CHAPTER V

CONCLUSION

The main focus of this dissertation centers round the issues of confidentiality and neutrality. In the relevant chapters we have tried to understand why they are to be regarded as ethical issues apart from being issues which constitute the basis of successful psychotherapy. In the conclusion we have tried to elaborate some of these points, adding a few more to have a better grasp of the issues.

In the recent scenario the practicing psychiatrists, psychotherapists and psychologists more or less respect patient’s confidentiality. Without exception they believe in the sanctity of confidentiality. But they are really skeptic whether confidentiality can always be maintained in practice. The problem regarding breach of confidentiality and its probable solution has been the main focus of discussion in the concerned chapter on confidentiality. Still we are in a position to think and rethink how far therapists can apply those suggestions in practice without causing any harm to their clients.

We get two parallel opinions expressed about the case-studies analyzed in the chapter on confidentiality. Many of the psychotherapists are in favour of keeping absolute confidentiality about the clients. They have preference for emphasizing on patient’s autonomy. Throughout the western world there has been a significant shift from a paternalistic ‘best interest’ argument towards dominance of client’s rights and respect for individual autonomy. From a duty perspective the ethical basis of confidentiality is grounded in the
principle of respect for autonomy. Therapists explicitly or implicitly promise their clients that they will keep confidential information confided to them. Keeping promises is a way of respecting people’s autonomy. There is also the consequentialist argument supporting the need for confidentiality: It is held there that without promises of confidentiality clients are less likely to share private and sensitive information required for their care.

The other opinion regarding the case-studies is in favour of divulgence of confidential information. According to this line of thought, confidentiality can be waived if the interest of the larger society is affected. If disclosure is judged to be justified then there is an obligation to disclose.

Such obligation may arise from two sources. One is public interest which is rooted in the principle of justice. Those who argue in favour of divulge of client’s confidential information, keeping in view a wider social context, accepts this as the ground for their argument. One more source comes out of the client’s best interest and it is based on the principle of beneficence. The solutions of moral dilemmas that have been discussed in the chapter on confidentiality are based on the principle of beneficence. There it has also been explained how ultimately client’s best interest can be served, even if confidential information of the client is divulged by the therapist initially for the sake of beneficence of others.

From our discussion it is evident that the issue of confidentiality is and always has been at the center of focus in the history of medical ethics. The psychiatrists and therapists are rather sensitized about the issue. The practitioners are of the view that confidentiality of patients should be revered. But interestingly enough, a peculiar stance or stunned reaction may be noticed among many of the practicing psychiatrist or psychotherapists regarding the issue of
neutrality. Many of them do not concede its necessity at all. Some of those who could address the issue observe that, since there is a very rigid and dogmatic view that claims psychiatry and psychotherapy to be science and science being always rational, reason-based and always gives absolute knowledge, it has to be neutral in attitude. Being within this paradigm, there cannot be any alternative view. So this issue of neutrality is trivial and irrelevant. In this context, it should be mentioned that in the code of medical ethics (in different countries) too ‘neutrality’ has not been included. It has not been pronounced specifically whether a therapist has to be neutral or not. So neutrality, following such trends, seems to be morally not obligatory for a therapist. Literature shows us that therapist’s impartiality and objectivity are generally mentioned in some psychiatric-ethical codes; as we have caught a glimpse of the Canadian psychiatric code\(^1\). Thus, if impartiality is comprehended as neutrality and vice-versa then we can hit upon certain instances where neutrality is included in the ethical code. But we had a thorough discussion in chapter IV on neutrality, (observing neutral therapist as an impartial, non-judgmental, value-neutral one) especially on the fact as to what kind of moral dilemma may take place if neutrality, in the above sense, is not maintained during therapy sessions. In this way we have tried to understand whether neutrality can be regarded as an essential element for therapy. Here our point of focus is on the moral dilemmas and their probable solution regarding neutrality in psychotherapy so that we can understand why psychotherapeutic practice concerns morality as a prime factor.

But there is a strong line of thought which we have focused on in the chapter on neutrality, - that the neutral stance of therapist is actually a myth. Certain group of recent practicing psychiatrists and psychotherapists strongly recommend neutrality as an absurdity which cannot be practically attained. Thus neutrality in
psychotherapy is impossibility. But after a vivid analysis in the fourth chapter it has been observed that the above mentioned claim can be well contested. We have analytically reflected that, how and most certainly very serious moral problems come up if the therapist does not maintain her neutral stance during therapy. Thus it has been suggested that neutrality in psychotherapy may be area-specific. Some cases have been marked in our dissertation where neutrality cannot be maintained as neutral stance of the therapist goes against patient’s benefit, while the rest of the cases are to be considered as ideal for keeping neutrality. But it is not an easy task to compartmentalize various and different types of cases in this way. Specification of the factor/s on the basis of which an attempt can be made to mark the different cases is indeed complicated. While we were discussing the confidentiality principle, we could locate certain principal exceptional cases where to waive confidentiality is regarded as moral or ethical and that need not be taken to imply the denial of the principle of confidentiality in general. In the above-mentioned context of waiving confidentiality, the conflict between the principle of autonomy and the principle of beneficence is found to merge. The question ultimately leads to another issue, viz. – which principle should be given primacy?

Again we cannot forget the other line of thinking as put-forward in the previous chapter on neutrality that in case of value-conflict the therapist should not force the client to fit neatly into her scheme of values. Moreover it can be mentioned that if value-conflict comes in the way of therapy centering round the issue of neutrality, then in this case also the autonomy-beneficence controversy may arise. For instance – if a client is lesbian and not ready to change her alternative life-style, and if the therapist believes that homosexuality is morally wrong then, would the therapist be able to respect her client’s beliefs and her right to live differently? Can the therapist be able to accept her as a client? In such cases of value-conflict, question arises as to, how the therapist will remain value-neutral? In reply to these
questions we can put-forward another question. Why does a therapist view it as her role to use her value-system as the standard for decision making for her clients? Why should she persuade her clients to live according to what she believes to be right and wrong? Perhaps this goes against the very essence of therapy. Because psychotherapy/counselling process is one which involves helping clients to deal with their problems and find their own solutions based on their value-system, it is essential that the counsellor should help her clients for self-exploration. So the question remains, is it at all justifiable for therapists to impose their values on their clients? Because, ethically sensitive therapists honour their client’s self-determination. They help their clients to realize whether they are truly living by their own values or just incorporating parental or societal values without evaluation. This realization may help the therapist to put aside her values/belief system from the course of therapy. Now if therapists impose their own values on clients and expect the latter would accept those without evaluation then it simply means that they have become a parent substitute. It is widely accepted in psychotherapeutic theories that the influence of the therapists’ values on the clients bears detrimental ethical implication when goals of therapy and therapeutic methods are viewed as expressions of the therapist’s philosophy of life only, as well as the therapists think that if their clients live on their (therapist’s) values then only the latter would become healthy and optimally functioning persons. In such cases, autonomy of the client would be diminished to the lowest level, which we all know is against one of the principles of medical ethics viz. right to autonomy. Here therapist is treating her client not as a person but as an object. The therapist would become an absolute authority by objectifying her client and spelling out each and everything for the client. The therapist, in this way, may become so empowered that she does not consider her client as a person. Consequently her client’s impaired autonomy can make her (client)
absolutely dependent on therapist instead of becoming functional. This certainly goes against the requirements of healing.

Professor Corey observed that one’s role as a counsellor is to create a climate in which clients can examine their feelings, thoughts, and actions and gradually arrive at solutions which are best for them. Therapist’s role is to help clients in finding answers that are most congruent with their own values. It is important for the therapist to be aware of the nature of her own values and how her beliefs and standards operate on the interventions she makes with clients. It seems important for counsellors to develop sensitivity to cultural differences if they hope to make interventions that are congruent with the values of their clients. It can be said that part of the process for developing oneself as a therapist includes the learning of how to recognize the diversities and shaping the therapy sessions to fit the client’s world. This would be difficult for the therapist unless she considers the socio-cultural context of clients. Culture is, simply speaking, the values and behaviours shared by a group of people. It is not only the ethnic or racial heritage, but includes age, gender, religion, lifestyle, physical and mental ability and socio-economic status.

It may be suggested that an effective therapist should try to understand her own cultural conditioning, the condition of her clients and the socio-political system of which both of them are parts and parcels. Pederson contends that culture will continue to influence both the client’s and the latter’s behaviour, with or without therapist’s awareness. This view may be contested. But what is important is that if a therapist becomes aware of such multicultural dimension, then this would help her to avoid value-conflict, at least partially, with the client. The function of a therapist is not to persuade or convince clients about the proper course of action to take but to help them assess their attitudes and behaviour so that they can determine what
is suitable for them. Any school of psychotherapy would accept the view that if clients admit that what they are doing is not working for them then it would be appropriate to ask them to develop new ways of behaving, to help them move closer to their goals.

It is to be noted that this process can be carried out if full respect is given to the rights of the patients, so that they can decide which values they will use as a framework of living. Clients coming for counselling, need to clarify their own values and goals, making informed decisions, choosing a course of action and assuming the responsibility and accountability for the decisions they make. If such approach is to be taken from the therapist’s side in order to develop an insight in her client, then the therapist, keeping this goal in mind, cannot impose her own values on the client. Therapist’s only value regarding the therapy would be ‘the best interest of the client’.

From this point mentioned above it would be possible to reconcile a contradiction which apparently seems to be laying here. When we are talking about area-specificity or contextuality in case of neutral stance of the therapist, we are very strongly recommending neutrality as a moral stance in some cases and immoral in some other. Similar type of observation has been made while discussing the issue of confidentiality. The most significant question in this context would be – whether there is any principle which may help to accommodate all these conflicting issues in a meaningful way? On this point we would like to submit that it is the principle of beneficence which can explain how the apparently conflicting views regarding confidentiality and neutrality can be maintained without involving any inconsistency. In other words, while reading and re-reading the chapters containing different shades of confidentiality and neutrality in psychotherapy and also the related issues specified in the conclusion till now, no other principle but ‘beneficence of the client’ can be spotted in the horizon which can offer an overarching scenario accommodating the solutions
of the ethical conflicts emerging in the arena of psychotherapy with respect to confidentiality and neutrality in psychotherapy.

Here we need to justify why the principle of beneficence receives preference and overrides the very popular principle of respecting autonomy. In the context of neutrality it has been revealed that if the therapist is not neutral then her client’s autonomy can be diminished. It may therefore appear that in case of maintaining neutrality the principle of autonomy enjoys primacy over that of beneficence. But we would like to argue that in the matter of neutrality also there is important reason to claim that the limits of the application of the principle of autonomy would in many cases be set by the consideration of client’s benefit. In certain circumstances it can be observed that if the therapist does not suspend her neutral stance temporarily, the very process of psychotherapeutic treatment cannot start off at all. Since the client has approached the therapist to obtain a treatment, it is the therapist’s primary responsibility to provide the client therapeutic care at the cost of even suspending one or other ethical norms of therapy for the time being. Otherwise the therapist would get caught into the trap of being unethical. How would the purpose of psychotherapy be fulfilled if the therapist fails to provide treatment to her client for which she has come to the former’s chamber? Ethical theory in any form is far from approving the non-fulfillment of a professional’s basic duty. As we see in cases of emergency and dependent clients (discussed in the chapter on neutrality), therapist has no other choice than to come out from her neutral chair, for the sake of treatment only, in which she finds her client’s ultimate beneficence. It would not be mere repetition to emphasize here the fact that it is psychotherapy’s aim to lend a hand to a person to become fully functional, that implies the ability to reflect upon a situation analytically, leaving the blind, dogmatic mindset as much as possible. This is a step towards making insightful decisions which is a foremost need for leading a healthy life. But
attainment of this goal is neither easy nor an instantaneous matter. Therapy is a process through which the client gradually proceeds towards this goal. As the therapist is in a position to evaluate the progress of the client as well as to understand why the client get stuck up at certain points, it is the therapist’s responsibility to decide up to which point she would maintain a non-neutral stance and when she can be thoroughly neutral. Since self-dependence is a mark of attaining full-functionality, the therapist’s goal would always be to help the client to become self-dependent. Accordingly the therapist can afford to be non-neutral, if at all required, only if such non-neutrality does not go against the client’s best interest which consists in attaining self-dependence. When the client becomes self-dependent to a considerable degree, the therapist would have to be thoroughly neutral in her approach.

At this stage of therapy the therapist would be in a position to maintain her basic medico-moral principle of remaining neutral during treatment; since the autonomy of the client is not diminished anymore. So we can claim that it may be required in client’s best interest to suspend the basic medico-moral principle of autonomy (if required) in the initial stage of treatment which can later on be applied as the therapy progresses. Here not only lies client’s beneficence but as harm can be avoided during treatment, non-maleficence principle may also be observed. Hence it would not be unethical at all from the side of the therapist to act in this way. We should also like to observe here that - those who are proponents of the autonomy based theory are prone to make a mistake of generalizing the ethical need of autonomy, especially applicable in certain exceptional cases like those of intellectually brilliant people, to that of all other ordinary cases. Perhaps it would be a wrong supposition to conceive something as ethical for all, which is pertinent for a specific group of people. Thus from the above discussion, we can claim that there can be two major segments of clients and whether the therapist would maintain her
neutral stance or not would depend to a large extent on the nature of these two segments.

<table>
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<tr>
<th><strong>TARGET</strong></th>
<th><strong>THERAPIST'S STANCE</strong></th>
<th><strong>STATUS OF MEDICO-MORAL PRINCIPLE</strong></th>
<th><strong>MORAL STATUS</strong></th>
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<tr>
<td><strong>GROUP A:</strong> certain exceptional cases of intellectually brilliant people</td>
<td>Neutral</td>
<td>Keeping autonomy with best interest principle.</td>
<td>Ethical</td>
</tr>
<tr>
<td><strong>GROUP B:</strong> certain other ordinary cases where autonomy is impaired; like-dependent ones, emergency cases.</td>
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<tr>
<td><strong>Phase I</strong></td>
<td>Non-neutral</td>
<td>Diminished autonomy, Beneficence gets priority.</td>
<td>Ethical</td>
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<tr>
<td><strong>Phase II</strong></td>
<td>Neutral</td>
<td>Autonomy rescued, Beneficence ultimately speaks up.</td>
<td>Ethical</td>
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It can be noticed from the above table that the second group has got a greater target and scope in comparison to the first. The uniqueness of the first group is that the group may pose challenge to the therapist regarding the therapeutic process in general. In such a circumstance since the clients are considered as autonomous agents, the factor of informed consent becomes crucial too. The exclusive feature of the second group rests mainly on offering the treatment at two different phases. As the therapeutic need of care and cure can be fulfilled with the help of treatment and providing treatment is psychotherapy's basic aim, it would not be unethical from the therapist’s end to come out from the neutral stance in the first phase of treatment where the client’s autonomy is impaired. Otherwise as we have mentioned earlier the treatment can not be initiated at all. In the second phase, with the advancement of therapy, when client’s functionality as well as autonomy would be regained to a considerable degree, therapist may afford to take the neutral stance which can be claimed to be ethical as
we have discussed before in the dissertation. One may think, on the basis of what has been discussed above, that the controversy between the principle of autonomy and beneficence would be resolved in the way suggested above. But this is only an apparent picture. In phase I of group B, mentioned in the above table, the debate between the principle of autonomy and beneficence may still persist, since at this phase the therapist would take a non-neutral stance.

The main ethical consideration in this context is the tension between the healthcare professional’s duty to respect the wishes of the clients and the complementary duty to act in the client’s best interests. It is observed that sometimes those two duties pull in the same direction, i.e., the client likes to have the treatment which is in her best interest. In such cases no problem arises. No conflict emerges in between the respect for client’s autonomous wish and her best interest. But problem arises, when these two duties go in opposite directions. In such cases a genuine moral dilemma follows from the conflict between these two duties. If the client cannot understand ‘her best interest’, especially this can be observed in cases of psychiatric patients and minors who are not capable to do so, i.e., the incompetent clients, it really becomes a very significant question as how or to what extent client’s autonomy can be given primacy.

An important feature about psychiatric patients is that often it is unclear just what the patient’s wishes are and this throws a different light on the tension between patient’s wishes and best interests. A case-study may be observed in this context. Mr.A, a 90 year old man, suffering from dementia, a behaviour disorder associated with anxiety and agitation, was admitted to a special care unit for treatment. After a few days his cognitive and functional status had improved dramatically. But due to an attack of pneumonia, his condition declined seriously and he became irritable and agitated which led to his refusal of food during assisted meals. After further consultation
with Mr. A’s wife, short-term physical restraints were adopted by the hospital staff during the administration of drugs and thus he returned to his previous daily nourishment and drug therapy.

Now, at first sight this case of Mr. A may seem to be an ordinary one involving a service of relatively straightforward clinical decisions. He was admitted to the unit in a very poor health condition and after being given treatment, his quality of life was greatly increased. This course of treatment was interrupted by his pneumonia, which was itself then treated and consequently Mr. A returned to his earlier much improved condition.

From a utilitarian or consequentialist perspective, that is, if we judge the morality of action in terms of its consequences, the treatment seems to have been justified. Because of the treatment including the use of restraints, the quality of life of the patient was greatly improved. So looking at the consequence of the action, the action itself may be rated as a just one. But at the same time, the use of restraints and compulsory treatment on a patient clearly raises ethical questions of great significance independently of their short-term consequences. While it is not that clear whether the patient was actually refusing treatment, its administration was obviously making him extremely anxious and agitated.

Considering all these facts, a very significant question arises: Under what conditions is it right to override someone’s wishes and to apply forced treatment on an individual on the grounds that it serves her ‘best interests’?

In the case referred above, assuming that the patient was attempting to refuse the treatment, there is clearly a sense in which he is a danger to himself and putting himself at risk by refusing both nutrition and treatment for his pneumonia. In such cases we can once
again raise the same question mentioned above, i.e. to what extent do we have the right to physically restrain another person from doing what she wants to do (assuming we know what this is), even where we consider it to be harmful for her or against her best interests?

In most of the branches of medicine other than psychiatry the above-mentioned doubt would be explained as a reflection of a conflict between paternalism (i.e., doing something against patient’s wishes, for her own good) and the patient’s rights to choose, whereas in psychotherapy it can also be described in terms of incompetence of the client. The argument here given by therapists would be that Mr. A, because of his dementia, confusion and anxiety was incapable of having sufficient understanding of his condition or of the proposed treatment to enable him to make an informed consent regarding either to refuse or to accept his treatment. Thereby, the healthcare professional’s attempt to act in client's 'best interests' despite his protest is justified.

The argument here is that the persons mentioned in the above cases and alike are in a mentally disordered state for which they are very much confused and anxious. For this reason they are incapable of having sufficient understanding of their conditions or of the proposed treatment that may enable them to make informed choice, i.e., either to refuse or to accept their treatment. In such cases, due to the impaired autonomy of the clients, it is quite justified from the side of the therapists to act according to the beneficence principle of the clients; despite the latter’s protest.

The application of the therapeutic process in accordance with the beneficence principle can thus ultimately help a client to get back her autonomous-self. The newly emerging autonomous self can help the client to aim towards becoming a better person, having a greater self-awareness or self-knowledge, attaining a state of fully functioning
personhood. The client at this stage would be able to think more freely to set newer goals for her, like - ‘I want to be more assertive/ risk-taking/ happy’ to ‘I want to try out everything life has to offer, I want to overcome all obstacles in my life and find the real me.’ One may wonder how the application of the principle of beneficence can help a client to regain her autonomy where the principle of autonomy and beneficence go against each other. The explanation of the above phenomenon would perhaps be found if we look at the nature of human beings. The human nature itself can be held to have both these two kinds of needs – the need for autonomy and also the need for beneficence which leads to a paradoxical situation as mentioned above. In the therapeutic context also these two kinds of needs get manifested. As a person she has a need for autonomy, and as a client to the therapist, she has the need for beneficence. Thus with the help of beneficence principle it is perhaps possible for the therapist to bring out the autonomous self in the client which consists in attaining individuality and maturity and also in finding the real self, being true to oneself, having increased self-awareness etc.

But, those who give priority to the principle of respect for autonomy may argue that, who will decide, what is the best interest of the client? In the context of psychotherapy, on what ground therapy can be recommended for a person? Who will account for the need of therapy for someone? An autonomous person may give consent for having therapeutic sessions. Dan Callahan opines that honouring the need for autonomy justifies that autonomy, meaning thereby self-rule, the ability and tendency to think for oneself, to make decisions for oneself about the way one wishes to lead one’s life based on that thinking and then to enact those decisions – is what makes morality possible. For, this autonomous free will is morally very precious and is to be nurtured as character traits or habits. In favour of primacy of autonomy it may be held that the need for beneficence, non-maleficence, justice can be properly addressed only if due importance
is given to clients’ autonomy. Because responding to client’s need for beneficence etc. would require respect for her autonomous views including her autonomous rejection.

Those who give primacy to autonomy principle may put forward many other arguments in favour of their principle. But what they fail to see is that no case for autonomy can be convincingly built up unless they address the questions like: how much autonomy is sufficient, for a person to be respected as an autonomous agent? Who is to decide how much autonomy a particular person possesses and on what basis? and who is to make decisions on behalf of those who are considered as non-autonomous or incompetent agents, and according to what criteria? What if in case of psychotherapy any dependent client gives consent for her therapist to make decision on her behalf? Moreover we cannot ignore the fact that therapeutic treatment carried out for the sake of client’s beneficence cannot be withheld in the name of respecting client’s autonomy where clients are incompetent to give consent for therapy. In this context it may be mentioned that when clients’ autonomy is sufficiently diminished or impaired then the autonomy that remains may justifiably be overridden not only if it threatens others but also if it threatens clients themselves. As we have mentioned earlier, in cases of emergency, suicidal client, acute drug addict client and so on, it is not possible for the client to find out what may serve her best interest. In such context the therapist has to leave behind her neutral stance and may need to be directive towards her client which cannot be designated as immoral.

In case of children or mentally retarded clients, can we talk about autonomous choice? A severely mentally challenged adult needs to be brought to therapy (even if she does not want to) and the most plausible justification for such decision is that – it is in the client’s best interest to do so. Further in such cases, it is really dubious as to how far the decisions taken by the clients belonging to the above-
mentioned categories can be given respect considering those as decisions of an autonomous agent. Since such clients, mentioned above, do not have sufficient autonomy of thought, their decisions may be self-damaging and whether such self-damaging decisions can be accepted on the ground that they are reflections of autonomous thought is quite questionable. In such case, if the therapist does not come out of her neutral stance then the very purpose of therapy, i.e., removal of suffering would not be possible.

Here it may be noticed that the debate between autonomy and beneficence in the field of psychotherapy would not arise at all if we take into account a very different voice of the anti-psychiatry movement. According to anti-psychiatrists, there is no such natural object like madness at all. Mad persons are victims of corrupt upbringing. What’s wrong is not in the person, but in her family and society. Breggin interestingly expresses his view by saying that – madness need not be all breakdowns. It may also be breakthrough\(^6\). A renowned member of the anti-psychiatry movement, Szasz stressed the need to abandon the entire psychiatric-medical approach to mental illness and to substitute theoretical viewpoints which may be appropriate to psychological, social and ethical problems\(^7\). Thus if the very concept of ‘mental-disorder’ has to be rejected following the anti-psychiatric model then there would be no relevance of psychotherapy also. Again if the question of therapy does not arise then the controversy of autonomous wish of impaired clients and their best interest and alike would not exist at all. Moreover the anti-psychiatrists, as mentioned above, would not accept the concept of impaired autonomy. According to them every individual is an autonomous agent. Thus the debate between the principle of autonomy and beneficence in the domain of psychotherapy would turn out to be a meaningless issue.
In response to the anti-psychiatric position it can be held that we cannot ignore the fact that an individual’s mental health has to be understood with reference to a societal framework, that the factor of context or situation has to be included in understanding any individual’s mental framework. An autonomous individual, contextualized in this way, may encounter various sufferings, some of which may be psychological too. According to the bio-psycho-social model of mental health the deepest level of somatic sensation and psychological sufferings are intertwined with technology, knowledge and culture. They accept the category of ‘mental illness’ within the realm of history, culture and politics to emphasize how discourse about mental-illness is appropriated at intimate levels.

In the present scenario of psychiatry, we may notice the schools like Critical Psychiatry that challenges the dominance of clinical neuroscience in psychiatry (but does not exclude it). It is influenced by critical, philosophical and political theories. It introduces a strong ethical perspective on psychiatric knowledge and practice and politicizes mental health issues. Therefore it would be quite likely that according to the particular context or situation, the need for one medico-moral principle or other would be required. It can neither be held that the principle of autonomy can be regarded as an all or nothing affair, nor can it be admitted that the need for the beneficence of the client can be held to be absolutely paramount or totally negligible. But from the argument already mentioned, it can be claimed that for the sake of healthcare need of the client the beneficence principle has to be prioritized. Thus from J.S.Mill, Pellegrino and David Thomasma argue that paternalistic internalistic interference is justified to benefit the mad or delirious children and the immature and that in general, ‘those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury’. David Thomasma holds that “Beneficence remains the central moral principles of the
ethics of medicine ... Our aim is to redefine and refine the notion of beneficence in terms of the new practicalities and dimensions of the physician-patient relationship today.”

The operative model embraced by Pellegrino is known as ‘beneficence-in-trust’ which means physicians and patients hold in trust, ‘the goal of acting in the best interests of one another in the relationship’.

It follows from this whole range of discussion that the pillar of medical ethics seems to be the principle of beneficence. The scope or range of this principle is much wider than the principle of autonomy. Does it make it any sense to talk about autonomy of a new born baby? But application of beneficence principle starts from the pre-natal stage of a baby. The question of autonomy for a new born baby arises in the long run but not in the earliest stages of the development of the person. In both the context of confidentiality and neutrality it has been observed that the issue of autonomy, after a depth analysis, ultimately stretches to the question of client beneficence. On this point, it may be doubted whether in all cases therapy really leads to client’s benefit at all. When a criminal, convicted for capital punishment is treated by a physician, what kind of beneficence does she (the criminal) receive? Does her treatment in that context directed in any sense towards client-beneficence? In this context, it may seem that the client cannot have any beneficence from the therapy ultimately as she is destined to have capital punishment. In reply to the above position one may argue that if not long-term beneficence, the client may have short-term beneficence from the therapy. As the therapy progresses the suffering (i.e., anxiety, depression etc.) of the client can be controlled temporarily which can be regarded as short-term beneficence of the client. It may be contended that if short-term beneficence does not cause any long-term harm then the client should not be deprived of the benefit specifically when she has the right to treatment. But instead of entering into the debate regarding whether in all cases treatment leads to beneficence, we would like to claim that cases like
the one cited above show that treating a client, whether it be for the client’s benefit or not, is the primary duty of the physician or therapist. This may be the reason why starting from the age of the Hippocratic Oath, till date, the medico-moral professional code revolves around the central concept of ‘service of treating patient’. A sea-change and paradigm shift has taken place in the history of psychiatric ethics. Considering that entire period and also looking at the future, the primary need of psychotherapeutic profession would be nothing but- ‘treatment for healing’, for which, if required any other secondary need of both the client and the therapist can be withdrawn temporarily. Accordingly we would like to propose that though the principles of medical ethics, including the principle of beneficence, are certainly very important, over and above these principles, we would like to emphasize that the duty of providing treatment is to be placed at a higher-level if considered hierarchically. It is indeed very significant that in the course of treatment only the question of autonomy and beneficence of the clients arises. So treating the client is the foreword which should be accepted with a different resonance. It may be proposed to be an important value compared to which other principles or values may be considered to be secondary in the field of medical ethics. The most popular debate of medical ethics, viz. the conflict between autonomy and beneficence subsides when the need of the duty of treatment from the side of the physicians/therapists come into the picture. We have put-forward a case-study about a convicted person’s beneficence, where it has been shown that therapeutic treatment’s ultimate goal can not be set to be the beneficence of client. This does not imply that the client cannot be benefited in any circumstance of therapeutic treatment. It may so happen that at the end, the client gets immensely benefited out of the therapy. But beneficence of the client can not be claimed to be the ultimate goal of treatment. It is possible to cite some other instances where it may be noticed that in spite of the removal of the suffering of the client takes place through treatment, the client ultimately cannot gain benefits out
of the process of therapeutic treatment. If we consider the cases of mentally-retarded clients, we would see that clients of this category enjoy a number of rights and privileges, since they are considered to be mentally challenged. These rights and privileges contribute to their beneficence too. If such treatment procedure can be invented by which it would be possible to treat the retarded people to bring them back to ‘normalcy’, then definitely they will loose the enjoyed benefits when they will be cured. Moreover such persons, who are recently cured, would most likely face all the challenges and competitions of the mainstream, which may not appear as quite comfortable for those persons. So it is conceivable that treatment of a client may even deprive her from some available benefits. In such circumstance, can we afford to withhold treatment as it may not be conducive to the benefits of the clients? As we have proposed earlier, we would like to maintain the position that not patient’s beneficence, but duty of treatment would be given ultimate priority. Treatment of clients would be considered as the duty of therapist, since the goal of treatment, we would propose, consists in attaining sound health or well-being of the client; because well-being itself can be considered as a value. In the context of therapy, well-being may be claimed to be consisted in healing or curing or alleviation of suffering and not in the attainment of any other benefit. To dispel the doubt as to whether alleviation of suffering is itself a benefit, we would like to argue, with reference to the case of the suffering of a convict who has been sentenced to death, that removal of suffering is not always considered to be a benefit for the client.

Leon Kass argued that –“Medicine’s proper end is the much narrower one of health or the healthy human being, and other goals such as happiness and gratifying patient desires are false goals for medicine.”\textsuperscript{12}
Kass highlights that “Physicians with their impressive body of scientific knowledge concerning human biological functioning and the impact of therapeutic interventions on diseases and their natural causes, would seem to be the proper judges of whether we are healthy and if, we are not, what therapeutic interventions will be likely to make us more so.”\textsuperscript{13} It should be mentioned that Kass’s view of the aim of medicine as health defined in terms of naturalistic and the biological terms was substituted with the advancement of medical ethics within the last two decades by the broader view of the aims of medicine that, the decision-making in medical treatment rests on an understanding of the quality of life. This refers to the socio-ethico framework or factor/s operating in the ambit of treatment. Dan Brock opines that the dominant notion of the proper aim of medicine focuses on medicine as an intervention aimed at preventing, ameliorating or curing disease and its associated effects of suffering and disability, and thereby restoring or preventing the loss of normal functions of life\textsuperscript{14}. It may be noted that when we talk about ethics in psychotherapy, we talk about how the therapists should conduct themselves in clinical practice with patients. This implies undoubtedly that the value of therapeutic needs to be a given priority over the other issues relating to such treatment. It can be held that the moral dilemmas evolved in the sphere of mental health can be resolved, if treatment of clients can be taken as the primary obligation or responsibility of the therapist.

\textit{Duty to treat or medical care} taken as a value, as it has been shown in this dissertation, ensures health which insists on well-being of client. If we admit therapist’s duty of treatment as a primary value then the question arises how can this duty provide guidelines in solving problems, viz, moral dilemmas existing in case of the ethical issues of confidentiality and neutrality in the field of psychotherapy.
In case of neutrality as we have understood, 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 question. 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. In such context we have tried to emphasize context-sensitivity or area-specificity which focuses on therapist’s decision to come out from the neutral chair and to be directive for handling the situation. But the question is, whether it can be designated as moral or not. We have shown earlier as to how and why such non-neutral stance of the therapist helps to treat the client in emergency situation. It has been claimed that it is client’s beneficence for the sake of which the therapist has to become non-neutral that leads her to being directive. But still we have been skeptical whether beneficence of the client can be regarded as the goal of psychotherapy? Thus the question, how can the non-neutral stance of the therapist in emergency situations be ethically prioritized? - still remains open. At this point, it can be held that it is ‘duty for treatment’ for the sake of which the non-neutral stance taken by the therapist can be said to be justified. Therapy ultimately looks at making clients fully functional, insightful and autonomous. It is of great consequence to indicate that such individual autonomy may gradually ameliorate to ripen an autonomous society on top. We can not ever imagine a non-autonomous society, given that, with no autonomy a society may grow to be absolutely crippled which is not desirable for human well-being. Health refers to a broad array of activities directly or indirectly related to the social well-being component included in the WHO’s definition - "A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity"15. (In case of mental health, it is related to the promotion of well-being, the prevention of mental disorders, and the
Overall health is achieved through a combination of physical, mental, and social well-being, which, together is commonly referred to as the Health Triangle. Widening health to the psychological and the social dimension was indeed a major advance. It should be noted that the factor of social well-being in this context can be understood as well-being for the society, i.e. well-being of the general mass over and above the well-being of the individual with respect to social dimensions.

Thus health related with social well-being 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. So, we can appreciate quite well that duty of treatment gets here first in all cases including emergency cases in therapeutic situation. This exhibits a leap from individual well-being to collective or group well-being which is ultimately greater. This shows a transcendence from self to others which touches a social dimension and thus can be viewed as ethical. In this way case where non-neutral attitude of therapist via short-term beneficence ultimately lead towards long-termed ones turn up to be ethical as there duty to treatment for clients is determined to focus at well-being of the society including individuals who are in those circumstances the worse-off clients. At this point we can explain the notion of long-term beneficence in two ways - firstly direct long-term beneficence for the client; secondly, indirect i.e. long-term beneficence via short term beneficence for the same. In both cases as main focus is addressed towards social well-being, they fall under the scope of morality. Thus moral dilemmas centering round neutrality in psychotherapy may seem to be resolved through a way-out emphasizing on the concept of duty to treatment for the individual, directed towards social well-being.
The issue of confidentiality can be justified following the same line of argument. Here the crucial moral dilemma revolves around divulgence of client’s confidential information by the therapist in the context of harm through private and public peril. There it has been shown that divulgence of confidential information does not seem to be immoral since there priority can be given to the social well-being principle, but not at the cost of entire exclusion of the individual, i.e. client’s autonomy and beneficence. It initially seems that client’s autonomy and beneficence are challenged in this context if social well-being is given priority. But in response to this it may be said that in therapy, client’s need is directed towards getting treatment and healthcare which ensures health. Again health according to WHO, as we have mentioned earlier, is physical, mental and social well-being. As a consequence, the consideration of social well-being becomes difficult to be ignored. Accordingly if continuance of client’s confidentiality in any way harms social well-being then that cannot be ignored. As a matter of fact, client’s autonomy can not also be awarded predominance in such an environment; since no one would suggest applying autonomy as an absolute principle. This position may face challenge. But instances where autonomy principle works within limits are not that rare. So, if autonomy comes in conflict with social well-being, it may be curtailed. We may exemplify instances related to vaccination regarding pulse-polio where even the consent of parents does not get much importance. The concerned authority may exercise his/her power to manage the situation for carrying out the defined medical policy. Furthermore the international policy to quarantine individual for infectious diseases like – bird flu, swine flu etc. can also be taken into account where individual autonomy is supposed to be sacrificed for the sake of social well-being. Last but not the least, as we have carved out the defining features of morality which involves the factor of self-transcendence and thus points towards social dimension of morality, we can conclude that the moral conflict highlighted in this regard, associated with confidentiality can be
resolved if we consider health to be a value in itself, the attainment of which is the aim of psychotherapy. Duty to treatment in the context of psychotherapy is also based on the notion of health as a central concept. It would thus be reasonable to claim that it would not be unethical on the part of a therapist to go against the principle of confidentiality and neutrality in a particular context, if it is possible both to protect and/or enhance social well-being and also to remove the suffering of the individual.