

## Concluding Remarks: Responsibility and Therapeutic Freedom

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As we have seen from the foregoing articles, counselors and psychotherapists and those who train aspiring clinicians appear to readily acknowledge and assume the mantle of responsibility. Clinicians are responsible to make sure not that counseling begins, and, crucially, ends well (Schnyders and Bruns, 2020), and throughout the therapeutic process they are responsible to stay abreast of research findings on the process and outcome of counseling, perhaps the most crucial of which is the use of client feedback to enhance clinician performance and clinical outcomes (Budesá, 2020). Educators are responsible to help students develop a deeply felt responsibility toward their future clients (Bowers & Hamlet, 2020) and to gatekeep as both a remedial activity and, failing a successful outcome, a way to remove students who are not able to meet standards set by the profession (Kimball, Phillips, Kirk, & Harrichand, 2020).

And for perhaps most in the field, their responsibility doesn't end with individual clients and students, but rather extends toward society in general. Social justice is a component of many codes of ethics, and these codes enjoin members of the various disciplines to consider the impact of pernicious "isms" (racism, sexism, classism, ageism, heterosexism, etc.) on the mental health of clients and to take action to be an ally, as Evans, Williams, Staton, Green, and Shepard (2020) urge. In our conclusion to this special issue, we would like to suggest an organizing principle for a discussion of responsibility in mental health counseling practice and training: that there exists a continuum, with responsibility on one end and something we might call therapeutic space or therapeutic maneuverability on the other. In an interesting way in both theory and clinical practice, any increase in therapeutic responsibility can be seen as decreasing the amount of therapeutic space, and counseling ethics may be seen as the way to balance the two in order to find some kind of acceptable middle ground.

"Therapeutic Space" may seem to be a bit of a New Age term, but it can be seen as what is implied in Freud's (1913/2002) foundational requirement: "You should say everything that comes in to your head" (p. 56), something that later analysts such as Spontnitz (1976; Sheftel, 1991) emphasized: *you must say everything*. In saying everything, clients come to the insight that what seemed to prevent their movement toward growth and cure may in fact be illusory. In recognizing the self-imposed linguistic confines in which they have placed themselves, Freud's patients could recognize that they may in fact be free to move in a newly created therapeutic space.

But this is too simple. Are there no impediments to one's newfound freedom? Are there to be no consequences? Freud gave license to speak of societally forbidden topics such as sex. However, even as Freud granted permission, he hedged it with the labyrinth of interpretation, and the bewildered patient had to take Freud's hand as he led them, via his interpretations, out of the maze. Freud's concept of therapeutic space may be seen as severely circumscribed by what he saw as an unfortunate yet implacable truth about the human condition: we are in thrall to the master of repressed sexuality, and he saw it as his responsibility to convey this to his patients. Jung protested the implications of this position to Freud, but Freud didn't appear to be fazed: when Jung (1961) said that "culture would then appear as a mere farce, a morbid consequence of repressed sexuality," Freud responded, "so it is, and that is just a curse of fate against which we are powerless to contend" (p. 150). Freud, even as he encouraged freedom of expression, felt responsible to remind his patients that while they might become more aware of their motivations and drives, this entailed a stoic recognition of their (powerless) condition. The best he could offer them was limited, that of transforming "hysterical misery into ordinary unhappiness" (Breuer & Freud, 1893-1895/1955, p. 308). Thus, even at the beginning, the clinician might be seen as responsible to simultaneously free the client and remind them of limitations to this freedom due to the human condition, struggling to find some middle path forward between the poles of responsibility and freedom.

The prescription, say everything, was carried forward in an interesting way in the work of Carl Rogers. Though Rogers often used Freud as a foil and objected to psychoanalysis for various reasons, such as his view that it was impractical, too focused on past rather than present experience, fanciful in its interpretations, and was seemingly unconcerned with empirical research, he did acknowledge the influence Otto Rank's more relational views of psychotherapy on his own theory (Kirschenbaum, 2009). What is perhaps less immediately clear is the degree to which his nondirective/client-centered/person-centered approach is aimed at facilitating an atmosphere for the client to follow Freud's dictum to say everything. Rogers (1959) used the term, *conditions of worth*, to describe the process which arises "when the positive regard of a significant other is conditional, when the individual feels that in some respects he is prized and in others not" (p. 209). And in a fascinating section, Rogers (1959) describes the impact of caregivers on the developing infant and child and how the child learns to reject some parts of their own experience because of disapproval from the caregiver, which sounds a lot like Freud's views on how repression is formed, albeit in different terms.

Rogers' healing prescription was, in essence, a restatement of Freud's. The unconditional positive regard of the therapist allows the client to speak about their own experience and come to prize it; the "unconditional" aspect only makes sense when one realizes that the healing space directly counters the conditions of worth that was experienced by the client. And the responsibility of the therapist? Rogers continually stressed that a large part of the therapist's work was to provide a space where the client could speak and the therapist would listen empathically; that is, it was the therapist's responsibility to create the space and then to get out and stay out of the client's way as the client discussed their experience and what they wanted to do with it. Ideally, the therapist made no demands, issued no directions, other than that the client should begin to trust their own judgment. Rogers (1949), in writing about the type of perspective that a therapist should take, emphasized that "only as the therapist is completely willing that *any* outcome, any direction, may be chosen—only then does he realize the vital strength of the capacity and potentiality of the individual for constructive action" (p. 94).

But this grand restatement—Therapy is a place where the client may proclaim any direction and path for their life—hit an immediate snag. As Kirschenbaum (2004) relates, participants in training workshops were quite happy to point out a central tension inherent in this nondirectivity and to satirize it for him in skits at the end of the training:

"Dr. Rogers," the client would say, "I'm feeling suicidal."

"You're feeling suicidal?" Rogers would answer.

"Yes, I'm walking over to the window, Dr. Rogers."

"I see. You're walking over to the window," Rogers answers.

"Look, Dr. Rogers, I'm opening the window," the client says.

"You feel like opening the window?" Rogers reflects.

"Yes, I'm putting one foot out of the window, now."

"You're halfway out, is that it?"

"Yes, now I'm jumping Dr. Rogers"

"Uh, huh, uh, huh, you're jumping," says Rogers.

And, sure enough the client jumps, making a whooshing sound as he falls through the air before landing with a crash.

Thereupon Rogers walks over to the window, looks out and reflects, “Whoooooosh . . . Plop!” (p. 119).

Rogers protested against this oversimplification, but the question remains: Is he saying that the counselor should just sit there, or does the counselor need to get up and shut and lock the window to prevent the client from jumping? Once again, the struggle is to find some middle ground between jumping up and taking action the moment a client says something even remotely suggesting suicide and sitting there passively even as they jump out the window.

As Strickland, Luke, and Redekop (2020) make clear in their article on coercion in mental health crises, a decision has been reached that there are limits to a therapeutic encounter: the window must be closed. In cases involving the active threat of suicide or homicide, and in cases involving child abuse and neglect, the field has seen and often participated in, willingly or not, the growth of legislation governing these cases. With the rise in mental institutions, there was a concomitant rise in involuntary commitment statutes by states over time and court action to address commitment in a substantial way, and a need for later revisions to commitment to focus on the key element of threat of harm to self (Myers, 1984), the assessment of which is in the domain of the clinician responsible for the treatment of the client.

Correspondingly, the landmark case of *Tarasoff v. The Regents of the University of California* set in motion legislation that ultimately defined the responsibility of clinicians when the client threatens others, albeit legislation that varies by state (Herbert & Young, 2002). This large variation can cause confusion to clinicians—some states mandate a clearly articulated duty to warn or duty to protect (through warning or other means) while others don’t, and even in those states with what appeared to be a settled understanding, revisions continue to occur. In Pennsylvania for example, in *Emerich V. Philadelphia Center for Human Development, Inc.*, the Pennsylvania Supreme Court found that a mental health professional has a duty to warn if their client or patient presents a serious danger of imminent danger to an identifiable third party (Fliszar, 2000); in so doing, “he or she must now must balance the competing interests of breaking patient confidentiality and its often negative impact on the therapeutic process with public safety and the possibility of liability” (p.212).

While this case provided some guidance and was for a time the standard for Pennsylvania clinicians—that a duty to protect through warning exists if the threat targets an identifiable third part—a recent court finding shrank the therapeutic space still more. In *Maas v. UPMC Presbyterian Shadyside* (2018), the Superior Court of Pennsylvania examined the case of Mr. Andrews who “expressly communicated threats to kill his ‘neighbor, but did not identify, by name or description, the specific neighbor” (para. 1148). While the threat was not directed at a specific individual, the Court found that since the threat was limited to “the fourth floor tenants of Hampshire Hall who were Mr. Andrews's neighbors,” whom the Court described as “a small, distinct, and identifiable group” (para 1148), then the defendants had a duty to warn the entire fourth floor of approximately twenty people. This ruling raises the specter of the clinician phoning entire floors of buildings, perhaps whole offices and schools, whenever a client makes a threat, something that may cause clinicians to feel that these court cases have painted the entire floor with liability and left clinicians trapped in the corner.

The requirements for the reporting of child abuse similarly saw an increase in legislation over time, and by 1967, all states had child abuse reporting laws (Myers, 2008); the system worked so well that the less-than-fully-staffed agencies responsible became overwhelmed with calls, a problem that persists to this day (e.g., DePasquale, 2017). These duties taken together, and without mentioning other duties that are in the process of expanding state-by-state (such as the mandatory reporting of elder abuse) suggest that the field has come a far distance from the original requirement of say everything. Or, more precisely, the client can still say everything, but there may be increasing consequences, such as the reporting of what the client says to authorities or the initiation of civil commitment of the client. Students who are being trained in the work are given two messages: Get your

clients to express themselves freely, *but* you're going to have to warn them that there may be consequences if they obey this injunction. They are instructed on the intricacies of informed consent and the need to fully apprise the client of the limits of confidentiality, but there remains the central dilemma, wherein the very structure of counseling is aimed at encouraging disclosure, even as this disclosure has strings attached. Students trying to find the path through this strenuous middle ground may find themselves to be overtaxed, and as they try to discern their professional responsibility to their future clients, it is no wonder that they seek clear-cut ethical answers (Bowers & Hamlet, 2020).

And it is not only in the legal sense that therapeutic space has been constrained due to the demands of therapeutic responsibility. Counselors and psychotherapists may be responsible for much more than protecting the client from harming themselves or protecting society from harm by their client: they may be responsible for their clients' very souls. London, in a work originally published in 1964 and later updated, suggested that "psychotherapy is a moral force, and psychotherapists, in turn, are moral agents as well as healing technicians" (London, 1986, p. 1). He argued that clinicians couldn't avoid moral problems, such as treating a client who is guilty and anxious over raping or robbing someone at gunpoint—or another client who reports feeling no guilt over committing these crimes. He stated that it is naïve or disingenuous to say that counselors can avoid moral issues, because "the nature of their interactions with patients involves therapists in moral confrontation where moral discourse, even communicating some of their personal morality, may be necessary to their therapeutic work" (p. 10.) He described counselors and psychotherapists as constituting a "secular priesthood" (p. 151), who find justification for their work not in "a theodicy revealed from heaven, but in a code discovered or inspired in clinic, laboratory, and other earthy premises" (p. 153). He suggested that counselors and therapists "fill a moral vacuum in modern life, acting as a third force in an area once dominated by philosophy and religion" (p. 159) who must squarely address "the responsibility of handling moral discourse which they can neither master nor fully dismiss" (p. 160).

London's argument still finds resonance, as it points to crucial unanswerable questions about clinicians' responsibility to address the moral dimensions of behaviors and choices that clients make. How can clinicians address the issues that London raised? Ethical codes may state, for instance, that "counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (American Counseling Association, 2014, p. 5), but nowhere is the gulf between ethical aspiration and clinical realization rendered clearer than in this grand pronouncement. It would take a dangerously naïve or disingenuous clinician to believe that not imposing one's beliefs is easy or even perhaps possible in actual work with clients. Too much is expected of the simple word, "impose," as if it were sufficient for the clinician to simply intone, "I shall not impose my views on my client."

With the foregoing in mind, clinicians may be well-advised to pause before assuming additional responsibilities. This point could be seen as germane to an intriguing recent debate about the societal and political responsibilities of mental health professionals. A group of mental health professionals have come together to discuss the mental fitness of Donald Trump and whether he is competent to serve as president, and, if he is not, whether they have a duty to warn the nation. Bandy Lee (2017), a psychiatrist at Yale, has presented this argument in her book, "The Dangerous Case of Donald Trump: 27 Psychiatrists and Mental Health Experts Assess a President." In this book, and at various symposiums, Lee and her colleagues have suggested that mental health professionals have a professional responsibility, arising from their knowledge of aberrant and potentially dangerous patterns of behavior, to warn the public about the dangerous behavior of Trump. This argument is often couched in the language of the "duty to warn" or "duty to protect through warning," discussed previously. To some, it may seem like a duty for the mental health professional, a responsibility to use our mental health knowledge and training to protect the country through warning them about Trump's instability or in the extreme, to advocate his removal through the 25<sup>th</sup> Amendment. Yet as the articles in our special issue and these concluding remarks suggest, clinicians and those who train them may already have their hands full with enough responsibilities as it is.

Regardless of how unsettled these theoretical arguments remain, clinicians can and must act on the information that clients relate to them and try to find their way to balance the opposing poles of responsibility and freedom. This work can be supremely challenging, since clients bring all manner of material to the unsuspecting counselor, material that is the domain of privacy. At times, however, privacy slides into secrecy, wherein the client murmurs, “psst, listen, I think I might have hurt my child...” or, “I want to die and am going to take my own life...”, followed with, “and by the way, you can’t tell anyone, right?”. Counselors are responsible to maintain privacy but not necessarily the kinds of secrecy that family systems and addictions treatment allude to, secrets that keep families and individuals sick. As seen in the articles in this special issue, responsibility is multifaceted, and begins with appropriate training, even to the point of blocking an applicant or candidate from even entering into this responsibility as counselors. Once in training, these responsibility-takers must learn the role of advocate, both in session and in the broader community. Counselors-in-training must learn the awesome responsibility of discerning when privacy turns to secrecy, and when and how to act.

Once in the profession, counselors are responsible to guide and nurture the therapeutic relationship at the beginning, through informed consent and goal and task alignment (Woodside & Luke, 2018); in the middle through obtaining and acting on client feedback, and at the end, to turn termination into the start of more skillful living. We use terms like termination to indicate the finality of the relationship, to disambiguate the future of the relationship, but in spirit the process is closer to transition or commencement. When handled deftly by the counselor, termination is less about the ending of one relationship, and more about a launching forth into new relationships with one’s self and with others. It also commences a life of living with new thoughts, feeling, and behaviors that lead one into a new experience. In this way, clients are reborn into new awareness and tools for living this new life.

We trust that the articles in this special issue have served as evidence of the central role that responsibility plays in the theory and practice of counseling and psychotherapy. The most obvious evidence for the centrality of the concept comes in the ethical principles and practices found in the various psychotherapeutic disciplines. Responsibility confronts clinicians in each and every clinical encounter as they think about how to answer the following question and how it might open or close therapeutic options for their clients: *Given what I know of this person in front of me and what they have told me and are telling me now, what must I do?*

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