ETHICAL EVALUATIONS IN PSYCHOTHERAPY: STUDY WITH MENTAL HEALTH PROFESSIONALS IN SPAIN

VALORACIONES ÉTICAS EN PSICOTERAPIA: ESTUDIO CON PROFESIONALES DE SALUD MENTAL EN ESPAÑA

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Extended Summary

There are international studies that link professional variables to the deontological assessment of some professional situations. This study aims to: 1) analyse the ethical evaluations carried out by mental health professionals from within the Spanish public health system with respect to some situations that may arise in psychotherapeutic practice; 2) determine controversial and/or low consensus situations; and 3) study the relationship between the professional category and the psychotherapeutic orientation with the ethical-deontological assessment.

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Method

Participants: 308 professionals (clinical psychologists, psychiatrists and residents; 209 women and 99 men) with an average age of 39.4 (age range 24 - 66), practising in various hospital fields of the National Health System in Spain.

Instruments: In order to establish the ethical assessment of the professionals, 14 of the 61 items of Pastor's (2017) *"Ethical and deontological adjustment scale"* were used. 14 items are described with reference to two domains: psychotherapy and establishing dual relationships. The professionals performed an ethical assessment of these fourteen situations. The possible responses to each of these items were: 1) unquestionably not, 2) Under rare circumstances, 3) I don't know / I'm not sure, 4) Under any circumstances, or 5) unquestionably yes. Likewise, an *ad hoc* questionnaire was completed that included questions related to the sociodemographic and professional profile of the participant.

Procedure: A link to the scale and the questionnaire was sent to the heads of service and to some of the professionals in Spain via e-mail. Before completing the scale and the questionnaire, informed consent was obtained from each participant. In addition, both the research project and the data collection protocol had been approved by the Andalusian biomedical research ethics committee.

Data Analysis: A univariate descriptive analysis was completed of the main variables related to the professional profile of the participant. Given the ordinal measurement of the items comprised, the median was used as the central tendency statistic and the semi-interquartile range (*SIQR*) as a measure of variability. The items were classified according to the variability statistic or the frequency obtained in option 3 of the answers:

1. With regards to the variability statistic: 1) *Inter-professional imprecision* items: low consensus responses among professionals. The items that offered the highest *SIQR* and 2) Items *of interprofessional regularity* were selected: responses with high consensus among professionals. Items with a lower *SIQR* were considered.

2. Considering response option 3 ("I don't know / I'm not sure"), we obtained a third group of items that we called *controversial items*, defined as those where the response to option 3 ("I don't know / I'm not sure") exceeded 20 % of the total sample.

Once the descriptive analysis was performed, bivariate contrasts were performed with the Chi Square test, to clarify whether the sociodemographic and professional variables considered were related to each other.

Finally, the influence of the above variables on each of the fourteen items of the scale used was determined. We did the Kruskall Wallis analysis and, subsequently, and as a post hoc test, the Mann Whitney *U* test was performed with Bonferroni correction. The extent of the Rosenthal (*r*) effects was analysed.

Results

Preliminary Analysis: Some of the psychotherapeutic orientations ('*humanist*' and 'others') were represented at a low level; on the other hand, the '*biological determinist*' orientation, in addition to not constituting a psychotherapeutic modality per se, was associated with the professional categories of 'psychiatrist' and, above all, ''MIR'' (medical resident intern), so it was decided that the categories *'humanist'*, 'others' and '*biological determinist*' would be excluded from the analysis and that the '*cognitive-behavioural*', '*systemic*', '*psychodynamic*' and '*eclectic-integrative*' orientations would be considered.

Analysis of the items and their relationship with professional variables

Analysis of the items: None of the items turned out to be controversial. The items with the highest interprofessional imprecision were items 1, 6, 8, 11, 12, 13 and 14, where *SIQR* = 1, none of them were related to dual sexual relationships.

Items 3, 4, 5 and 10 turned out to be hardly controversial at all, with very low scores in the answer choice ''I don't know / I'm not sure''. In both, a *SIQR*= 0 was obtained, from which it appears that the responses of the participants were unanimous. Items 6 and 12, related to accepting establishing a professional relationship with an ex-patient, were the ones that gave rise to most doubts among professionals.

In contrast, the items with the highest interprofessional regularity were those related to dual sexual relationships (items 3 and 4, with *SIQR* = 0).

Variables related to the psychotherapy:

1) Professional category: We found significant differences in items 2 [$H(3, 308) = 8{,}309$, $p = 0{,}04$] and 8 [$H(3, 305) = 14{,}746$, $p = 0{,}002$]. After the post hoc analysis using the Mann Whitney *U* test with Bonferroni correction, we found no differences between the professional groups in item 2; differences were observed in item 8, where psychiatric residents offered more answers that were misaligned with ethical standards, with moderate measures of effect.

2) *Psychotherapeutic orientation:* We found significant differences in item 2 [$H(3, 245) = 10{,}562$, $p = 0{,}014$] . We observed, after the post hoc analysis, that the greatest differences occurred between the cognitive behavioural paradigm and the psychodynamic and eclectic-integrative orientations.

Differences in item 13 were found for the therapeutic orientation of the professionals [H (3, 245) = 31,769, $p = 0.000$]. After the post hoc analysis, we found that there is an important difference in the ethical-deontological assessment when comparing those who intervene from the *cognitive behavioural* paradigm, and the rest of the psychotherapeutic orientations that were analysed. Thus, cognitive behavioural therapists use techniques that are not evidence based to a lesser extent than professionals from other orientations, obtaining moderate effect sizes when comparing *cognitive behavioural* orientation with *psychodynamic* and *systemic* ones. Despite the aforementioned difference, in some cases cognitive behavioural

therapists also gave ethical-deontological assessments that support carrying out therapies that are not evidence based (note the score of 4 in the median obtained) regarding the use of non-empirically validated techniques.

Finally, we found significant differences in item 5 [H (3, 245) = 10,194, p = 0,017] and ten [H(3, 245) = 8,232, p = 0,041]. After the post hoc analysis, we observed that the greatest differences occurred between the answers given by the cognitive behavioural participants and the systemic ones.

Variables related to establishing dual relationships:

1) Professional category: We only found significant differences in item 7[H(3, 308) = 12,680, p = 0,005]. The post hoc analysis with the Mann Whitney U test with Bonferroni correction showed that psychiatric residents provided responses that were more mismatched with regard to ethical standards, with moderate measures of effect moderate.

2) *Psychotherapeutic orientation:* We found significant differences in item 3[H(3, 245) = 10,622, p = 0,014]. In the post hoc analysis, we observed that the only significant difference was in item 3, where the *systemic* therapists, compared to the *eclectic-integrators*, offered more misaligned responses regarding ethical standards.

Discussion

Professionals consider that neither the evidence-based practice is exclusively represented by empirically validated techniques, nor should the benefit in psychotherapy be interpreted as due to the rigorous application of such technical procedures.

With respect to managing the therapeutic relationship, the classic paternalistic attitudes in psychotherapy should not be perpetuated. However, many of the participants in our sample, especially those assigned to eclectic-integrative and psychodynamic positions as opposed to cognitive-behavioural therapists, continued to exhibit difficulties in maintaining principle of autonomy rigorously. We have found that the paradigm the professional bases his intervention on, influences the therapeutic relationship that is established. In some orientations, such as psychodynamics, some therapists may be less inclined to respect the patient's preferences, a fact that far from paving the way for psychotherapeutic intervention affect the professional relationship. Faced with these paternalistic attitudes, the literature has coincided in pointing to confidentiality as the most accepted and internalised value in psychotherapy. However, the items used to assess confidentiality aspects were related to therapies with a family or couple format, a circumstance that adds nuances to our conclusions since item 8 was identified, which refers to agreeing to interview one of the family members without the others being aware of the interview, as one of the most variable situations, although it is true that it was the psychiatry residents who came up with the most misaligned ethical-deontological evaluations regarding this item, so we do not know if the imprecision referred to was due to the greater dispersion of the data conceded by the participation of this

professional group.

With respect to using therapies that are not evidence based, the participants consider it ethically appropriate to implement techniques that have not been scientifically proven, regardless of their psychotherapeutic orientation, although especially among those who start out from paradigms other than cognitive behavioural ones. Perhaps this result give support to the approaches that emphasise the value of the processes or of the integrationist models in psychotherapy, something we can verify when observing that not only the majority of the clinicians who took part in our study said that they were intervening from an eclectic-integrative model, but also that the resident internal psychologists also do it, even to a greater extent than their tutors. Could integrative intervention pose an added ethical-deontological challenge for psychotherapists? In our opinion, these integrative positions should not be confused with the lack of rigor or with unsystematic use of psychotherapeutic techniques. Under the label of eclectic-integrative therapist, there are clinicians with very different backgrounds and different ways of conducting psychotherapy with few or no points of methodological, empirical or epistemological consensus. This itself don´t imply inappropriate and ethically reprehensible professional praxis, provided that the integrative therapist made systematic use of the techniques that he applied or was able to epistemologically convey his interventions under the protection of metatheoretical models such as narrative or constructivist ones.

As far as professional biases are concerned, we have found that systemic participants have more difficulties in adhering to ethical standards in situations that involve intervention with homosexual people using techniques to reverse their sexuality (item 10), a bias that could be related to the theoretical bases in which these psychotherapists are trained and, therefore, with the psychological assessment that they may do of homosexuality, without this necessarily entailing, from our point of view, prejudiced attitudes towards this group. Respect would be the starting point for showing genuine interest towards human groups who might, face specific evolutionary challenges that are not detected by evidence-based treatments, and therefore the interventions would not be adapted to their real needs.

As far as dual relationships are concerned, the participants in our sample considered dual sexual relationships to be the most inappropriate ones. The participants were unanimous in considering that these relationships with patients are inappropriate, but the psychiatry residents were not so firmly against maintaining such relationships as the rest of the professional groups. This might be because psychiatry residents at the beginning of their training have little training in psychotherapy, so they may not have enough information on aspects related to therapeutic relationships and the limits they entail. It should be borne in mind that the majority of psychiatry residents approach their interventions from the 'biological determinism' paradigm, so they might neglect the aspects mentioned above, since in professional actions based on prescribing medicine, the variables related to the therapeutic relationship probably aren´t as relevant as the psychotherapeutic

processes. With respect to dual relationships that are non-sexual, items raised significant ethical-deontological doubts among the participants. An intervention with a psychotherapy patient should never take place because of unmet needs on the part of the therapist: the personal detachment that keeps the professional from malpractice must coexist along with the professional interest towards the client, since psychotherapy cannot be sustained on the basis of a confused professional relationship with poorly defined limits.

In future research it would be interesting to expand on the variables to be explored. For example, adding items related to other multiple therapies (family or groups), with children, with multicultural patients, when there are judicial requirements, etc.