CHAPTER I

INTRODUCTION

Ethical issues are considered as very significant in a number of branches of study. We cannot ignore the fact that in the applied field of natural science, ethical issues have received considerable prominence. In the field of social sciences, the ethical issues crop up much more quickly, since the individual is of primary focus there. But in psychotherapy the issues emerge perhaps with most vivacity as the personal, inward, subjective matters are involved here. Carl Rogers contemplates, “....here a relationship is lived not examined, and a person not an object emerges, a person who feels, chooses, believes, acts, not as an automation, but as a person”

The cardinal importance of ethical considerations in the helping profession need not be overemphasized. In this dissertation we shall concentrate on the ethical issues, specifically confidentiality and neutrality that centers round psychotherapeutic practices. Here the key questions that are to be raised are – how can we distinguish moral or ethical issues from non-moral or non-ethical ones? How do we ascertain that confidentiality and neutrality in psychotherapy are ethical issues? Additionally we shall discuss what kind of moral dilemmas may be revealed if we violate the principles of confidentiality and neutrality in the context of psychotherapeutic practices.

In dealing with the concept of psychotherapy, philosophers have brought in some issues which are subsequently discussed in psychiatric ethics which fall under the broader umbrella of medical
ethics. Traditional medical ethics was concerned primarily with what we call matters of etiquette, the daily proper conduct of physicians. In western tradition, these concerns were first given expression in the Hippocratic Oath, which emerged in early Greek medicine. Although Hippocratic Oath has a central position in the arena of medical ethics, Thomas Percival’s *Medical Ethics* is generally considered to be a source book for the formulation of the ethical guidelines of medical professionals till date. Percival’s work formed the basis of the early ethical codes of the American and British Medical Association till as late as the 1940s and 1950s. With the advent of the codes of medical ethics, as well as the increasing awareness of the consumers of medical services about their rights regarding such services, gave rise to healthcare related ethical issues of various types.

In the course of discussion we have already mentioned terms like ‘psychiatry’ and ‘psychotherapy’. These two terms need to be explained clearly. Psychiatrists are medically qualified doctors having postgraduate diploma and training for treating patients with mental illness. They treat mental patients with the help of medicine. Psychotherapy, on the other hand, is the treatment of mental disorder by discussing somebody’s problem with them rather than by giving drugs. It is the treatment of mental disorder outside medical settings. Psychotherapists are skilled helper after taking professional training. Psychotherapists are sometimes called counselors. They need not be medical doctors. Psychotherapists/counselors without medical degree cannot prescribe medicines for the treatment of mental disorder. When they realize that a person with mental disorder needs drugs, they refer the case to a psychiatrist. Similarly, when a psychiatrist thinks that a person with mental disorder cannot be helped with just medicine, they refer the case to a psychotherapist. Because, psychiatrists do not, in general, take professional training in psychotherapy. Sometimes, a person with mental disorder needs the help of both a psychiatrist who administer drug and a psychotherapist...
having professional training in the art of conversation with a person with mental disorder.

Colin Feltham, in his “What are counseling and psychotherapy” reflects that –

“Counseling and psychotherapy are mainly, though not exclusively, listening and talking based methods of addressing psychological and psychosomatic problems and change, including deep and prolonged human suffering, situational dilemmas, crises and developmental needs and aspirations towards the realization of human potential. In contrast to biomedical approaches, the psychological therapies operate largely without medication or other physical interventions and may be concerned not only with mental health but also with spiritual, philosophical, social and other aspects of living. Professional forms of counseling and psychotherapy are based on formal training what encompasses attention to pertinent theory, clinical and/or micro skills development, the personal development/ therapy of the trainee and supervised practice.”

Sometimes, psychotherapy is distinguished from counselling. But in this discussion we shall take counseling and psychotherapy interchangeably.

It may be noted in this context that the therapeutic sciences in the Indian tradition, both for body and mind, were formulated by philosopher sages. Ayurveda, part of Athravaveda (1500 BC), Shusruta Samhita (800 BC approx.), Charak Samhita (600BC approx.), Chhandogya Upanisad (Mid first millennium BCE), Samkhya Philosophy (9th century AD), Patanjal Psychology (treatise which existed in written form approximately 1,700 to 2,200 years ago, although they may have existed much earlier that in unwritten form) and many other treatises of ancient India had enormous contribution to the therapeutic sciences. They propagate a philosophic-religio view
regarding facilitate the human body-mind conglomeration with the aim of achieving the higher goal of self-realization or realizing atman. They generally believe that all sufferings are causal by lack of knowledge of the self (atman). They express their views with the slogan ‘atmanam biddhi’ (know thyself). This self is to be distinguished from ordinary psycho-physical organism or ‘Mind’ as it is sometimes called by some western philosophers. It is rather to be understood in the sense of permanent self, eternal and transcendent, which is different from the body. The Western psychotherapeutic trends do not have any such aim in view. Their aim is to achieve our mundane psycho-physical well-being only.

Psychotherapy, in the sense in which it is used today was not probably there in ancient India. In the west also it is a recent phenomenon. The concept of psychotherapy actually came in vogue with the research of Sigmund Freud (1851- 1939). Freud’s theory which is officially known as psychoanalysis actually marks the beginning of the concept of psychotherapy. Psychotherapy took different forms in different hands subsequently – some following Freud and some criticizing him. Philosophical underpinnings and theories changed giving rise to different types of psychotherapy. These are Freudians, neo-Freudians, different types of behaviour therapies, existential psychotherapy developed mainly by Carl Yung, humanistic psychotherapies developed and advocated by Carl Rogers and others. All these different types of therapies are in practice both in the west and India.

In all these kinds of psychotherapy ethical issues are extremely important. It is noteworthy that multiple shades of ethical issues may be seen in different areas of psychotherapy. These issues may emerge on violation of multifarious principles and codes of ethics related to psychotherapeutic practices. All such codes, which according to the Standards and Ethics Committee for British Association for
Counselling are ‘rules for the obedience of fools and for the guidelines of the wise’.\(^\text{10}\) They share a common aim in seeking to support the development of ethical awareness and practice. Being ethical is perhaps a continual process. Professional codes of ethics serve a number of purposes. Professor Gerald Corey, in his “Ethical issues in Counselling Practice\(^\text{11}\)”, mentions that the ethical codes educate both the counselling practitioners and the clients about the responsibilities of the profession. It is to be noted here that the word ‘client’ is used here in a specific sense. Persons who come to a psychotherapist were usually referred to as a patient. But since all those helpees do not have any illness – mental or otherwise – it is better to use a neutral term. The common practice now-a-days is to refer to them as a ‘client’ rather than a ‘patient’\(^\text{1}\). That is why; we have, subsequently used the term ‘client’ instead of ‘patient’. We find a two-fold implication of this comment. They provide a basis for accountability with the help of which both the therapists and the clients can get the chance of avoiding certain unethical circumstances. If the ethical codes are properly enforced then the therapists and the clients can both be empowered to enjoy their own rights and accordingly can have protection from unethical intrusion. But if such principles and codes are not properly followed then various ethical questions emerge mainly centering round the therapist-client relationship. From the client’s side ethical issue like confidentiality, neutrality, right to informed consent, etc can be raised. From therapist’s side issues like boundary transgression, confidentiality, neutrality, right to referral etc can be brought in among which we would like to focus in our dissertation on confidentiality and neutrality. But it is an observation of Gerald Corey that it is ethical practice to focus more on promoting the welfare of clients than on making minimal interventions that can protect therapist from a malpractice suit. At the same time it can be claimed that by educating the clients about their rights and responsibilities mentioned earlier, the chance of therapists’ being sued can be reduced\(^\text{12}\).
The ethical issues mentioned above, are attached with the personal and professional codes of ethics of the therapists. But certain other ethical issues can be observed when the laws and regulations are imposed by the government or a similar authority. The question of ethics may also become crucial in cases of involuntary hospitalization, insurance matter etc which all need serious evaluation. The new models of treatment in psychotherapy also pose ethical problems with regard to their evaluation, use and misuse. Regarding modalities of treatment different moral issues can be raised. We often find psychotherapists following an eclectic method which may be very well questioned from the ethical viewpoint. A practicing psychotherapist may opine that such a method may be advisable, if it works and suits the client. But here once again one may question that – is it always the case that, anything that works is undoubtedly the ethically right course of action? Can means be always justified by the end? This is a very important point in the given context.

As there are various ethically complicated issues in psychotherapy, we may attempt to find some general ethical code of conduct that is supposed to be followed by each and every therapist during practice. At the same time it requires mention that although ethical codes are living documents that change over time, certain moral principles constitute the foundation of all professional codes. One way of reviewing codes is to look at their underlying principles. Welfel & Kitchener\textsuperscript{13} and Kitchener\textsuperscript{14} have described five basic moral principles that are reflected in all professional codes. These are: i) \textit{benefit others}, ii) \textit{do no harm}, iii) \textit{allow autonomy}, iv) \textit{be just and fair} and v) \textit{be trustworthy}. Each of these principles can be briefly elaborated in the following manner:

\begin{itemize}
  \item[i)] \textit{Beneficence} implies accepting responsibility for promoting what is good for others. In the therapeutic relationship, it refers to doing what enhances the client’s wellbeing. When
clients enter into the therapeutic process, they do so with the expectation that they will benefit from the services.

ii) *Non-maleficence*, which means doing no harm, involves the commitment of practitioners to exercise care in avoiding activities (such as situations involving conflicts of interests and so on) that have a high risk of hurting clients, even inadvertently.

iii) *Autonomy* refers to the ability and right to client’s self determination. It pertains to the belief that clients can take their own decisions and as such have freedom of thought and freedom to choose their direction. The therapist has an ethical obligation to decrease client’s dependence and foster independent decision making. This principle implies that therapists do not have the right to interfere in the lives of their clients by making decisions for them. Instead therapists may try to help their clients think clearly and understand the consequences of their actions. The therapists also are supposed to put before the clients the different alternatives to help clients choose the best among them.

iv) *Justice* refers to the commitment of therapists to provide equal and fair treatment to all clients. This includes doing what is possible to ensure that all people are given equal access to psychotherapeutic services, regardless of factors such as, age, sex, race, ethnicity, cultural background, disability, profession, socioeconomic status, lifestyle, orientation and religion. This principle also refers to the fair treatment of an individual when his or her rights and interests need to be considered in the contexts of rights and interests of others.

v) *Fidelity* involves therapist’s willingness to do what is necessary to create a trusting and therapeutic climate in which people feel safe to open up in front of the therapist,
discuss their problems and able and/or ready to participate in the process of such decision making for their solutions. This principle involves being careful not to deceive or exploit clients and build a trusting relationship.

Gillon in 1985 described seven principles underlying medical ethics. Apart from these five principles just mentioned, two more principles are included by Gillon, - confidentiality and informed consent.\textsuperscript{15}

It requires discussion why such ethical codes are at all significant in psychotherapy? Professional code of ethics serves a number of purposes. They educate therapists and general public about the responsibilities of the profession. They provide a basis for accountability, and through their enforcement, clients are protected from unethical practices. Perhaps most importantly codes can provide a basis for reflecting on and improving ones professional practice. Herlihy & Corey opine that self-monitoring is a better route for professionals to take than being policed by an external agency\textsuperscript{16}. There is a real difference between merely following the ethical codes and making a commitment to practicing with the highest ideals. Mandatory ethics entail a level of ethical functioning at which therapists simply act in compliance with minimal standards.\textsuperscript{17}

Aspirational ethics pertains to striving for the optimum standards of conduct. Rather than merely focusing on ways to avoid malpractice suit, therapists who are committed to aspirational ethics are primarily concerned with doing what is in the best interests of their clients.\textsuperscript{18} Here Herlihy & Corey, 1994, suggest that when therapists carefully study the ethical codes of their profession, they should apply relevant standards to deal with the situation they encounter, and should periodically review such standards; codes of ethics can become a vehicle to improve and enhance their professional practice\textsuperscript{19}. But it should be noted in this context that in Corey’s view the modification of
the ethical codes should be done in a guarded way so that the
distinction between moral and legal codes can be maintained. He
holds that in the era of litigation it makes sense to be aware of the
legal aspects of practice for reducing the chances of malpractice in
action, but it is a mistake to confuse legal behaviour with ethical.
Following the law is part of ethical behaviour, but being an ethical
practitioner involves far more\textsuperscript{20}.

It is to be noted here that ethical codes are necessary, yet they are not
sufficient for exercising ethical responsibilities. Although it is essential
that one knows the contents of the codes of one’s profession, it is also
important that one be aware of their limitations. By their very nature,
codes provide general guidance on what constitutes behaviour that is
in the client’s best interests. In writing about limitations, Welfel &
Kitchener, 1992, indicate that codes are conservative by nature,
balancing the protection of the consumer against the protection of the
professional from outside regulation. Codes may become outdated and
thus need to be revised periodically\textsuperscript{21}.

It should be noticed that over time, most of the ethical codes of
various mental health professions have evolved into lengthy
documents, setting forth what is desired behaviour and prescribing
behaviour that may serve the client’s welfare. On the contrary, such
codes neither convey the ultimate truth, nor do they provide
readymade answers for the ethical dilemmas that practitioners will
encounter. According to Corey, professionals are expected to exercise
prudent judgments when it comes to interpreting and applying ethical
principles to specific situations. According to him, ethical codes are
best used as guidelines to formulate sound reasoning and serve
practitioners in making the best judgments possible in the given
situation. Since ethical codes are creations of human beings, and
because they are evolving documents that are modified over time,
some degree of flexibility is essential in applying them\textsuperscript{22}. No code of
ethics can delineate what would be the appropriate or best course of action in each problematic situation a professional will face. In this way we have attempted to clarify, at least a little, why and how ethical codes are important in therapeutic practices.

A client is supposed to open up her secrets to her therapist and the therapist is supposed to listen to the client without any bias. But unless the therapist vouches for confidentiality and neutrality, the client will hesitate to open up in front of the therapist. Therefore, without any assurance from the therapist, the client will naturally not open up and as a result the process of therapy will be hampered. Hence, we can at best say that the issues of confidentiality and neutrality are issues related to the possibility of successful therapy. But this does not mean that these two issues are related to ethics or morality in the context of psychotherapy. They may be said to be very important non-moral issues in the context of successful therapy. Why should they be regarded as moral issues in the context of successful therapy? One simple answer to this question is as follows. Since the therapist vouches for neutrality and confidentiality before the therapy starts, the therapist is supposed to keep the promise. It will be unethical on the part of the therapist to break the promise of maintaining confidentiality and neutrality. This answer is unacceptable. Because, this poses that breaking the promise is unethical as any promise-breaking is unethical. This does not prove that issues of neutrality and confidentiality are ethical issues.

We have already pointed out that confidentiality and neutrality are two very important ethical codes that a therapist should obey to protect the interest of the clients. But question arises as to why they are regarded as moral or ethical codes? In order to answer this question we have tried to understand the criteria by means of which we can ascertain that an issue is ethical. This question occupies a major position of our second chapter. After determining the criteria we
have shown that confidentiality and neutrality are ethical issues. To say this is to say that if a therapist violates the principles of confidentiality and neutrality, she is violating ethical principle. This should not be confused with the issue of promise-breaking. Thus the question which gets highlighted mainly in the second chapter is – how to distinguish ethical or moral issues from the non-ethical or non-moral issues? This discussion will be started by pointing at a very relevant question raised by the famous ethicist Peter Singer. It is – “What it is to make a moral judgment, or to argue about an ethical issue, or to live according to ethical standards? How do moral judgments differ from other practical judgments? ... ... What is the difference between a person who lives by ethical standards and one who doesn’t?”

To deal with the above line of questions, we have attempted to develop a set of necessary and sufficient conditions which may help us to distinguish between moral and non-moral issues. For this purpose we have considered some instances from our everyday experience. In some instances moral issues have been distinguished from immoral issues and in some other moral issues have been distinguished from non-moral ones. In this context we have discussed Immanuel Kant’s view. For Kant not only tried to make a distinction between moral and immoral, he also distinguished between moral and non-moral. H.J.Paton discusses this point in his commentary on Kant. Stephen Korner also seems to think that Kant’s distinction between moral and immoral and also between moral and non-moral can be established with the help of his universalizability criterion. We have tried to show that Korner’s argument is not conclusive. Hence, we went back to Paton who thinks that with the help of the notion of ‘motive of action’ the distinction between moral and non-moral can be established. But here also we have found that the argument is inadequate to prove the distinction.
We have then considered the opinion Peter Singer as it is portrayed in the introduction of his *Practical Ethics*. According to him, an action’s being ethical or non-ethical depends on a type of justification. But justification in terms of self-interest is not sufficient to demarcate moral actions from non-moral ones; rather justification has to be in terms of a point of view which is not personal or sectional groups’. It should be rather universal. By universalizability or universal point of view, he intends to convey, a way to transcending our inward looking concerns and identifying ourselves with the most objective point of view. Here certain argument and counter argument have been begotten in favour and against Singer’s position and finally it has been argued that it is not always the case that which is universal is always ethical.

The third chapter is on *confidentiality* which is a very important ethical issue in psychotherapy. To protect the confidentiality of personal and sensitive information of the client is fundamental to therapy. Without this protection few people would feel to talk openly about themselves as the therapy requires. Psychotherapy often creates and recreates circumstances in which someone is being invited to explore areas of their life gives that have remained hidden and unvoiced even to them. Sometimes such exploration may be painful and even terrifying. Psychotherapy is a journey into the unknown that is supported by the belief that whatever emerges is protected by confidentiality. The adequacy of this protection is a fundamental component of the personal trust which is placed on the counsellor or psychotherapist. In most circumstances the therapist should not disclose such information or collect information from other informants without the client’s consent. This is a good example of an ethical rule with defined exceptions which creates interesting and important moral dilemmas.
On confidentiality The Hippocratic Oath states:

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

The Declaration of Geneva (1948) states:

“I will respect the secrets which are confided in me, even after the patient has died.”

The first part of this chapter mainly deals with the nature of confidentiality. The questions raised there include – what is confidentiality? Why and how is it important in psychotherapy? What is the difference between confidentiality in psychotherapy and confidentiality in other professions? In this context the notions of *privacy and secrecy* are also introduced. The focal point centering which the moral dilemma may arise or any ethical implication can follow stands on the concept of breach or divulge of confidential information of the client from the side of the therapist. This is a very significant problem. The point is, can we claim that client’s confidentiality is absolute in nature; that confidentiality has to be maintained in each and every case without exception? It is generally believed that confidentiality, being an ethical code, should be maintained for the client’s benefit. But exceptional practical situations give impetus to the psychotherapists to raise the question whether confidentiality is always beneficial for the client and whether also by considering client’s benefits, the therapist is actually harming other people or not. In this context, we have to try to understand, what do we mean by client’s benefit? In all such instances serious moral conflict or dilemmas have to be faced by the practicing therapist. In this context certain questions become very crucial, like, – whether waiving patient’s confidentiality is moral or not? Can we ethically
support certain exceptional cases where that particular client’s right is breached?

Paul Cain’s concept on the limits of confidentiality\textsuperscript{30} is found to be very much relevant here, where it has been mentioned that – explicit or implicit autonomous consent marks such limits of confidentiality. So to act without the client’s consent is to go beyond such limits and thus break confidentiality. Now where both the consents are lacking, e.g. if the client is psychotic, what account can be given, has also been analyzed. This discussion can be properly carried out if some case-studies regarding the moral dilemmas that may evolve in practical situations in the field of psychotherapy be discussed. In the first two case studies mentioned in this context, we notice that the institution where the clients were being admitted for treatment, maintained silence over the issue of divulging information to the concerned authority or any other person. They gave client’s confidentiality absolute primacy. While in the other two (one is a case of harm to others, i.e., a homicide case and the fourth one is a case of harm to self, i.e., an attempt to suicide case) information were divulged by the therapist to the legal authorities. The relevant questions here are why, in the first two cases confidentiality was maintained and why in the third and fourth it has not been, and also how and whether the above mentioned positions can ethically be justified? These questions have been discussed in this chapter.

We would like to claim in this context that in all the four cases client’s beneficence has been given absolute primacy. It is this principle of beneficence which works as the underlying reason for the justification of therapist’s behaviour. We have also mentioned Paul Cain’s concept of healthcare need of the client at this place\textsuperscript{31}. Even in case of divulging confidential information, it is client’s beneficence which is primarily observed from the side of the therapist. When cases related to harm to others are considered, there should be more concern for
client’s beneficence than for beneficence of others, i.e., the society. Actually when there is a threat regarding the harm towards society, client herself is also no less threatened from being harmed. Because if the client takes up any harmful step towards others, she also has to face certain grave legal and/or social consequences which may aggravate her worse mental condition. Accordingly her life may become much more complicated and problematic. In such case, divulging confidential information to concerned authorities may be said to help the client. This is generally for her beneficence. This chapter finally comes to an end by analyzing the fact whether the principle of beneficence is the center of the focus or the fundamental ethical principle based on which the moral dilemma regarding confidentiality can be resolved.

The fourth chapter is on neutrality which is also a significant ethical issue in psychotherapy. From the early development of psychotherapy it is assumed that the therapist must show a neutral attitude towards the client during therapy. A neutral stance by the therapist is often believed to be the backbone of the therapeutic endeavour. The therapist suspends judgment by attentively listening and remaining objective towards the client and her nature of problem. Theoretically this concept implies that practitioners are expected to exercise professional restraint and are admonished against imposing their own views or values on the client. Thus it seems that therapists should be neutral in their attitude towards clients. It can be observed in the changing scenario of the history of psychotherapy that as opposed to the traditional view, in later phase, the concepts of the authority of the therapist and neutrality have been questioned. Presently therapy is sometimes viewed more as a process between equals than between an uninformed patient and a knowledgeable authority. Sections of contemporary thinkers often view neutrality as a theoretical ideal, impossible to attain in actuality. Nevertheless, some continue to favour attempting to approximate this unattainable ideal.
The chapter begins by addressing the issue that - what do we mean by neutrality in psychotherapy? What it is to take a neutral stance from the therapist’s side? How the therapist has to act in order to be neutral? At first we have taken some ad hoc related notions to understand the concept of neutrality which are very familiar notions in the history of psychotherapy. The pertinent dictionary definitions of neutrality that have been mentioned are – not allied with, supporting or favouring either side in a dispute; belonging to neither side nor party. The allied concepts relevant in the field of psychotherapy that may seem to have a close connection with the concept of neutrality are – being impartial, being detached or value free, being non-judgmental, being non-directive. In this discussion each of these concepts is scrutinized to elaborate the possible moral conflicts or dilemmas which may occur in the field of psychotherapy centering round the notion of neutrality. We may observe how much importance each role of such ethical implications have in psychotherapy as a clinical as well as moral practice.

The discussion has taken into account whether the concept of neutrality implies that the therapist should be impartial during therapy. If so then what kind of moral crisis may follow if the therapist does not remain impartial? In this context the concept of impartiality along with its relation to morality has been examined. Question is raised whether a psychotherapist can afford to be partial during therapy sessions in any respect. Here two specific case studies have been brought forward to elaborate what kind of ethical implications occur if the therapist comes out of her impartial chair. Efforts have been made to argue that lack of impartiality transgresses the autonomy of the client, genuinely touches certain gender issues and last but not the least violates the demand of human rights. In the course of discussion it can be noticed that some concepts like – free from bias, being evaluative, values etc. have come into consideration and from there further query arises. Like – whether a therapist can
incorporate her personal emotions in the process of therapy or she should remain absolutely detached or value-free in the therapeutic context. This triggers some other very important questions - what do we mean when we say that a therapist is detached or value-free? Is it, ethical in each and every situation to remain so? Even if it may be claimed to be ethical, is it, as a matter of fact possible to maintain such a stance in practice?

In psychotherapy it is generally believed that the therapist should be neutral in attitude. But the question is – in order to be neutral in attitude should the therapist allow her values to enter into the therapy or should she keep them aside? The controversy is deepened by raising the question – can the moral therapist be expected to withhold good advice or renounce sound standards in the name of neutrality? In this context, the value-laden – value-neutral controversy between the positivist and the humanist tradition in the history of philosophy of science has been highlighted. This discussion has been put forward in order to clarify whether psychotherapy is value-neutral or value-laden and what it means by value-neutrality or value-laden-ness of psychotherapy. It has been argued here that a therapist should not be vitiated by any kind of subjective value, bias or social norm and must accordingly be non-judgmental and non-directive in attitude. We can see the reflection of the same line of thought in Carl Roger’s view. Sigmund Freud also warns us against the authoritative therapist as they are nothing but authoritative parent-substitute. Finally two separate sections have been laid down to ruminate on the issues as to what sort of moral problem may brought in sight, if psychotherapy appears to be value-laden and then if psychotherapy is reckoned as value-neutral. This chapter on neutrality comes to an end pledging that a dialogue would be reopened on the morally valuable related dimensions of neutrality in psychotherapy, in the concluding chapter.
The problem regarding divulgence of confidentiality and its probable solution is the main focus in the concerned chapter on confidentiality, still in the conclusion we have tried to think and rethink how far therapists can apply those suggestions in practice without causing any harm to their clients. In the case of neutrality we have said in the conclusion that it is clinically ideal and ethically sound for the therapist to take a neutral stance (i.e. – impartial, non-judgmental, value-free and non-directive) while providing therapeutic treatment to the client. But we have also pointed out some areas where this attitude comes under scrutiny. In cases of emergency (like – suicide attempt, diminished autonomy etc) it is questioned again and again whether therapist’s remaining silence in the name of neutrality would be moral or not. Taking into account the moral dilemmas that may occur in the context of confidentiality and neutrality, we have tried to emphasize on the concept of context-sensitivity or area-specificity for solution. The concept of context-sensitivity focuses on the therapist’s decision to come out from the neutral chair and be directive for handling the situation; in case of confidentiality divulgence of confidential information of client happens to be ethically permissible where threat to public and private peril is concerned. This ultimately points at the beneficence principle. Giving a keen eye at the ethical relevance of context-sensitivity, we have finally introduced the notion of ‘duty for treatment’ where client’s beneficence has been given ultimate primacy. Still the query which pricks us is – isn’t it the case where the client’s autonomy gets diminished?

In this course of discussion we have unearthed the fact that the pillar of the medical ethics seems to be the principle of beneficence. The scope of this principle is really wide. In this context the question, ‘does it make any sense to talk about autonomy of a new born baby?’ has been come under consideration. In both cases of confidentiality and neutrality it is observed that the issue of autonomy, after a depth analysis, ultimately stumbling on the question of patient beneficence.
But can we say all cases of therapy ultimately lead to patient’s beneficence?

While dealing with this problem, it has been emphasized in this dissertation that in the context of medical care and psychotherapeutic help perhaps treatment of client is the first and last word. The primary need of the psychotherapeutic profession would be nothing but- ‘treatment for healing’, for which, if required any other secondary need can perhaps be withdrawn temporarily. This implies undoubtedly that the question of clinical practice or therapeutic intervention or in a word *treatment* comes first and then the question arises as to how it can be carried out. If the notion of ‘treatment’ in this way receives utmost primacy then perhaps the problems, discussed in the dissertation, may get resolved. From this point of view the concept of ‘treatment’ itself can well-taken be as a value.

Furthermore a very significant point which has been highlighted in the conclusion is that, *duty to treat* or *medical care* taken as a value ensures *health* which insists well-being of the client. It has been stated that according to the concept of the World Health Organization, health is achieved through a combination of physical, mental, and social well-being, which, together is commonly referred to as the Health Triangle\(^{31}\). If we admit the therapist’s duty of treatment as a primary value then the question arises as to how this duty can provide a guideline in solving problems, that is, moral dilemmas or conflicts existing in the case of the ethical issues viz. confidentiality and neutrality in the field of psychotherapy.

Health related with social well-being or ‘good-life’ can be said to be contributed by health-care and treatment as one important vector; i.e. treatment can bestow health which implies social well-being too. Likewise, we can appreciate quite well that *duty of treatment* receives primacy in *all cases including emergency cases in the therapeutic*
situation. This exhibits a leap from individual well-being to collective or group well-being the latter being ultimately greater than former. This shows a transcendence from self to others which touches a social dimension and thus can be viewed as ethical. The concluding remark of the dissertation is that, it is ethical for psychotherapy to ponder on social well-being. If any conflict arises out between individual and social well-being in case of treating patient/client, it is society which ought to be prioritized.
NOTES & REFERENCES


2. Percival, Thomas, Extracts from the Medical Ethics on a Code of Institutes and Precepts Adapted to the professional Conduct of Physicians and Surgeons: Private or general Practice, T.Smith Co., Lexington. Ky., 1821.


5. Shusruta Samhita (800 BC approx.), sawal.ibido.com>Health>Alternative Medicine.


7. Chhandogya Upanisad, (Mid first millennium BCE), en.wikiwikipedia.org/wiki/

8. Samkhya Philosophy (9th century AD), en.wikiwikipedia.org/wiki/

9. Patanjal Psychology (approximately 1,700 to 2,200 years ago, although they may have existed long before that in unwritten form) en.wikiwikipedia.org/wiki/Patanjali.

10. Standards and Ethics committee for British Association for Counselling.


12. ibid.


18. ibid.


28. Hippocrates, *Corpus Hippocratinum*, 400 BCE.


31. Preamble to the constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946, signed on 22 July 1946 by the representatives of 61 states (official records of the WHO, no 2, p 100) and entered into force on 7th April 1948. The definition has not been amended since 1948.