Chapter 13
Ethical and Legal Issues in Psychotherapy

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Abstract The chapter presents an overview of ethical and legal issues pertaining to the clinical practice of psychotherapy. Psychotherapy is an English word of Greek origin, deriving from the ancient Greek words 'psyche' (ψυχή meaning 'breath; spirit; soul') and 'therapia' (θεραπεία meaning 'healing; medical treatment'). Psychotherapy is a science which alleviates pain, suffering, stress or anxiety. Psychotherapy may also be used in combination with medicines to treat mental illness. Ethical and legal issues which are likely to be encountered in practice; like record keeping, confidentiality, boundary crossings and violations, medical negligence and other practical issues have been examined in this chapter. The ability to think rationally and apply general ethical principles to specific situations is vital. The purpose of this chapter is to provide an understanding of ethical and legal issues related to psychotherapy. However, it does not replace advice based on legal expertise.

Keywords Ethics · Legal · Psychotherapy

Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist or other mental health service providers. However, a precise definition of psychotherapy is, "Treatment, by psychological means, of problems

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of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the objective of removing, modifying or retarding existing symptoms; mediating disturbed patterns of behaviour and promoting positive personality growth and development" (Wolberg 1988).

There are different types of psychotherapies such as, psychoanalytic therapy, cognitive behavioural therapy, family therapy, interpersonal therapy, supportive therapy, eclectic therapy and brief therapies. These therapies have have varied underlying theories, approaches, target ingredients, durations, modalities and may be recommended for specific populations. However, these therapies show that there are certain ingredients which are common to all kinds of psychotherapy. Psychotherapy includes interactive processes between a person or a group; and a qualified mental health professional. The goal of psychotherapy is to alleviate pain, suffering, stress or emotional distress through exploration of thoughts, feelings and behaviour (Wolberg 1951). Psychotherapy is an agreement between a practitioner (usually called 'Psychotherapist') and a client to work together towards alleviating pain by entering into a therapeutic relationship (Sills 2006). By this agreement, the therapist and the client form a therapist–client relationship. Once this relationship is established, the therapist has a duty of care to the client. Guidelines have been established to maintain minimum standards of ethical practice. Considering the dynamic interaction between the practitioner and the client, there are many ethical and legal issues that arise during psychotherapy (Norcross et al. 2011; Wolberg 1988).

When a professional psychotherapist agrees to attend to a patient, there is an unwritten contract between the two (Croxton 1985; Sulzer 1962). The contract can be defined as an agreement between two or more persons which creates an obligation between them, to do or not to do a particular thing. The contract may be expressed or implied. The patient entrusts himself to the therapist and the therapist agrees to do his/her best, at all times, for the patient (Croxton 1985). The therapist–patient contract is almost always an implied contract, except where a written informed consent is obtained. Under the therapist–patient contract relationship there are certain obligations for the therapist such as to continue treatment, provide reasonable care within reasonable skill, and not to undertake any procedure beyond his/her skill and professional secrets (Feldman and Ward 1979; Simon 1991; Van Hoose and Kottler 1985). Increasing legal and regulatory demands on 'health-care practitioners', including demands that directly conflict with the central tenets of traditional professional ethics (such as confidentiality), were a major factor in motivating the formation of the professional associations to form minimum standards for care, licensing, remuneration and ethical guidelines (Simon 1991; Van Hoose and Kottler 1985). The industrialization of health care and information technology revolution has added more complexities in this therapeutic relationship. Consequently the proliferation of guidelines, ethical issues, legislation designed to 'protect the client/public' were greatly limiting psychotherapists' and psychoanalysts' clinical freedom (Austin et al. 1990; Schutz 1982; Thompson 1983). To overcome these barriers, this chapter discusses ethical and legal issues involved in psychotherapy practice and also attempts to provide general guidelines for safe practice. The case vignettes used in the chapter are fictitious and are used to

illustrate common dilemmas. Further, this chapter does not intend to serve in lieu of clinical, ethical and legal consultation. It neither gives legal, ethical nor clinical advice. In this dynamic world, each situation, context, therapist and client is different, and, therefore, each situation needs to be evaluated independently.

Case 13.1
Mr. X, 33 years, an unmarried advocate, from middle socio-economic status, diagnosed with depression and personality disorder, was on treatment from a well-known hospital. He was on medication and also on psychotherapy. He had already completed 24 sessions of psychotherapy. During the psychotherapy sessions, he developed transference towards the therapist and started making frequent phone calls, sent messages on the mobile phone and wrote emails. The therapist worked on handling the transference and tried to explain the boundaries in the professional relationship but he became further depressed and stopped going to work. Finally the therapist terminated the sessions. This resulted in immense distress and pushed Mr X to commit suicide.

Did the psychotherapist fulfil the therapeutic obligation of providing care? Was the psychotherapist negligent in terminating the sessions prematurely? What are the ethical and legal ramifications in this case?

13.1 Professional Negligence

Psychotherapy is a well-known profession in which the practitioner provides mental health care to the suffering (Jenkins 2002). Professional negligence, occurs when a person, in the course of practicing his or her profession, improperly performs the duties of that profession, and someone is harmed as a result (Bernstein and Hartsell 2004; Jenkins 2002; Packman et al. 2004) see Case 13.1.

The Black Law dictionary definition of negligence is:

> … conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of statue or valid municipal ordinance or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes.

In simple terminology 'Negligence' means 'Lack of Proper Care'.

The Supreme Court of India discussed the conduct of professionals and what may amount to negligence by professionals in Jacob Mathew v. State of Punjab (2005):

> In the law of negligence, professionals such as lawyers, doctors, therapist, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution.

Various professionals have complained about the large number of litigation suits and have urged legal reforms to curb large damage awards, whereas tort attorneys have argued that negligence suits are an effective way of compensating victims of negligence and of policing the profession. Professional negligence can be best understood by studying 'Medical Negligence', because there are large numbers of case laws available across the globe. When there is a breach in a contractual obligation of providing care, with a breach of duty which invites the intervention of judges to grant certain remedies for the damages, then the tortious liability arises.

A person who alleges negligent medical malpractice must prove the following elements:

1. A duty of duty care: a duty exists whenever a hospital or healthcare provider or therapist undertakes care or treatment of a patient.
2. Breach of duty: the provider failed to conform to the relevant standard care.
3. The breach caused an injury/damage: the breach of duty was a direct cause and the proximate cause of the injury/damage (losses which may be pecuniary or emotional).

These are the basic elements that are essential to prove the case of negligence. Above elements were well discussed in Bolam v. Friern Hospital Management Committee (1957) and Jacob Mathew v. State of Punjab (2005). All the above criteria must be satisfied in cases of professional negligence. The standard of skill and care required of every healthcare provider in rendering professional services or health care to a patient shall be that degree of skill and care ordinarily employed in the same or similar field of medicine as the defendant, and the use of reasonable care and diligence. These issues have been discussed very well by the Supreme Court of India under Dr. Laxman Balakrishna Joshi v. Dr. Trimbak Bapu Godbole (1969).

All professionals are expected to exercise knowledge and skills which they profess to have beyond that of the non-professionals. However, this skill and knowledge is to be judged by criteria and standards determined by the profession itself. It is only when the skill and knowledge fall below the established standard is the practitioner guilty of being negligent. Further, the Supreme Court has defined this duty in the celebrity case Indian Medical Association v. Shantha (1997) as "In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing service". On setting out parameters of the standard of care required, the Court held that the standard should be established by the profession.

Various acts falls within the ambit of medical negligence, as noted in a case K. Gracykutty v. Dr. Annamma Oommen and Another (1992), of the Kerala State Consumer Disputes Redressal Commission that the following acts would fall under the ambit of medical negligence:

1. Recklessness in undertaking a treatment or recklessness in the treatment of it
2. Indifference in handling of medical cases
3. Failure to act diligently and alertly at the appropriate time
4. Wrong diagnosis or treatment which under no norms of practice can be justified
5. Evident negligence like amputating a wrong limb or administering a prohibited or known counterproductive medicine
6. Misrepresenting that one possesses the skill or expertise which he/she does not possess.

Hence, all practitioners must bear in mind that they should bring in a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Failure to exercise a reasonable degree of skill in diagnosis and providing care can constitute negligence.

13.1.1 The Tests of Liability: Bolam and Bolitho

The Bolam Test To succeed in proving liability, one needs to prove that the therapist was negligent and acted in a manner that no other therapist would have done. There are two tests of liability: the Bolam test and the Bolitho test.

The Bolam Test was developed by Bolam v. Friern Hospital Management Committee (1957), an English tort law case that develops rules for assessing standards of reasonable care in negligence involving professionals. Bolam was suffering from mental illness of the depressive type and was advised by the doctor attached to the defendants' Hospital to undergo electroconvulsive therapy. Prior to the treatment, Bolam signed a form of consent to the treatment but was not warned of the risk of fracture involved. Even though the risk was very small and on the first occasion when the treatment was given, Bolam did not sustain any fracture but when the treatment was repeated for the second time he sustained fractures. No relaxant drugs or manual control were used except that a male nurse stood on each side of the treatment couch throughout the treatment. About this treatment, there were two bodies of opinions, one of which favoured the use of relaxant drugs or manual control as a general practice, and the other opinion confined the use of relaxant drugs only to cases where there are particular reasons for their use and the Bolam case was not under that category. Ultimately the Court held the doctors were not negligent. In this context, the following principles were laid down: "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art". In other words this test states that if a therapist failed to reach the standard prescribed or

practiced by a responsible body of psychotherapists' opinion, then it is termed as negligent.

The Bolitho Test The Bolitho test, developed by the Bolitho v. City and Hackney Health Authority (1993), modified the standard of care required by medical specialists in 'the Bolam Test'. In the case of Bolitho, the House of Lords would not accept a defence of being 'respectable', 'reasonable', or 'responsible' without first determining whether the professional opinion can withstand logical analysis. This Bolitho test further qualifies 'the Bolam test' with logical basis. This clearly says that the court had to be satisfied that the expert opinion had a logical basis.

In India, clients can approach Consumer Protection Act (CPA) 1986, which is a quasi-judicial mechanism set up at district, state, and national levels, where consumers can file their complaints, which are entertained by the judicial bodies referred to as consumer forums. The psychotherapy profession comes under the ambit of the CPA. As per the Consumer Protection Act, a consumer (client) is a person who hires or avails of any services for a consideration. Under this legislation, a therapist owes certain duties to the client, who consults him for his psychological problems. A deficiency in this duty results in negligence. A client can approach the consumer court, if he or she has suffered loss or damage as a result of any deficiency of services.

To summarize, professional negligence occurs when a therapist fails to act as a reasonable therapist would have acted under the circumstances. In the presented case vignette, Mr X committed suicide in spite of providing reasonable degree of care and if he had referred the case to another, which is endorsed by the professional body, then the therapist is not considered negligent but the unfortunate incident is an outcome of the disorder. A therapist must exercise that level of skill, diligence and judgment that a reasonable therapist would have exercised under the same or similar circumstances. On the other hand, if the therapist did not provide adequate reasonable degree of care then the therapist is liable for prosecution. The client can file a civil suit (for compensation) and a criminal case (for punishment), as well as in the Consumer Fora (to claim for damages), against the negligent psychotherapy practitioners. However, one should remember that psychotherapy for a consideration (paid) comes under the ambit of the Consumer Protection Act 1986. Free psychotherapy services do not come under the ambit of the legislation.

Case 13.2
Mrs. Y, 22 years old, a married engineer, from middle socio-economic status, diagnosed with schizophrenia, is on treatment from a government hospital. She is on medication and also on psychotherapy. She has already completed 12 sessions of supportive psychotherapy. During the sessions she had revealed certain private details about her premarital relationship with one of her college mates. She had requested for confidentiality. After a few weeks the therapist comes to know that Mrs.Y's husband has filed for divorce in the

court of law and now he is asking for a copy of the medical record and also the psychotherapy notes.

What should the therapist do? Is the therapist legally obligated to keep the therapy session notes? Does the husband have a right to access the medical records of his wife?

13.2 Record keeping

Practitioners should be familiar with the legal and ethical requirements for record keeping in their specific professional contexts (see Case 13.2). A psychologist must make efforts to see that legible and accurate entries are made in client records as soon as is practicable after a service is rendered. The nature and extent of the record will vary depending upon the purpose, setting, and context of the psychological services (Bond and Mitchels 2014; Wheeler and Bertram 2008). The process of keeping records involves consideration of local legal requirements, ethical standards, supervisory needs, research protocol obligation as well as the demands of the particular professional context (Bond and Mitchels 2014; Luepker 2003). Appropriate records can also help protect both the client and the psychologist in the event of legal or ethical proceedings. Adequate records are generally a requirement for third-party reimbursement for psychological services.

Therapists are ethically and legally required to store records in a secure manner and to protect client confidentiality. Failing to maintain adequate client records potentially could lead to a malpractice claim because it breaches the standard of care expected of a mental health practitioner (Luepker 2012). The assurance of confidentiality is critical for the provision of many psychological services. Maintenance of confidentiality preserves the privacy of clients and promotes trust in the profession of psychology (American Psychological Association 2007).

Recordkeeping guidelines delineate three types of content (American Psychological Association 2007)

1. General file information: This includes demographic details, presenting problems, diagnosis, intervention plan, fee agreement, billing information and informed consent.
2. Documentation of service: This includes the date, duration and type of psychotherapy services and session notes. These notes should be updated for each contact with a client. Recognizing that client and other professionals may review these records (team members, colleagues and insurance agency), the practitioner may want to be sensitive to the language he or she uses to describe the patient.
3. Other information: A variety of other types of information may be included in the record, such as assessment data, crisis management documentation, consultation with other professionals, and telephone and email contacts.

American Psychological Association (2007) mandates psychologists to retain full records until seven years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later. If there is no state statute, the psychologist may be held to what is determined to be 'customary practice' in his or her area.

According to Medical Council of India (2002) guidelines

1. Inpatients records should be maintained in a standard proforma for three years from the commencement of treatment.
2. If any request is made for medical records either by the patients/authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.
3. Maintain a register of certificates with the full details of medical certificates issued with at least one identification mark of the patient and his signature.
4. Efforts should be made to computerize medical records for quick retrieval.

13.2.1 Patient Access to Records

Patients have a right to access their personal health information both under Medical Council of India (MCI) Regulations (2002) and the Right to Information Act (2005). Certain personal records must be given to the patient as a matter of right. Discharge summary, referral notes, and death summary in case of natural death are important documents for the patient/immediate family member. These individual personal documents have to be given to the patients, even to those who leave against medical advice.

Physicians cannot refuse to grant a patient access to their records for the purpose of avoiding a legal proceeding. With the enforcement of the MCI Regulations (2002), it has been held without confusion that the patient has a right to claim medical records pertaining to his/her treatment and the hospitals are under an obligation to maintain them and provide them to the patient on request. Request for medical records by the patient or an authorized attendant should be acknowledged and the documents should be issued within 72 hours. The hospitals can charge a reasonable amount for the administrative purposes including photocopying the documents. Failure to provide medical records to patients on proper demand will amount to deficiency in service and negligence.

Certain records cannot be given to patients without the direction of the Court. The files of medicolegal cases including autopsy reports cannot be handed over to the patient or relatives without the direction of the Court. But if these medicolegal cases are being referred to another centre for management, copies of records could be given. Suggestions for patients general clinical record include:

1. Patient contact and basic information
2. Intake materials including the initial intake history, evaluation and assessment

3. Progress/session notes, initial and interval treatment/service plans and closing/termination summary
4. Referrals made, consultation reports and testing results obtained
5. Details of communication with other practitioners
6. Correspondence with the patient or non-clinical collateral contact details
7. Billing records
8. Informed consents for treatment, consents and authorizations to use and/or disclose clinical information/records.

The following information should be included when documenting a counselling session:

1. Subject being discussed;
2. Scope of the discussion (e.g. educational components, management options, prognosis);
3. Patient's response to the discussion;
4. Therapy prescribed (if any);
5. Action plan or goal including follow-up.

It is important to know that the information contained in the case belongs to the client. The client has the right, or privilege, that his or her information will be kept confidential. The case information in the client file should be considered a legal document that can be subpoenaed by the court.

Information recorded should be complete so anyone reading the notes can understand who this client is, what brought him/her to the therapist's office, the goals established, the clinical plan, interventions utilized, their effectiveness and plans for referral/follow-up, if any. A simple standard can be that documentation should enable anyone who reads notes to: understand the client's reasons for seeking treatment, treatment plan to address the presenting problem, results of the interventions employed and the client's disposition.

Documentation takes time and can be tedious. It is good for the practitioner to get into the habit of establishing some allocated time to get the documentation done. In many countries, therapists do an audio recording of the sessions for documentation purposes; however prior written consent of the patient needs to be taken during the intake session.

In general, a summary of psychotherapy is produced in case of legal matters but according to the current legal reforms it is required to have each sessions report otherwise it is amenable to liability. The new Mental Health Care Bill (Narayan and Shekhar 2013) mandates proper record keeping. The bill also dictates that the patient and the nominated representative have the rights to access the records. Against this background, an effort has been made to have uniform session reporting guidelines taking into consideration ethical and legal issues. These guidelines do not establish rules for practice, but rather provide an overall conceptual model and strategies for resolving divergent considerations.

To summarize, the records should reflect the therapist's competence, thoughtfulness, decision-making ability, and capacity to weigh available options, rational for treatment selection and knowledge of clinically, ethically and legally relevant matters (Simon and Sadoff 1992). In the Case 13.2 Mrs Y's psychotherapy session records and medical records cannot be given to her husband without Mrs. Y's consent. The records can be released to the court only after following the proper procedure. In this regard, the therapist can only release information relevant to the case, and the summoned records should be presented to the court in a sealed envelope marked 'confidential'. It is illegal to destroy or tamper with records to avoid disclosure.

Box 13.1: GUIDELINE ON SESSION REPORTING FORM

Name of the Patient:
Date: Time:
Session No:
Duration of the session:
Last session:
Review of the last session:
Focus/Goal Planned: Short-term and Long-term goals
Emotional atmosphere during the session:
Main themes (Give details of the major issues discussed/explored/transpired):
Type of Psychotherapy approach used (Cognitive, Behavioural, Mindfulness, etc.):
Therapeutic interventions:
Comments on the session (Behaviour/Dynamics/Progress/Other Processes):
Advice/suggestion given during the session:
Details of supervisory discussion (if any):
Next session on:
Plans for future interventions:
Medication (if any):

It is good practice to take the patient's consent before submitting the patient's record to the court. If the client wants the therapist to comply with the subpoena, then the therapist should get a written authorization from the client before sharing the requested information. If the client does not consent, the therapist can continue to assert the privilege, until a court hearing which may judge that the privilege should not be upheld. At this point, the therapist must abide by the court order (if not, a contempt-of-court citation can be issued) (Simon 2003; Simon and Sadoff 1992).

13.3 Confidentiality

Confidentiality is the secret-keeping duty that arises from the establishment of the professional relationship psychologists develop with their clients (Younggren and Harris 2008). This therapist–patient privilege only applies to secrets shared between the therapist and the patient during the course of providing care. This confidentiality dates back to at least the Hippocratic Oath, which reads

> Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice. This is important for the therapeutic alliance, as it promotes an environment of trust. There are important exceptions to confidentiality, namely where it conflicts with the clinician's duty to warn or duty to protect. This includes instances of suicidal behaviour or homicidal plans, child abuse, elder abuse and dependent adult abuse (see Case 13.3).

Case 13.3
Mr. Z, a 32 years old unmarried engineer, from high socio-economic status, was diagnosed to be suffering from paranoid schizophrenia. He is on medication and also on psychotherapy. He has already completed three sessions of psychotherapy. During the fourth session, he reveals to the therapist that he is planning to harm Ms. X for refusing to marry him. Mr. Z has also revealed details of this plan to the therapist. Mr. Z has also requested his therapist not to reveal his plan to anyone.

What should the therapist do? Is therapist legally obligated to keep confidentiality? ÅDoes the therapist owe a duty to general public at large?

The Supreme Court of India has endorsed the principle of medical confidentiality as deriving from the classical conception of the right to privacy. Doctors are morally and ethically bound to maintain confidentiality. In such situations, public disclosure of even true private facts may amount to an invasion of the Right of Privacy which may sometimes lead to the clash of a person's 'right to be left alone' with another person's right to be informed.

13.3.1 Confidentiality and the Public Interest

Public interest requires that confidences be maintained. Breaking confidence is possible if the information is:

1. In the public interest (to prevent/report crime, malpractice, suicide, professional misconduct, suspected child abuse)
2. Related to illegality or breaking of law
3. Already in public domain

Legal opinion has supported the principle of the counsellor's 'fiduciary duty' of confidentiality in student counselling.

13.3.2 Confidentiality and Privilege

1. Confidentiality arises where trust is reasonably expected in a relationship.
2. Marital negotiations for reconciliation or separation can be privileged from disclosure.
3. Professional privilege (protection against compulsory disclosure of confidences) applies only to client–lawyer communications for legal advice.

The Supreme Court of United States created a psychotherapist–patient privilege in the Federal Rules of Evidence Jaffee v. Redmond (1996). The Court also noted that in a draft of the Federal Rules of Evidence, the Congress had listed *psychotherapist–patient privilege* as one of nine privileges, but in the end decided that the determination of privilege should be left to the courts. Hence, it clearly dictated that confidentiality is not absolute. A legitimate breach of confidentiality is upheld in reporting suspected child (sexual) abuse by their contract of employment or professional code of practice. Similar is the case of breaking of confidentiality in the public interest, in order to report serious crimes such as providing information to legal agencies regarding terrorist offences.

13.3.3 Child Abuse and Confidentiality

Therapists must make a report to an appropriate authority upon knowing or suspecting the occurrence of child abuse. There are no time limits on child abuse reporting in the sense that as long as the victim is still a minor, therapists have an obligation to file a child abuse report. Child sexual abuse laws in India have been enacted as part of the nation's child protection policies. The Parliament of India passed the 'Protection of Children against Sexual Offences Bill, 2011' (POCSO Act, 2012) regarding child sexual abuse on May 22, 2012 into the Act. When a doctor or a therapist has reason to suspect that a child has been or is being sexually abused, he/she is required to mandatorily report this to the appropriate authorities (i.e. the police or the relevant person within his/her organization who will then have to report it to the police). Failure to do this would result in imprisonment of up to 6 months, with or without fine (Section 21, Protection of Children from Sexual Offences Act, 2012).

Making a report to the police under Section 19(1) of the POCSO Act (2012) states that any person, including a member of a non-governmental organisation (NGO), may make a report under this section. Many NGOs work closely with vulnerable children and are in a position to detect child abuse. In many cases, a child may feel more comfortable disclosing abuse to an NGO worker rather than to someone from his/her own family. An NGO that has the knowledge of sexual abuse of a child is also bound by the principle of mandatory reporting under Section 21(1) of POCSO Act, 2012.

13.3.4 Suicidal or Homicidal Clients and Confidentiality

A breach of confidentiality is permitted when a client poses an imminent danger to himself/herself or to others. Failure of a therapist to ensure client safety within a high risk for suicide situation could end in harm or death to the client. Therefore, therapists must weigh consequences of breaking confidentiality versus potential client harm. Self-inflicted harm or damage to property is not a strong enough public interest area to infringe upon the need for confidentiality. Procedurally, the therapist's response to suicidality can include formulating a 'suicide prevention contract' with the client, informing the client's family, and/or having the client hospitalized. If possible, the therapist can discuss his/her intended action to resolve the situation with the client. Communication with others may be best limited to information pertinent to the present situation to protect client confidentiality.

In Tarasoff v. Regents of the University of California (Beck 1985) case, the California Supreme Court found that, despite patient–psychotherapist confidentiality, a duty to warn exists when the therapist determines a warning is essential to avert a danger rising from the patient's condition. The mental health profession quickly responded to this decision, claiming that they have no inherent ability to predict violence and that such a ruling violated their 'special' relationship and would prevent patients from trusting them. It could also generate false positive predictions as a means of diverting liability just in case something happened. Overall, this would be a detriment to those needing treatment, as well as a deterrent to clients who might otherwise expose their violent fantasies.

The court agreed to rehear the case and issue a second opinion. It still found that therapists have a duty to potential victims, but they need only use 'reasonable care' to protect the person. That is, the therapist needs to consider admission or hospitalize the patient to avoid the potential for harm.

To summarize, confidentiality is not absolute. In case of a homicidal or suicidal threat, the therapist has the responsibility to warn the potential victim or to inform the police regarding the risk, when the therapist determines a warning is essential to avert a danger rising from the patient's condition. At the same time, the therapist should consider admission of the violent patient in a mental hospital.

13.4 Boundary Crossing and Violation

A boundary is a line, point or plane that indicates or fixes a limit or extent. Boundaries are also the limits we set in relationships, which establish clear roles for therapists and define the therapeutic territory (Herlihy and Corey 2014; Lamb and Catanzaro 1998; Simon 1992). They do not undermine the therapist–patient relationship (Gabbard 1997; Smith and Fitzpatrick 1995). If boundaries are ignored, therapists can find themselves acting in their own best interest instead of the patient's best interest and may exploit the patient. Boundaries are derived from ethical treatise, cultural morality and jurisprudence. Sometimes, it is difficult to clearly define the perimeter of these boundaries and the integrity of the relationship (Gutheil and Simon 2002). As per researchers (Gutheil and Gabbard 1993), there are two types of boundary issues, (a) Boundary crossings and (b) Boundary violations. Boundary crossings are harmless deviations from traditional clinical practice, behaviour, or demeanour. Neither harm nor exploitation is involved. For example, giving a patient an emergency taxi fare in a heavy downpour, or accepting cake on a client's birthday, etc. Boundary violations, in contrast, are typically harmful and are usually exploitive of patients' needs—erotic, affiliative, financial, dependency or authority. Examples include, having sex with client or for financial demands beyond the fee, etc. (Folman 1991; Gabbard 1997; Gutheil and Gabbard 1993; Norris et al. 2014).

The American Counselling Association (1995), the American Association for Marriage and Family Therapy (AAMFT 2015, 1.4, 1.5), and the American Psychological Association (APA 2010, 10.5, 10.08) all agree that sexual contact before two years after therapy termination is unethical. All of these associations indicate that in the case of sexual relations with former clients, even after two years have elapsed, the burden of demonstrating the absence of exploitation rests with the therapist (see Case 13.4).

Case 13.4
Ms. M, 22 years, an unmarried engineer, from high socio-economic status, diagnosed with Borderline Personality Disorder. She is on medication and also on psychotherapy. She has already completed nine sessions of psychotherapy. During the psychotherapy sessions, Ms. M, gets attracted to her therapist. She starts giving gifts (such as sweets, flowers, greeting cards, watch, etc.) to her therapist. Therapist also gets involved romantically with his client and has a physical relationship with Ms. M, after consent from her. Now, they both are planning to get married.

Is it acceptable for a therapist to get into a consensual sexual relationship with his client? Can the therapist marry his client?

Following are some suggestions which are helpful when a boundary crossing causes, or seems to be leading towards, serious problems (Pope and Keith Spiegel 2008). Therapists need to continue to monitor the situation carefully. Be open and non-defensive. Talk over the situation with an experienced colleague who can provide honest feedback and thoughtful consultation. Try to see the matter from the client's point of view. Keep adequate, honest, and accurate records of this situation as it evolves. If you believe that you made a mistake, consider apologizing. Sometimes if the emotional turmoil is too much, termination of therapy is advised, with referral of the client to another therapist (Pope and Keith Spiegel 2008).

To summarize, psychotherapists need to be aware of their influential position with respect to their clients and need to avoid sexual contact with their clients, whether such contact is consensual or forced. It is unethical and also illegal.

13.5 Practical Issues

In case of personal problems and conflicts, psychotherapists should recognize that their personal problems and conflicts can interfere with the effectiveness of their work (Pope and Keith Spiegel 2008). In such cases, they should refrain from that particular work (therapy, research) and seek help for the same.

Late to the session It is not uncommon that clients report late to the session. Though it is difficult for the therapist to conduct session in such instances owing to time constraints, it is advisable to discuss the difficulties in reporting on time and the possible solutions for the same.

Cancellation Generally, clients are asked to inform therapist at least 24 hours in advance if they want to cancel a session. Though there is a practice of charging clients if they fail to do so, it is rarely done in the Indian setting.

Emergency contact Clients/family may be provided with emergency contact numbers of the emergency psychiatric settings so that they do not have to wait in distress till the designated appointment date for session. Client and family members also have to be made aware that therapist's privacy and personal time needs to be respected. If a client is making repeated phone calls it would be prudent to explain the client about the professional relationship and request to call only during emergencies. If the client continues to make phone calls it would be advisable to block the number during non-working hours. Hence, it is advisable that all therapists should avoid giving personal mobile number, residential phone number and residential address. If a patient threatens self-harm over the phone, the therapist should contact family members of the client, explain the situation and make a referral to the nearest emergency mental health centre or hospital. If no family members are available or traceable, it would be prudent to inform the law enforcing agencies about the client's self injurious behaviour to protect him/her.

Interruption of services Psychotherapists have to take steps for the provision of uninterrupted services to the client in circumstances such as psychotherapist's illness, death and therapist's or client's relocation. Appropriate referral has to be made when client has financial constraints to pay for the services. In this regard, abrupt ending of sessions is not appropriate and ethical (American Psychological Association 2002).

Termination Psychotherapy is terminated when the therapist evaluates that the client does not need therapy any more, is not benefitting from the same or is counterproductive for the client (American Psychological Association 2002). Termination of sessions needs to be planned and conveyed to the client well in advance. However, severe pathological transference may call for abrupt termination of the sessions with proper documentation of the reason for termination and referral of the client to another therapist. This is also true in case of severe counter-transference, during which the therapist should seek consultation.

Gifts Currently, the empirical data available on the impact of gift-giving by therapist or client is sparse. In one study (Knox et al. 2003) therapist's experiences of receiving gifts from clients suggested that gift-giving had symbolic value which ranged from appreciation, boundary violation to manipulation. Therapists needs to be aware of the ethical guidelines, cultural norms related to gift-giving or accepting gifts. There is need for clear communication to clients at the outset of therapy if the therapist has a strict 'no-gifts-policy' as well as discussions about the client's emotions and experience in the context of therapist refusal to accept a gift.

Self–disclosure In a qualitative study (Audet and Everall 2010), it was found that therapist self-disclosure has both facilitating (closeness, comfort, feeling understood/not judged) and hindering effects (role confusion, role reversal, feeling misunderstood, etc.). Some authors support a balanced and careful use of self-disclosure without indulging in disclosing too much or too little (Bloomgarden and Mennuti 2010). Newer ethical dilemmas are emerging with respect to client-therapist personal contact via social media.

Telephone counselling Therapists need to avoid telephone counselling in regular counselling services. Telephone counselling needs to be used only during crisis. Ethical and legal norms have not been well established in telephone counselling.

To conclude, psychotherapist–client relationship is a complex and multifaceted. In the era of consumerism, the therapist needs to be aware of the client's rights, ethical issues and prevailing legal system. Professional codes of ethics are fundamental for ethical practice; however simply knowing these codes is just the beginning. The ability to think critically and apply general ethical principles to specific situations is vital. Relevant laws vary substantially from state to state and from context to context and from time to time. When appropriate, practitioners are encouraged to consult legal counsel who can review the pertinent law and facts and provide legal assistance as needed.

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