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PROCESS ETHICS: A COLLABORATIVE PARTNERSHIP

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This presentation and reflection of thoughts on process ethics is designed with the goal of constructing and assessing alternative ideas of ethics in therapy. Our intent is to explore how traditional content ethics in therapy can be honored but also supplemented to allow process ethics to flow from the partnership of client and therapist. In keeping with this objective, we will share our experiences of listening to the voices of clients, students, and therapists who have been invited to share their ideas of ethics in therapy. Hopefully, their stories will create curiosity about what types of social actions constitute ethical relationships.

Only if "you respond to me" in a way sensitive to the "relations" between your and my actions, can "we" act together as a "collective we"; and if I sense you as not being sensitive in that way, then I feel immediately offended, ethically offended.

—Shotter & Katz (1999, p. 152)

The quote above eloquently introduces the notion of ethics into therapy, tied to a therapeutic stance of collaboration and responsibility with clients. We consider ethics to be the respectful and meaningful interpersonal space between therapist and client. To contrast this concept with standardized codes of ethics, we use the phrase *process ethics*.

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PROCESS ETHICS: BEGINNING THOUGHTS

Process ethics represents the collaborative efforts and decisions of therapists and clients. Clients and therapists mutually set the tone and agenda of their therapeutic endeavor. The guiding premise within process ethics is the co-creation of ethics that occur within relational opportunities—where client, therapist, educational facilitator, or learner collaborate on ethical cojoint actions. These collaborations are designed to reflect the generation of meaning, which challenges "the taken for granted conventions of understanding," and invites "new worlds of meaning and action" (Gergen, 1999, p. 116).

Ethics, envisioned in this way, embraces the perspectives of social constructionism, turning away from modernistic ideas and claims of being able to generalize and legislate what constitutes ethical therapeutic practice (Anderson, 1997; McNamee & Gergen, 1999; Tomm, 1999). From a social constructionist position, the creation of social meaning, including ethical actions, is established by communicative actions. Gergen (1999) notes communicative action as always involving a vocabulary that is:

> porous, and every concept is subject to multiple renderings depending on the context. Each different meaning also generates a bridge to another community, to other conversations, and to still other meanings. In effect, the profound malleability of words works to destroy firm boundaries, and lends itself toward broadening the range of participants in the conversation. (p. 236)

In describing his thoughts on social constuctionism, Gergen proposes a "reconsideration of representation" (Gergen & Kaye, 1992, p. 173). The narrative of the client reflects reality as "one type of meaning generated account, a social product of community, and the therapeutic discourse is one discourse that takes place abnegation of the role of the therapist as superior knower, standing above the client" (Gergen & Kaye, 1992, pp. 173–174). From this view, ethics is a collaboration of values and morals.

We address traditional understandings of ethics adopted without participation by the individual client consumer as content ethics. Content ethics is not based on the unique conversations of therapists and clients, but instead is based on general formulations of conduct. In content ethics, we are describing the standards of practice whether the American Psychology Association, American Association of Marriage and Family Therapy, or other psychotherapeutic organizations (Canter, Bennet, Jones, & Nagy, 1999; Grayson, 1982; Keith-Spiegel, 1977).

These ethical codes of content provide guidelines regarding a therapist's responsibility to respect the dignity and integrity of clients and prevent defined forms of harm from occurring. Professional organizations and licensure laws implement these ethical codes. They attempt to protect the client as well as the therapist and are common across all theoretical approaches. They are developed

from actual circumstances when ethical conduct was questioned or violated, are intended to reflect minimal standards and requirements, and are often complex, leading to ambiguity, uncertainty, and vagueness when applied (Corey, Corey, & Callahan, 1998). Professional ethical codes of conduct outline principles, standards, and guidelines that attempt to structure therapeutic interactions in ethical ways. By necessity, they are broad and abstract. These standards are deontological ethics (Angles, 1981).

In contrast to content ethics, process ethics is created in the immediate client and therapist relationship. Process ethics honors the consumer of therapy and protects the clients' dignity and integrity *as* therapeutic interactions evolve. Process ethics does not attempt to deem whether codes of professional conduct and licensure laws are negotiable or necessary. To bridge vagueness and universality, process ethics is concerned with the ethics of the therapeutic relationship and the conversations that occur within relational therapeutic dialogues. Process ethics is vital to creating an environment in which therapist and client can co-create liberating narratives, privileging the local and unique nature of each therapeutic relationship. Process ethics privileges the client's view of the nature of the problem while simultaneously valuing the therapist's experience as a practiced facilitator of therapeutic discourse.

Process ethics in large measure supports and reinforces the principles outlined in official codes, but goes the next step to include the specific ways that such principles will be enacted in any given therapeutic relationship. The participants (client and therapist) define ethical partnership together and orchestrate therapeutic actions. Therapeutic conversations thrive where we do not label clients with modernistic terminology and subsequent practice, but allow for the thought that the consumer is valued and accessed.

Our reflections on process ethics are proposed to invite discussions regarding the place of ethics in therapy: Are ethics an organized pre-set code of conduct, an evolving and fluid set of interactions, or both? We wish to invite thought on the collaboration between content and process ethics. We offer what we believe to be three key components involved in process ethics: relational connectedness, full presence, and sacred conversations. Relational connectedness refers to the completely shared experience of the client and therapist in defining the focus and direction of therapy. Full presence describes a therapist's position of honoring and valuing the client's narratives by speaking honestly and caringly, opening the door to developing trust, and by staying humble (not claiming to know what is going on with a client or what may be the best opportunities for change). Sacred conversations refer to the practice of seeing conversations with clients as worthy of the highest respect and reverence—they are unassailable.

OUR JOURNEYS INTO PROCESS ETHICS

People [psychologists/therapists] need to realize that everybody is human and nobody is better than the next, some may be a little more confused, some may be stressed,

some may need guidance. Some may be overwhelmed at times and some people simply need to verbalize to somebody who has time to listen and who cares.

—a client

Our interest in process ethics is rooted in listening to our clients speak about their experiences of therapy. We have repeatedly heard stories of success as well as failure, but we were struck by the recurrent stories of marginalization they felt in their process of therapy. Clients explained that their stories were not heard or not heard within the spirit in which they were intended. Their stories were cast in problematic or dysfunctional frames by their therapists, with little or no recourse by which to address the misrepresentations. Even worse, out of these modified stories came treatment agendas that led to further diversions and misadventures (Goolishian, 1991).

Intrigued by client stories for two decades, Susan has been researching with clients and their therapists' the nature of their experiences of therapy (Swim, 1995; Swim, Helms, Plotkin, & Bettye, 1998), with specific attention to the ethical nature of the therapeutic relationship. She has been noting from client interviews interactions among therapy participants that reveal the development of themes of hopelessness, devaluation, loss of dignity, and humiliation that replaced initial hopes and expectations in seeking professional help.

Susan's research has led to her discovery that the research endeavor itself can include the "researched" more fully and ethically. In fact, the researched can be considered co-researchers, sharing the research stage in ways that give the researched an active voice in how they are construed and to what ends the research is devoted (Anderson & Swim, 1993; Anderson & Swim, 1994; Swim et al., 1998).

Sally's involvement and interest in process ethics is more recent. Her ideas come from clients' and students' voiced concerns. She used ethnographic questions within the course of therapy to better grasp what clients saw as good and desirable in therapy. Sally has also dialogued with her supervisees regarding their views on how to best approach clients—as whole persons or as simply the locus of intervention.

Co-designing the process of therapy with clients has provided the experience for Dan to find ways of using the same (or similar) processes in education. Student-teacher interactions, in addition to being considered sites where traditional hierarchical arrangements are dominant, can also be subjected to hierarchy-flattening efforts in order to offer liberating contexts that combine the voice of the learner (student) and facilitator of the learning context (teacher).

RELATIONAL CONNECTEDNESS: A PARTNERSHIP

Genuinely respecting people, allowing people to experience dignity in their relationship with you and in their lives, to have responsibility for their own lives—that is an ethical base. To be open and public rather than closed and private in my thoughts as a

> therapist, to allow my views, my ethics to be questioned by the other, to reflect continuously on my own values and morals—that is an ethical base.
>
> —Holmes (1994, p. 156)

Relational connectedness refers to the degree to which clients and therapists engage with one another and how they organize and coordinate their interactions (McNamee & Gergen, 1999). Relational connectedness reflects the propensity to embrace and understand the personal narratives of clients experiencing life burdens.

Ethical conduct evolves enabling the therapist to engage in dialogue that provides an opportunity for the social, relational action of listening and talking. The voice of the client is heard without the therapist needing to interpret what clients say from their value system, experiences, or formalized research findings and paradigms of practice (Andersen, 1995).

Within relational connectedness, discourse defines social communicative ethical action. A relational process unfolds to serve the creation of negotiated meaning that produces a self-tailored partnership (Anderson, 1997; Anderson, Carleton, & Swim, 1999). The conversational process is one that necessitates exploration and participation within client narratives. Through participating in the client discourse as legitimate and real, dialogue is valued and representational of the client's ability to "know" their own perspectives of their dilemmas, and identity of self. Here the "cycle of progressive infirmity" deconstructs in favor of endorsing clients' to talk about is sought from therapy (Gergen, Hoffman, & Anderson, 1996, p. 1). Through these dialogues, endless possibilities develop that are owned by neither client nor therapist, but by both.

We believe that relational connectedness is located at the core of process ethics. As clients privilege us with their dilemmas, confusions, and pains, we must respectfully join in with their telling. This process is by nature unscripted and engenders an uncertainty and ambiguity for the therapist that can be quite distressing (Anderson & Swim, 1994; Schön, 1983; Swim et al., 1998). We cannot know the nature of the relationship until we are in it and developing it. We also cannot rely on one way of developing a working relationship to suffice for all clients. In our attempts to help, we must guard against invalidating what our clients perceive as problems and what they think will lead to resolutions. Clients have reported that their painful experiences are worsened when their thoughts are misconstrued and misunderstood. They desire a therapist's participation, but not a taking over. Clients have spoken of wanting to be partners in their search for ways to alleviate their hardships in life. A challenge arises in the creation of conversational partnerships of what is good and proper.

> During a consultation, I was reminded to talk "with" him as a "human being" who was suffering and not to be so fixed on finding solutions or using the same techniques my colleague had out of my fear of "looking" different than she. When I began to talk to him as a human looking for solutions in his pain, instead of some

> suicidal treatment failure, I was able to hear his pain and join his search for peace and healing.
>
> —Kevin, a therapist

In relational connectedness, the responsibility for the direction of therapy is co-constructed between therapists and clients. It may appear to be a simple action to listen to clients with genuineness, immediacy, and authenticity, and to concentrate on what the client desires to talk about but this rapidly becomes more difficult in scenarios such as the following.

A supervisee comes to supervision with the following dilemma. This person is seeing a family who has three high school aged sons. The parents are disturbed about two of their sons—one son's drug experimentation (two times trying marijuana) and one's non-caring attitude about school and helping out at home. The third son is doing fine. The supervisee has seen the family three times. He has a good relationship with the family and is making progress with communication in the family. The supervisee has a teenaged daughter who attends the same high school and joyously came home one day and announced that she had a date with one of the sons—the one who has been experimenting with drugs.

If you were in this supervisee's situation, how would you balance content and process ethics? Unfortunately, situations such as this are not neatly covered or ever meant to be satisfactorily resolved by codes of ethics. The intersection of the personal relationship between the therapist and his daughter and the professional relationship with the family must be reconciled. We are in multiple relationships simultaneously and when they intersect we believe we must find guidance from those who are involved.

Because process ethics attends to traditional ethical standards in both scenarios, the therapist must simultaneously consider ethical codes on suicide and dual relationships along with the local and immediate ethical interaction of the therapeutic partnership. In situations such as these, the therapist as a partner dialogues about standardized ethical dilemmas. Because we avoid being the ethical expert or the external authoritative "policing agent," we share with our participants (clients, supervisees, students) our thoughts and perceptions. As in any conversational theme, we explore the dilemma and search for effective alternatives. Here is the collaboration between content and process ethics.

In this manner, one cannot state what will most certainly occur in either scenario. In Kevin's situation, he adhered to licensure and agency mandates for suicidal clients. He talked with his client about agency guidelines, his licensure standards, as well as his fear for his client's ability to live through the weekend. Together in the therapeutic relationship, they talked of Kevin's concerns as well as the client's grief and hopelessness. Through the dialogical partnership, self-tailored ethics occurred instead of any unilaterally made decisions. Kevin was compliant in his standardized mandates and did not embarrass or invalidate his client's hopelessness by being in an authoritative status. A quest for process and content ethics was sustained.

FULL PRESENCE

What I wasn't prepared for was that my immersion into a postmodern posture would produce a gut wrenching, life changing, but ultimately intensely rewarding experience and evolution. The process of learning to become a therapist with Bettye created a cataclysmic confrontation between my previously held belief system and these new challenging ideas. What I came to realize and value was that not only were my faculty and peers my teachers in this profound experience, but that Bettye and her family were also my teachers—regarding the invaluable lessons about the capacity for people to manage their own lives and self solutions that can arise from conversations.

Sallie's Story (Swim et. al., 1998, pp. 75–76)

Full presence co-creates a relational process where a client maintains the freedom to tell his/her perspectives, memories, ideas, and thoughts, perhaps that were never allowed the conversational space to be spoken before. Through the act of hearing and talking, a relationship develops that honors and values the psychotherapeutic discourse. The intensity of the listening and hearing and the flow of the exchange of constructed meaning embraces and collaborates the development of integrity and "feeling fully present in the moment to moment exchange of words" (Anderson, 1991, p. 54).

Full presence encourages the natural usage of the strengths between the client and therapist. This happens through such relational constructs as uncertainty, honesty, caring, trust, and humility. The client can trust the relationship to honor his/her identity of self, thoughts, memories, and words. The therapist's humility occurs in discourse that is guided by the client's direction, the client's aspiration for change. The natural resources and self-competency of individuals and families are accessed, since the therapist is not the cupbearer of what is real, nor the predictor of what should happen.

Full presence deconstructs fear for the client and therapist. Full presence allows the therapist to be free from the false confidence of pre-understandings and can therefore hear and talk within the client's discourse of pain and burden without a need to control the outcome. This is allowed to occur because the process of the right and good is developed cooperatively, not unilaterally.

Being honest allows a therapist the privilege to genuinely offer what he/she thinks about the client's story, which includes their ambivalences, inconsistencies, fears, and doubts. The therapist can trust in the therapeutic relationship as a medium for change without the requirement of being the expert.

Anderson has often said we evolve to like our clients (Anderson, 1997). In full presence, the relationship is client friendly and becomes therapist friendly also. Not as friends as outside the arena of therapy, but friendly—friendly that comes from mutual respect, mutual caring for the outcome of the process, mutually caring of the multiple voices, and mutual journeys for hope (Swim et al., 1998). Clients become heroes and heroines of their dilemmas, and we as therapists become privileged participants in their journey.

Full presence is demanded at the most difficult of times. In the middle of a session, Susan received an emergency call from a teenager, Mary, with whose family Susan had been working. Susan sensed that Mary had been using a substance and perhaps was suicidal. Against Mary's protests, Susan called the police. Mary came in for her next appointment furious at Susan. As they each explained what had happened from their points of view, Susan expressed her overwhelming fear for what might have happened to Mary and Mary's anger melted. Susan was interpersonally invested in Mary and risked it all for their relationship. In later interviews, Mary said this was the turning point in therapy. She realized Susan cared for her well-being and that they both shared in the struggle for Mary's misery to change.

Full presence requires us to hear clients in all their complexity. Sally worked with a family in-home who became so frustrated that they fired her. Sally left that day quite hurt, but returned the next day to better understand their decision. The mother explained that she was tired of having so many social service people in her family's life, with no appreciable improvements. Sally said she could understand her view and supported the mother's efforts to make her family's life better. The mother then asked Sally to continue working with them, explaining that she felt that Sally was really listening and supporting them. The mother further explained that they had not experienced a relationship with a therapist where conflict did not lead to hostile cut-off.

In full presence, each of us can be the person we need and desire to be in the context of the relationship. Our interaction is genuine, humble, and generative. Clients and therapist are free to be themselves and "conserve their integrity" (Andersen, 1991, p. 21). Real, honest talking and listening along with "the idea of collaboration in which no one has the final word" occurs instead of what Hoffman describes as "a search for the 'cause' or 'truth'" (Hoffman, 1992, p. 22).

SACRED CONVERSATIONS

> One might enter the observer's language and become distant and cold, the language of the participant and be near and warm, the language of the technician and become standing still and lonely, or the language of religion and become distant and violent. Whatever question one asks is chosen from many possibilities and whatever answer is one of many possible answers.
>
> —Andersen (1995, p. 33)

We believe that the therapist is in a sacred conversational place when one is in therapeutic conversation (Andersen, 1993). If we approach conversations with clients as inviolate exchanges, then we can invite relational connectedness and enact with full presence. We can appreciate the uniqueness, weight, meanings, and complexities of the clients' situation. We recognize the privilege we are

afforded—to come to understand and share in the depth and breadth of the intimacies of another's life. Our focus is on fostering a continuity of dialogue, rather than re-constructing perspectives that can lead to more pain and/or harm because they deviate from that originally brought into the therapeutic discourse (Andersen, 1992; 1993; 1995).

Conversations flourish when as therapists, we do not create too unusual of discourse—"what is unusual might be experienced by the client as somewhat painful" (Andersen, 1993, p. 303). The art within conversation is to participate in a way that allows the client's story of self to occur that attempts to prevent the opportunity for more pain and/or harm, from that originally brought into the therapeutic discourse (Andersen, 1992; 1993).

Sacred conversations are not fixed, but occur moment to moment, from word to word, from therapy session to therapy session. There is not one correct sacred conversation. This is not a technique-based intervention. It is a continuing, evolving attempt to listen to clients' self-described stories where the client and therapist gain clarity on opportunities and directions. The therapist enters into the conversation as perhaps a visitor to the narrative. Our conversations grow to possess an intensity and intimacy. Treating them with sacredness liberates clients to talk in new ways and frees therapists to participate fully in these conversations as human being to human being—we seek to understand and collaboratively join to develop action or change (Waldegrave, 2000).

REFLECTIONS

> There was after a time a genuine bond between us. She knew I cared about her and she cared about me and therefore our relationship could survive the ups and downs of me not understanding or believing at times. Authentic curiosity is not genuineness on command. It was a strong relationship based on mutuality rather than dependence.
>
> —therapist/co-researcher

> I think through listening and talking it helps. If someone just gave me advice I would be offended. I need to be listen to. I am most effective when I can just listen, be honest and share the responsibility without letting my intentionality rule the therapy session. I think process ethics is honoring the individual concerns and journey of each person. Compassionate listening and honesty are fundamental.
>
> —trainee/co-researcher

In continuing to ponder the differences between ethics as codes of preferred therapist conduct and ethics as an interpersonal process, we consistently come back to our foundational belief in partnering with our clients. Clients become partners in defining their diagnosis and insurance company updates. We as therapists do not act as investigators or judges. Our only information that we privilege is our client confidentiality. Therefore, clients are aware of what referral

agencies request. Clients are not viewed as dysfunctional entities to hide information from or to slowly manipulate.

When consumers are valued as participants in their journey toward greater happiness, such processes naturally involve compassion, honesty, genuineness, trust, humility, and caring. Clients will hopefully be seen as people moving through life rather than being bound to problems and as partners in their quest toward resolution. Here, the opportunity occurs to develop advantageous ethical solutions. Narratives of self maintain legitimacy, respect, and consumer-driven participation. Content ethics is supplemented to encourage the co-evolution of ethical relatedness for the client. The client is not perceived as an individual to be fixed or altered from some theoretical postulate. Instead, through relational discourse, the client is encouraged to discover what they wish to occur and how.

Process ethics is an interpersonal process that privileges the thoughts, ideas, and needs of all participants. Thus, therapist, facilitator, and clients become partners and make decisions based upon the "right and good" conditions that are pertinent and local to their unique relationship. This, of course, has implications for larger systems issues of third party payment and diagnosis, but even that does not overshadow the local knowledge and wisdom within the therapeutic system.

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