ETHICAL AND LEGAL ISSUES IN PSYCHOTHERAPY

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The three pillars of the ethics of autonomy.

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All therapy students and practitioners develop personal systems of ethics for how they work with clients. The word ‘ethics’ is sometimes defined as the science of morals in human conduct. Morals are concerned with the distinction between right and wrong and with accepted rules and standards of behavior. Thus, ethical codes or ethical guidelines for therapy attempt to present acceptable standards for practice within the profession.

Sometimes it is obvious when there has been an ethical lapse: for instance, engaging in sexual relations with clients. However, in the complexities of therapeutic intervention practice, ethical issues often are unclear. Consequently therapists are faced with ethical dilemmas involving choices about how best to act. Confidentiality is the area for ethical dilemmas most frequently reported by both British psychotherapists and American psychologists.

In order to have best ethical practice, Barnett has discussed three important strategies for best ethical practice, which include a combination of positive ethics, risk management and defensive practice.
Positive ethics focuses the psychotherapist on constantly striving to achieve the highest ethical standards in the profession. It is guided by a series of aspirational virtues which include doing good and providing maximum benefit to the client (beneficence), being faithful to the explicit and implicit obligations that a therapist has to his/her client (fidelity), promoting client’s independence over time and not creating increased dependence on the therapist through the therapist’s actions (autonomy), providing fair and equal treatment, and access to treatment, to all individuals (justice) and providing fair and equal treatment, and access to treatment, to all individuals (justice) and providing adequate attention to our own physical and psychological wellness so that we are effectively able to implement the above virtues (self care).

Risk management although has the same goal as positive ethics for the clients, but it is more specifically focuses on minimizing risks for the psychotherapist that may result in ethics complaints or malpractice claims and it addresses the issues of informed consent, effective documentation and consultation.

Defensive practice focuses on the direct protection of the psychotherapist. It involves making decisions based on reducing the possibility of adverse outcomes for the psychotherapist. For example, a practitioner may restrict the range of clients worked with and refuse to work with certain types of clients, such as those with suicidal ideation or severe personality disorders, out of fear that they materially increase risk.

Based on the above principles, ethical issues in psychotherapy includes the headings of professional codes, competence of therapist, responsibilities of therapists towards their clients, therapeutic contract, informed consent, confidentiality, privilege and psychotherapy supervision, beneficence, boundaries, termination and post termination issues.

**Professional codes**

Professional codes of ethics are published by a number of organizations that work with therapists, such as the American counseling association, the association for specialists in group work, the American association for marriage and family therapy, the American psychological association, the national academy of certified clinical mental health counselors, and therapists. These guidelines, however, are often difficult to apply to
individual cases, are sometimes contradictory, and are challenging for the professional organization to enforce (Talbutt, 1981). Furthermore, the field is so fragmented in its various licensures, certifications, and governing bodies that practitioners are often left to sort out the confusion for themselves (Bradley, 1995). For this reason, ethical rules cannot just be memorized; rather, ethical behavior must be learned and decision-making skills developed to be internally consistent and yet compatible with acceptable societal and professional standards.

Depending on the state or country in which they reside, the institutions in which they work, their training, type of degree and client needs, they can differ widely in what may be described as “ethical conduct”. In this field, many experienced practitioners have spent their whole careers attempting to set forth these standards of acceptable conduct.

There is a distinction between the ethical decision making of the beginner and that of the experienced practitioner. Whereas the seasoned expert has logged years of therapeutic hours, the beginning therapist is starting in a haze of confusion it is difficult enough to track client statement, analyze underline meanings, plan interventions strategies and respond effectively with having additionally to contemplate open ended moral issues and ethical conflicts.

It is for this reason urged that to read and study the professional ethical codes and follow them to the letter. It is only with vast experience and intensive study that a scholar or practitioner can expect to improvise individual moral decisions based on solid empirical and philosophical grounds. And even with such wisdom may believe, or publicly announce, something different from what they actually do within the privacy of their offices. The problem is further compounded by the often conflicting demands from a number of sources.

**Competence of the therapist**

With so many approaches to psychotherapy, the issue arises as to what is competence. *Competence includes relationship competence, technical competence, readiness to practice and recognizing limitations and making referrals*. To distinguish between relationship competence, offering a good counseling relationship, and technical competence, the ability to asses’ clients and to deliver interventions. There is far greater agreement between the different therapeutic approaches on the ingredients of relationship competence – such as respect
and support for clients as persons and accurately listening to and understanding their worldviews – than there is for technical competence.

Readiness to practice means that counselors require appropriate training and practice before they are ready to see clients and to use their counseling skills competently. Fitness to practice assumes that counselors have satisfactory counseling skills in their repertoires and it only becomes an ethical problem when they are precluded in some way from using these skills competently. An example of readiness to practice as an ethical problem is when therapists take on cases referred to them: for example, anorexic clients, that are beyond their level of training and competence. An example of fitness to practice as an ethical problem is that of a counselor who drinks at work and so fails to maintain competence.

In addition to the above, some of the authors also include ‘emotional competence’ to knowledge and technical skills. This actually means, whether the therapist is aware of his emotional state while dealing with their clients. It is important that the therapists refrain from initiating or continuing a therapy when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work in a competent manner. Further, when a therapist becomes aware of personal problems that may interfere with performing their duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance; and determines whether they should limit, suspend, or terminate the therapy.

**Responsibilities of Therapist**

From an ethical point of view, it is important that the therapists are aware of their responsibility towards their clients. These include:

**Responsibilities to the client**

1. Therapy should be undertaken only with professional intent and not casually and/or in extra professional relationships.
2. Contracts involving the client should be realistic and clear.
3. Therapists take all reasonable steps to avoid harm to their clients as a result of the therapy.
4. Therapist should seek supervision or refer the client in situations which are beyond their competence.
5. Therapist should promote client autonomy and encourage clients to make responsible decisions on their own behalf.
6. Therapist should maintain the professional boundaries.
7. Therapist should avoid any other relationship with their clients which can be detrimental to the therapeutic process.

8. Therapist should maintain confidentiality. This applies to all verbal, written, recorded or computer stored material pertaining to the therapeutic context. All records, whether in written or any other form, need to be protected with the strictest of confidence.

9. In exceptional circumstances when confidentiality has to be broken, attempts must be made to seek client’s permission.

10. Agreements about confidentiality continue after the client’s death unless there are overriding legal considerations.

11. Therapists should not exploit clients (past or present), in financial, sexual, emotional or any other way.

12. Sexual relations between the client and the therapist are never acceptable. This is not restricted to sexual intercourse and includes any form of physical contact, whether initiated by the client or the therapist, which has as its purpose some form of sexual gratification, or which may be reasonably construed as having that purpose.

13. Therapist should not accept or offer payments for referrals, or engage in any financial transactions, apart from negotiating the ordinary fee charged for the therapy.

14. If a therapist makes an attempt to make a relationship with a former client, he should seek supervision.

15. When a client is incapable of giving informed consent, therapist should obtain consent from a legally authorized person.

16. Any publicity material and all written and oral information should reflect accurately the nature of the service offered and the training, qualifications and relevant experience of the therapist.

**Responsibilities to self as a therapist**

1. It is the responsibility of the therapist to maintain their own effectiveness, resilience and ability to help clients. They monitor their own personal functioning, and seek help or refrain from therapy when their personal resources are sufficiently depleted to require this.

2. Therapists should not undertake therapy when their functioning is significantly impaired by personal or emotional difficulties, illness, alcohol, drugs or any other cause.

3. Therapists should have regular suitable supervision and use such supervision to develop counseling skills, monitor performance and provide accountability for practice.
Informed Consent / client autonomy

The principal of informed consent is based on the notion that clients have a right to be protected against any form of coercion, manipulation and harmful treatment. They have a right to be provided with clear, accurate and comprehensible information on such things as fee policies, limitations and dangers of treatment approaches, access to records, therapist qualifications training, and the right to refuse treatment.

Informed consent should be seen as the primary means of protecting the self determination and self-governing rights of clients as it gives the client an opportunity to make an informed decision about engaging in psychotherapy and it communicates respect for personhood and reflects the collaborative nature of psychotherapy. It also emphasizes the patient’s role in making treatment decisions and increasing a sense of ownership over the process. A proper informed consent procedure also helps the therapist and the client establish a partnership, with a common goal, decreases the likelihood that patients will put the therapist on a pedestal and become overly or dangerously dependent on the therapist. Last but not the least, a proper informed consent procedures can reduce the client’s anxiety by demystifying the therapeutic process.

Whenever the psychotherapist plans to take the informed consent (either written or verbal), they should make every effort to follow the following principles:

1. Use the language that is understandable to the patient.
2. Understand the competence issues of the client to give consent.
3. Obtain informed consent as early as possible.
4. Consider informed consent as a procedure and discuss all the issues in piece-meal, rather than in one go.
5. Provide information about the alternative treatments.
6. Provide information about the expectations from the client.
7. Provide information about the fees and payments.
8. Discuss about confidentiality and its exceptions.
9. If the therapist is a trainee, inform the client about the same status and the role of supervisor.

It is ideal to obtain informed consent in the first session, but this is not always possible or clinically feasible because sometimes the clients present in crisis, which requires urgent attention. In such cases, consent should be obtained at the first possible opportunity once the crisis has subsided.

Further, it is also important to understand that informed consent to psychotherapy should be best conceptualized as an ongoing process, designed around a patient’s evolving treatment needs and the
subsequent treatment plans to which he or she must consent. It is the duty of the therapist to provide complete information to the client and the family members or the legal guardian about the nature of treatment and goals of therapy, and viable treatment alternatives with the evidence for their effectiveness in the condition which the client may be suffering.

During the informed consent procedure it is very important that the therapist informs the client about the appointment schedule, the duration of each session, homework assignments, anticipated duration of therapy with due importance given to various eventualities during the therapy and the general treatment objectives and therapeutic techniques which he is going to use. Depending upon the clinician’s treatment approach, the client should be informed that the therapist is going to follow cognitive behavior principle, supportive therapy or psychodynamic psychotherapy.

It is important that the therapist informs the client and their family members or legal guardian about the fees he/she is going to charge for the therapy at the earliest with the option of re-negotiation of fees in the later dates if the therapy continues for years.

*It is of utmost importance that the therapist maintains confidentiality and doesn’t disclose the information to anyone with the permission of the client, but it also important to stress the exceptional situations where the information may be disclosed against the wishes of the client.* For example, it is common that the therapist may come across child sexual abuse, suicidal or homicidal plans which may warrant mandatory reporting to the legal agencies or the family members.

It is important that, when a trainee provides psychotherapy, the therapist informs the client that he is a trainee, that his supervisor is responsible for the therapy, and that the trainee meets regularly with the supervisors for guidance and advice.

**Confidentiality**

Maintaining confidentiality is the foundation of the psychotherapy. Without the assurance about the confidentiality, the clients cannot be expected to reveal embarrassing, sometimes personally damaging, information in treatment setting. As part of the medical profession, the therapists are expected to maintain the confidentiality of their clients. However, it is important to remember that the ethical requirement of confidentiality overlaps with the law, hence, answers to some of the situations can only be predicted by an
understanding of both ethics and law. Hence, in situations where things are not clear the therapist should seek legal consultation.

However, it is also important to note that there are certain exceptions to maintaining privacy. Hence, information about the exception should be part of both informed consent procedure and therapeutic contract, because not doing so can place both the therapy and the therapist at significant risk. In the following section exceptions to the confidentiality rule are discussed.

The confidentiality exceptions can be broadly divided into the following situations:

1. Therapist can or has to release the confidential information without patient consent (example reporting abuse, protecting clients and their potential threatened victims, defending oneself from inappropriate or threatening client behavior).

2. The information collected in the professional relationship must be submitted as evidence in a legal proceeding.

3. Therapist can breach the confidentiality if the client threatened the therapist for his life or files a case against the therapist.

4. Besides the above, there are situations where the issues of confidentiality are not defined specifically for psychotherapy by the law enforcement agency. In such cases, the general laws related to confidentiality in medical practice should be applied. Some of the important situations where there are grey zones include confidentiality issues in case of minors, when the parents are having conflictual relationship or are undergoing the divorce proceedings; confidentiality in case the client is dead and confidentiality issues in case of marital or family therapy. In such situations it is always better to discuss such issues in the informed consent procedure and should be incorporated into the therapeutic contract. However, for things which are not clear, it is always advisable for the therapist and the client to seek opinion of the colleagues and lawyers before finalizing the contract.

**Boundary issues during psychotherapy**

Boundary issues in psychiatry and psychotherapy per se, don’t have black and white answers. Nonsexual boundary crossings can enrich therapy, serve the treatment plan, and strengthen the therapist-client working relationship. They also can undermine the therapy, severe the therapist-patient alliance, and cause immediate
or long-term harm to the client. Choices about whether to cross a boundary confront us daily, are often subtle and complex, and can sometimes influence whether therapy progresses, stalls, or ends.

Over the last thirty years a large amount has accumulated, mostly in the western literature with regard to dual relationships, bartering, and nonsexual touch, meeting therapy clients outside the office for social visits, and other nonsexual boundary issues. Gutheil and Gabbard also emphasized that crossing boundaries “may at times be salutary, at times neutral, and at times harmful” and that the nature, clinical usefulness, and impact of a particular crossing “can only be assessed by a careful attention to the clinical context”. Hence, the issue of boundary violations should be understood on case to case basis by taking into consideration the situations in which violation occurred, type of therapy and possible harmfulness it has on the client.

Boundary and boundary violations are addressed under the heading of role, time, place and space, money, services and related matters, clothing, language, self-disclosure and related matters and physical contact. These are briefly discussed mainly in relation to dynamic therapy.

*Role* as a boundary should answer the question “is this what a therapist does”. Although answer to this question will depend on the ideology of the therapist, it is a useful orienting device for avoiding pitfalls of role violations.

Sticking to the *time* of the session is considered to be an essential boundary, as it provides structure and containment to many patients, because many clients feel reassured that they have to experience the various stresses of reminiscing, relieving and so on for a set time only. Hence, beginning and ending the sessions beyond the schedule are susceptible to crossings of boundary. Essentially time boundary suggests that, whenever possible the psychotherapy should be scheduled in working, high movement/traffic hours when other people are around.

The *place* of meeting of therapist and client should be limited to the psychotherapy sessions in the therapists working place, except for some exceptional situations, like when the client is admitted in emergency/intensive care unit after a suicide attempt. Regarding the therapist meeting outside the office (attending the personal/family get-togethers of the client), doesn’t have one answer and should be interpreted and scrutinized in the light of kind of therapy and the situation.

*Money* as a boundary is meant for the therapist, as an indicator of work during the therapy, for which they are paid. However, this doesn’t mean that if the therapist decides to see a client free of cost at the beginning, he should not do so, but this implies that if a therapist ignores nonpayment of fees, or stops collecting fees, it
should be scrutinized as a boundary violation. Further, if a decision is made to see the client free of cost at the beginning, it should be documented in the therapeutic contract.

*Clothing* of the therapist, which is excessively revealing or frankly seductive, may represent boundary violation, as it can have potentially harmful effect on the client. However, some of the issues of social manners/obligations must not be outrightly interpreted as boundary violation.

*Language* as a boundary includes the words used by the therapist, tone of the speech (which can be seductive) and how the therapist addresses the client.

In terms of dynamic therapy, *self disclosure* (especially about their personal fantasies, dreams, social, sexual, financial, vacation) should be interpreted as a boundary violation. However, some of the issues like taking examples from their own life or trying to explain the effect of a borderline client on the therapist may not always represent a boundary violation and should be looked in the context in which it occurred.

As far as *physical contact* is concerned, anything beyond hand shake should be scrutinized.

However, Pope and Spiegel argue that rather than making decisions about boundary violation in the context in which it occurred, it is important to assess the boundary violation in the context of a more general approach to ethics. They described *nine steps* which could be helpful in considering whether a specific boundary crossing is likely to be helpful or harmful, supportive of the client and the therapy or disruptive, and in using due care when crossing boundaries, which are as follows:

1. Imagine what might be the ‘‘best possible outcome’’ and the ‘‘worst possible outcome’’ from both crossing this boundary and from not crossing this boundary. Does crossing or not crossing this boundary seem to involve significant risk of negative consequences, or any real risk of serious harm, in the short- or long term? If harm is a real possibility, are there ways to address it?

2. Consider the research and other published literature on this boundary crossing (If there is none, consider bringing up the topic at the next meeting of your professional association or making a professional contribution in the form of an article.)

3. Be familiar with and take into account any guidance regarding this boundary crossing offered by professional guidelines, ethics codes, legislation, case law, and other resources.

4. Identify at least one colleague you can trust for honest feedback on boundary crossing questions.

5. Pay attention to any uneasy feelings, doubts, or confusions—try to figure out what’s causing them and what implications, if any, they may have for your decisions. Many therapists feel troubled in some way about the
path they took across a boundary, but that they had failed to take it seriously, had shrugged it off, or pushed it out of awareness for any number of reasons such as fatigue, stress, being in a hurry, not wanting to disappoint a client who wanted to cross that boundary, or failing to appreciate the potential that boundary crossings have to affect clients and the therapy.

6. At the start of therapy and as part of informed consent, describe to the client exactly how you work and what kind of psychotherapy you do. If the client appears to feel uncomfortable, explore further and, if warranted, refer to a colleague who may be better suited to this individual.

7. Refer to a suitable colleague any client you feel incompetent to treat or who you do not feel you could work with effectively.

8. Do not overlook the informed-consent process for any planned and obvious boundary crossing (e.g., taking a phobic client for a walk in the local mall to window shop).

9. Keep careful notes on any planned boundary crossing, describing exactly why, in your clinical judgment, this was (or will be) helpful to the client.

Pope and Spiegel also point out common cognitive errors in relation to boundary violations, which are:

1. What happens outside the psychotherapy session has nothing to do with the therapy (this error may lead us away from considering how our interactions with clients outside of therapy sessions might influence the client and our work with him or her).

2. Crossing a boundary with a therapy client has the same meaning as doing the same thing with someone who is not a client (Some of the activities which are considered as general courtesy and humanistic, but when done with a client often have different meanings and effects when they occur in the context of therapy).

3. Our understanding of a boundary crossing is also the client understands of the boundary crossing.

4. A boundary crossing that is therapeutic for one client also will be therapeutic for another client.

5. A boundary crossing is a static, isolated event

6. If we ourselves do not see any self-interest, problems, conflicts of interest, unintended consequences, major risks, or potential downsides to crossing a particular boundary, then there aren’t any

7. Self-disclosure is, per se, always therapeutic because it shows authenticity, transparency, and trust (hence, when self disclosure is to be done it is important for the therapist to answer to himself – is it consistent with the client’s clinical needs and the therapy goals? Is it consistent with the kind of therapy you are providing

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and your theoretical orientation? Does it mainly reflect or express your own personal needs (to talk about yourself, to bring the focus to yourself)? What is your purpose in self-disclosing at this particular time? What is your assessment of the possible risks, costs, or downsides, if any, of self-disclosure with this client in this situation at this time? Does self-disclosure—or disclosing this particular content or level of detail—represent a significant departure from your usual practice? If so, why the change? Will you hesitate to discuss this disclosure with your supervisor or consultant or document it in the client’s record? If you would hesitate, what are the reasons?

Pope and Spiegel also suggest some steps which are helpful when a boundary crossing causes, or seems to be leading towards, serious problems. These are:
1. Continue to monitor the situation carefully, even though paying attention to it may be uncomfortable.
2. Be open and non-defensive, even though this may be hard for any of us at times.
3. Talk over the situation with an experienced colleague who can provide honest feedback and thoughtful consultation.
4. Listen carefully to the client.
5. Try to see the matter from the client’s point of view.
6. Keep adequate, honest, and accurate records of this situation as it evolves.
7. If you believe that you made a mistake, however well intentioned, consider apologizing.

Thus, the issue of boundaries and boundary violations is complicated and influenced by various factors like kind of therapy and the context in which a particular behavior will be considered as a violation or not. Besides, these other important factors which can influence the boundaries include the socio-cultural background of the therapist or the client. For example, in contrast, to the West, a therapist accepting a gift (box of sweets on a festival) from his client in India (even if that has been mentioned in the therapeutic contract), where refusing a gift is considered as an insult, can’t be interpreted as a boundary violation in true sense.

Ethics in psychotherapy Termination
Termination in psychotherapy is conceptualized as an intentional process that occurs over time when a client has achieved most of the goals of treatment, and/or when psychotherapy must end for other reasons. Because it is an end of the process (whether successful or unsuccessful), it has important ethical issues. First and most
important issue is ending the therapy in a planned way, rather than abandoning the client, which may convey betrayal and abuse of power. In term of planned termination, it is important to remember that “termination of psychotherapy is not a point but is a process”, hence the termination of psychotherapy should be discussed from time to time in the therapy (i.e., some day patient will be able to manage his/her affair without the help of the therapist, by the gains made in the therapy), so that it doesn’t come as a shock to the client. For the same, the client can be asked from time to time to review what all he is able to manage outside the psychotherapy sessions, what all they consider as gains in terms of their ability to handle the previously unmanageable situations and how they see themselves in relation to the original goals of the therapy.

The therapist can also give their feedback in terms of improvement/gains which they notice in the client to validate or contradict the patients self assessment of psychological growth, resilience and strengths. Further, discussions should also focus on as to when to return back for psychotherapy in future so that termination of psychotherapy is not perceived as end of it for ever. Another way to proceed towards termination is asking the patient to imagine, how they are going to handle the situations of life in the absence of the therapist.

Premature termination of psychotherapy may occur at the initiative of the therapist, client or external factors. One of the issues which may lead to premature termination can be default on the part of the client to pay the fees due to various reasons. In such a situation, it is not ethical to communicate to the client, that “we are not going to meet again”, because of the non-payment. Rather it is advisable to foresee such eventualities and proper alternatives should be discussed during the informed consent procedure and must be mentioned in the therapeutic contract. In such eventualities the alternatives must be exhausted before making the final call. The alternatives should be such that it provides ample time to the therapist and client to end the therapy in a congenial environment.

As far as therapist is concerned ‘psychotherapy should be terminated from the therapist side, when it is evident that client no longer needs psychotherapy, is not likely to benefit, or is being more harmed than benefited from continuing psychotherapy’. Such a decision can be reached by continuously reviewing the progress in the psychotherapy and the goals (original or adjusted from time to time in therapy) of psychotherapy. If it is evident that the client’s mental state is gradually deteriorating, than it is advisable to consider stoppage of psychotherapy. However, in such situations, proper supervision or a referral to another psychiatrist could be very beneficial for the therapist to validate/contradict his decision. Other important issue which might lead to termination of psychotherapy from psychotherapist’s side is continued unmanageable
counter-transference and distress to self in continuing the therapy. Another reason for termination of therapy is when the client files a case (starts legal proceedings) against the therapist. Besides these, other reasons of termination of therapy from therapist’s side include shifting in work place of therapist, therapist falling sick or retiring from his job.

Some of these situations can be expected prior to starting of psychotherapy, like end of tenure/training date, retirement date etc. If such is the case, it is advisable to include same in the therapeutic contract. Similarly, name of a colleague can be incorporated in the therapeutic contract, as an alternative therapist, in any unforeseen eventuality.

In all the situations which warrant termination of psychotherapy from the therapist’s side, therapist should make all possible attempts to have a pre-termination counseling session before ending a therapeutic relationship. This session should be seen as an opportunity of providing advance notice to the client or an opportunity to negotiate an end date, discussing the gains made during the therapy and the deficits which are still persisting, planning for relapses and future stressors and finally providing alternative therapist’s details for future treatment needs.

In case the termination is initiated by the client, then also the therapist have some ethical obligations to their clients. Usually when the therapy is terminated by the client, they either stop coming or stop responding to phone calls due to various reasons. In such a scenario, it is ethical to let the client know (possibly by writing a letter, with the appointment date and time) that therapist is willing to continue treatment or meet for one/few sessions to summarize and end the therapy, willingness to resume therapy in future if the client desires so, and if the patient wishes the therapist can refer them to another therapist.

Mention of the aforesaid in the therapeutic contract makes it easier for the client to convey discontinuation of the therapy to the therapist, rather than making the therapist feel abandoned.

**Post termination ethical issues**

As with other issues related to boundaries, post-termination relationships between therapist and the client have always being an issue of debate. Although, there is no law to bar the physician to have sexual relationship with their ex-patients, but it is more or less accepted that it is unethical to terminate the psychotherapy for having a sexual relationship with the client. Regarding the post-termination sexual relationship, there are different views. Some of the authors take the stand that the client may agree for such a relationship because of unresolved transference and hence it is unethical. Others consider that if a proper
termination of therapy has been done, transference should be considered as resolved, and hence having sexual relationship after proper termination is not unethical. However this issue becomes more complicated when the therapy (therapies other than dynamic) doesn’t encourage transference. Hence, there is no clear consensus on the issue on sexual relationship with an ex-client. In view of the same, the sanctity of the same will depend on case to case basis. When faced with such a situation, therapist should seek supervision.

**Documentation in psychotherapy**

Documentation in psychiatry should be regarded as a medical and legal record of assessment, diagnosis, investigations, decision-making, pharmacological and non-pharmacological management done in the specific case. From the medico legal point of view psychiatrists are expected to maintain factual, legible and accurate records because it serves as a guide to the clinician to provide and plan care for the patient and also as a guide for the care of the patient in case of change of psychologist. Another important usage of medical record is in the court of law in cases of litigations due to various reasons involving the patient or the clinician. A proper documentation of what has transpired between the patient and clinician can at times come to the rescue of the psychologist in the court of law or when such an evaluation is done by Medical Council of India in cases of complaints against the clinicians.

However, the other side of the coin is that psychotherapy involves sensitive, personal information about the patient and other people in the patient’s life. The patient reveals this information to the psychiatrist in the faith and trust that it will be used to advance the treatment and that no information from that treatment will be revealed to any other person without informed consent for disclosure. But despite ethical issue of confidentiality of the doctor-patient relationship, medical records are open to disclosure in unanticipated ways that are beyond the control of the patient or the clinician, as in the cases where such a demand is made by the court of law. In United States, there are provisions in the law, where the therapist has the discretion as to what to disclose and what not to disclose in relation to information obtained during psychotherapy, but such is not the case in India. Another important aspect, which can lead to breach of confidentiality, is use of computers to store the data and clients treatment records. Such information can be assessed by or transmitted to unauthorized persons, inspite of use of all possible security systems.

Thus, weighing the pros and cons about documenting everything what transpired in the therapy or not documenting anything is a big dilemma. From medico-legal aspects, not documenting anything can put the therapist into a bigger risk. However, documenting everything can lead to lot of damage to the client, if these
documents are disclosed or assessed by someone. From ethical point of view too, not documenting anything is unacceptable. Hence, the extent of documentation may vary from session to session and also will be heavily influenced by the kind and intensity of psychotherapy. Also the documentation must be based on the probability of records being assessed by others. Hence, the clinicians should use their clinical judgment to maintain concise, factual documentation of psychotherapy while respecting the privacy of the patient. However, documentation must include notable events in the treatment setting or the patient’s life, clinical observations of the patient’s mental and physical state, psychiatrist’s efforts to obtain relevant information from other sources, investigation findings including psychological test findings, information provided to the client in relation to medications if any, suicidal ideation with intention to act, child abuse, threats of harm to others, consultation with other clinicians if any, and basic information required to maintain continuity of care in any eventuality. Documentation of information with regard to intimate personal relationships, fantasies and dreams and sensitive information about other individuals in the patient’s life must be based on the clinical judgment. However, documentation of any hypotheses or speculations must be avoided. The therapist can maintain a personal note which can be kept physically apart from the medical record, containing details of the intimate issues of the client, issues related to other people in the patient’s life, therapists own observations, hypotheses, etc, which can act as a guide to future psychotherapeutic work. However, important aspect of it is that it should not have any information which can disclose the identity of the clients to others. Further, informed consent must be obtained from the client in case the therapist wants to use such records for teaching purposes without the client being identified. Further the notes should be destroyed as soon as they have served the purpose for which they were maintained. It is also important to note that content of such notes may not be useful for the therapist in case of legal proceedings.

**Conclusion**

In conclusion to routine practice, psychotherapy should be considered as a special situation especially in our setting where there is no much distinction between psychotherapists per se and psychologists. Whenever a client approaches a psychiatrist and if he thinks that psychotherapy could be an appropriate treatment modality, or if the client request for psychotherapy in the light of his competence, the therapist should obtain informed consent. This should include providing information to the client as to what is psychotherapy, what is expected out of the patient, what is expected from the therapist, what are the limitations of the therapy and
therapist, fees involved, alternative modalities of treatment along with efficacy of each in condition in which the client is suffering from. After an informed consent is obtained the therapist along the client should draw a therapeutic contract, with do’s and don’t for either of them. Throughout the therapy and during drawing therapeutic contract, therapist should be aware of the confidentiality and also make the client aware about the expectations to the confidentiality issues. Similarly therapist should be aware of the boundaries and boundary violations and try to work in the limits of the boundaries. However, if boundary violations occur, steps must be taken to minimize the harm. Whenever therapy ends, it should be in congenial environment, with the scope for the client to seek treatment again if he desires so, or an opportunity to be referred to someone else.

References: