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ABSTRACT

The patient-therapist model, the oldest form of mental health treatment, is at the core of reconstructive psychotherapy. Because this therapeutic partnership is subtle and vague, ethical concern is at the heart of the reconstructive therapeutic process. The aims of reconstructive therapy can be defined in terms of an existential, a psychoanalytic or an ego-psychoanalytic framework. In the therapist-patient relationship, usually only the therapist is knowledgeable about how the therapeutic process works to relieve symptoms. The patient has only hope and faith, which provide the groundwork for therapeutic influence. Emotional growth seems related to the patient's cognitive or perceptual response to the healer's curing powers, or the influence of personality. Thus, essential features of the psychoanalytic process include the therapist's characteristics and competencies, the working alliance, transference and countertransference, submission, and the nature of the therapist's authority. Factors that may lead to unethical practice include a God-like complex the therapist may derive from unrealistic feelings of superiority and power, and a strong narcissistic tendency that may be expressed through a need to control. Preventive measures for the therapist include personal analysis, case supervision with a mentor, and interdisciplinary as well as social relationships. (JAC)

ETHICAL ISSUES IN THE PATIENT-THERAPIST RELATIONSHIP

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ETHICAL ISSUES IN THE PATIENT/THERAPIST RELATIONSHIP

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INTRODUCTION:

The patient-therapist model is the oldest form of treatment in the mental health profession. Since the early work of Freud in the nineteenth century, psychotherapy has become a diverse treatment modality in today's culture. Psychotherapy may be divided into three forms: supportive, re-educative and reconstructive (Herron & Rouslin, 1982). The former two have more obvious intentions, while the goals of reconstructive therapy are less defined to the observer's eye. The amorphous character of reconstructive psychotherapy is linked to the early writings of Maslow, Horney and Fromm (Arieti, 1975). The global aim of helping the patient to achieve "self-realization" or "self-actualization" as the ultimate ethic considered not the actual ethical issues in the therapeutic partnership.

Because of this rather lofty and vague goal, concern regarding the nature of the psychotherapeutic experience, and its validity as a healing art has risen in recent years (Szarz, 1965; Goldberg, 1977). Since the patient-therapist model is at the core of reconstructive psychotherapy, some authors (Szarz, 1965; Goldberg, 1977) have advocated closer scrutiny of the relationship; and an examination of the ethical issues and hazards that surround it (Arieti, 1975; Redlich & Mollica, 1976).

The actual doing of reconstructive psychotherapy is a very personal and unique affair. Friedson (1976) writing to the

medical profession, illuminates the role of individuality in the healing process:

> "Each doctor builds up his own world of clinical experience and assumes personal, that is, virtually individual resonsibility for the way he manages his cases. In this way, the work of healing gives rise to a special frame of mind oriented toward action for its own sake (p. 172)...Such action relies on firsthand experience and is supported by both a will to believe in the value of one's actions and a belief in the inadequacy of general knowledge for dealing with individual cases (p. 178) ...The healer feels that his work is unique and concrete, not really assesable by some set of stable rules or by anyone who does not share with him the same firsthand experience." (p. 180).

Friedson's (1976) statement may be applied to the way the patient-therapist model has existed for years. That is, the therapeutic relationship has been draped in a veil of secrecy. The theory, objectives and goals have remained in the personal mind-set of the therapist, but are virtually unclear to the patient. It is this very one-sidedness that has led to mixed impressions of reconstructive psychotherapy. Depending on the observer, reconstructive psychotherapy may do everything or do nothing for the individual (Herron & Rouslin, 1982). The worth or lack of it rests in the eye of the beholder, that is, the patient as receiver and the therapist as provider. Most often than not, the naivete of the patient makes the therapist the sole judge of therapeutic relationship's efficacy. Some authors (Redlich & Mollica, 1976; Goldberg, 1977) have suggested that the "therapeutic partnership" cannot continue to reside in a cloak of mystery. The "moral" and "ethical" rules need to be

more clearly defined, so the patient's dignity and rights can be protected (Redlich & Mollica, 1976).

To some (Goldberg, 1977) the main ethical dilemma at hand are the more "subtle" and "elusive" issues in the "therapeutic partnership" that beg for more clarity; rather than the rare and clearly defined gross unethical practices. Goldberg (1977) observes these more vaporous features in the therapeutic relationship have resisted ethical guidelines.

So, in effect, the ethical concern is at the very heart of the reconstructive psychotherapeutic process. That is, the emotional attachment that develops from the patient's faith and idealization of the therapist's curative powers. Although the therapist-patient relationship is psychotherapy's strength, it is also its weakness (Karasu, 1980). At issue is the balance between the persuasive power of the therapeutic transference and the establishment of a true working alliance or partnership. Only with this patient-therapist equity can the aims of reconstructive psychotherapy be realized.

The goal of this paper on ethical issues in the patient-therapist relationship is to consider the more "subtle" and "elusive" ethical issues that may exist in this treatment model. However, to reach this end, it seems wise to discuss the patient-therapist model from its therapeutic aims, its historical and present influential nature, its therapeutic elements, and its ameliorative features.

> "The aim of a life can only be to increase the sum of freedom and responsibility to be found in every man and in the world. It cannot, under any circumstances, be to reduce or suppress that freedom, even temporarily." Albert Camus (1961).

II. AIMS OF RECONSTRUCTIVE PSYCHOTHERAPY

Through the years, many authors have attempted to define the aims of psychotherapy. Albert Camus' statement perhaps summarizes the ultimate end goal of the therapeutic partnership. It is within this existential framework that some psychotherapists have defined therapeutic aims. Arieti (1975) has offered that the psychotherapeutic relationship attempts to free the patient from circumstances that limit, and impede his will to succeed. The aim is to increase personal choices, or as Szarz (1965) has suggested to enhance "personal freedom." Although well intended, most psychotherapists tend not to lean on this existential viewpoint.

More specifically, therapists rely on theoretical constructs in discussing the aims of psychoanalytic, uncovering or reconstructive psychotherapy. In a more traditional psychoanalytic vein, the original tenet of psychoanalysis was to assist the patient to deal with his/her illness, and to de-emphasize the role of others who contributed to the illness (Szarz, 1965). Marmor (1953) delineated more succinctly the goals of the psychoanalytic process. He suggested therapy helps the individual gain emotional maturity; secure freedom from Oedipal fixations; and acquire a sense of self-respecting adulthood. Herron and Rouslin (1982) have explained the aims

of reconstructive psychotherapy within an ego psychological framework. The objectives include: personality growth, alteration of the character structure, awareness of important unconscious conflicts, ego strengthening, interpersonal maturity and creativity. Others (Hutt, 1976; Frank, 1961) have simply stated the goals in terms of changing attitudes, feelings and modifying or adding an improved cognitive structure to work from.

The aims of psychoanalytic or reconstructive psychotherapy hold out then the possibility of "making a new person" (Herron & Rouslin, 1982) or "increasing the sum of freedom" (Camus, 1961). However, assessment of these goals is a very subjective process. It often depends on the therapist's view of how and when these aims are accomplished (Herron & Rouslin, 1982).

> "Psychotherapy is the name we give to a particular kind of personal influence. By means of communications, one person, identified as "the psychotherapist," exerts an ostensibly therapeutic influence on another, identified as "the patient." What kind of influence do psychotherapists exert on their clients?"
> (Szarz, 1965)

III. SUGGESTION OR INFLUENCE IN THE THERAPIST-PATIENT MODEL

Each patient enters treatment with a set of undesirable or alien symptoms (Szarz, 1965). The therapist and patient thus have a mutual goal in mind, that is, to remove these

symptoms. Actually, the rudiments of the "therapeutic partnership" (Goldberg, 1977; Redlich & Mollica, 1976) are initially formed in this mutual goal. However, only the therapist, more times than not, is knowledgeable of how the therapeutic process works to relieve the symptoms (Goldberg, 1977). The patient has merely hope and faith that he has come to the right place for a cure. The patient's belief is founded initially on the therapist's established reputation, impressive office, and perhaps a waiting list (Calestro, 1972); and is further reinforced by early therapeutic interpretations (Hutt, 1977). Ehrenwald (1966) believes the patient's original hope is formed in reaction to the therapist's "therapeutic presence." Thus, the seeds for "therapeutic influence" (Szarz, 1965) begin with the patient's hope in the therapist's curative powers (Frank, 1961; Hutt, 1977).

PRIMITIVE MODEL: Some authors have suggested that this "therapeutic influence" (Szarz, 1965) predates the formal patient-therapist model. Marmor (1953) on writing of the dangers of superiority in the therapeutic relationship stated: "The psychotherapist has become the shaman of our society, the all-seeing father with Cyclopean eye. He is endowed with God-like perceptiveness" (p. 37). Strupp in 1978 commented that, "psychotherapy has become the secular religion" in our culture (Herron & Rouslin, 1982, p. 22).

Both authors strongly link the therapist's influential power to primitive forms of psychiatry, e.g., witchcraft, faith healing and priests. These rituals, much the same as psychotherapy, have always contained a high degree of emotional intensity (Frank, 1961). The shaman or priest's power to heal emanated from the influential process of belief and emotional discharge. Calestro (1972) perhaps most clearly describes the link between the formal patient-therapist relationship and primitive healing practices:

> "Psychotherapy is the progeny of a long tradition of neo-religious and magical practices. It is not necessarily better than all that has gone before it. It has simply taken on the cloaks and trappings of Western man who has abandoned the ancient gods and demons and sought new prophets in the form of Freud, Skinner and others," (p. 83).

Most therapists believe that suggestibility, trust and hope are necessary for positive treatment outcome (Calestro, 1972; Hutt, 1976; Frank, 1961). As noted above, this idea is not new, and, in fact, has existed for centuries. Calestro (1972), in an insightful article, has traced the evolution of the patient-therapist relationship to primitive forms of psychiatry. As a result of anthropological studies, psychopathology seems to exist in all cultures, literate and illiterate (Calestro, 1972; Fossage & Olsen, 1978; Frank, 1961). In primitive cultures, physical or emotional illness is due to a supernatural power. The shaman or faith healer, through a demonstration of magical powers or communication with the offended spirit world, grants

the victim absolution. The idea that the victim's peer group adheres to this belief reinforces his/her suggestibility, and thus a cure comes about. Early Judeo-Christian healing believed disturbance was due to sin and advocated absolution from an "ordained" holy one. The confessor/priest structure here appeared to be more sophisticated, since the aim was to reduce guilt (Calestro, 1972).

Quesalid, a shaman, wrote in his autobiography about the powerful influence he had over his followers. Quesalid, originally skeptical of the shaman's power, joined to expose these men as powerless and ordinary. After some success, he concluded the cure was due to the psychological interaction... "because the patient believed strongly in his dream about me," (Frank, 1978).

Primitive and Judeo-Christian healing rituals are similar, since their therapeutic value is mainly based on suggestibility. To maximize this suggestibility the healer: 1.) focused attention on the patient's affliction; 2.) created an atmosphere of increased emotionality; 3.) shared with the patient certain common beliefs regarding the culture; 4.) and held a special position in the community, that is, his knowledge was power (Calestro, 1972).

MEDICAL MODEL: Placebo, used in medical studies, has also shown to be a powerful and influential element in patient improvement. Since the placebo is an inactive substance, the beneficial results seem due to the placebo's symbolic power (Frank, 1961). The placebo

effect has been defined..."as the psychological, physiological or psychophysiological effect, which is independent of the pharmacologic effects of the medication...and which operates through a psychological mechanism," (Shapiro, 1959, p. 299).

A "double-blind" experimental approach is most often used in placebo effect studies. Both physician and patient do not know whether the patient is receiving the "real" medicine or the placebo. Responses to placebo and medicine are recorded and then compared for differences. The aim of placebo effect studies has been to determine the effects of patient expectations, that is, the impact of patient-physician interaction on physical and emotional conditions (Frank, 1961). For example, Frank's (1961) discussion of a study by Volgyesi in 1954 demonstrates the influential nature of the patient-physician interaction. A group of patients hospitalized with bleeding peptic ulcer condition participated in this placebo effect study. Seventy percent of the patients receiving a combination of placebo and physician reassurance demonstrated an excellent recovery rate. The control group participants, who received the same placebo injection, but from an unreassuring nurse, showed a mere twenty-five percent remission rate. Some patients had a negative reaction, additional physical complications, when they expressed fear of the method of treatment and mistrusted the physician.

Shapiro (1959) has concluded from a review of placebo effect studies that patient improvement is due to the doctor-patient relationship. In effect, the doctor is historically the primary therapeutic agent in such studies. To this relation-

ship Shapiro added some of the variables that may be in operation: the patient's predisposition to have faith; a doctor-patient mutual belief that some action leads to remission; and other nonspecific factors, such as enthusiasm, conviction, suggestibility, attitude, and psychodynamic elements. In concluding, Shapiro suggests the same influential factors operate in the psychotherapeutic relationship.

SOCIAL MODEL: The aims of the psychotherapeutic process generally reflect the emotional growth of the individual. Some authors have stressed more theoretical constructs (Marmor, 1953; Herron & Rouslin, 1982), while others have leaned on more simply defined goals (Hutt, 1976; Frank, 1961). Despite these various definitions, personal change seems to be based on the patient's cognitive or perceptual response to the healer's capacity to cure (Calestro, 1972; Frank, 1961; Shapiro, 1959). Social psychologists have sought to experimentally explain this process of persuasive or influential communication.

Bowden, Caldwell and West (1934) in an early study found that high suggestivity resulted when the person believed the communicator had high credibility and expertise. Another study (Kelman & Hovland, 1953) found that the communicator's good intentions, e.g., sincerity and trustworthiness, exerted influence on the receiver, and thus increased the level of suggestibility. Freedman, Carlsmith and Sears (1974) have indicated that studies on the communicator's prestige and intent have resulted in steady conclusions. That is, the receiver's views or attitudes undergo

change if the communicator is seen as an expert or genuinely interested. Without these characteristics, the communicator can be easily rejected.

Certain personality types have been found to be more responsive to placebo effect and persuasive influence, while others seem to be more resistant. Placebo responders tend to be more dependent, responsive to outside stimuli and conventional. Those not responding to placebo were mistrustful and less accessible to others (Lasagna, Mosteller & Von Felsinger, 1954). Individuals most susceptible to persuasive influence felt socially inadequate, aggressively inhibited, and depressed (Janis, 1940, 1955; Lindberg, 1940). Most of these individuals were characterized as passive-dependent personalities. A submissive attitude was an outstanding feature.

RECONSTRUCTIVE MODEL: Primitive psychiatry (Calestro, 1972), placebo effect studies (Frank, 1961; Shapiro, 1959), and persuasive communication research (Bowden, et. al., 1934; Kelman & Hovland, 1953) have shown that suggestion operates strongly in human interaction, especially in the process of healing and changing attitudes. The role of suggestion or influence in the patient-therapist model has been discussed by many authors (Calestro, 1972; Strupp, 1972; Hutt, 1976; Frank, 1961; Szarz, 1965). Most of these writers, with possibly the exception of Szarz, believe the therapist's influential nature may be constructively used in the curative process. Ehrenwald (1966) and Frank (1971) have attempted to explain how the power of suggestion

develops in the patient-therapist relationship. Three features, interconnected with the therapist's technical tools, seem to promote positive treatment outcome: the therapist's myth; existential shift; and doctrinal compliance (Ehrenwald, 1966).

Both the patient and the therapist define the therapist's myth. A mutual process of expectation resides in the patient-therapist relationship. The patient expects to be helped, while the therapist believes he/she can be a provider of such help. The therapist's own myth is formed by unconscious ideas of "magic belief" and "narcissistic fantasy." These elements diminish with the therapist's clinical experience, but they do not completely disappear. The patient's myth in the therapist is essentially based on the therapist's "therapeutic presence." This "therapeutic presence" seems to be initially formed by the therapist's status in society (Calestro, 1972; Frank, 1971); and then is further confirmed by the face to face therapeutic encounter, that is, the therapist's early acceptance and positive posture toward the patient (Ehrenwald, 1966).

With the patient's awareness of the therapist's "therapeutic presence," and the therapist's reinforcement of his/her presence, an "existential shift" is possible (Ehrenwald, 1966). That is, the patient has faith new interpretations will be forthcoming from the therapist to make clear the mysteries of his/her inner life. This existential shift is responsible for promoting the therapeutic transference and the parent-child dyad.

Frank (1971) perhaps delineates further the type of process that reinforces the therapist's "therapeutic presence" and promotes the "existential shift." In the course of the patient-therapist relationship, the therapist provides a rationale or explanation of the cause for the patient's distress, and a method for relieving the sypmtoms. The infallibility of the rationale has a reciprocal effect upon therapist and patient. On the one hand, the rationale protects the therapist's belief in his/her treatment approach. Simultaneously, the therapist's belief system supports the self esteem of the therapist; and indirectly strengthens the patient's confidence in the therapist. As the rationale is reinforced, the therapist makes sense of the patient's "chaotic" or "non-sensical" life. In effect, the therapist is actively demonstrating his power to control or comprehend the life matter that until then eluded the patient's grasp. Thus, the therapist's power to use influence or suggestion is enhanced in the curative process.

When the patient accepts the "therapist's myth," and participates in the "existential shift" a "doctrinal compliance" occurs (Ehrenwald, 1966). By this "doctrinal compliance" stage, the patient is taking the therapist's myth as a fact. The patient continually seeks to confirm the therapist's "therapeutic presence" through his/her verbal offerings. Simultaneously, the therapist is reinforcing the patient's belief in the power of the "therapeutic partnership" (Goldberg, 1977; Redlich & Mollica, 1976) by maintaining the "helper idea" and offering

direct evidence of his/her worth.

The patient's perception of the therapist is maintained by: gaining meaning into the presenting problem; believing in the accuracy of the therapist's interpretations; and trying successfully new alternatives (Ehrenwald, 1966; Frank, 1971). Continuation of this mutual belief system and more successful experiences lead to trust and hope in the therapist's capacity to cure, and thus helps the patient to a sense of well being (Calestro, 1972; Frank, 1971).

The therapeutic relationship is doomed to failure when the patient distrusts the therapist. The patient will not accept the therapist's rationale or myth or listen to the information, e.g., interpretations he/she receives from the therapist. Such a failure prevents the patient from gaining hope or experiencing success (Frank, 1971).

It may be said that the therapist acts very much as a catalytic agent in the patient-therapist model. The therapist as a catalytic agent is akin to the influential relationship in the primitive faith healing (Calestro, 1972), placebo studies (Frank, 1961; Shapiro, 1959), and social research (Bowden, et. al, 1934; Kelman & Hovland, 1953). A network of common elements seem to be in operation, namely: the factors used to highten suggestibility in the healing rituals (Calestro, 1972); a mutual belief system in the treatment approach (Shapiro, 1959; Ehrenwald, 1966; Frank, 1971); and the receiver's recognition of the prestige and genuineness of the provider (Bowden, et. al,

1934; Kelman & Hovland, 1953).

> "Freud developed a form of therapy dependent on a child-parent relationship to help the patient drop his facade and thus divulge his inner strivings and secrets. The child was expected to have no secrets from his parents, but not the reverse." (Frank, 1971).

IV. UNIQUE FEATURES OF THE RECONSTRUCTIVE PROCESS

In the process of doing reconstructive psychotherapy, the therapist is responsible for creating in the patient a sense of hope, trust and faith in the therapeutic partnership. The therapist has at his disposal two inseparable ways of achieving this end -- that is, by means of having a positive influence on the patient (Ehrenwald, 1966; Frank, 1971); and by means of the therapist's technical tools (Herron & Rouslin, 1982). It seems one does not exist without the other in a true working partnership or alliance.

In the therapeutic relationship, the patient's belief, even prior to the first encounter, is initially based on the therapist's status (Calestro, 1972; Frank, 1971), and increases as the patient and therapist interact (Ehrenwald, 1966; Frank, 1971). However, other than the therapist's "therapeutic presence" (Ehrenwald, 1966), what does the therapist bring to the therapeutic partnership to recreate the parent-child relationship; and to help the patient express innermost feelings?

The Therapist: The patient comes to treatment with the expectation that he/she will be helped. This hope has developed after the patient has vainly tried to solve his/her own problems. Typically, the therapist has learned to do uncovering psychotherapy through technical training and clinical experience. Sharaf and Levinson (1964) have discussed the specific pressures and strains that the therapist encounters in learning to work in the patient-therapist relationship:

1. The therapist has learned to understand and accept the patient's emotions. Often these emotions are intense in nature, and may be directed toward the therapist in transferential situations.

2. The therapist has learned to understand the meaning of the many diverse and complex motives, fantasies and defenses that arise in the therapeutic process. Often the therapist makes logic where no sense of logic existed before.

3. While the therapist grasps the patient's emotions and complex psychological nature, he/she must be aware of countertransferential issues (his own wishes and feelings). Knowing these countertransferential issues permits an understanding of how the therapist's personality impedes the patient's progress.

4. Finally, the therapist needs to find an even balance between emotional involvement and distance in the patient-therapist relationship. Two messages exist in the therapist's attempt to balance the relationship. On the one hand, the therapist needs to be warm and supportive, but also maintains distance and dispassionateness, so the patient's needs are met, and not his own.

The Real Patient-Therapist Relationship: With the therapist accepting the patient's feelings, understanding the complexity of human behavior, grappling with his own self-feelings, and finding a balance between activity-nonactivity (Sharaf & Levinson, 1964), the therapist has the potential to develop a "real relationship" or "working alliance" with the patient (Greenson, 1967). The term "real relationship" is distinguished from transference or countertransference reactions because it is realistic, genuine and undistorted, as opposed to artificial. Strupp (1972) maintains it is the power of this "good" human relationship that permits the patient to change. The important element to the "working alliance" is the patient's capacity to work purposefully despite transference phenomena; and the therapist's ability to maintain the "real relationship" in the face of countertransferential reactions (Greenson, 1978).

More recently, Herron and Rouslin (1982) have stressed the necessity of self-object differentiation in the working alliance. The presence of self-object differentiation, in both the patient and the therapist, serves two functions: self-object differentiation protects against one individual becoming an extension of the other; while simultaneously promoting the confidence and self-esteem to enter a "healthy fusion" with the other. Herron and Rouslin (1982) have stated quite explicitly that the therapist is initially the gatekeeper of the working alliance, since the patient is not developmentally ready for such a working partnership. As the gatekeeper, the therapist deepens a realistic

object relationship with the patient by conveying understanding, interest, optimism dedication and therapeutic restraint (Frank, 1961; Fiedler, 1950; Greenson, 1967). Once the patient has gained more self-object differentiation, and the therapist has been a watchful gatekeeper, a rich and creative working alliance is possible for both of them (Herron & Rouslin, 1982).

Transference/Countertransference: It is well-known that the therapeutic relationship recreates the parent-child relationship (Frank, 1971; Strupp, 1972; Namnum, 1976; Campbell, 1978). It is also well-documented that the re-establishment of this parent-child relationship in the therapeutic situation is dependent on the mutual belief system of the patient and therapist (Ehrenwald, 1966; Frank, 1971); the training and clinical expertise of the therapist (Shraf & Levinson, 1964); and the formation of a "real relationship" or "working alliance" (Greenson, 1967, 1978; Strupp, 1972; Herron & Rouslin, 1982). These three factors seem most essential to allowing the patient to suspend the reality testing he/she has relied upon; and in effect permits open expression of fantasies, feelings, drives and wishes (Hutt, 1976).

The therapist's efforts to provide a setting for a therapeutic relationship helps the patient participate more actively in the process (Hutt, 1976). In so doing, the therapist is prepared to enter a more deeply involved relationship that is marked by transferential/countertransferential reactions.

In contrast to the "real relationship," transference phenomena, in both the patient and the therapist, have been defined

traditionally as unrealistic, distorted and inappropriate reactions to the analytic situation. Transference is the inappropriate re-experiencing of feelings, drives, attitudes, fantasies and defenses in the present; and is a repetition of reactions the patient or analyst had to significant others in the past (Greenson, 1967). Even though transferential reactions are distortions, they are truly felt by the patient or the therapist; and suggests that the patient-therapist relationship has become more important than mundane issues (Greenson, 1967, 1978). Both positive and negative transferential phenomena are possible in the therapeutic relationship.

Positive transference is a frequent occurrence in the patient-therapist relationship. These positive reactions are always in some form of love, that is, fondness, trust, liking, concern, devotion and admiration. The patient is most susceptible to falling in love with the therapist. The intensity of this situation often resembles falling in love in real life. Frequently, this love is the result of past painful experiences where the patient has felt unfulfilled and unsatisfied. The therapist's therapeutic posture, acceptance and interest often allows these repressed feelings to emerge during transference phenomena. These positive reactions are likely to create countertransferential issues for the therapist, especially when he is inexperienced or unhappy in his personal life (Greenson, 1967, 1978). Negative forms of transference often contribute to progress in the patient-therapist relationship. These reactions may be expressed as hatred, anger,

mistrust, etc. Negative forms of transference tend to be more difficult to uncover during the therapeutic process.

Absence of negative transference is often due to the patient's resistance, but also to the therapist for encouraging the maintainance of this resistance for some personal gain (Greenson, 1978). The presence of all "positive transferential" reactions may be a warning sign that patient and therapist are colluding to avoid issues (Namnum, 1976); and the therapeutic "holding environment" is worked beyond its usefulness (Herron & Rouslin, 1982).

So, in effect, "real" and "transferential" elements exist in the patient-therapist relationship. But what is the process that maintains the "real relationship" and transferential relationship? Originally, Freud suggested that transference phenomena appears in reaction to the therapist's "mirror-like" image. At the same time, the therapist's anonymity protected the therapist from his own feelings (Namnum, 1976). More recently, however, transference phenomena are felt not to exist apart from the human or reciprocal nature of the therapeutic relationship. There is a degree of emotional participation by the analyst, and therefore some real basis for transferential reactions (Namnum, 1976; Searles, 1978).

Although previously the therapeutic relationship may have been mistaken as a "one-sided" affair (Namnum, 1976), the emotional demands of the relationship are no less for the therapist (Greenson, 1967, 1978; Namnum, 1976). The same "ego splitting"

appears to take place in the therapist as in the patient (Namnum, 1976). For the patient, the ego's capacity for object relations temporarily regresses to a more child-like, infantile state, while other ego functions remain intact. As a co-partner, the analyst is able to use a regressive mechanism as well to greet the patient's regressive condition. With the therapist's regression, countertransference is likely to occur (Namnum, 1976). Searles (1978) has expressed that this mutual participation in the therapeutic relationship is potentially helpful in two ways: 1.) the therapist gains insight into the interpersonal motives of the patient; 2.) the patient sees his/her reactions do not damage the continuation of the interpersonal therapeutic arrangement.

Namnum (1976) feels it is the patient's ability to split the ego between temporary regression and reality that enables analysis to continue. For example, the patient may experience deep longings and desires for closeness during transference phenomena, but the patient maintains this separation, not completely out of resistance, but also to secure a realistic human relationship. The therapist who allows the patient to become too familiar with his/her "real person," is likely to upset this beneficial balance and impede the therapeutic relationship.

Submission: With the "real relationship" established and the presence of transference phenomena, the therapist has prepared the patient to acquiesce to a more supplicant role. Keisman (1977) feels the patient's submission is essential to the

treatment process. Submission is defined as the patient forfeiting his/her power to the therapist for the purpose of understanding his/her emotional distress. In submitting, the patient's past hope of wanting to be helped in childhood is rekindled in the present. The patient's ability to submit suggests he/she is emotionally close to the therapist. That is, the healthy part of the ego is able to trust and believe the therapist is interested in him as a person. Such a posture allows the patient to work purposefully to grasp the therapist's meaningful interpretations (Greenson, 1967, 1978).

Authoritative/Authoritarian: Inherent in the patient's submission there is a giving in to the therapist's authority. Miller (1977) has cautioned against the misuse of this authority, and has made a distinction between "authoritative" and "authoritarian." The therapist, in an authoritative sense, brings to the patient his/her knowledge and expertise in doing psychotherapy. The therapist is therefore entitled to be credited and accepted on this basis. The therapist is "authoritarian" when he/she misuses the patient's submissive role in any way. For example, basing the interpersonal relationship on force with no consideration for the patient's needs.

> "You're thinking about something, my dear, and that makes you forget to talk. I can't tell you just now what the moral of that is, but I shall remember it in a bit."
> "Perhaps it hasn't one," Alice ventured to remark.

> "Tut, tut child"! Said the Duchess. "Everything's got a moral, if only you can find it." (Alice's Adventures in Wonderland).

V. THE POSITIVE FEATURES OF THE PATIENT-THERAPIST RELATIONSHIP

Most therapist's admit that influence or suggestion is an integral feature of the patient-therapist relationship (Campbell, 1978; Calestro, 1972; Strupp, 1972; Hutt, 1976; Frank, 1961). Some authors (Strupp, 1972; Hutt, 1976) more than others speak strongly to the positive virtue of such influence to find meaning, and thus personal growth. Strupp (1972) is of the conviction that a non-manipulative patient-therapist relationship does not exist. He feels this influence can be used positively to "skillfully manage" or "manipulate" the parent-child relationship. More explicitly Strupp (1972) continued to say:

> "Where there exists a strong need in the client to reinstitute a parent-child relationship, and the therapist partially but effectively meets that need, a matrix of virtually unequaled power has been created; it is within this that the therapist's operations [features] achieve their unique effectiveness." (p. 117).

Similarly, Hutt (1976) has expressed "...it is the therapist's primary function to persuade the patient that he/she has come to the right place for help" (p. 260), while MacAlpine, in 1950, discussing the therapeutic connection between suggestion and the development of transference has stated that "in the classical technique of psychoanalysis, suggestion so defined is used only to induce the analysand to realize that he can be helped and that

he can remember," (Campbell, 1978, p. 3).

In its proper sense then, influence or suggestion can be used by the therapist as an aid to foster the parent-child dyad or therapeutic experience. Apart from the hopeful feelings the patient derives from early perceptions, and then by reconfirmation of the therapist's "therapeutic presence" (Ehrenwald, 1966; Frank, 1961; Calestro, 1972), the therapist is using his unique features to promote a therapeutic experience. Frank (1961), speaking broadly, has outlined some of the most common features to the therapeutic process. To reach the ultimate goal of promoting the patient's self knowledge, the therapist: 1.) invites the patient to express feelings openly; 2.) transmits an understanding of the patient's motives, drives, feelings, fantasies, etc., and not his own; 3.) and dispells any claim of being superior, and may admit openly to errors.

During this global process, the patient is likely to feel confused and bewildered by the therapist's dissimilar nature when compared to others in his/her life (Frank, 1971). This ambiquity may be due to two factors. To begin with, the therapist has built some sense of hope in the patient. Secondly, and perhaps integral to promoting more hopeful feelings, the therapist is willing to understand that behind the reach for help, the patient is reluctant to let go of symptoms, and will activate resistances to avert changes (Hutt, 1976). The patient's recognition that the therapist is different promotes the feeling in the patient that the therapist is for him/her alone, and thus

the patient is able to entrust to the therapist the more shameful and frightening aspects of himself (Frank, 1961; Hutt, 1976). It is here that the therapist needs to manage constructively the therapeutic partnership. On the one hand, the therapist needs to frustrate prudently, and avoid satisfying the patient's wishes with neutrality and objectivity. But at the same time, the therapist needs to convey interest and empathy in the patient's powerless and inadequate sense (Sharaf & Levensen, 1964; Namnum, 1976; Karasu, 1980). By the therapist maintaining this "impartial interest" (Greenson, 1967), the patient is motivated to participate more fully in the therapeutic partnership (Frank, 1961).

The patient's hightened motivation, in the face of the therapist's restraint, is essential to the transference phenomena. That is, the patient-therapist relationship becomes the core of the treatment, while worldly issues diminish (Greenson, 1967). With the therapist's "impartial interest" the patient may attribute or read into the therapist's words more than is there. The therapist's words become especially "memorable" to the patient, and a search for meaning in nonverbal behavior and emotional tone increases (Campbell, 1978). The analyst's behavior is essentially responsible for the resurfacing of past, repressed conflicts in the patient-therapist relationship. Hutt (1976) expressed that the therapist's insightful interpretations advances the patient's hope, while increasing chances for more temporary ego regression during the therapeutic hour.

The rekindling of the parent-child relationship revitalizes the patient's wishes to be nurtured, cared for and protected (Campbell, 1978). It is here that positive transference phenomena may surface. In some instances the patient may seek the therapist's love (Greenson, 1967, 1978; Campbell, 1978). On the opposite side of the coin, when the patient's attempts to find out what the therapist wants and give it to him fail, negative transference phenomena is likely to occur. Since the patient cannot determine the therapist's wishes, the patient is frustrated having to work on his/her own (Greenson, 1967, 1978). As the therapist maintains his/her impartial interest, and does not assume a leadership role. the transference becomes easily analyzed (Campbell, 1978). In a positive vein, the therapeutic relationship for both patient and therapist is likely to reach its most productive state during transference phenomena (Searles, 1978). However, it also may be a danger zone for the therapist ill-prepared to meet the emotional demands and ethical considerations during transferential reactions.

> "Bellak, 1974, writing about the life of a psychotherapist stated quite prolifically," It is as close a vantage point on the human condition as there is. As you listen to a life history and to the symptomatology, you have a ringside seat all day, everyday, to the human drama! (Herron & Rouslin, 1982, p. 85)

VI. REASONS FOR UNETHICAL PRACTICE IN THE PATIENT-THERAPIST RELATIONSHIP

Bellak's statement brings into focus, in a dramatic way, the therapist's position in the therapeutic relationship. The unfolding of the "human drama" is what the therapist listens to daily. Of course, in this drama the patient's foibles, secrets, myths, and fears co-exist with the more reasonable and rational aspects of the patient's self (Greenson, 1967). Although accurate, Bellak's statement only speaks to the therapist's opportunity to view the patient, and not to the personal problems the therapist is likely to bring to his work (Herron & Rouslin, 1982).

The therapist is faced with an enormous personal task in doing reconstructive psychotherapy. In the wholesome therapist-patient relationship, the therapist works to understand transferential/countertransferential phenomena (Sharaf & Levinson, 1964; Greenson, 1967, 1978; Namnum, 1976; Searles, 1978; Campbell, 1978);to build the "real" working alliance (Greenson, 1967, 1978); to maintain impartial interest (Frank, 1971); and to avoid an overt or a covert leadership role (Campbell, 1978). Within this therapeutic framework, the therapist acknowledges and works constructively with the patient's submissive posture (Hutt, 1977; Strupp, 1972; Frank, 1971); and also realizes simultaneously the patient's need to grow autonomous from the patient-therapist process (Frank, 1971).

Although the patient-therapist model has been described as psychotherapy's strength, the nature of the relationship can also be deemed its weakness (Karasu, 1980). In the eyes of most reconstructive psychotherapists, the patient profits most from the thera-

peutic process when the therapist upholds the intention to help the patient reach an autonomous state. This goal is realized when a balance is struck, during the therapeutic process, between the persuasive power of the therapeutic transference and the true working alliance (Karasu, 1980). Certain factors operating in the therapist, however, may work against and impede the therapeutic partnership; and thus lead to unethical practice of a subtle, or in some instances, of a gross nature (Goldberg, 1977).

One of these factors is the "God-like Complex" or feeling of superiority in the therapist. As early as 1913, Ernest Jones, in discussing the "God-like Complex," hypothesized that individuals who pursued professional psychology or psychiatry have an unconscious identification with God. More recently, the "God-like Complex" has been considered to be a potentially dangerous occupational hazard to the therapist, and thus a danger to the patient's human right to emotional growth (Sharaf & Levinson, 1964; Marmor, 1953). Marmor (1953) felt that the therapist is especially susceptible to develop an unrealistic feeling of superiority from being in a constant position of authority or power.

As we have seen, influence, hope and trust and transference phenomena can be employed constructively to incite the patient on to personal change and growth (Ehrenwald, 1966; Greenson, 1967, 1978; Frank, 1971; Hutt, 1976; Namnum, 1977). However, some authors (Szarz, 1965; Marmor, 1953) have suggested these features, and especially the child-parent or transferential reaction, are susceptible to misuse through the therapist's power. This misuse

can occur quite easily. As the patient's idealization of the therapist, as a child looks to a parent, becomes more powerful during t sference, the patient's dependency or submission in the therapeutic unit increases the chances of arrogance in the therapist (Marmor, 1953). The feeling of arrogance or superiority may then cause the therapist to control overtly or covertly the patient's path in treatment (Campbell, 1978); and thereby promote an insufficient regard for the patient's own personal intentions (Karasu, 1980).

The therapist's feeling of superiority, like any other character trait, is a defense against anxiety. Marmor (1953) suggests this defense is activated to minimize the therapist's shortcomings. In extreme situations the therapist may take refuge in the "God-like Complex," to avoid the anxiety. There are a number of reasons why the therapist assumes a superior role: the patient's problems are constantly changing and shifting; the nature of the material is sometimes incomprehensible; the therapist has an unusual need to be professionally successful; the wish to be the all-knowing figure; and finally the disparity between the therapist's limitations and the patient's idealization of him.

The therapist who actively maintains this role of superiority is jeopardizing the wholesomeness of the patient-therapist relationship, and indeed may be unethically stalling the patient's growth. But how might such unethical behavior appear in the therapeutic relationship?

Campbell (1978) has suggested the therapist may either overtly or covertly influence the patient. Overt suggestion, of course, is a direct command or order by the therapist to abide by his/her wishes. This direct influence is clearly unethical. Another example of overt suggestion, perhaps less authoritarian than direct influence (Miller, 1977), may be demonstrated when the therapist over communicates, that is, holds himself out as a model to the patient (Frank, 1971); or as Namnum (1977) has suggested, the therapist reveals too much of his "real person," and thus negates his/her neutrality.

Campbell (1978) defined covert suggestion as..."an activity on the part of the analyst or therapist not explicitly stated which purposely produces an alteration in the patient and is not subjected to the patient's critical examination" (Campbell, 1978, p. 12). Campbell (1978) suggested that the therapist may impart to the patient, either consciously or unconsciously, his/her own morality or other countertransferential attitudes. If these covert suggestions are not balanced by the therapist's neutrality, then they may come to have an enormous influence over the patient. When mutually examined by both patient and therapist, the power of the suggestion is deflated. However, for the therapist who assumes blindly or intentionally a superior or God-like image, there is a danger the covert suggestion will go unanalyzed; and because of the patient's dependent posture, he/she is likely to abide unwittingly to the therapist's covert messages.

More recently, Herron and Rouslin (1982), taking a different slant, examined strong, unanalyzed, narcissistic tendencies in the therapist as a factor working against the patient-therapist relationship. They explain, from supervisory sessions and from colleague observations, that the field of psychotherapy seems to draw obsessive personality types.

By way of background, the obsessional defense, in patients as well as in therapists, is in reaction to an injury at the narcissistic stage of development. Briefly, narcissism arises from the infant's need to fuse initially with the mother to obtain sufficient care and protection. With the mother's emotional giving, the infant becomes emotionally capable to begin a separate and autonomous existence. Failure to get sufficient supplies from this early symbiotic relationship, enhances the desire to secure from the other what was lost in the past. A major feature of the narcissistic personality then is based on the need to give, and receive in return, emotional supplies from the other person, in this case, the patient, and not to work therapeutically in the patient's best interest.

The therapist may express his/her narcissistic tendencies in the patient-therapist relationship in the following ways (Herron & Rouslin, 1982):

"Control" may be present in the therapeutic relationship. The therapist, in his/her need to control the surrounding world, structures the patient-therapist relationship in the same way. Since the therapist is unable to participate with zest or vitality in his own life, he/she seeks to inhibit the patient, so the patient

does not exceed, threaten or emotionally leave the therapist's services.

"Power struggling" can occur in the patient-therapist relationship. The power struggling reaction, simply put, is the inclination for the patient and therapist to attempt to win the other over to his side. The patient and the therapist have difficulty recognizing the real presence of the other. Most often the therapist squelches, with his/her skill, the patient's more assertive attempts.

"Fear of compliance" is present in the therapeutic relationship when the therapist resists the temptation to try new techniques, even though the patient seems to be at a standstill. This act by the therapist is associated with an unconscious wish of non-compliance with his/her internalized mother, even though he/she recognizes the need for an altered approach. To risk something new would mean to comply with the other's wishes.

"Fear of influence," an outgrowth of the "Fear of compliance," arises when the therapist cannot allow the patient to take the lead and direct the flow of the relationship. The therapist, like his/her mother, cannot be open to the child's influence.

"Role certainity" may happen in the therapeutic relationship when the therapist assumes he/she has no doubt about interpretations, and conveys this sense to the patient. The therapist's certainity is a reaction to a poor self-esteem, and a fear of feeling powerless.

Whether the therapist overtly directs (Campbell, 1978); openly

reveals his/her "real" person (Frank, 1971; Namnum, 1977); covertly suggests (Campbell, 1978); or narcissistically conducts the therapeutic relationship, these behaviors may enforce the patient's dependency, and thus prevent autonomous functioning (Karasu, 1980; Frank, 1971).

Karasu, (1980) has suggested that the patient may fall prey to the therapist's unending search for unconscious material under the pretense of helping the patient grow emotionally; or the therapist may capitalize on the patient's dependent posture in an attempt to influence for personal gain. Both situations prolong the treatment process beyond its usefulness. It may be then, that the presence of either or both of these conditons in the therapeutic relationship may mean a "God-like Complex" (Marmor, 1953), with its derivatives (Campbell, 1978; Frank, 1971; Namnum, 1977); or narcissistic tendencies in the therapist (Herron & Rouslir, 1982) are operating latently in the patient-therapist relationship, and therefore no "real" relationship has been established (Greenson, 1967, 1978).

> "The therapist is assumedly an expert; but if he is not first of all a human being, his expertness will be irrelevant and quite possibly harmful." (Rollo May)

PREVENTION OF UNETHICAL PRACTICE

Marmor (1953) has suggested a number of ways to prevent problematic working alliances, and thus he offers a means to curtail

subtle or gross unethical practice. Marmor's (1953) preventive measures for the therapist are as follows: personal analysis for the therapist to ensure emotional security; case supervision with a mentor; continual vigilance of the ego's temptation to take refuge in arrogance; interdisciplinary contact with other professionals; outside work with colleagues; social relationships with individuals in other fields; and forming a democratic interpersonal relationship with all people.

In more recent years, some authors (Seabury, 1976; Goldberg, 1977) have suggested a therapeutic contract between both patient and therapist to ensure a real partnership, and thus promote ethical practice. Seabury (1976) and Goldberg (1977) agree that it is the ongoing therapeutic encounter, beginning in the first face-to-face meeting, that the therapeutic contract unfolds. Seabury (1976) has delineated the following stages:

1. The "exploration and negotiation phase" occurs when both members of the encounter search for the purpose of coming together, and what they hope to obtain from the meetings. There is a mutual sharing between patient and therapist to establish a working alliance.
2. The "preliminary contract phase" is characterized by more clarity and definition as to the reason for the encounter. Much "ambivalence and reservation" however, is apparent.
3. The "primary working agreement phase" occurs when the patient and therapist mutually agree upon the specific treatment goal(s), and time to accomplish the task. Also, they have jointly discussed and decided about

the way to treat each other in the relationship. Finally, there has been some discussion as to the method of evaluating and reviewing treatment outcomes.

4. The "termination phase" takes place with a mutual evaluation of treatment outcome. Consideration at this point is given to whether or not to terminate or formulate new goals.

Despite some of the old and new ideas to safeguard the therapeutic relationship (Marmor, 1953; Seabury, 1976), Goldberg (1977) has added depth to the former suggestions. The secrecy that has surrounded the patient-therapist is waning in favor of a more egalitarian approach (Goldberg, 1977). Goldberg has offered the following joint approach to forming a therapeutic contract:

1. The first task in the therapeutic situation is to explore issues surrounding the relationship, rather than the patient discussing his/her problems.
2. In developing a contract emphasize "operational terms," e.g., change of feelings, attitudes, and de-emphasize theoretical constructs.
3. The contract needs to address such questions as, "Why are we here?" "What are our expectations of one another?" "What do we have to offer each other?"
4. The therapist needs to be honest with his assessment of what can be accomplished with the patient in the therapeutic relationship.

5. The therapeutic contract needs to be equitable for both the patient and the therapist.
6. The therapist discusses with the patient the techniques he/she will employ, as well as informing the patient of any other consultations outside the relationship that may be needed.
7. A therapeutic contract needs to contain a means to evaluate and review therapeutic aims; and include a method for presenting grievances.
8. Finally, the therapeutic contract defines a well-developed plan for termination at any time in treatment.

REFERENCES

Arieti, S. Psychiatric controversy: man's ethical dimension. American Journal of Psychiatry, 1975, Vol. 132, 39-42.

Bowden, A. O., Caldwell, F. F. & West, G. A. A study in prestige. American Journal of Sociology, 1934, Vol. 40, 193-204.

Calestro, K. M. Psychotherapy, faith healing and suggestion. International Journal of Psychiatry, 1972, Vol. 10, 83-114.

Campbell, L. A. The role of suggestion in the psychoanalytic therapies. In R. Langs (Ed.), International Journal of Psychoanalytic Psychotherapy, Vol. VII, New York: Jason Aronson, 1978-79.

Camus, A. Resistence, rebellion and death. New York: Alfred A. Knopf, 1961.

Ehrenwald, J. Psychotherapy: myth and method; an integrative approach. New York: Gurne and Stratton, 1966.

Fiedler, F. E. The concept of an ideal therapeutic relationship. Journal of Consulting Psychology, 1950, Vol. 14, 239-245.

Fosshage, J. L. & Olsen, F. Healing, New York: Human Sciences Press, 1978.

Frank, J. Therapeutic factors in psychotherapy. American Journal of Psychotherapy, 1971, Vol. 25, 350-361.

Freedman, J. L., Carlsmith, J. M., Sears, D. O. Social psychology. New Jersey: Prentice Hall, 1974.

Friedson, E. Profession of medicine: a study of the sociology of applied knowledge. New York: Dodd, Mead, 1976.

Goldberg, C. Therapeutic partnership: ethical concerns in psychotherapy. New York: Springer Publishing Company, 1977.

Greenson, R. R. The technique and practice of psychoanalysis I. New York: International Universities Press, 1967.

Herron, W. G. & Rouslin, S. Issues in psychotherapy. Maryland: Robert J. Brady, 1982.

Hutt, L. Interpretation and hope. Psychotherapy: theory, research, and practice, 1976, Vol. 13, 259-262.

Janis, I. L. Personality correlates of susceptibility to persuasion. Journal of Personality, 1940, Vol. 504-518.

Anxiety indices related to susceptibility to persuasion. Journal of Abnormal and Social Psychology, 1955, Vol. 51, 663-667.

Karasu, T. B. Psychotherapies: an overview. American Journal of Psychiatry, 1977, Vol. 134, 851-863.

Keisman, I. B. The role of submission in the curative process. Issues in Ego Psychology, 1977, Vol. 3, 22-24.

Kelman, H. C. & Hovland, C. I. "Reinstatement" of the communication in delayed measurement of opinion change. Journal of Abnormal and Social Psychology, 1953, Vol. 48, 327-335.

Lasagna, L., Mosteller, F., Vol Felsinger, J. M. & Beecher, H. K. A study of the placebo response. American Journal of Medicine, 1954, Vol. 16, 770-779.

Lindberg, B. J. Suggestibility in different personality types. American Journal of Psychology, 1940, 53, 99-108.

Marmor, J. The feeling of superiority: an occupational hazard in the practice of psychotherapy. American Journal of Psychiatry, 1953, Vol. 110, 370-376.

Miller, D. The ethics of practice in adolescent psychiatry. American Journal of Psychiatry, 1977, Vol. 134, 420-424.

Namnum, A. Activity and personal involvement in psychoanalytic technique. Bulletin of the Menninger Clinic, 1976, Vol. 40, 105-117.

Redlich, F. & Mollica, R. F. Overview: ethical issues in contemporary psychiatry. American Journal of Psychiatry, 1976, Vol. 133, 125-136.

Seabury, B. A. The contract: uses, abuses and limitations. Social Work, 1976, Vol. 21 (1), 16-21.

Searles, H. F. Concerning transference and countertransference. In R. Langs (Ed.), International Journal of Psychoanalytic Psychotherapy, Vol. VII, New York: Jason Aronson, 1978-79.

Shapiro, A. D. The placebo effect in the history of medical treatment: implications for psychiatry. American Journal of Psychiatry, 1959, Vol. 116, 298-304.

- Sharaf, M. R. & Levinson, D. J. The quest for omnipotence in professional training. Psychiatry, 1964, Vol. 27, 135-149.

- Strupp, H. H. Needed: a reformulation of the psychotherapeutic influence. International Journal of Psychiatry, 1972, Vol. 10, 114-119.

- Szarz, T. S. The ethics of psychoanalysis. New York: Basic Books, Inc., 1965.