ETHICAL AND LEGAL ISSUES IN PSYCHOTHERAPY

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INTRODUCTION

Psychotherapy is defined differently by various authors. However, the most complete definition of psychotherapy as given by Wolberg defines it as "a treatment, by psychological means, of problems 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 behavior and promoting positive personality growth and development".

When we look at the literature, different types of psychotherapies (Psychoanalytic, Cognitive behaviour, Family, Interpersonal, Supportive, Eclectic, Brief therapies etc) have been described based on different theories (different views about the nature of behavior and change) on which they are based, and duration of treatment. However, closure looks at all these therapies show that there are certain ingredients which are common to all kinds of psychotherapy[1].

The purpose of this guideline is to establish minimum standards of ethical practice for psychiatrists. Regardless of the wide range of approaches preferred by individual psychiatrists, there are common ethical issues arising out of common ingredients of psychotherapy[1].

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[2]. 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), avoiding exploitation and harm of clients and those associated with them (nonmaleficence), 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 therapists actions (autonomy), 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)[3]. Risk management although has the same goal as positive ethics for the clients, but it 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[3,4]. 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[2,4]. 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

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ideation or severe personality disorders, out of fear that they materially increase risk[3,5].

Based on the above principles, these guidelines will cover the ethical issues in psychotherapy under the headings of competence of therapist, responsibilities of therapists towards their clients, therapeutic contract, informed consent, confidentiality, privilege and psychotherapy supervision, documentation, self disclosure, matters of business (advertising, fees etc), research, counter-transference, boundaries, termination and post termination issues.

However, it is important to remember that the purpose of these guidelines is to present a framework and it is not a substitute for professional knowledge and clinical judgement. These guidelines cannot specifically address every situation or dilemma that a therapist may face.

Competence of therapist

Competence is defined as "the possession of required skill, knowledge, qualification or capacity" [6]. It is very important that therapists are aware of their competence, with regard to the level of his/her knowledge, training and supervised experience in a particular kind of therapy. In addition to the above, some of the authors also include 'emotional competence' to knowledge and technical skills[7]. 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 determine whether they should limit, suspend, or terminate the therapy[8].

Recommendation-1:

- The therapist should possess required skill, knowledge, training and supervised experience in a particular kind of therapy.
- Therapist should be aware of his emotional state while dealing with their clients.
- How well trained a therapist may be, he should seek supervision from colleagues.

Responsibilities of Therapist

From an ethical point of view, it is important that the therapists are aware of their responsibility towards their clients[9]. 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 authorised 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 counselling skills, monitor performance and provide accountability for practice[9].

Recommendation-2:

- The therapist should be aware of his responsibilities towards the clients and self.
- With regard to the clients, the therapist should take the therapy with a professional intent, should draw realistic treatment contract, should not harm the client in any way, should seek supervision from colleagues or supervisors, should be prepared to refer the client when they feel that they are incompetent to handle a particular situation, maintain confidentiality and professional boundaries.
- Therapist should maintain their own personal functioning and effectiveness.

Informed Consent

Informed consent to therapy is invaluable as it ensures that a patient's decision to take part in psychotherapy is informed, voluntary, and rational[10]. Although it is presumed that seeking help of the therapist for their problems by the patient means implied consent, but this does not amount to "informed consent".

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[10]. 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[10, 11]. Last but not the least, a proper informed consent procedures can reduce the client's anxiety by demystifying the therapeutic process[10].

Some of the components of the informed consent, as discussed will also be covered under the heading of "therapeutic contract', but it is important to remember that the therapist and client enter the contract only after they have mutually discussed and have agreed on the issues to be included in the contract. Further, it is also possible that some of the patients may not agree for the therapy if they are given proper information about the various aspects of therapy. Hence including various aspects of therapy as part of the informed consent procedure is necessary.
When ever 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[10].

While taking the informed consent of clients, therapist should take into consideration the cognitive impairments of the clients arising due to conditions like mental retardation, schizophrenia, or Alzheimer's disease. Although in India, we depend on the family members or a legally appointed guardian for medical and mental health care decisions of the clients, psychotherapists must nevertheless provide patients with an appropriate explanation of services, consider the patient's preferences and best interests, and seek the patient's assent[10]. Further, it is important for the therapist to view consent capacity not as an all-or-none ability but as a continuum[12]. It is suggested that the therapist should aim to formulate a "goodness-of-fit model of the informed consent process" that fits to each client's cognitive strengths, vulnerabilities, and decision-making capacities and styles[13, 14]. It is not uncommon to have clients in India, who can understand the reasons for and nature of therapy, but may not be able to take decision, because of lack of experience in making healthcare decisions on their own, or undue trust on their doctors. In such situations, it is important to approach the whole informed consent procedure in a manner of educating the client about the procedure and things involved in the therapy and encouraging discussion between client and other family members to make more informed decisions. However, it is also important that just on the basis of clinical diagnosis, the therapists should not assume that the patients can't give consent. Studies have shown that there is marked within diagnosis heterogeneity, with level of cognitive confusion or distortion, particularly verbal and executive functioning skills- a more reliable predictor of consent capacity than diagnostic criteria[15, 16].

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[17]. While some parts of the informed consent process can reliably occur at the outset of therapy (e.g., confidentiality and disclosure procedures, fees and payment options, cancellation policies), more substantive parts of the informed consent process may continue into the second, third, or even fourth session. Many therapists have reported that information such as the specific goals of the therapy, the techniques used, and the estimated duration of the therapy may not be clearly formed during the initial meeting; in such cases, it is neither in the best interest of the client nor the therapist to establish such matters in haste [10, 18].

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[19].

During the informed consent procedure it is very important that the therapist informs the client about the appointment schedule, the duration of each session, home work assignments, anticipitated 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 behaviour 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 supervisor for guidance and advice[10].

Recommendation-3:

- A client seeking help, shouldn't be interpreted as "implied consent"
- Therapist should obtain informed consent from the client after 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 which the client is suffering from.

Therapeutic contract

The therapeutic contract should be a written document, which includes the responsibilities of the therapist and the client in participating in a particular psychotherapy. It should cover the following:

1. **Time:** the time of the day when the therapy is to be conducted and provision of change in exigencies.

2. **Duration:** the contract must include the duration of each sessions (say 50 minutes)
3. **Frequency of sessions:** Frequency of the sessions will be_____ per week (usually agreed upon between the client and therapist depending on the variety of the problems and symptoms).
4. **Late to the session:** If the therapist will be ever late, he will try to let the client know in advance, even if the delay is just a few minutes. If the therapist is responsible for delay in start of the session and the client can stay longer, then the therapist will see the client you for the full time. If the client arrives late for an appointment, then the session may still end at the scheduled time, however if it is possible than the session may go to the full time. If either the therapist or the client is late by more than 15 minutes and don't inform the other party than the session will stand cancelled. However, in such a situation either of the party has to bear the financial liability.
5. **Cancellation:** In the event of either the client or therapist are unable to keep the appointment, they are required to provide twenty-four (24) hours notice of cancellation or they will be charged for the session.
6. **Fees:** the client is supposed to pay Rupees ____ for each 50 minutes session. Client should make the payment is to be made at the beginning of the session. If the duration of the session extends beyond one hour than the patient will be required to pay an additional fee.
7. **Emergency contact:** If the patient needs to contact the therapist between sessions, she/he should call at _____number and leave the message and also mention that it is an emergency. If the therapist doesn't call back the client in _____ time (say 30 min), patient should attend the emergency outpatient department of the hospital.
8. **Issues of confidentiality:** The therapeutic contract should mention that the therapist will maintain confidentiality of the information revealed during the psychotherapy. However it should also provide the provisions under which the information would be disclosed to others, for example the confidentiality clause can be worded as:

   "Information shared by the client will be maintained strictly confidential except in the following situations:

   a) To ensure the best treatment, therapist will at times discuss the case with his colleagues or supervisor, keeping the identity of the client confidential.
   b) If the client communicates threat of bodily injury to self or to another the information would be disclosed to the family members and the legal authorities.
   c) When there is reasonable suspicion of child abuse or abuse to a dependent adult has occurred, or is likely to occur.
   d) If ordered by a court of law, the details of the treatment will be revealed to that court.
   e) In case of the couple and family therapy, the therapist should mention that "if you tell me a secret, you are asking me to help you disclose it, which I will assist you in doing". "I maintain the right to disclose confidential information to other participants in the family or couple if I feel it is in the best interest of the family or couple to do so. You have equal rights to release information to outside parties but I will withhold it unless it is in your best interest".
   f) Therapist will disclose the information to a third person or agency, if patient gives in written to release the information
   g) If the patient files a case in the court against the therapist then the patients his privilege of confidentiality".
9. **Termination:** If the client decides to discontinue the therapy, he will make this known to the therapist within a session, so that an end date can be decided and the client and therapist can work towards an appropriate ending. Termination of therapy cannot be done on phone, nor be the decision solely of the client (This is to safeguard the client as frequently, during the therapy, client may have to discuss underlying difficult material which has been kept suppressed for the years. Certain defenses/aspects of client may stop him to discuss the same and that may convince their

ego that either - they can't afford therapy, they don't have the time, therapy is not working, or nothing is happening, when, actually a breakthrough is about to happen. So it is important that they ask for inner guidance with the help of their therapist when they have these doubts, rather than leave just when life can begin to have new meaning).

10. **Gifts:** No gifts will be accepted by the therapist from the client and neither the therapist will offer any gifts to the client.
11. **Self disclosure:** The therapy will focus on the issues of the client and the therapist will not respond to any questions regarding the personal details, and any such attempt by the client will be interpreted.
12. **Home work assignments:** As part of the therapy client will be given some home work assignments in between the sessions, and the client is expected to carry out the same. If the client comes to the session, without completion of the homework assignment, then the therapist has the right to cancel the session. However, in such situation, the client has to pay for the session.
13. **Documentation:** The therapist may take notes during the therapy session.
14. **Recording:** The therapist may tape record/video record the therapy session for documentation and supervision purposes.
15. **Provision for revision:** If required by either the therapist or the client the contract will be revised after mutual discussion.
16. **No suicide contract:** In case, patient is suicidal, the contract can include the clause that patient is not going to harm her/him, and in case she/he has the urge to indulge in the self harming behaviour, she/he will contact the therapist.

Recommendation-4:

- A therapeutic contract should be signed by the client and the therapist before starting psychotherapy.
- Whenever there is conflict between the requirements of the client and the contract, a legal opinion should be sought.
- Issues of confidentiality/ privileged communication regarding the information obtained during therapy should be clearly mentioned in the contract.

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[20]. 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 [21]. 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.

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.

Recommendation-5:

- Therapist should maintain confidentiality.
- Therapist can release the confidential information without patient consent which requires mandatory reporting by the law.
- The information collected in the professional relationship must be submitted as evidence in a legal proceeding.
- Therapist can breach the confidentiality if the client threatened the therapist for his life or files a case against the therapist.
- For situations which require interpretation of law, therapist should seek legal advice.

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[22]. 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[22].

Over the last 30 years a large amount of data has accumulated, mostly in the Western literature with regard to dual relationships, bartering, nonsexual touch, meeting therapy clients outside the office for social visits, and other nonsexual boundary issues[22]. Gutheil and Gabbard[23] noted that those who consider the ethical boundaries to be inflexible, they rely on Freud as an authority. But the authors pointed out that Freud used to send postcards to his clients, lent them books, gave them gifts, corrected them when they spoke in misinformed manner about his family members, provided them financial support at the time of need, provided meals to an analytic patient, while on vacation conducted analysis of a person while walking through the countryside and shared meals with him, and analyzed his own daughter. The authors point out that it is possible that for Freud the boundary outlines may be limited only to the time of analytic sessions, and other relationships are possible outside the therapy sessions. Gutheil and Gabbard[23] also point out some of the similar behaviours by M. Klein and Winnicott. The latter on one occasion held the hand of a client for hours together during the therapy, disclosed information about another patient and ended each session with coffee and biscuit. However, authors mention that these historical descriptions don't mean that these are acceptable behaviours. The authors also quote Eissler (1953), who suggested that in ideal situation the therapists should limit themselves to interpretation only[23]. However, a major conflict again arises

when one moves from the classical analytic interpretative psychotherapy to expressive-supportive psychotherapy where interpretation is not the main ingredient of psychotherapy and other ingredients like suggestion, confrontation, advice and praise take the forefront. At times in supportive psychotherapy actually partial gratification of the patients transference needs may be therapeutic. Hence there is an in-built confusion with regard to psychotherapeutic boundaries. In this background the issue becomes more complicated when it comes to talking about boundaries of the clients, which are considered to be more flexible[22]. Gutheil and Gabbard[23] 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.

Boundaries and boundary violations are addressed under the heading of role, time, place and space, money, gifts, services and related matters, clothing, language, self-disclosure and related matters and physical contact[23]. 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, reliving and so on for a set time only. Hence, beginning and ending the sessions beyond the schedule are susceptible to crossings of boundary. Further, the time schedule is also very important, because knowingly or unknowingly scheduling/rescheduling psychotherapy at the end of the day's work, or beyond the working time, rather than the usual working hours may also at times go against the therapist, if there are allegation of sexual misconduct against the therapist. Especially, in the case of rescheduling, such behaviour of the therapist requires interpretation. Essentially time boundary suggests that, when ever 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 non payment 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. Any *gift (including medication samples)* from the therapist to the client, how small it may be, must be interpreted as a boundary violation. Similarly, use of favour or services from the client for the benefit of the therapist must be considered as a boundary violation. However, some of the issues of social manners/obligations must not be out rightly interpreted as boundary violations. *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. *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[23].

However, Pope and Spiegel[22] 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 therapist 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. Reasons to refer range from insufficient training and experience to personal attributes of the client that make you extremely uncomfortable in a way that makes it hard for you to work 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[22] 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's understanding 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 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[22] 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 behaviour 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 sweet 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.

Recommendation-6:

- There are no definite answers to boundaries and boundary violations. However, certain behaviours like having sexual relationship; self disclosure of personal fantasies, dreams, sexual information; wearing seductive clothes may be considered as boundary violations in any context and any kind of therapy.

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[24]. 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[24].

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 deteriating, 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[24].

In all the situations which warrant termination of psychotherapy from the therapist's side, therapist should make all possible attempts to have a pretermination 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[24]. 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.

Recommendation-7:

- Provide patients with a complete description of the therapeutic process, including termination during the informed consent procedure.
- Termination of psychotherapy should be discussed from time to time during the therapy.
- If the therapist decides to terminate the therapy, pretermination counseling should be done.
- When patient terminates the therapy on his own, willingness to resume therapy in future if the client desires so and willingness to suggest alternative therapist should be communicated to the client in written if attempt to contact on phone fails.

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.

Recommendation-8:

- It is unethical to terminate the psychotherapy for having a sexual relationship with the client.
- If a therapist desires to make a relationship with a former client, he 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 medicolegal 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 psychiatrist[25]. 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[25]. A proper documentation of what has transpired between the patient and clinician can at times come to the rescue of the psychiatrist 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[25].

Thus weighing the pros and cons about documenting everything what transpired in the therapy or not documenting anything is a big dilemma. From medicolegal 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 judgement 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 judgement. 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[25].

Recommendation-9:

- Not maintaining any record of psychotherapy is unethical.
- While documenting, clinicians should use their clinical judgement to maintain concise, factual documentation of psychotherapy while respecting the privacy of the patient.
- 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 regards to intimate personal relationships, fantasies and dreams and sensitive information about other individuals in the patient's life must be based on the clinical judgement.
- Documentation of any hypotheses or speculations must be avoided.

Conclusion

In contrast to routine clinical practice, psychotherapy should be considered as a special situation especially in our setting where there is no much distinction between psychotherapist per se and psychiatrist. When ever a client approaches a psychiatrist and if he thinks that psychotherapy could be an appropriate treatment modality, or if the client requests 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 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. Through out the therapy and during drawing the therapeutic contract, therapist should be aware of the confidentiality issues and also make the client aware about the exceptions 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.

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