as well as the way he responds to it is constantly checked by referring to a religious narrative. In theory at least, birth, growth, conflict, stress, love, aggression, death—all the basic human experiences—are evaluated and responded to in light of the vision.

The way in which a believer experiences his marriage, responds to his children, suffers disappointment, arranges principles of conduct, and adheres to rules is affected by his belief, or at least such is the challenge associated with the vision. To say this is not to deny the role of the unconscious but to insist that for ethics, especially for religious ethics, the central concern is with the conscious interiorization of a vision.

Religious vision can have a great deal to do with the patient's experience of himself and the world. But this is no less the case with the therapist. Religious belief can function as the ultimate foundation of the therapist's commitment to the relief of suffering. It can be the source of his sensitivity as well as the justification for his respect of the patient's worth and dignity. Specific norms which govern good practice can be rooted in a religious vision—for example, confidentiality and the prescription against sex with patients. The same is true of general principles such as truth, fidelity, freedom, and the like. The major impact, however, is likely to be in the development of inner attitudes and dispositions which substantially influence the way a therapist conducts his practice and resolves his conflicts.

Secular Visions

Religion is not the only source of vision. Historically, philosophy has been either a secular influence or the reflection of a movement toward secularization. The great philosophical systems can be seen as articulations, in less colorful language, of a vision which had formerly been expressed in religious myth. The ethics which corresponds to the great philosophical systems then attempts to communicate a vision of the good which does not depend upon belief in God or commitment to theological categories. Philosophical visions attempt to put good and bad, right and wrong, principles and rules of conduct, and the very purpose of life on a more objective or conceptual footing. Where once there was talk of such concepts as God, sin, and salvation, secular thinkers talk of superego development, categorical imperatives, and the greatest good for the greatest number. In effect, philosophical ethics presumes to provide guidance for those who do not belong to a faith community or who do not share the same religious faith.

Even though philosophical systems provide an alternative to religious valuation, they never completely escape the influence of religion and its language of myth and imagery. Despite their use of linear logic and more objective categories, philosophical ethical systems remain tied to a vision. The classical Greek ethics of Plato and Aristotle rely on an image of man as soul. Utilitarianism is tied to the myth of the English gentleman. Deontology is linked to an enlightenment image of rationality. Existentialism assumes the myth of the solitary hero and Freudianism holds to a mixed biological and humanistic vision of man as a sexual, autonomous, productive individual. The content of secular philosophical theories is communicated without reference to mythology, but a vision of the real and the good is always present. This cannot be expurged even by the use of metaphysical language. And while faith as a category may not appear in the philosophical system, it too plays a part. Human beings want to think that they know what is right or wrong, and ultimately the source of any certainty about such matters comes from faith in a certain vision of the real. In an ambiguous and complex world, human beings secure their righteousness not so much by the force of logic as by the force of faith. Both religious and secular persons are "religious" in the Tillichian sense of commitment to a vision of what is ultimately real and good (Drane, 1976).

Psychoanalysis

Is there a particular ethical vision peculiar to psychotherapy? Among psychoanalysts, one may guess that a Freudian vision of human reality and human good is more influential than any other. Psychoanalysis is on a level with other great philosophical systems and aspires to provide a vision of the real and the good (Rieff, 1968, 1978). It is more than likely, then, that vision influences the psychoanalyst more than he himself may realize. Those beliefs that are closest to the center of our lives influence us without even being noticed.

The audience to which this book is directed needs no review of
Freudian theory. Suffice it to say that Freud developed a philosophical vision not only of the nature of man but of the nature of ethics as well. Freud's vision (1962) includes details of the origin and development of conscience, guilt, right and wrong, justice, ideals, and the purpose of life. His ethical vision is integrated with a broader vision of the human reality and combines to form a powerful influence on modern man's morality. Obviously, it has an impact on clinical practice.

His ethical vision is integrated with a broader vision of the human reality and combines to form a powerful influence on modern man's morality. Obviously, it has an impact on clinical practice.

On the basis of Freud's concept of man's nature, certain behaviors are judged good, others bad; principles such as universal love are downplayed, others such as personal love are highlighted. And there are certain ethical rules or guidelines that follow from his vision, rules such as "Don't be aggressive," or "Don't be harsh toward yourself" (Feuer, 1955).

Utilitarianism

It is altogether possible that a psychotherapist may be influenced by more than one vision or theory of the ultimate basis of right and wrong. If, for example, the psychoanalyst is a physician, his training makes it more than likely that he will also be influenced by a utilitarian vision of the good.

Developed by Jeremy Bentham (1970) and John Stuart Mill (1947), utilitarian theory proposes a standard for determining right and wrong, based on an objective calculation of consequences. The right action is that which produces the best consequences. In this tradition ethics is primarily concerned with ways of determining and then quantifying the consequences of an act.

Utilitarian theory holds to one principle which is the standard by which all other principles and rules are assessed and by which conflicts between principles and rules are settled. "The greatest happiness for the greatest number" is the ordinary articulation of this super principle.

In a situation of choice or conflict, one can determine what ought or ought not to be done by referring to consequences which follow from the alternatives. The right act is that which brings about good consequences or happiness (differently defined by different utilitarian thinkers). In psychotherapy, happiness may be variously considered adjustment, relief of pain, productivity, or sensual satisfaction.

The utilitarian vision is attractive for many reasons. For one thing, it is very liberal. No action is prescribed or proscribed in an a priori manner. Only after identifying and calculating the consequences, can a decision be made about an act's morality. What was once wrong may later become right because of changes in the effects of the act. In addition, the quantifying spirit is well suited for a scientific age. The utilitarian does ethics with means and ends that are familiar to persons who consider themselves scientific.

In the helping professions with urgency pushing toward pragmatism, a modified version of utilitarianism is used as a cornerstone of ethical practice. "What produces the most benefit and the least risk for my patient is the right thing to do" may be considered the therapeutic super principle. Since Hippocrates, the cornerstone of ethical practice has been, "Do what benefits the patient" (positive form), or "Do no harm" (negative form). Assessing the risks and benefits of every intervention then is at the heart of medical and psychotherapeutic practice, such that the ethical therapist is inevitably utilitarian, either exclusively or in conjunction with other visions.

In its classical form, the utilitarian vision is universalistic in the sense that the good and bad consequences are calculated equally for all who are affected by the action. But in medicine and psychotherapy, the good consequences of an intervention for a particular patient is the basis of calculation. What benefits my patient is considered good, and indeed the highest good, which may sweep aside considerations of other persons and other values such as truth, freedom, and justice.

The utilitarian vision, then, provides a theoretical foundation for particular judgments, principles, and rules, and it establishes a procedure for conflict resolution as well. But it is open to criticism and indeed roundly criticized, especially when it presumes to be the only theory. Most often it operates conjointly with other visions.

Deontologism

Contrasted with utilitarianism with its orientation to consequences, is deontology (from the Greek deon, meaning duty), which insists upon a basis for right and wrong, independent of consequences. This one term covers a number of different theories about right and wrong, all of which share in denying that right ultimately depends upon the effects of an act. The deontologist believes that certain features of the act itself ground its ethical substance. It is the nature of the act which is the foundation of its rightness and the ultimate reason why it ought to be done.

Kant (1909) provides us with the clearest example of this reasoning:

The duty of being truthful is unconditional.... Although in telling a certain lie I do not actually do anyone a wrong [i.e., do not create bad consequences], I formally but not materially violate the principle of right.... To be truthful in all declarations, therefore, is a sacred and absolutely commanding decree of reason, limited by no expediency.

Thus, the definition of a lie as merely an intentional untruthful declara-
What comes through clearly in Kant's writing is the vision of man as purely rational in the sense of an ideal, neutral, reflective capability. He insists that truth telling is right in itself, and that its right-making characteristics can be recognized by anyone who thinks about the issue calmly. To the question, "Why be ethical," Kant would respond, "Because it is the very nature of man to be ethical." And as to what one must do, he insists that one's duty creates obligation. Deontological theories provide a foundation for principles, but supply very little guidance when principles or duties come into conflict.

Different deontologists hold to different right-making characteristics of acts. An insistence on justice is another example of deontology. Justice, like trust, is held to be a right-making characteristic even if the consequences are not the best. An item-by-item calculation of goods and harms is not required for the deontologist. Unequal distribution of goods is prima facie wrong, and fair distribution is prima facie right.

Medicine and psychoanalysis are deontological in the sense that certain right-making actions are considered part of the medical and psychoanalytic tradition. Freedom, justice, promise keeping, secret keeping, are included in medical and psychoanalytic codes, and their validity does not depend solely upon calculation of consequences.

In effect then, psychotherapy generally and psychoanalysis in particular presuppose a mixed formalism in the sense of a combination of utilitarianism, deontology, Freudianism, and possibly religious faith. To answer the question, "Why be ethical," one could refer to Freud (1962) or to Erikson (1964), who show the inevitable place of ethics in human life. Rules and principles which establish obligation independently of calculation of consequences are codified by the profession. And in situations of conflict between principles and rules, the professional may use a utilitarian, deontological, or even a religious standard for their resolution.

The psychotherapist does not ordinarily come across references to ethics at this final level. But if the concrete case and the particular patient are the ground of ethics, they cannot be the total picture. Every case has unique characteristics, as well as common aspects. Norms and principles and theories do provide an important perspective from which to view the concrete. General principles and methodology are needed to resolve individual cases. Without these there can be neither continuity, nor consistency, nor systematic progress in professional ethics for psychotherapists.

NOTES

1. One finds reference to these concepts in the Rhetoric, among other places (I, 2, 1356, a13, 15, 16; III, 1, 1404, a15). Although in the Rhetoric, he is talking of rhetorical discourse rather than poetic, the psychological action of the word was a constant concern of Aristotle, as it was for many Greek thinkers. What he says about rhetoric or the persuasive word applies to an understanding of psychotherapy as much as to his theories about catharsis. Aristotle agrees with Plato that the effectiveness of the word depends upon the reordering of the passions and beliefs of the listener. This may take place by
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2. Using the term "value" can increase rather than dispel confusion. It is used in different ways by different thinkers. In twentieth-century American and continental philosophy, value came to take the place of "that Plato talked about under the headings of the good, the right, obligation, virtue, moral judgment, etc. We are using value here in a broad, generic sense to refer to all the phenomena traditionally discussed in ethical treatises: rightness, obligation, duty, virtue, ideals, goals and norms of behavior, those qualities of the thing which make it pleasurable, noble, healthy, just, holy, and finally ethical theory. For our purposes, we are not considering economic and aesthetic values.

9. The act combines with its attending circumstances to provide us with the meaning of the act. Without this context of meaningful circumstances, an act has no meaning and certainly cannot be the object of an ethical evaluation. The movement of a piece of steel through a skull might be interesting and meaningful to the pathologist, but it becomes a meaningful ethical object only when the full context is supplied: "One person has deliberately taken the life of another in the course of a robbery, after shooting up on heroin." Another, different set of circumstances can easily be imagined. The same act by the same person may be committed in defense of one's family against a violent attack by the other person. Ethics as an enterprise cannot neglect the personal and the standards of society. Verbs like should, ought, prefer, desire, and must, and adjectives like preferable, desirable, responsible, good, bad, right, and wrong figure prominently in therapy.

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5. Man is never completely rational. It is unrealistic to expect that perfectly rational assessment will be made of the facts of any case. Rational assessments which strive for objectivity are influenced by intuitive factors rooted in deep-seated feelings and grounded in sharply held beliefs. And if the rational assessment which is preliminary to any application of rule has its nonrational facets, so too has the application of the rule itself. Judgment is required as to which rule applies, and to what extent it is applicable. This act of decision strives for the greatest objectivity, but always has its irrational facets.

8. The abortion controversy is a good example of such a clash. The right-to-life forces appeal to the principle of freedom, which is translated as a positive power on the part of the woman to control her body and its functions. It is not that one side is ethically and the other unethical. In fact, both sides are basing their case on an

6. The most recent code with direct importance for the psychotherapist is the Declaration of Hawaii of the World Psychiatric Association. It went through many drafts in an ideological tug of war between psychiatrists from democratic and Marxist regimes. The latter emphasized the psychiatrists' duties and responsibilities toward society, while the former pushed for the strongest guarantee against societal interference in the doctor-patient relationship. What was finally agreed upon is an important ethical statement, but one full of ambiguity.

7. If the psychotherapist is a physician, he might be bound by a number of other international codes in addition to the Hippocratic oath: the International Code of Medical Ethics, 1949; the Declaration of Geneva, 1949 and 1968; the Declaration of Helsinki, 1964 and 1975; the Declaration of Sidney, 1968; the Declaration of Oslo, 1970; the Declaration of Tokyo, 1975; and the Declaration of Hawaii, 1977. At the national level, he would be bound by the principles of medical ethics of the AMA, 1980, and by the Annotations to the principles of Medical Ethics of the APA, 1978. If a therapist belongs to the American Psychoanalytic Association, he is also bound by their code. And then there is the Patient's Bill of Rights adopted by the American Hospital Association. If he is involved in research, there are any number of additional codes and rules by which professional behavior is evaluated.

10. According to advocates of this alternative, its adoption would mean the abandonment of priestly pretensions on the part of a therapist. Contractualists consider themselves secularizers and demythologizers. Their fundamental values are those of liberalism, individual freedom, and personal autonomy. Whatever rights, duties, or obligations are to bind the therapist would be specified by the contract. Symmetry and mutuality would replace the paternalism and loyalty of the present doctor-patient relationship. Self-interest would take the place of professional virtue, and each party would have easy legal recourse in case of disagreement.

11. A union may disagree with all the laws and rules governing the responsibilities of a worker, and fight for changes under the banner of justice. A revolutionary feminist may object to every traditional norm or rule governing the behavior of a wife and laws governing women in society as well, but she may not object to the basic principle of justice—"Give to every person his or her due." Both the union leader and the feminist attempt to use the principle of justice in order to support their case for a change in concrete norms.
established ethical principle that neither side would want to deny. The pro-
abortionists do not want to deny the value of biological life or the principle
of respect for biological integrity. They would object just as loudly as anyone
to acts of mutilation or torture. The pro-lifers, in turn, do not want to forego
or to reject the value of individual autonomy. But in a particular situation,
both values cannot be realized. Acting according to one principle means
violating the other. The abortion controversy repeats the classical conflict of
Antigone. Her case involved a clash between the principles of obedience to
authority and respect for the dead.

13. Rawls' fairness test is expressed in different formulae: "The higher expecta-
tions of those better situated are just if, and only if, they work as part of a
scheme which improves the expectations of the least advantaged members
of the society." In another version, "The expectations of all those better off
at least contribute to the welfare of the more unfortunate. [In other words, if
the benefits of the better off were lowered, the worse off would comparably
suffer.] An inequality of opportunity must enhance the opportunity of those
with lesser opportunity."

14. Some great thinkers use both media of communication. Plato, for example,
resorted to myth in the midst of his philosophical search for the real. In the
analogy of the cave he gives his vision of reality in mythical form. He tells us
what it is to be in the human condition (ontology) and also how a person
should behave (ethics). Even in secular philosophies, there is a certain reli-
gerous quality to the highest and deepest levels of thought. Up against the
ultimate questions, argument always give way to vision and faith.

15. Critics of contemporary culture in both the Christian existentialist and Mar-
xist traditions explain the increase in mental illness today by the erosion of
meaningful world views and the substitution of superficial myths for sub-
stantial ones. For an elaboration of this theme, see James F. Drane, The

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Ethical Issues in the Training of Psychotherapists

Henry Grayson

Various articles and books have been written to deal with ethical or moral issues and values in the practice of psychotherapy (Buhler, 1962; Dragon, 1974; Franks and Burtle, 1974; Graves, 1976; Szasz, 1965; Van Hoose, 1977), yet there is a dearth of publications which discuss the ethical issues in training. Let us look briefly at those few publications.

Barnat (1977) studied the supervisory process and noted that a supervisee’s identification with a critical devaluing introject interferes with his or her developing feelings of professional identity. He concluded that by internalizing certain aspects of the supervisory character style, such as spontaneous supervisory metaphors, students experience less potency from the introject. Parker (1976) and Jorgenson (1973) focus on the clinician’s need for more adequate ethical training. Sanders (1979) reported one issue brought before the ethics committee of the American Psychological Association regarding supervisory confidentiality. No references which deal with the complexity of ethical issues in the training of psychotherapists were discovered. The purpose of this chapter is to begin to fill some of that void by discussing a number of such issues, raising numerous questions surrounding these issues, and suggesting a few possible alternatives or solutions. I do not purport to possess the answers to so many complex issues, though my bias will undoubtedly come through occasionally. The reader should not consider my bias a fait accompli, but should rather use it to stimulate his own thinking and considerations regarding the ethical issue being raised.

For the purposes of this discussion, the training ethical issues are presented in the following general categories: (1) How do we select whom to train? (2) What do we teach? (3) How do we train and what models of ethics do the training institutes and universities themselves set? (4) What are our criteria for certification or graduation?

1. Whom to train is one of the foremost ethical issues facing us, both at the university graduate or medical school level and at the independent training institute. What are the criteria used for the selection of candi-