

Chapter 2

The Ethical Private Practitioner

Rathna Isaac

Abstract Psychotherapy is increasingly being carried out in private practice settings across India. This highlights the need to understand and address ethical concerns, unique to private practitioners. The private practice setting is described as one with greater freedom to act, coupled with greater ethical responsibility. Ethical practices and challenges through the course of therapy from setting up a practice, advertising, informed consent, competence, documentation; through to termination and therapist unavailability are discussed. An attempt has been made to define the scope and limitations of private practice. Concerns around training, qualifications and continued professional development are explored with specific reference to the Indian setting; where creating a uniform standard of care is a special challenge. The business end of therapy and the impact on practitioner, client and therapeutic agendas are explored. A comprehensive and simple model for ethical decision-making is illustrated with an example. Where relevant, suggestions designed to help one build ethics into the structure of one's professional life, have been made. The article is relevant for all mental health practitioners engaging in psychotherapy.

Keywords Private practice • Ethics • Indian setting • Psychotherapy

2.1 Introduction

Being ethical is about more than following a set of guidelines and getting signatures where appropriate. It is about thinking and desiring to act ethically; understanding ethical principles and consciously developing one's personal and professional identity along ethical lines (Anderson and Handelsman 2010). For a mental health professional working in private practice, ethical decision-making is often carried out alone. This paper is intended to assist the private practitioner in understanding, preventing or resolving ethical challenges. It could be useful for psychologists,

R. Isaac (✉)
Private Practice, Bengaluru, India
e-mail: rathnaisaac@gmail.com

psychiatrists, psychiatric social workers and counsellors; though it is presented largely through the lens of clinical psychology.

2.2 Working as a Private Practitioner

To illustrate the special challenges faced by private practitioners, I only have to remember what it was like to launch a practice.

I was trained in a well-known tertiary care mental health hospital and training centre in South India, and spent many years cocooned in a safe institutional blanket. I did not need to engage with the client until they had completed all administrative procedures, had been evaluated by a psychiatry consultant and referred for therapy. Clients were less concerned with who 'I' was, than they were with the fact that I was a therapist recommended by the institution. I had no control over the room, its décor, or privacy; neither was I held responsible for them. I did not need to concern myself with billing except for keeping track of the number of sessions. Documentation was regulated as per institutional procedure and the institution took responsibility for maintaining confidentiality and availability of records. Supervision was mandatory and interdisciplinary discussion was the norm. The huge library offered easy access to all the best literature and new ideas in the field which were eagerly discussed both in formal and informal settings.

As a private practitioner, sitting alone in my room, far away from everybody else, I felt truly out in the cold. I was cut off from the support system I had grown used to. Just being a good therapist was suddenly not enough. On the other hand, I had a lot more say in the type of clients I chose to work with, on my timings, on the space that I occupied and in how I chose to proceed with the therapy. Clients came to see 'me' and felt freer to ask about my training and qualifications. They looked around my room and observed and inferred what they might. There was no one looking over my shoulder. No judgement; but no help either.

Private practice offers more freedom and flexibility with work, but also a greater burden of clinical and ethical responsibility (Brennan 2013).

Brennan (2013), in a comprehensive article on ethical issues in private practice identifies four dimensions of ethical knowledge crucial to private practitioners.

1. *Understanding the foundations and principles of ethical conduct*: This includes being aware of various codes of conduct and reflecting on the principles underlying them. For instance, psychologists practicing in India need to be familiar with the ethical codes of the Indian Association of Clinical Psychologists (2015) and the Rehabilitation Council of India (1998). Awareness of the laws of the land as related to the provision of psychological services is also vital as private practitioners typically set up their own system of service delivery. The Mental Health Care Bill (2013) is a good reference in this regard (Narayan and Shekhar 2015).

2. *Understanding the self as the agent of ethical action, or introspective ethics:* This refers to increased self-awareness that helps anticipate potential ethical lapses. Brennan (2013) recommends three areas of self-reflection for the private practitioner: personal history (positively or negative emotion laden events/experiences), emotional-temperamental (personality and typical interpersonal stance as well as current stressors) and conventional-functional (the ability to organize and manage yourself, including keeping/scheduling appointments, records, track of fees and completing paperwork).
3. The need to establish an *ethical decision-making process*.
4. *Keeping current and attending to self-care:* The private practitioner needs information about evolving codes and new areas of ethical concern; for instance, the use of text messaging, social media and online interventions. The private practitioner also needs to engage in regular self-care practices, be aware of issues like compassion fatigue and burnout (Figley 2002) and seek suitable and timely help for the same.

Issues like informed consent, confidentiality, minimizing multiple relationships, creating and maintaining boundaries, self-disclosure, prejudice and openness remain ethical guideposts for all mental health professionals, and as such are crucial for private practitioners as well. While ethical concerns and principles themselves are more or less universal, their application may pose particular challenges to the private practitioner. The next few sections will highlight challenges unique to private practice. The following areas will be addressed:

- *Starting a therapeutic relationship* (a) setting up a practice (b) advertising and accessibility and (c) informed consent.
- *Sustaining a therapeutic relationship* (a) competence (b) continued professional development (c) the business side of therapy (d) documentation (e) complex issues (f) ethical decision-making.
- *Ending a therapeutic relationship* (a) refusing clients (b) termination (c) therapist unavailability.

2.3 Starting a Therapeutic Relationship

2.3.1 Setting up a Practice

For the private practitioner, being ‘professional’ and keeping to time and commitments is entirely between the self and the client. As the individual with more power in the equation it is up to the professional to maintain standards of fidelity and transparency in the day-to-day operations of the practice (Brennan 2013). In addition,

ethical considerations can be built into the structure of the practice itself, to minimize the likelihood of violations and dilemmas.

2.3.1.1 Treatment Set-up and Boundaries

Maintaining appropriate boundaries between a therapist and a client is made easier with a more neutral space and personal style, as these minimize the likelihood of inadvertent self-disclosure. A fair number of practitioners work from their homes. Here, the scope for self-disclosure is greater and obviously harder to control (Zur 2011). A client coming into your home may feel a bit more like a guest and they may ask more personal questions about their surroundings. Not all personal queries are intrusive. For instance, clients from a different socioeconomic status may feel that the therapist will not be able to grasp their worldview. The author recommends non-defensive but clear boundary setting.

A statement along the lines of “I am happy to respond to any questions that you feel are relevant to your view of me and our professional relationship; however I would appreciate it if we kept away from discussing my personal life, as that may distract from the purpose of therapy” could be useful.

This statement recognizes that the principle underlying less self-disclosure is to keep the therapy space neutral and non-judgemental, and not so much to keep the client ‘away’ from the therapist (Roberts 2012). It demonstrates how understanding basic principles can help you frame positive statements for clients. It models awareness of own needs (in this example, the need for privacy), and willingness to be constructively assertive about them.

2.3.1.2 Advertising and Accessibility

The private practitioner needs to be accessible to potential clients. Appropriate contact procedures and information can be provided, either on a website or visiting card. If available on the phone, it is useful to specify how (through text/call/email) and when (when you will receive calls, expected turnover time for texts or emails) clients can contact you. On a website, one needs to limit information provided to the description of qualifications, area(s) of interest, fees, availability, address and contact information (Tran-Lien 2012). All information on the website or in any form of advertising needs to be accurate and updated when applicable (American Psychological Association 2010). False advertising and tall claims call the integrity of both the professional and the profession into question. Creating unrealistically high expectations can be actively harmful to clients.

2.3.1.3 Informed Consent

As with any relationship, the first impression sets the tone for subsequent contact and a good intake session is half the battle won. In the author's experience, private practice clients tend to be more aware and articulate about their preferences. They need to be told about the expected process of therapy, their role, the therapist's role, estimated frequency/duration (and by implication, cost) of treatment, likelihood of success, etc. Clients also need to be made aware of alternate treatment options, both psychological and non-psychological. Their understanding of this material forms the basis for informed consent (Bearhs and Gutheil 2001). Some practitioners find a written informed consent form to be useful, particularly in the private practice context. Spelling out the contract can leave both client and therapist feelings safer. The author has evolved a brief sample form in a checklist format (see Appendix B). This format offers both flexibility and simplicity; it encourages discussion and is not too long. Both Bearhs and Gutheil (2001) and Brennan (2013) emphasize that informed consent is an ongoing process. As therapy evolves, new areas may come up for discussion. For example, if a family member is coming in for a consultation session in an individual therapy, confidentiality and boundaries will need to be redrawn.

Along with describing the process of therapy and discussing items on the informed consent form, the author also recommends being explicit about details surrounding the process of scheduling and rescheduling appointments, extra session contact, contact on social media and fee structure.

2.3.2 *Sustaining the Therapeutic Relationship*

2.3.2.1 Competence

Ethical codes emphasize that one should not do anything one is not trained/qualified for. Professionals should only use only those forms of treatment they have received training in, for clients they are qualified to see (British Psychological Society 2009). This seems pretty straightforward, but it is a fairly tall order for the Indian private practitioner. In a survey of 250 mental health practitioners across the country, lack of competence was listed as the single biggest limitation, experienced by 41 % of the sample (Bhola et al. 2012).

The issue here is that it is hard to decide what exactly one is qualified to do. While all mental health professionals have *some* training; there are various levels of training (Misra and Rizvi 2012). Mental health professionals include clinical psychologists with PhDs or MPhils, psychiatrists with MDs or DPMs, psychiatric social workers with PhDs or MPhils, masters level graduates in psychology, counselling or social work, counsellors who have undergone accredited or 'not-so-accredited' counselling courses, etc. The training system in India typically offers some insights into all the major schools of therapy, without a very in-depth

training in any one school. We do not usually have access to treatment manuals. For instance, can one say they are doing dialectical behaviour therapy (DBT; Linehan 2014) when they have not done Linehan's course? What if one does not even have the manual? Should one then refuse to see clients who require DBT? And if one does refuse to see such clients, who will? The APA code (American Psychological Association 2010) says that if there is no qualified person to see a client, the next best or closest in qualification may do so, as long as they commit to training themselves as much as possible. But what does that actually translate into here?

It is up to the practitioner to be aware of what they are qualified to do and to communicate their scope and limitations clearly to the client. Private practitioners may feel more pressure to try out a new treatment. This pressure often comes from clients themselves and many of us may end up attempting work that we are not fully trained to do. One must be willing to draw boundaries and refuse to undertake certain treatments if not adequately trained, as illustrated in Box 2.1.

Box 2.1 Drawing Boundaries*

A long-term individual therapy client was very upset that I would not do Eye Movement Desensitization and Reprocessing (EMDR) with her. She had symptoms of post-traumatic stress, and had read that this was the best form of treatment for her condition. She was unwilling to see anyone else this late into therapy, and expressed every confidence that if I read a bit, I could do it with her. I needed to explain that it was a technical procedure that required special training that I did not have. I explained the process I would use to address her symptoms and the theories on which my choices were based. She agreed only reluctantly, and did feel short-changed and a bit let down by my refusal to comply with her request. I still felt it would be inappropriate for me to try and execute a treatment which I was not sure of.

**Note* All case illustrations in this chapter are composites and do not refer to specific clients.

2.3.2.2 Continued Professional Development

The ground reality of mental health in India is a huge gap between numbers of qualified mental health professionals and actual need for the same (Isaac 2009; Murthy 2011). Given this gap, the author recommends that every effort be made to improve on ones' training through focus on continued professional development. We do not have the luxury of sticking to our comfort zones. It is extremely important to expand our knowledge with reading and supervision. We may *need* to try out newer forms of treatment or get acquainted with new client groups; *but* we should always do so under direct or online supervision. The author recommends the

following practices to help identify strong points and comfort zones and to keep current with new methods (see Box 2.2).

Putting time and effort into continued professional development can give both financial rewards and deeper professional satisfaction.

Box 2.2 Good Practices for Continued Professional Development

1. Consider the syllabus that has been covered during training, in terms of diagnostic groups, forms/schools of therapy, child or adult client populations; to determine what you know and the potential scope of your practice.
2. Consider areas of comfort or expertise created or enhanced by supervision opportunities or because of interest and available reading material.
3. Consider special areas of discomfort or poor training. Seek additional resources to address these gaps if possible.
4. Work together to organize continuing education programmes to help address new issues (for e.g., road rage)/client groups (for e.g., children of divorce)/diagnostic categories (for e.g., eating disorders).
5. Do not overstate the scope of your practice/training. For instance, a weekend workshop on couple therapy does not qualify you to start seeing couples. If you do choose to engage in a new area or if clients are unable to access more qualified professionals (which necessitates that you see them), do inform clients of your limitations and extra measures you are taking to ensure that they receive quality help (Brennan 2013).
6. Try to do case-based reading from classic textbooks as well as currently available online information.
7. Always have a supervisor/someone you respect who you can discuss cases with. This can be a formal arrangement where you pay for supervision or an informal arrangement, where a group of psychologists meet and discuss therapy (peer supervision).
8. Always have a therapy plan and frequently review the same.
9. Engage in self-reflection. You can use the areas suggested by Brennan (2013) as a good starting point.
10. Keep session notes and keep time for reflection on them.
11. Listen to feedback from your client.
12. Be willing to accept when you are out of your depth. Examine whether your desire to refer is a competence issue or a transference issue.
13. Refer to other disciplines where necessary. For instance do not start sex therapy without a review by a medical doctor.
14. Become a member of a society, attend conferences and CMEs, talk to colleagues and find out what standard practice is. Be willing to share about your practice.

2.3.2.3 The ‘Business’ of Therapy

Both clinicians and clients can have difficulties with the business end of the relationship. Reconciling the unconditional acceptance and support of the therapeutic relationship with the mundane reality of “This is how much I charge” is not very easy. When the same person is playing both roles, the therapeutic contract and the business contract can impact each other, as illustrated in Box 2.3.

Box 2.3 The Business of Therapy

A young client (21 years) once wanted to negotiate a small reduction in fee. She was aware that I worked on a sliding scale. My agreeing or disagreeing would have more of an impact on our therapeutic relationship than on my financial condition. Agreeing would have set a bad precedent of inconsistent rules and porous boundaries, and violated the ethical principle of ‘justice’. However, I could see that for her, the meaning of the interaction was more to do with personal power and a belief that the world could not be trusted to recognize/acknowledge/help her in any way. I needed to decide which course of action would cause the least harm to her, while preserving my professional integrity and creating a sustainable therapeutic contract.

Private practitioners are usually left to set their own fees. Determining how much an hour of one’s time is worth can be a nerve wracking experience indeed. The Canadian Psychological Association code (CPA 2000) recommends setting fees that are “fair in light of the time, energy, and knowledge of the psychologist and any associates or employees, and in light of the market value of the product or service” (p. 10). But how does one decide what is fair? A consensus or at least communication among private practitioners with similar qualifications practicing around the same area will be very useful in this regard.

If using a *sliding scale* of payment, Brennan (2013), asks practitioners to consider: (a) Are levels on the sliding scale fixed? (b) Are income and other criteria to access lower fees clear and transparent? (c) Are all clients aware of the existence of a sliding scale? (d) Does it accommodate to clients whose income may change during the course of therapy so that they move up or down the scale? (e) Are clients fully informed about billing practices? (f) Do they pay at the beginning or the end of the appointment, and who do they pay? A written document spelling out billing practices can help increase clarity and consistency.

Many practitioners charge a fee for missed sessions known as a *cancellation fee*. It is usually applied only for last-minute cancellation of a session. It may be the full session amount or a percentage of the same. A cancellation fee helps the client to take therapy seriously and also protects the income of the practitioner. The cancellation fee is of particular relevance to private practice, as each hour contributes to overall monthly income and cancelled sessions can lead to a dent in income and possible negative feelings toward the client.

The provision of mental health services by a professional is recognized as a paid activity, and we need to be comfortable with the fact that we do this for money. It is important, however, not to take advantage of the trust or dependency of the client to force services on them; for example, in recommending an assessment or further sessions of therapy. Referrals should be made and received on the basis of the best interest of the client and not for monetary gain. The practice of taking a percentage or a ‘cut’ off referrals made is clearly and unequivocally unethical.

Finally, some clients may not be able to afford on going or very long-term therapy. The practitioner can refer such clients to another centre/therapist that charges less, offer to continue at a lower slab on the sliding scale, or even accept services as barter. However, if the client does not wish for any of these solutions, and does not pay their fees, the therapeutic contract and ethical liability are terminated (American Psychological Association 2010).

Third party payments The issue of “who is the client” or “whose needs the therapy should address” is particularly relevant when parents are paying for sessions for their (legally) adult children, spouses or parents. The person who is making the payment may assume that the therapeutic contract is being made with them and may often request the practitioner push for a particular change. They may ask the therapist to “make the client realize...” or “make her stop...” something. This is a tricky situation as the practitioner can neither ignore their perspective nor give into it completely. The following suggestions are partly based on recommendations by de Sousa (2010), a child psychologist, on dealing with parents and families in the treatment of children. They are relevant for adults as well, and reflect our interpenetrative culture.

- Discuss the validity of the expectation/suggested agenda with the client. Not all expectations are harmful/negative. Perhaps the client also wants to make similar changes in themselves.
- If the client feels that the expectation is unfair, but is disempowered to negotiate with their family member, help them learn how they can do this. If they need extra support, you can offer them session time to facilitate this conversation.
- If the family member requires psycho-education to understand the limits and potential of the client, it is the duty of the psychologist to try and provide this information.
- Do not negotiate on behalf of the client, but empower them to negotiate for themselves.
- Refer a client to family therapy if issues seem very intractable.

2.3.2.4 Documentation

‘Documentation’ is a term that raises some dread in the hearts of most practitioners. While we all know we need to document, how much and what is documented varies from practitioner to practitioner. In the absence of institutional guidelines for the same, each private practitioner tends to evolve their own parameters.

In the context of psychotherapy, documentation ideally covers the following areas:

- Name and contact information of the client(s)
- Informed consent, either in the context of a written form or notes on the content discussed
- Presenting problem, reason for referral and source of referral
- Case work up/history
- Medication and diagnosis if applicable (both psychiatric and non-psychiatric)
- Therapy plan
- Session notes including date, time, aim, content, process and observations
- Details of extra session contact
- Changes in the therapy plan and reasoning for the same
- Ethical dilemmas and their resolution
- Termination notes

Very few people actually enjoy tedious paperwork. Detailed documentation is often the first thing to fly out of the window as we gain our feet and confidence in the professional world. Not only are there limitations of time, we realize that we can go from session to session without the notes—and clients do not really notice or ask about them. Adequate documentation, however, is crucial for competent practice.

Let us apply Brennan's (2013) perspective to the issue of adequate documentation: Many practitioners see documentation as an extra burden, required to protect oneself legally. It is important to understand that good documentation reflects the principles of openness and integrity and enables you to confirm that what you are doing with the client is beneficial and not harmful. The process of documentation aids self-reflection. It is often during the writing of the session notes that we become aware of our own reactions and feelings; it is only after the session that we have time to connect session experiences to our personal lives. The process of documentation enables ethical decision-making and helps us keep track of evolving ethical issues/dilemmas. Finally, going through our notes can help to pick up larger themes of commonly faced issues (text messaging with many clients) or need for self-care (a therapist might notice that they feel emotionally overwhelmed with many clients and not just one).

If you deepen your understanding of why you document and what to document, it gives meaning, purpose and relevance to your effort. This underlines the perspective that being ethical is an ongoing process that permeates all aspects of our professional lives.

Clients need to be informed that session notes would be made, and also what is being recorded. If the client reveals information that they do not wish to have documented, it is required for one to leave it out of written records, unless it is central to the understanding of the client and therapy-related decisions. Even where it needs to be recorded, the information should be retained in the most innocuous form possible. Avoid conjecture and when you are stating an opinion, clearly state it (Canadian Psychological Association 2000). For example, if the client brings up

sensitive material that does not have a direct impact on the issue (for example, my father was accused of bribery and corruption by his employers, when I was ten years old), it need not be recorded. If the material is relevant (...and therefore he lost his job and we had to shift to another city...), it can be recorded as ‘Client moved to B... when he was ten due to work difficulties faced by his father’.

Complete documentation can prevent ethical violations from arising as it encourages reflection and thoughtfulness about therapeutic choices. It may also be a private practitioner’s only defence against claims of malpractice. Good documentation serves both the practitioner and the client.

Storage of documents Having written or typed out the material, the practitioner also needs to be sensitive to how it is stored, and who has access to it. If other staff is being employed, for example, in a secretarial role, their access to records, sessions and clients need to be clarified. They would need to understand the necessity for confidentiality and discretion. Physical papers need to be stored in a locked space, which others do not have access to. Digital material should be stored in a password-protected and encrypted form. If you are storing contact information on your phone, it may be better to have a separate work phone so that this information is not accessible to others.

Use of client data If the practitioner intends to use client data for teaching, supervision, or other professional activities, they need to get permission from the client for this. If this is a regular practice for the practitioner, it is a good idea to include a sentence about this in the informed consent form itself. If information is going to be used in research or publication, it may be better to get separate written permission for the same. The practitioner needs to be aware of inherent power differentials between themselves and the client and make every effort to ensure that the client understands that this is completely their choice and that refusing to allow their data to be used will not have an impact on the therapeutic relationship.

2.3.2.5 Scope of Private Practice

Private practitioners can handle most of the issues that clients may bring in. Developing a strong network of psychiatrists, psychologists and social workers can help you address more complex issues with multiple ethical, legal and competence-based questions. However, some clients may do better with institutional support from a multidisciplinary team. In the author’s experience, actively suicidal clients; clients with interrelated medical, neurological, psychiatric and psychological problems (for instance, severe eating disorders); clients requiring frequent admission (for instance poly-substance dependence), or clients where the entire family needs help and requires individual and family therapists to work in tandem with each other and with psychiatrists, are best treated in an institutional set up.

When seeing a more complex case, particularly suicide, it is doubly important to: (a) explain the limits of confidentiality; (b) get an emergency support contact number; (c) establish procedure for such emergency contact at the onset of therapy itself; (d) if making referrals, identify the other members of the ‘team’; (e) and

explain how and when information will be shared with them (Hawgood 2015). We may feel reluctant to bring these issues up with highly emotional clients, especially when we are trying hard to create a rapport. But failure to do so in the beginning can lead to clients feeling unsupported or ‘cheated’ and lose trust in the therapeutic process entirely.

Psychological services are increasingly coming under the legal scanner. Appropriate documentation (as described) can ensure and explain clinical and ethical choices. Clients may also come up with legal queries, most often related to divorce, alimony, child custody, child protection, etc. They may ask when they should time their divorce, who should file, the laws under each religion/marriage act, the amount of alimony they can expect to give/receive, etc. Clients may also ask about their legal recourse in cases of abuse (especially child abuse) or other wrongful behaviour. While it is useful for a practitioner to be aware of the laws relating to mental health issues, it is important to refer them to proper legal counsel as well. “But you said he wouldn’t get custody, and I trusted you” is not a phrase you want to hear in session.

Narayan and Shikha (2013) reviewed the legislation related to marriage and divorce in the context of different religions in India; for example, Hindu Marriage Act (1955), Special Marriage Act (1954), Muslim Marriage Act (1939), Indian Divorce Act (1939), Indian Divorce Act (Amended 2001). Some of the other relevant laws and acts include the Indian Succession Act (1925), guidelines from the National Commission for the Protection of Child Rights (NCPCR), Protection of Women from Violence Act (2005) and Protection of Children Against Section Offences Act (2012).

2.3.2.6 Ethical Decision-Making: When Principles Conflict

A conscientious practitioner may be able to avoid most ethical violations. However, there are situations where any choice has ethical implications, and no choice is completely right. Having a process of how to think through such ethical dilemmas decreases the likelihood of an ethical blunder. This process is referred to as ethical decision-making and will be illustrated using a model based on the ACA model (American Counselling Association) as described in Brennan (2013) and the Canadian Psychological Association models (CPA 2000).

Box 2.4

A couple (Mr. A and Ms. B) came for couples’ therapy, following disclosure that the husband had had an affair. The couple was doing well, had re-established trust and was working on building their relationship. At this stage, through an inadvertent disclosure by the husband, I became aware that his affair partner (Ms. C) was also an ongoing client.

For a situation as in Box 2.4, the American Counselling Association (ACA 2005) recommends first determining the nature and dimensions of the dilemma. Issues arose at two levels: (a) What to tell the clients and what to keep confidential. While principles of integrity and openness required that I revealed information that clients would find pertinent, it also seemed that it would cause harm to all three individuals as well as the couple relationship. It would be particularly damaging to Ms. B, to have to share both her husband and her therapist with Ms. C. Ms. C might perceive it as a betrayal that the therapist was working on building a relationship that she hoped would break. Mr. A might find his ambiguities emerging and his loyalty being questioned again! (b) To examine if this would interfere with carrying out the therapy work effectively. It is difficult to keep such knowledge out of one's consciousness. In couple sessions, there would be a lot more information about one person (Mr. A) than the other. This could lead to a skew either towards or away from him. I would be aware of aspects of Ms. C's situation that Ms. C herself had not shared with me. How then is one to have a genuine and open therapeutic relationship?

The Canadian Psychological Association (2000) describes a comprehensive ten-step process for ethical decision-making.

1. *Identify the stakeholders or individuals/groups likely to be affected by the decision* There were three stakeholders involved (Mr. A, Ms. B and Ms. C), all of who were responding well to therapy. The integrity of the therapist and that of the profession could also be affected by the choice.
2. *Identify ethically relevant issues and practices based on both the client group and the treatment setting* This was an issue of multiple relationships, couple and individual clients, being seen in a private practice. The therapist was the only mental health professional involved with all three clients. Questions arose around principles of integrity, respect for client autonomy and rights, and potential harm to the clients.
3. *Consider how personal bias/stress might influence your choices* Not telling the clients would create personal discomfort, and the influences of the dual relationship might remain largely underground. Telling them on the other hand, would definitely be a 'difficult' conversation to have, and challenge my skills and rapport. It would also open the door for clients to question my values. The appropriate choice may be influenced by how well I am able to contain the dual relationships and remain genuine with all three parties. My values surrounding marriage and extramarital affairs (who is the victim? who needs protection?), surrounding openness to self and appropriate resolution of emotions (emotion focused versus pragmatic, self-exploration versus reducing negative emotions, stability versus exploration) will all have an impact on the final decision and need to be acknowledged.
4. *Develop several courses of action* (a) I could keep the dilemma to myself; handle the cognitive and emotional dissonance through supervision, a clear therapy plan and self-reflection; and allow both therapies to continue to termination. (b) I could disclose the dual relationship and enable clients to make an informed decision about what to do.

5. *Analyse short-term, ongoing and long-term risks and benefits for all stakeholders including professional bodies and the profession itself* Potential consequences of choice 'a' include: the burden of the 'secret' could become too much to bear and intrude on the therapy process or clients find out about the dual relationship. Mr. A and Ms. C may be aware of the dual relationship all along and assume that I am colluding with them. Choice 'b' could damage progress made at both individual and couple levels. The couple/Ms. C might discontinue therapy, therapist may be asked to *choose* which client she will continue with, etc. On the positive side, it could also create a space for greater integration, forgiveness and understanding for all three and ultimately benefit clients and therapist alike.
6. *Choose a course of action after applying existing ethical standards and values* Let us assume that (under supervision) I chose not to disclose the dual relationship as this would be deemed too harmful for all three clients whose stability was still fragile. I might conclude that the burden of the knowledge should rest with the professional and not the clients, and that non-maleficence was more important than integrity. I may be influenced by other factors like unavailability of alternate therapists to refer to or reluctance to lose income from three clients at the same time.
7. *Take action and take responsibility for the consequences* Once the decision is taken, I need to remain aware of potential pitfalls; and monitor my neutrality and objectivity, as well as client comfort and progress in therapy.
8. *Evaluate the results* I might find that I could not keep information out of clinical responses and decisions. I would then need to consider the alternate choice.
9. *Correct any negative consequences and re-engage in the decision-making process if issue is not resolved* Subsequently, I might choose to reveal the dual relationships, as I observed that it was not possible for me to remain neutral and provide the best quality care for all three clients. I may conclude that such a secret would not be easy to keep, as all three clients do know each other. Also, that my integrity would be completely damaged by keeping further secrets rather than modelling openness and willingness to confront and address difficult emotions and situations. Ultimately, this could damage all three clients beyond my ability to help them. It would be easier to make this choice if I felt that the clients have progressed far enough in therapy and that relationship decisions have already been made, therefore it will be easier for clients to handle the dual relationships successfully.
10. *Take action to prevent future recurrence of this dilemma* This could include discussing such possibilities during initial sessions, developing a more effective network of referrals and/or clarifying and crystallizing own personal and professional values.

As illustrated, making an ethical decision is not easy. There are circumstances in which ethical principles *do* conflict with each other (beneficence/non-maleficence versus respect/integrity in the example above). In general, it is recommended that

non-maleficence be the governing principle, while relative weight to the other principles varies from case to case. Such a decision can only be taken contextually. Using a written format ensures that each situation gets the time and attention it requires.

2.3.3 Ending the Therapeutic Relationship

Just as relationships begin, so too do they end. Sometimes they stop before they get started, sometimes they end messily or prematurely and sometimes they end well.

2.3.3.1 Can You Refuse a Client?

It is unethical to refuse a client on an arbitrary or discriminatory basis. Kaplan (2014) quotes the American Counselling Association code of ethics (ACA 2005), to emphasise this point. ‘Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law’ (p. 10).

However, this does not mean that one needs to see all clients who call to fix an appointment. Kaplan (2014) distinguishes between ‘inability’ to see a client and ‘unwillingness’ to do so. Time constraints, inadequate competence to deal with an issue and harmful multiple relationships are valid reasons to refuse a client. Sometimes, at the end of the initial session, the practitioner may feel that therapy would be potentially harmful at the time, with no balancing benefits. The pros and cons of therapy need to be discussed and alternate therapists/means suggested.

It could happen that the practitioner cannot take on new clients at that moment because their slots are full. If this happens, the author recommends giving the client an approximate session date and offering to refer to an alternate professional if they wish to see someone sooner. Clients really appreciate our consideration for their time, money and emotional states.

Even where it is permissible or beneficial not to see that particular client, the practitioner still has responsibility for appropriate referral (Kaplan 2014). If the client is unwilling for referral, one can discontinue the relationship with no further ethical obligation (American Mental Health Counsellors Association 2010).

Busy private practitioners may use a waitlist system, where clients will be taken as and when free slots are available. This system is useful in protecting the income of the practitioner. It is one way of handling high case-loads, particularly when there are fewer alternative professionals to refer to. However, the wait may be indefinite and the client might need help immediately. The practitioner must always offer a referral as an alternate to the waitlist.

2.3.3.2 Termination

The duration of therapy is usually based on experience and standard practice more than on manual or RCT-based recommendations (Goldfried and Wolfe 1998). Each practitioner may have a duration that is typical for him or her. For example, the author finds that 10–15 weekly sessions are usual, with a small percentage of clients continuing on for long-term therapy, and of course a small percentage terminating earlier. Clients need to be informed about the average or expected duration, as well as systems of review of therapy to decide on future directions.

Premature termination Sometimes, clients may wish to discontinue therapy before the practitioner feels that they are ready to do so. Respect the right of persons to discontinue therapy at any time. It helps to discuss and validate possible reasons for termination (health, financial, move, therapy not helping). It is important to give clients an understanding of what they need to do if they wish to stop sessions, as this reduces the likelihood of unexplained dropouts. It is also necessary to let them know what to do if they change their minds and wish to restart therapy. Clarify specially about availability; will they need to go back on the waitlist or will they be seen immediately.

Practitioners are also advised to terminate professional services when clients do not appear to be deriving benefit and are unlikely to do so. If the practitioner feels that they have made their best efforts with reading and supervision and are unable to help the client, it is best to refer to someone else or discuss termination. When doing this, it is important not to convey to the client that they are a ‘hopeless case’ or that their therapist has given up on them. This can be construed as ‘abandonment’. Finally, never terminate without a plan in place for further contact as and when required.

2.3.3.3 Therapist Unavailability

This is an issue of particular relevance for the private practitioner, who often has sole responsibility for the well-being of the client. Practitioners may sometimes become unavailable during the course of therapy, due to anticipated or unanticipated events in their personal life. However, they retain responsibility for client care. In such a situation the following are recommended:

- If it can be anticipated (for instance, pregnancy, moving to another city), the practitioner needs to inform clients in advance so they can both plan how to respond. Clients might feel abandoned by therapists experiencing life events. A long-term client was visibly upset at hearing of my second pregnancy. Attending to her feelings about this helped us to begin talking about her own pregnancy experiences and the lack of support she felt around them.
- If the client is moving on to another practitioner, one must do whatever possible to make the transition smooth. Having a joint session with the new practitioner can be very useful in this regard. One needs to remain available to the client and liaise with the new professional during the transition phase.

- If experiencing burnout or other psychological issues, the private practitioner needs to get appropriate help. High caseloads, high levels of trauma in clients, or many clients with similar issues; put practitioners at greater risk (Figley 2002).
- The practitioner should practice self-care activities that help avoid such situations from arising. These could include personal therapy, yoga/meditation, supervision or self-reflection among others (Baruch 2004).
- If the practitioner becomes physically incapacitated, or dies, they need a ‘professional will’ in place. This is a document that will help clients deal with the loss, and transition as smoothly as possible to new modalities of care. It includes information on accessing/protecting records, notifying clients and ideally, appointing an ‘executor’ who can meet clients and organize referrals (ACA 2005).

2.4 Conclusion

As Brennan (2013) pointed out, the private practitioner needs to police herself, as there is no one else to do so. Awareness of ethical issues and potential pitfalls is essential. At the same time, one cannot be an effective therapist in an atmosphere of fear and self-protection. When the supporting structure of one’s practice is constructed on ethical grounds, the whole edifice is more secure. Both therapist and client can then be freed to play.

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