I

CLINICAL DILEMMAS: AN INTRODUCTION

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FUNDAMENTAL CLINICAL DILEMMAS IN PSYCHOTHERAPY: INTRODUCTION TO A TRANSTHEORETICAL CONCEPT

Dilemmas and emotional conflicts are endemic to the human condition and to life itself. Throughout history and literature, personal conflicts have been a recurring theme in amassed evidence to the ubiquity of this problem in daily living. When Shakespeare's *Hamlet* posed the question, "To be or not to be," he was fundamentally confronting the question about which avenue was more intolerable to him at that moment in time: continued life with his suffering of the "slings and arrows" of his particular "outrageous fortune" or the finality of death. On what bases are important choices in life to be made?

The notion of intrapsychic conflict has been basic to psychological theorizing since its early beginnings (Kendler, 1968). Freud (1940/1964b) saw conflict as the basis of neurotic disturbances and anxiety-based behavior. In

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parallel fashion, Pavlov (1927) demonstrated that dogs in a laboratory setting displayed behaviors that could be described as "neurotic" if they were continuously subjected to discrimination learning tasks that were increasingly difficult to perform. The dogs were trained to salivate and expect food in response to the stimulus of a circle and not so to the stimulus of an ellipse. As the ellipse was gradually changed to be increasingly like the form of a circle in which discrimination was difficult (i.e., on what basis is a choice–expectation with reasonably predictable consequences to be made?), the previously calm animal demonstrated increasingly agitated behavior. Also, social psychological field theory (Lewin, 1935) viewed conflict as the effect of the bipolar opposites of *attracting* and *repelling* aspects of an organism's environment, yielding a classic threefold categorization of conflict in approach–approach, avoidance–avoidance, and approach–avoidance terminology.

A *dilemma* is defined as "a situation involving choice between two equally unsatisfactory alternatives" (Merriam-Webster's Collegiate Dictionary, 1986, p. 355). Synonyms include predicament, quandary, and impasse, as well as the colloquial expressions of "catch-22" (Heller, 1961) and a "tight spot." In social psychological terms, such a scenario would be classically described as an *avoidance–avoidance conflict* (Lewin, 1935). An individual caught in an avoidance conflict, or dilemma, might describe him- or herself as "caught between the devil and the deep blue sea" or "caught between a rock and a hard place." Avoidance conflicts have been described as having a "damned if you do, damned if you don't" quality (Coon, 1980). Because such conflicts are highly stressful and rarely resolved fully, they are a source of anxiety. The psychotherapy patient faced with such alternatives frequently "freezes" and finds it difficult to make a decision or take any action whatsoever. Such a life impasse is often the precipitant for the patient to seek therapy. The psychotherapist, however, is generally not seeking a full resolution to an unsolvable conflict, knowing that complete resolution rarely, if ever, exists. The experienced therapist also knows that inaction is rarely a viable or desirable solution.

Why are dilemmas critical to the practice of psychotherapy? The answer to that question is in part related to the nature of avoidance–avoidance conflicts. In contrast to avoidance conflicts, *approach–approach conflicts* are typically resolved more easily. For example, "Shall I see a drama or a comedy when I go to the movies this weekend?" Approach–approach conflicts are often resolved so rapidly that people are frequently not cognizant of the momentary conflict that they produce (Kendler, 1968). Rather, patients are prone to request help in dealing with consequences that are more substantial. However, even while approach conflicts such as "Shall I respond to the acceptance that I received from Harvard or from Yale?" may result in seeking advice from family and friends, they tend to be resolved without seeking professional help. People typically do not need to seek such assistance in resolving conflict between two positive alternatives. We know from basic psychological learning research (Miller, 1959) that aversive consequences

entail a much greater valence than a choice between positive alternatives. We, therefore, might conclude that the avoidance of severely negative alternatives carries with it a certain survival value in an evolutionary sense (Buss, 1999).

The *approach–avoidance conflict* tends to be prevalent in life and is therefore more difficult to circumvent than the avoidance–avoidance conflict. In this situation, the person is both attracted and repelled by a given selection (Kendler, 1968). For example, "Shall I go swimming (which I enjoy) in the cold water (which I detest)?" A central characteristic of an approach–avoidance conflict is the experience of *ambivalence*, or the mixture of positive and negative feelings about the same event. Furthermore, many of life's more important decisions are characterized by approach–avoidance conflict, such as wanting to eat when overweight, or wanting to marry someone of whom one's parents strongly disapprove (Coon, 1980). Such concerns may entail sufficient emotional distress to bring one to engage the services of a skilled psychotherapist.

Dilemmas, or avoidance–avoidance conflicts, however, are truly the "sticking points" of life. They may, fortunately, be experienced less frequently, in part, because of the person's tendency to "leave the field" of conflict to escape the aversive nature of the consequences of choice. In questions of responsibility for actions, one way to leave the field is commonly known as "passing the buck." Hence, President Harry Truman accepted the responsibility of the presidency and committed himself to not leave the field, with the sign on his desk that read, "The buck stops here." In situations in which escape is not possible, indecision, inaction, and freezing are common responses. Even when not choosing carries with it its own undesirability, it may be preferable to electing one of two severely negative choices. Such inescapable situations are frequently the precipitants of psychological trauma, even after a choice has been made on whatever grounds. A poignant example of such trauma is *Sophie's Choice* (Styron, 1979) in which a young woman in a concentration camp is forced by a sadistic Nazi officer to choose which of her two children will live or die, when it is the civilized obligation of a parent to equally ensure the survival of all of his or her children. People who have undergone such traumatic life experiences almost always find benefit from the assistance of professional help to achieve a personal understanding of the event, even if only partial resolution or accommodation of the event is possible.

CLINICAL DILEMMAS AND THE PSYCHOTHERAPIST

The concept of the *clinical dilemma* (e.g., Dryden, 1997; Horowitz & Marmar, 1985; Ryle, 1979; Scaturo & McPeak, 1998) is one of the ubiquities in the practice of psychotherapy, for not only the psychotherapy patient but

also the psychotherapist. The process of psychotherapy itself can be viewed as a constant series of clinical choices and recurring dilemmas for the psychotherapist. For the practicing clinician, such decision making is a part of everyday occupational life. It is often said that one may find oneself "on the horns of a dilemma," that is to say, somewhere between two points, hoping not to get stuck on or by either. It requires of the therapist substantial tolerance for ambiguity. It is no wonder that an ability to think and function within the finer gray hues of life, rather than either the black or white polarities, tends to be a requirement of the job. The ability to clearly conceptualize such dilemmas is perhaps best captured by the term *clinical judgment* or *clinical reasoning*.

An undercurrent throughout this volume is that the clinical dilemmas discussed herein, and the corresponding demands for sound professional judgment and comprehensive clinical reasoning, will be readily recognizable to clinicians of all theoretical orientations to treatment. The substantial trend in the fields of psychology and psychotherapy, which began to escalate over the past decade, has progressed toward greater integration among theoretical approaches and treatment modalities and is likely to continue (e.g., Arkowitz, 1992b; Norcross & Goldfried, 1992; Scaturo, 1994; P. L. Wachtel, 1977, 1991). The notion of *psychotherapy integration* and the transtheoretical concept of clinical dilemmas go hand in hand throughout the everyday lives of psychotherapists who practice from a wide range of clinical perspectives and for whom this volume is intended to provide clinical utility.

Hospitalization of the Suicidal Patient

When dilemmas present themselves clinically, the psychotherapist, like the psychotherapy patient, is susceptible to anxiety—sometimes intensely so. No doubt the degree of anxiety varies according to a number of factors, at least two of which are (a) the importance or criticality of the consequences in a given dilemma and (b) the increased difficulty in making a discrimination between the most favorable and most unfavorable option. When the consequences of a mistake in judgment are severe, and the stakes are high, the anxiety of the clinician is at its peak. There are, perhaps, few judgment calls that produce the feeling of anxiety and agitation in the clinician as that of the suicidal patient. When a seriously suicidal patient presents to the clinician and the question of psychiatric hospitalization is broached, intense consternation fuels clinical thoroughness. Concern for the patient's well-being and the costs of a potential misjudgment both personally and professionally take their toll. If the patient is particularly reluctant to be hospitalized, and especially if the hospitalization will be a first admission for a given patient, then alternatives to admission (e.g., medication consultation, increased frequency of outpatient contacts) are likely to be even more thoroughly considered by the clinician. Hospitalization is approached with such

caution, in part, because the well-documented social consequences of psychiatric hospitalization (e.g., stigmatization, feelings of shame) are still very present (e.g., Corrigan, 2005; Goffman, 1961, 1986; Szasz, 1970), even in this new millennium. Furthermore, men often find the experience of a psychiatric hospitalization emasculating. Therefore, the prudent clinician does a thorough review of the risk factors, indices of lethality (e.g., Drowns-Allen, Allen, & Larson, 1980), consultation with colleagues when possible, and the recollection of clinical wisdom offered by almost every preceptor ever given on this topic, in an attempt to ensure proper clinical judgment in this critical situation. If the judgment call is close, and the feeling is that of a coin toss, then the criticality of the situation often lends clarity to the decision. If an error is to be made, the prudent clinician is likely to err on the side of safety, wishing of course, first of all, if possible, to do no harm (e.g., Greenblatt & Levinson, 1967) in accordance with the long-held principle of nonmaleficence in medical ethics (Beauchamp & Childress, 1994). In such a scenario, hospitalization is likely to occur or at least be strongly recommended, although the other factors arguing against hospitalization in a given instance are likely to remain.

Compliance With Reporting Requirements

Another "difficult call" in psychotherapy in a critical situation concerns the sense of divided loyalties that an individual therapist may feel. At stake is the balance between the individual needs of the patient (e.g., preserving the patient's confidentiality) and the therapist's desire and obligation to, for example, protect the welfare of the patient's child in the case of suspected child abuse, by complying with mandated reporting requirements to child protective services (e.g., Keller, 1999).

ATTEMPTS AT TAXONOMY: TECHNICAL VERSUS ETHICAL DILEMMAS

One basic distinction in the array of dilemmas in the practice of psychotherapy is that of courses of clinical action that have predominantly *technical versus ethical* consequences on the treatment process and the patient. Although there is a substantial literature of ethical dilemmas in psychotherapy (Clarkson, 2000), there exist myriad daily decisions in treatment that are essentially matters of psychotherapeutic technique and cannot readily be answered by decision trees, empirically supported therapy manuals, and "best practices" guidelines. And, although consulting such sources is indeed part of what a prudent and competent practitioner does in this process in attempting to resolve technical questions and dilemmas, manualized answers are only variably sufficient.

What distinguishes ethical dilemmas from technical dilemmas? Because the psychotherapeutic relationship and alliance (Safran, 1993) are critical to any method of psychotherapy, a considerable gray area exists between technical and ethical dilemmas in treatment. This may be represented visually by the simple Venn diagram of the relative intersection of technical and ethical dilemmas in Figure 1.1a. Precisely how much of the variance is shared between the technical and ethical struggles of the field differs in perspective from professional to professional. Indeed, there are therapists (e.g., Kaschak, 1999) who reasonably argue that all psychotherapeutic decisions can only exist within a moral framework, as does each and every human relationship.

Technical Dilemmas: Decisions Regarding Psychotherapeutic Technique

The process of clinical reasoning to establish even seemingly minor clinical decisions on a minute-to-minute basis can cause some consternation in the conscientious and reflective clinician but may not necessarily take on the magnitude of ethical overtones or implications. For example, how much confrontation of defenses is needed and tolerable for a given patient in insight-oriented psychotherapy with a given history at a given point in treatment (Scaturo & McPeak, 1998)? An error in judgment on this score may have ethical implications. However, such an error in psychotherapy may not have any more ethical implications than, by analogy, the degree of misjudgement in surgery regarding the needed length of an incision during an operation. Most prudent clinicians would likely regard such daily decisions as more a matter of clinical technique than a matter of neglect or questionable competence or ethics. Thoughtful clinicians, substantial in number, are likely to feel that the degree of shared variance between the technical and the ethical in psychotherapy is predominant, but not a complete one-to-one correspondence. Such thinking is likely to be reflected diagrammatically in the Venn diagram of Figure 1.1b.

In trying to consider what constitutes a chiefly technical dilemma, it may be helpful to consider an example of what might constitute a *technical error* in clinical judgment in the area of "known contraindications" in psychotherapy. The treatment of psychological trauma has formed one of the cornerstones of the mental health professions since their inception. Patients who have experienced severe, emotionally traumatic events, from either natural disasters (e.g., flood victims), technological catastrophes (e.g., auto accident survivors; Blanchard & Hickling, 1997), or traumas of intentional human design (e.g., combat veterans; Scaturo & Hardoby, 1988; Scaturo & Hayman, 1992), are likely to suffer from the intrusive memories of the traumatic event and disruptive symptomatology of posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994). Cognitive–behavioral exposure treatments, which gradually expose patients to their fearful recol-

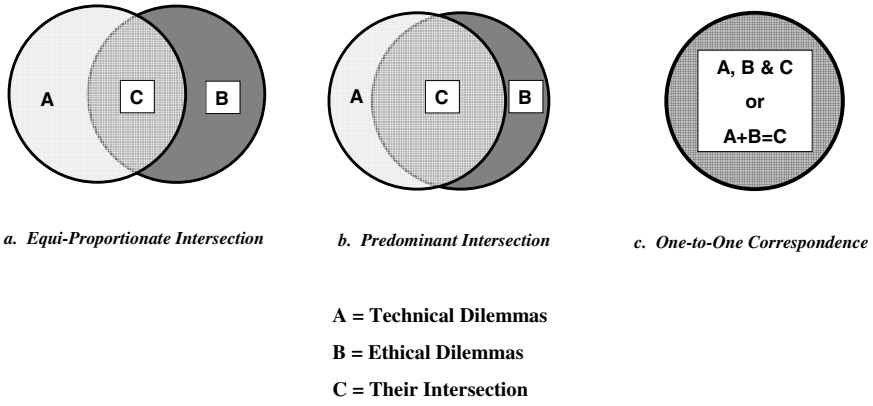


Figure 1.1. Technical versus ethical dilemmas in psychotherapy: (a) relatively equiproportionate distribution of technical and ethical dilemmas and their intersection; (b) predominantly shared variance between technical and ethical dilemmas; (c) one-to-one correspondence between technical and ethical dilemmas. From "Fundamental Dilemmas in Contemporary Psychotherapy: A Transtheoretical Concept," by D. J. Scaturo, 2002, *American Journal of Psychotherapy, 56*(1), p. 119, copyright 2002 by the Association for the Advancement of Psychotherapy; and "Fundamental Dilemmas in Contemporary Psychotherapy: An Overview," by D. J. Scaturo, 2003, *Ethical Issues in Mental Health Counseling, 6*(1), p. 3, copyright 2003 by The Hatherleigh Company. Adapted and reprinted with permission.

lections with either imagery or in vivo techniques, have come to be accepted as one of the major, empirically supported treatments for PTSD (Foa, Keane, & Friedman, 2000). However, despite the demonstrated effectiveness of exposure-based treatment, Meichenbaum (1994) has reviewed a long list of contraindications for this otherwise highly recommendable form of treatment. These clinical considerations include a history of impulsivity, suicidality, inability to tolerate intense emotional arousal, and the presence of other comorbid diagnoses (Allen & Bloom, 1994; Litz, Blake, Gerardi, & Keane, 1990). In addition, in some instances, exposure-based treatments have been found to have deleterious effects on patient functioning (Davidson & Baum, 1993; Pitman et al., 1991), including the augmentation of shame and guilt associated with the traumatic event.

It is incumbent on the clinician to have not only a working knowledge of these contraindications but also an ability to assess them accurately in the PTSD patient with considerations given to potential treatment recommendations, particularly if direct exposure therapy is being considered. Overlooking treatment contraindications would minimally constitute a technical error, and more glaring deviations would likely bring forth questions concerning the clinician's competencies. However, a technical dilemma, largely separate from that of an ethical dilemma, would nevertheless exist for the cautious, caring, and prudent clinician, who thoroughly evaluates all known

contraindications before providing treatment recommendations and is left with an unclear judgment call. On the horns of this particular dilemma, the choice might be characterized as (a) providing less-than-effective supportive therapy for someone who may potentially benefit from the alternative versus (b) providing a more aggressive exposure-based therapy that has the potential for deleterious effects in a patient with an unclear mix or moderate degree of contraindications (Dryden, 1997).

Such decisions exist universally for practicing clinicians, regardless of theoretical persuasion. Similar contraindications exist, for example, in intensive short-term dynamic psychotherapy (Davanloo, 1978) that utilizes intense confrontation of the patient's defensive structure to facilitate the treatment process. Many contraindications for these approaches, including fragile ego structure, major affective disorders, bipolar disorders, psychosis, borderline disorders, and substance abuse, are among the many diagnostic elements that require a rule-out (Davanloo, 1988).

Ethical Dilemmas: Decisions Regarding the Overall Welfare of the Patient

What then distinguishes an ethical dilemma from a technical dilemma? In effect, what distinguishes a given treatment decision as an ethical dilemma generally involves the question of proper professional conduct concerning the patient's well-being. Are there technical dilemmas that exist apart from an ethical implication? To be sure, the gray area of overlap between them is a substantial one, and the identification of discrete categories is by no means definitive. In addition, there is reasonable concern over the tendency of dilemmas that are fundamentally ethical in nature to masquerade as problems of clinical technique (e.g., boundary management in the therapeutic relationship; Scaturo & McPeak, 1998). There are, however, several general principles that guide decision making and clinical reasoning in the area of professional conduct in health care. The traditional principles of biomedical ethics generally include those of (a) nonmaleficence, (b) beneficence, (c) justice, and (d) patient autonomy.

Nonmaleficence requires that the health care professional not intentionally, or through neglect, create needless harm or injury to the patient. It is that tenet of the physician's Hippocratic Oath that requires that we first, and above all, do no harm to the patient. Meeting requisite clinical competencies is a fundamental necessity in order to be able to hold true to this value. Avoiding potential harm to the patient is considered to be "self-evident," that is, a prima facie duty of the health care professional. *Beneficence*, also a prima facie duty, means that the practitioner's treatment efforts are always intended to be of benefit to the patient. Beneficence is, however, a more limited duty of the clinician in that it is restricted to those people with whom the practitioner has a treatment agreement and a practitioner–patient rela-

tionship. Third, *justice* in health care encompasses the notion of fairness in allocating valuable medical resources among the various members of a society, which has increasingly become an issue within a managed health care system. Finally, the *autonomy* of the patient to make health care decisions in a fully informed and genuinely voluntary manner is an operative value throughout. It presupposes that the patient has the capacity to understand the decisions that are to be made and, therefore, becomes the basis for the process of informed consent for proposed treatment interventions.

Against this backdrop of ethical principles in health care, the more specific types of dilemmas that fall into the category of ethical conflict for psychotherapists are several. Survey research studies in both the United States (Pope & Vetter, 1992) and the United Kingdom (Lindsay & Clarkson, 1999) among psychologists found common localized areas of ethical concern. In order of most frequently identified were the following categories of concern for professional ethical dilemmas: confidentiality, dual relationships, colleagues' conduct, sexual issues, academic/training issues, and professional competence.

The largest category of ethical concerns surrounded events that might require the suspension of the time-held obligation of confidentiality of the patient. Such instances involve the possible risk to third parties (i.e., reporting child or sexual abuse), risk to the patient (i.e., suicidality), disclosure of information to other third parties even with written consent of the patient (e.g., to the patient's significant others, as well as other health care providers and insurance agencies), and the possibility of careless or inappropriate disclosures without written consent.

A second area of concern consisted of the possibility of dual relationships with a patient, excluding those involving sexual behavior. These include other types of social relationships with patients (e.g., providing treatment for colleagues and their families) or working with two separate patients who have a relationship with one another (e.g., a patient who refers his or her coworker). Third, a significant number of ethically troubling events concerned the professional conduct of their colleagues, including concerns over the professional competence of a colleague, unprofessional comments by colleagues, professional conflicts regarding referrals, and inappropriate disclosure of clinical information. Fourth, there arose a considerable number of issues surrounding the sexual relationship between a psychotherapist and a patient; these included (a) the mere existence of a sexual relationship with a patient, (b) the time of onset of the relationship (i.e., during or after treatment), (c) who initiated the relationship, (d) the vulnerability of the patient, and (e) sexual relationships between supervisors and trainees. Fifth, a number of ethical dilemmas surrounded academic training that involved the supervision of trainees whom they consider either unready or unsuitable to practice for any of a number of reasons. Finally, there were general questions about competence of self and others at the outset of one's career in dealing

with cases of exceeding complexity, as well as questions concerning impaired providers (e.g., knowledge of a colleague's alcohol problem).

Clinical Dilemmas Identified by Master Psychotherapists

Another approach that has been taken to identify the salient dilemmas, both technical and ethical, in psychotherapy has been to consult an array of master therapists regarding the dilemmas that they have experienced in their own clinical practices. Dryden (1997) conducted 14 interviews with different psychotherapists in the United Kingdom and the United States. The 14 dilemmas discussed were classified into six overlapping categories, or themes, with some discussions being relevant to more than one category.

Compromise dilemmas involved the therapist's struggles between the ideal and the pragmatic in psychotherapy, such as accepting more limited and traditional therapeutic goals for a patient versus striving for more radical (but perhaps riskier) goals. Another category consisted of *boundary dilemmas* in which the therapist is confronted by a choice as to whether he or she should cross the boundaries of a given technical framework, such as how much the therapist should reveal about him- or herself. Third, there were *dilemmas of allegiance* in which a therapist may struggle to maintain a certain allegiance to a particular school of thought versus branching out into new avenues of therapeutic intervention and the potential loss of support that one receives from one's primary collegial reference group. The fourth grouping was that of *role dilemmas* such as the conflict between educator and healer or scientist and practitioner. The fifth theme concerned *dilemmas of responsibility* in which the psychotherapist struggles between accepting a certain degree of responsibility for a given patient's welfare and respecting the patient's autonomy for his or her own life choices, given the varying degrees of functionality exhibited by different patients. Finally, there was the class of *impasse dilemmas* in which the therapist confronts varying avenues of response when a certain course of treatment has become intractable or reaches a limited plateau.

P. L. Wachtel (1997) exemplified the impasse dilemma associated with what he termed the *nonimproving patient*. He aptly noted that no psychotherapist is universally effective. Yet, there are many patients who seem to form an important bond with their psychotherapist, despite a prolonged absence of symptomatological improvement. In a fee-for-service model, Wachtel talked of the ethical misgivings that the therapist has in such a circumstance about the patient paying for services in which he or she appears to derive no symptomatic benefit. However, he noted great concern about the patient experiencing serious relational rejection by even addressing this topic in treatment. This situation may be further complicated by managed health care. Frequently, it may be expected that third-party reimbursement for treatment will be terminated for lack of symptom improvement, despite the patient's

potential sense of rejection and any emotional harm that may result from that scenario. Often, behavior change is the patient's "calling card" for treatment, although some sense of self-acceptance for one's life in the absence of any behavioral alterations may well be what many patients are seeking. Admittedly, in many cases of dysthymia, for example, one might reasonably expect some abatement of depression when self-acceptance is enhanced, but not in all cases. Is there a place for palliative psychological care for chronic depression in the current health care lexicon? This may be less of a dilemma in circumstances in which the patient's condition is, in fact, worsening despite the best effort of a given clinician (P. L. Wachtel, 1997). In such instances, it may be very clear to both the patient and the therapist that a referral to another clinician or another form of treatment is indicated and is, thereby, experienced as less rejecting to the patient. Unfortunately, however, much like Pavlov's (1927) experiments in which it is increasingly difficult to discriminate between the circle and the ellipse, cases in the gray area of intractable, but nonworsening depression frequently exist. It is clear that grappling with clinical dilemmas is not designed for clinicians who may be seeking an array of manualized answers to what are invariably exceedingly complex questions (Dryden, 1997). The examination of psychotherapeutic dilemmas remains an area in which the concept of clinical wisdom continues to have relevance (Karasu, 1992; Scaturo & McPeak, 1998).

Dilemmas Relevant to Circumscribed Areas of Psychotherapy

Another method of attempting to circumscribe the broad array of dilemmas that occur in the process of psychotherapy has been to delimit a given discussion to a specifically defined subarea of psychotherapy. A sampling of four such circumscribed areas of psychotherapy would include the dilemmas that clinicians have encountered in (a) brief therapy, (b) managed behavioral health care, (c) sexual issues in treatment, and (d) feminist therapy.

Dilemmas of Brief Therapy

The fundamental question for brief psychotherapy is "whether it can be more than shallow?" (Gustafson, 1995, p. vii). The main task of brief psychotherapy is to select a focus for the episode in which the patient has sought treatment and adhere to it (Gustafson, 1995; Ryle, 1979; Schacht, Binder, & Strupp, 1984). Whether this involves a focus on target behaviors for change as in classical behavior therapy, centering attention on the modification of the patient's thought processes and maladaptive self-statements as in cognitive–behavioral therapy (e.g., Meichenbaum, 1977; Meichenbaum & Cameron, 1974), a psychodynamic focus as in time-limited psychodynamic psychotherapy (e.g., Scaturo, 2002c; Schacht et al., 1984), or the central relationship dynamic in brief marital and family therapy (e.g., Budman & Gurman,

1988; Scaturo, 2002a), the clinical focus of psychotherapy necessarily favors one area of exploration and change while neglecting others.

In considering this dilemma, Gustafson (1995) provided the useful analogy of acute versus peripheral vision. The acute vision from the fovea of the retina is excellent in the singular task of providing detailed focus but dangerous in the broader task of living unless balanced by the qualities of peripheral vision. Although it is essential for the psychotherapist to explore what the patient is consciously seeking in any given hour of treatment, it is also the responsibility of the therapist to consider what the patient may have omitted unconsciously in his or her narrative that may pose a contributing factor to expressly verbalized concerns. Even interpersonal therapists like Harry Stack Sullivan, who maintained less of an emphasis on unconscious processes, believed that the patient always leaves out the most important part of his or her story (Gustafson, 1995).

The ability to grapple with and identify possible unconscious and related factors in interpersonal difficulties are partly why the mental health consumer seeks out a professionally trained psychotherapist instead of accepting "good advice" from friends. It is incumbent, therefore, on the psychotherapist—even the brief psychotherapist—to have the capability of conceptualizing the patient's problems broadly, even though he or she may choose to intervene in a more focused manner in a given phase of treatment. Generally, such broad case conceptualization involves the ability to view the case material from a behavioral/symptomatic level of understanding, an intrapsychic/psychodynamic level of abstraction, and a multigenerational family systems perspective (Scaturo, 2001).

Dilemmas of Managed Health Care

Another broad subarea of rapidly emerging dilemmas in contemporary psychotherapeutic treatment, in part related to and extending the previously noted dilemmas of brief therapy, is the advent of managed health care. Managed care has affected the practice of medicine and its impact on traditional medical ethics (LaPuma, 1998), as well as the practice of psychological and behavioral health care (Sperry & Prosen, 1998). Prior to the age of managed behavioral health care in which constraints on clinicians impelled them to work within increasingly shorter time limits, the vast majority of clinicians were aware of their ethical obligation to alleviate patient suffering in a time-efficient manner. This concern, however, was always counterbalanced by the concern about thoroughness in treatment (i.e., Gustafson's admonishment for the clinician not to overlook what the patients themselves may do unconsciously) and the concern with the substance and durability of the changes made in therapy. Whether the duration of treatment is conceptualized as 2 weeks, 2 months, or 2 years, clinicians know that it is incumbent on them to work to eventually make themselves increasingly obsolete in the patient's life. In the age of the fee-for-service model, the responsible clini-

cian was always aware that extending the duration of treatment for the purposes of his or her own financial gain was a clear infraction of his or her ethical duty. In the age of managed health care, where the conservation of health care resources is primarily concerned with shortening and imposing limits for reasons other than the alleviation of the patient's suffering, it now becomes the clinician's ethical obligation to make certain that limiting treatment does not sacrifice the thoroughness of care for the purposes of the managed care company's financial gain.

Sperry and Prosen (1998) provided a number of examples of newly emerging ethical dilemmas surrounding psychotherapy and managed mental health care. These include managed care's pervasive use of serotonin reuptake inhibitor (SSRI) antidepressant medications because of the reduced cost of such treatment in comparison with even brief courses of psychotherapy with limited regard for the patient's treatment preferences. Paradoxically, they noted that the use of SSRI medications is also being encouraged for subclinical or normal variant mood conditions in a practice that they have termed *cosmetic psychopharmacology*. In addition, they noted concerns over breaches of confidentiality to supply patient information to managed care's administrative personnel, and the potentially damaging effects on the therapeutic alliance. Finally, they also cited concerns about limitations of treatment to patients with serious chronic conditions, and the clinicians' concerns over not abandoning such patients. These dilemmas constitute severe challenges to the time-honored values of many clinicians.

Dilemmas Involving Sexual Emotions in Psychotherapy

If the anxiety surrounding psychotherapeutic dilemmas were exclusively limited to the difficulty in discriminating a course of action in a close judgment call, then the question of sexual intimacy with patients (Pope, Lief, & Bouhoutsos, 1986) could not be considered a dilemma by this criterion. The ethical guidelines in all of the psychological helping professions (psychiatry, psychology, social work, and marriage and family therapy) are quite clear on this point: Dual relationships (i.e., the intimately personal and the professional) are never acceptable in practice and always compromise treatment in some fashion and to some degree. So, the notion of a viable sexual relationship is never a question of a judgment call and is never an option for the helping profession. No doubt, the same standard must hold true for other professional relationships as well, including academia and the teaching profession, the medical profession, the clergy, and the legal profession. Is this, however, the end of the discussion of this topic as a dilemma? From a behavioral standpoint (i.e., professional conduct) certainly, but the topic of sexual feelings in psychotherapy (Pope, Sonne, & Holroyd, 1993) is a broad topic worthy of extensive discussion and beyond the scope of this overview. Although it is incumbent on psychotherapists to behave in a manner that observes and respects appropriate professional boundaries consistently, it would

be a mistake to conclude that the dictates of one's professional guidelines cease to make this a dilemma for people working in this complex human endeavor.

To the contrary, most authorities that work in this area of study feel that "a repressive, punitive attitude toward normal personal feelings" (Edelwich & Brodsky, 1991, p. xv) is nothing less than disastrous for the practicing clinician. For preceptors in our clinical training programs to behave as if the discussion of interpersonal attraction in the therapist–patient relationship is necessarily dangerous and countertherapeutic and is, therefore, to be shunned does a grave disservice to our trainees and future practitioners (Pope et al., 1993). In such instances, our interns, residents, and trainees are likely to feel a lack of preparedness to conduct competent, let alone sophisticated, clinical work. A serious danger is to accept confusing transferential and countertransferential emotional dilemmas to remain unexamined for the clinician (Edelwich & Brodsky, 1991). Transferentially, these reactions then remain unavailable as important clinical data for effective psychotherapeutic intervention. Far worse, countertransferentially, such unaddressed emotions in the clinician carry the risk of being deleteriously acted out in treatment rather than being talked out and sorted out in the context of consultation and supervision.

Dilemmas in Feminist Therapy

One of the many contributions of clinicians and authors who practice psychotherapy from the standpoint of a feminist perspective (Feminist Therapy Institute, Inc., 1990) has been the prompting that psychotherapy is not a value-free profession. Kaschak (1999, p. 1) wrote the following: "No human relationship can exist outside a moral framework. . . . The psychotherapeutic relationship is no exception. Psychotherapy is as much a morality play as it is art or science." In its extreme form, this approach is an uncompromising systems theoretical perspective that believes that "context is everywhere" (Clarkson, 2000, p. 27). Ethicists remind us that ethicality permeates all human relationships, therapeutic and otherwise. Further, an increasing number of clinicians have argued that psychotherapists must take a more proactive stance in promoting moral responsibility among their patients and families in treatment (Doherty, 1995). These therapists are likely to view the intersection of technical and ethical dilemmas as a one-to-one correspondence that looks more like the Venn diagram shown in Figure 1.1c than the more proportionate diagrams depicted earlier in either Figure 1.1a or 1.1b.

Accordingly, psychotherapy is viewed as not only a cluster of behavior change techniques (e.g., cognitive restructuring or resolution of inner conflict) for behavior change and symptom relief but also an opportunity to live a more fulfilling life (Kaschak, 1999). In this broader perspective, the femi-

nist principle of personal *empowerment* (Kaschak, 1999), viewed within a systemic context, is central to the practice of psychotherapy. In this regard, however, the concept of *justice* (Kaschak, 1999) among all of the participants of either an institutional or a family system is a critical component of the mental health and well-being of the patient in feminist therapy. Historically, family therapists were among the first to address this fundamental dilemma of human existence of what one owes to oneself versus others (e.g. Bowen, 1978; Bowlby, 1969; Framo, 1976), representing the need for independence and autonomy, on the one hand, and the need for attachment and affiliation, on the other. This worldview is also consistent with the integrative therapist's belief that "only in concert with others can we achieve the conditions for harmony within" (P. L. Wachtel, 1981, p. 15).

Included in this broadened context is consideration for the substance and personhood of the clinician as well as the patient. Carroll, Gilroy, and Murra (1999) discussed what they regarded as the moral imperative of the self-care of women psychotherapists. These authors echo concerns voiced earlier by Keith, Scaturo, Marron, and Baird (1993) from a family systems perspective that the self-care of all health care professionals, regardless of gender, is a critical prerequisite for adequate patient care. This notion can be somewhat "anticultural" to the espoused values of traditional medical education in which, quite understandably, "the patient comes first" (Keith et al., 1993). In the case of the impaired or beleaguered professional, however, these authors question whether this should always be so. Perhaps, making self-care for the professional a priority is putting the patient first. What emerges, then, from this feminist and systemic dialogue is the observation that our "rule books" and professional codes of ethics, although critically important, are not able to address all of the complex "uncodified decisions" that confront the clinician on a daily basis (Kaschak & Hill, 1999). Accordingly, the invisible decision-making processes of the psychotherapist become increasingly visible when the choices that confront the clinician are not readily classifiable into the expectable categories of our codebooks (Kaschak, 1999).

Technical Dilemmas Fundamental to the Psychotherapeutic Process

Scaturo and McPeak (1998) have articulated a number of clinical dilemmas that are fundamental to the processes of psychotherapy. These dilemmas are endemic to various interventions of psychological treatment (e.g., cognitive–behavioral therapy, family therapy) and various tasks of psychological practice (e.g., psychological assessments) by virtue of the foci that these various areas of practice encompass. For example, when conducting cognitive–behavioral therapy, psychotherapists may find themselves in some degree of dilemma in the assignment of behavioral homework and the directives that tend to be an integral part of such treatment. As many patients

experience such directive treatment as confrontation, and thereby a withdrawal of the psychotherapist's support, the timing and magnitude of such assignments must be carefully judged by the therapist so as to not disrupt what may be at times a fragile therapeutic alliance (Safran, 1993). Such clinical reasoning and judgment become increasingly central to the conduct of psychotherapy, particularly with the trend and influx of manualized (i.e., empirically supported) treatments (Scaturo, 2001).

Family therapy, for example, has many problems that are unique to the expansion of the treatment system to include the marital couple or other family members (Scaturo & McPeak, 1998). E. F. Wachtel (1979) noted that these difficulties pose various dilemmas to the individually trained psychotherapist attempting to adapt his or her treatment approach to a family systems perspective. Most prominent among these dilemmas tends to be the question of "blame" for the presenting problems (Scaturo & McPeak, 1998). In individual psychotherapy, poor child-rearing practices (i.e., parents) have tended to be blamed for any dysfunctional behavior and emotional problems in the identified patient. In family systems treatment, by contrast, the responsibility for any given form of behavioral dysfunction does not reside exclusively with any one individual (i.e., either parents or spouse or identified patient) but rather with the complex interplay of interactions among the parties concerned. This reduces the tendency to blame (including excessive self-blame) and, thereby, paves the way for better interpersonal connectedness among significant others. Such a perspective, however, requires a more complex view of reality and relationships for both the psychotherapist and the patient.

As a final example, the process of psychological assessment can entail its own array of dilemmas for the clinician. One example involves the question of non-treatment-oriented psychological assessments. When an evaluation is done for the purposes of treatment, then, at least, the presumption of an intention to help the patient exists. In non-treatment-oriented assessments, no such presumption exists. To clarify, it becomes important to ask the question, "Who is the customer (i.e., the person or institution) paying for the evaluation?" in the current health care lexicon. When the answer to this question involves someone other than the patient, then there is the accompanying question, "For whose good is the evaluation being done—the patient or the institution?" (Scaturo & McPeak, 1998). Many such clinical scenarios exist; these may include child custody evaluations (Gardner, 1986), determinations of sanity for legal purposes, alcohol assessments for DWIs, and psychosocial evaluations for medical procedures. In such instances, the patient may rightfully question whether the results of the examination are intended for his or her benefit. In each instance, it is critical that the clinician be able to adequately articulate the dilemma from multiple perspectives, which include that of the patient or examinee, the particular institution involved, as well as the examiner.

CONCLUDING REMARKS: THE TRANSTHEORETICAL NATURE OF CLINICAL DILEMMAS

The concept of clinical dilemmas in psychotherapy has been difficult to conceptualize because of their nondiscrete quality. The varieties and range of clinical dilemmas in psychotherapy challenge attempts at taxonomy and categorization. In part, because of the inseparable and inherently interpersonal character of psychotherapeutic treatment, clinical dilemmas are ever present within the psychotherapeutic context, regardless of the type of therapy or theoretical framework being used or the availability of a therapy manual for consultation.

The concept of the psychotherapeutic dilemma can be best seen as a transtheoretical experience (Prochaska & DiClemente, 1984). A transtheoretical approach is one that attempts to go beyond eclecticism in an attempt to form a higher order theory of psychotherapeutic processes that cuts across or transcends the major theoretical schools of treatment (Prochaska, 1979). In this way, Prochaska and DiClemente's (1992b) concept shares a similar theoretical goal with Wachtel's notion of integrative psychotherapy and cyclical psychodynamics (P. L. Wachtel & McKinney, 1992). The transtheoretical conceptualization has been most often associated with the concept of *stages of change* (Prochaska & DiClemente, 1992a), that is, the psychotherapy patient's readiness for change at any given point in time. The stages of the psychotherapy patient's preparedness for change involve precontemplative, contemplative, taking action, and maintenance of change. The notion of change-related readiness is essentially within the province of the patient, regardless of what form or orientation of therapy he or she seeks out. The concept transcends the various theoretical approaches to treatment, necessarily intersects with them all, and has broad applicability.

Other theorists have also postulated concepts that have transtheoretical relevance as well. When Bandura (1977a) first advanced the notion of *self-efficacy* in treatment, he viewed this as a potentially unifying concept in behavior change processes. He hypothesized that psychological treatment procedures (i.e., psychotherapy), "*whatever their form*" (Bandura, 1977a, p.191; italics added), that is, whatever their theoretical foundations, affect the level of the patient's self-efficacy (i.e., perceived control or mastery) in a given problem situation, to the extent that those methods are effective in bringing about behavior change. Thus, it may also be suggested that Bandura (1977a, 1997) was advancing a concept that was not only transtheoretical in nature but also transmethodological and transtechnical. Furthermore, it is a testament to the transtheoretical aspects of this concept that parallel notions appear in other writings on psychotherapeutic treatment. One such concept includes Seligman's (1990) notion of *learned optimism* that has been predicated on his classic and well-documented empirical research of its opposite

concept, *learned helplessness*, and its role in the development of depressive disorders. Likewise, the transtheoretical nature of Bandura's self-efficacy in all forms of psychotherapy is corroborated by the feminist therapist's view of *empowerment* (Kaschak, 1999) in treatment noted earlier.

Similarly, the transtheoretical phenomenon of *therapeutic alliance ruptures* or breaches, that is, negative shifts in the quality of the therapeutic alliance or its establishment, also has applicability to psychotherapists from diverse theoretical orientations (Safran & Greenberg, 1993). Regardless of theoretical framework, a pattern of negative patient–therapist complementarity has been associated with treatment failures (e.g., Henry, Schacht, & Strupp, 1990). Different therapeutic approaches and the specific techniques that emanate from them, each, for different reasons, place the patient–therapist alliance at risk for rupture (Scaturo, 2003b).

In sum, like the concepts of stages of change, self-efficacy, or the therapeutic alliance rupture, the perspective advanced presently is that the notion of the clinical dilemma in psychotherapy, whether predominantly technical or ethical or admixture, transcends the particular mode of therapy being used by the clinician (Scaturo, 2002b). Psychotherapists, regardless of their particular theoretical persuasions, frequently find themselves grappling with similar judgment calls in the treatment of a given patient or family (Scaturo, 2001). The comprehension of this complex notion, in both its technical and ethical realms, likely differentiates the professional psychotherapist from the behavioral technician and may ultimately lead to the patient's improvement and betterment.

A COGNITIVE MAP OF THE BOOK

As is apparent from the foregoing discussion, there have been a number of attempts to classify the various dilemmas that psychotherapists experience during the course of their clinical day. These include the dichotomy between ethical and technical dilemmas, those dilemmas identified by master psychotherapists, dilemmas relevant to various circumscribed areas of psychotherapy, and technical dilemmas fundamental to the process of psychotherapy. All of these approaches have validity, although none seem to dominate the field. As a result, the approach taken in this book is to outline the major dilemmas that have been encountered in the field as various schools of psychotherapy have evolved as attempts to grapple with the complexity experienced in the clinical context over the past century of treatment.

The book is divided into four parts. Part I provides an overview of clinical dilemmas and of the major schools of theoretical thought—psychoanalysis, cognitive–behavioral and social learning theory, interpersonal and family systems theory, and humanistic psychology—and the dilemmas that have emerged as they each have confronted their respective limitations in addressing the complexity of human experience (chap. 2).

Part II discusses the dilemmas involved in five treatment modalities that have emerged from those theoretical approaches and the dilemmas that are particular to those forms of treatment (chaps. 3 through 7). A focus on how clinical dilemmas play out in the treatment modalities that have evolved from psychodynamic and insight-oriented approaches, through the behavioral and cognitive–behavioral treatments, to those involving more that just the individual patient (i.e., couple and family therapy, group therapy) is a logical extension of the theoretical conceptualizations of human psychological functioning and psychopathology from which they have emerged as discussed in Part I. In some instances, dilemmas that might initially appear to be exclusive to a particular approach often, on further examination, share the same struggle, but in different forms or terminology. For example, the psychodynamic psychotherapist's classic dilemma of confrontation versus support of the patient's defensive structure tends to entail the same risks to the therapeutic alliance faced by the behavior therapist in balancing the directive (i.e., behavioral homework assignments) and nondirective (e.g., empathic listening) aspects of treatment.

Part III describes a number of clinical dilemmas that emerge from the inherently interpersonal process that is at the heart of psychotherapy. These include unconscious processes in interpersonal behavior such as transference, countertransference, and resistances (chap. 8), as well as dilemmas involving where precisely to draw the professional boundary while still therapeutically engaging with the patient (chap. 9). These are common to all treatment approaches, regardless of specific differences in theoretical underpinnings, as the recent literature's recognition of countertransference in cognitive–behavioral therapy would attest.

Finally, Part IV concludes by proposing a three-phase learning-based theoretical model for integrative psychotherapy that incorporates a consideration of the therapeutic alliance and technical interventions in treatment that result in a relearning of more adaptive interpersonal behaviors in the patient's life space (chap. 10). In addition, an illustration of the management of various dilemmas in actual integrative practice is provided in the treatment of panic disorders with agoraphobia (chap. 11). Chapter 12 concludes the book with a discussion of the pervasiveness of dilemmas and dialecticism, as well as the importance of integration and synthesis, throughout the history of psychology, psychotherapy, and life itself.