Welsh Psychotherapy Institute

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Course- Advanced Diploma in Psychotherapy

Name of Trainee: John Dray

Presentation Title: Ethical Dilemma

Date of Presentation: 24 March 2026

Marker Comments

John, this is a well written and well presented ethical dilemma. You have followed due process in both the practice and the explanation of the work. Your reflections show further insight and highlight areas for potential future growth. Having confidence in your own clinical thinking as a therapist whilst also ensuring compliance with ethical codes and agency policies is sometimes a difficult path to navigate. You have proven that you are well on the way towards ethical maturity within your practice, able to reflect honestly and seek appropriate support when necessary.
Well done

06/05/2026

Please use this document to write up your Presentation. Start on the next page.

Introduction

I am currently a fourth year student with the Welsh Psychotherapy Institute (WPI). I have been seeing clients through my placement with New Pathways since April 2024 and through my Affordable Therapy Placement (ATS) since September 2024. I have accumulated more than 370 hours of clinical practice. As a trainee member of the United Kingdom Council for Psychotherapy (UKCP), I adhere to the New Pathways Safeguarding Adults policy (*Adult at Risk Safeguarding Policy and Procedure V4 Sept 2024*, 2024), UKCP codes of ethics (*UKCP Code of Ethics and Professional Practice*, 2019) and WPI code of ethics (*WPI Members Code of Ethics and Professional Practice*, 2019/2025). I use these ethical frameworks as a foundation for my private practice, from the content of written contracting and GDPR statements to safeguarding and keeping the therapeutic work in the best interest of my clients. I attend weekly therapy, with a UKCP-registered integrative psychotherapist, which provides me with space to take personal process work that arises from any area of my life. Additionally, I undertake individual supervision at a ratio of one hour for every six clinical hours with a UKCP-accredited supervisor. I work with long-term clients through my private practice and with short-term clients through my placement with New Pathways. In my placement I have additional supervision with a BACP registered supervisor, covering those clients.

In the analysis of this ethical dilemma I am going to use the 10-step ethical framework put forward in Barnett & Johnson (2008).

The ethical dilemma arose when a client disclosed that he had taken a potentially dangerous overdose, but did not want his GP contacted. Here is how the dilemma unfolded.

Ethical Analysis

Stage 1: Define the Situation Clearly

This dilemma comes from my counselling placement with New Pathways. New Pathways is a charity that offers many support services to victims of sexual violence. Among their services is counselling for both pre and post-trial clients. I was part of the team that offers counselling to post and no-trial clients.

Alex, 38, is male presenting. He is very personable. Some years ago he fell off a ladder and seriously injured himself. The subsequent long-term effects are that he is on constant, strong medications including co-codomol (35mg/500mg) as well as other pain-killing medications. His work as a decorator means that he is constantly on and off ladders in the course of a working day. This work makes the pain from his injuries worse. He has a female intimate partner (IP). Between them they care for two children. Alex's partner has a history of drug misuse, so Alex has to keep his drugs locked in his work van. When we touch on his childhood he reveals that he was abandoned as a 5 year-old child and suffered sexual abuse over many years.

The week before the incident, I saw Alex for the first time and took him through the standard New Pathways intake process. This involved going through personal details, medical details, including current medications, previous types of therapy, other support that he is receiving. We also do CORE-10 (Barkham et al., 2013) as part of the standard intake. His overall score for CORE-10 is 24. The way New Pathways categorises clients is Level 1 - CORE-10 is less than 15, Level 2 - 15 to 25, Level 3 - more than 25. For counsellors who are freshly through the New Pathways training, only level 2 clients and below are given. At this stage in my work with New Pathways, I am beginning to be considered for more complex level 2 cases and simpler level 3. Notably in the CORE-10, Alex scores zero for the question about suicidal ideation. The intake form re-iterates that he does not want to end his life.

At the second session Alex explained to me that he is not feeling very well. Two days before he had taken 30 co-codomol. This was to get high from the codeine content. He wanted to have some time away from the pain and other worries. He has subsequently vomited. I am aware, from training I received as a teenager, that 20 paracetamol is considered a fatal dose for an adult male and that fatality can result from as few as 12 tablets. I am also aware from training received that the toxic effects of paracetamol can take up to 2 weeks to effectively kill the liver, at which point the client would need a liver transplant. I also know someone who had tried to end their life with paracetamol and the resulting, permanent disabling effects.

I explain the serious implications of Alex's actions to him: that the situation requires prompt action to reverse the effects of the paracetamol; that this is a safeguarding issue; and that I will need to involve the safeguarding team from New Pathways. Internally I am aware both of the importance of taking this situation immediately to safeguarding and balancing that with the potential for shaming Alex in this situation which may affect how he wishes to engage in remedial action.

Stage 2: Determine Who Will be Impacted

In terms of impact, the clear centre of this is Alex. There will also be his intimate partner and his children.

In terms of the organisation, I will be impacted and New Pathways and WPI could suffer reputational damage. Further effects could be felt by his GP, the A & E staff, as well as public trust in therapy as a safe intervention.

Stage 3: Refer to both Universal Ethical Principles and the Standards of Your Profession's Code of Ethics

As an adult, Alex has the right to take his own life. Suicide is no longer a crime (Suicide Act 1961, 1961-08-03, 1961). In the language of the UKCP ethical code (*UKCP Code of Ethics and Professional Practice*, 2019) his autonomy needs to be respected. I am somewhat conflicted, as he has stated that he has no suicidal ideation. As I speak to him, he appears

competent. The potential effects of the medication feel like an accidental side-effect of his self-administered dose of medication, rather than a deliberate attempt to end his own life. As his therapist, I am aware of my responsibilities of beneficence and non-maleficence - to act in the best interests of the client and ensure that no harm comes to him. Rescuing someone from an accident feels like a different process to preventing someone from deliberately ending their own life.

Stage 4: Refer to Relevant Laws/Regulations and Professional Guidelines

The UKCP Code of Ethics and Professional Practice (*UKCP Code of Ethics and Professional Practice*, 2019) emphasises that psychotherapists must work to protect clients from serious harm while also respecting client autonomy and confidentiality. Confidentiality may be breached where there is a risk of significant harm to the client or others. In this situation I therefore needed to consider whether the potential medical consequences of the overdose justified breaching Alex's confidentiality by contacting his GP. I also considered the Mental Capacity Act (2005) (Mental Capacity Act 2005, 2005-04-07, 2005), which assumes capacity unless proven otherwise. Alex appeared able to understand the situation and communicate his wishes, suggesting that he retained decision-making capacity. However, the potential medical risk meant that safeguarding procedures within New Pathways also needed to be followed, which required consultation with the safeguarding officer and consideration of various referral pathways.

Stage 5: Reflect Honestly on Personal Feelings, and Competence

Alex was lovely and I was looking forward to working with him. I am deeply aware that what I do in these coming moments may impact the quality and length of Alex's life. In the short time I have known him, I have heard of the intense sexual, physical and emotional abuse he has experienced. My heart feels for him and I know that I want the best for him.

I was also aware that the way I responded to Alex's disclosure would shape the relational field between us. If my response was experienced as shaming, punitive or overly controlling,

it could reinforce patterns of mistrust that may already have been present, given Alex's history of abandonment and abuse. Therefore, I tried to balance the need for safeguarding with maintaining an attitude of attunement and respect for his autonomy, so that the therapeutic relationship could remain a place of safety rather than further intrusion.

Stage 6: Consult with Trusted Colleagues

As part of the support for training counsellors, New Pathways ensures that there are experienced staff around. In this case, Independent Sexual Violence Advisors (ISVAs). I initially consult with them and ask them about contacting the Safeguarding Officer (SO) of the organisation. They explain that the usual SO is away and give me the name of the acting SO. I contact them.

Stage 7: Formulate Alternative Courses of Action

Together with the SO, we formulate various plans of action: Send the client immediately to A & E; Accompany the client to A & E - they are my last client that day and we are in the grounds of the hospital; Suggest that the client go to A & E on the way home - this would entail the client letting their IP/driver know what they had done.

The client is resistant to the first two and promises to go to A & E at his local hospital on his way home.

I also suggest contacting his GP. He is resistant to this, too. With the SO I go through the following possibilities: Do not contact the client's GP, in accordance with their wishes; Contact the client's GP, against their wishes - this would require a breach of confidence but is a course of action allowed in the New Pathways contract.

Stage 8: Consider Possible Outcomes for All Parties Involved

The client is concerned that if I contact their GP the GP will cut off their supply of medication. The client states that the thought of pain is more than they can bear. If I contact the GP there is the possibility that the client will not be prescribed painkillers. This could impact the client's

quality of life, and impact their ability to carry out their job. I am also aware that if I contact the GP against the client's wishes that there could be a sense that trust has been breached, even though this scenario is clearly stated in the New Pathways client contract.

On the other hand, if I do not contact the GP there is the possibility of permanently disabling liver damage or death. There is risk that this could get into the local newspapers with a headline such as, 'Therapy organisation using trainee therapists allows a man to die needlessly'. There is also the other consequence that the client's GP will not be aware of how their patient misuses prescribed medication, with possible deleterious consequences in the future.

Stage 9: Make a Decision and Monitor the Outcome

Following further discussion with the acting SO, we decide to act in accordance with the client's wishes and NOT contact the GP.

The following day I have supervision. My supervisor with New Pathways listens to me recount what has happened and expresses concern that the GP should have been contacted. This is not only because of the risk of injury to the client, but also the potential for reputational damage to the organisation. My supervisor made it very clear that I acted correctly, but that she is concerned about the choice of action made. During the supervision, my supervisor calls her manager to review the decision and see if an alternative course of action should be taken.

All of this was documented on the OASIS system, which is used to store client notes.

Over the following days the decision is taken through to the head of counselling for the organisation.

The decision is taken to stick with the current course of action, but to make a Multi-Agency Referral (MARF) so that if there are further developments people in other agencies are aware of the situation.

The Social Services response to the MARF is that Alex is a competent adult and can decide to do what he likes.

In further discussions with my supervisor, she points out that I would be perfectly within my right as a therapist to have contacted the GP, even though it would have contradicted the advice of the original SO. In my mind, I wonder what it would have been like to have followed that line of action and to have possibly lost the support of the organisation. I also reflected on the importance of working within organisational structures and safeguarding procedures, even when alternative courses of action might be defensible.

Stage 10: Engage in an Ongoing Assessment and Modification

Alex does not attend the following week. He does not notify the organisation, so under the rules of New Pathway his program of therapy is cancelled.

Aware that paracetamol can take a fortnight to have fatal effect, I am left not knowing if he is alive or dead. Also, I am forbidden by the New Pathway guidelines from contacting the client. I am left staring into a figurative hole of not-knowing. The support in this situation, that I am finding painful, is that I do know that I did everything I could for him.

A few months later, Janice, another client who explains to me that she definitely has no suicidal ideation, but who likes ‘dancing with the devil’, explains to me that she has taken sixteen strong cocodamol to get high. My brain kicks into the safe-guarding process. As part of the support for the client I have a conversation about how it is really important to have support from the GP. The conversation is similar to the one that I had with Alex, but I am clearer about the support that the GP will be able to give. Janice agrees. Following the appointment I contact the GP surgery. They ask me to put the situation in an email. As a result, the GP issues the prescription on a weekly basis, rather than a monthly basis. Janice and I are able to have a conversation about this the following week. Janice tells me how she feels supported. Janice completes her program of counselling with me. I feel relieved that I was both able to safeguard the client and maintain the therapeutic alliance.

This experience reinforced for me the importance of balancing respect for client autonomy with the responsibility to protect clients from serious harm. It also highlighted the value of consultation and supervision when facing complex ethical decisions. While uncertainty remained regarding Alex's outcome, the experience has shaped how I approach safeguarding conversations with clients in subsequent work.

Reflections

I presented the above at the WPI Residential at Waunifor on 24 March 2026 to the current student and staff body. Following the presentation, there was opportunity for questions. A member of staff asked me ‘What does breaching confidentiality mean for you?’ A member of the student body asked ‘What was the impact of not knowing?’ with a follow-up question around whether I was tempted to find out whether the client had survived.

In the moment, I answered the question from the staff member by reflecting on the difference between confidentiality and secrecy. I reflected that secrecy is a place where a problematic power-dynamic can hang out. Secrecy can be a place that protect the perpetrator and maintains complicity from the victim. This is explored more thoroughly in Bond & Reeves (2021, p. 166ff). On the other hand, confidentiality represents a safe container that allows the growth of the therapist/client relationship. I did say that I was clear on that difference. To mix metaphors, I say that confidentiality has holes in it to keep the relationship safe, whereas secrecy does not. The allowable ‘holes’ are outlined in the contract between me and the client, provided by New Pathways. The meaning of confidentiality is more eloquently described by Bond & Reeves (2021, p. 162) as “…confidentiality is ‘strong trust’ (from the Latin con-fidere).” Subsequently, I am wondering if the staff member was emphasising the word ‘breach’. I experience the word ‘breach’ as a breaking of the rules, a tearing down of walls. What would it have been like to contact the client’s GP against their wishes? I would have been in compliance with the contract, but I wonder if I would have felt that I had betrayed the ‘strong trust’ client. In the context of ‘strong trust’, I am wondering which would be the most ‘trust-ful’ action–to tell the GP, or go along with the client’s wishes. In TA terms, would telling the GP be treating them like the Child and coming from the Parent ego state? What would it be like to contact the GP against the client’s wishes and try to maintain Adult to Adult communication? I could try to stay in Adult, but I would have no control of the client’s ego state. Would acting without their permission be re-creating the circumstances of their childhood abuse and abandonment, where they had no control over the unfolding of events?

In the presentation, I shifted my interpretation of Alex's action from one of suicidality to one of accidental harm. I also chose to privilege autonomy, as it aligned with my attempts to preserve the therapeutic relationship. In framing Alex's actions as 'accidental harm', it could be argued that I should have privileged the protection of the client over protection of the therapeutic relationship. I acknowledge that I have a tendency to follow rules and be confluent–for me that is a safe place. How important is it for me to act from a 'safe place' when dealing with difficult situations? I suppose that the challenge of this dilemma is that there are no truly 'safe places'. All the solutions are partial and have risks associated with them. I am satisfied that I followed an ethical path, but I also see other valid ethical paths that I could have followed. This aligned with Barnett, Psy.D., & ABPP (2023) and the idea of 'least harmful' rather than 'correct' action. I am left considering what my threshold for going against organisational advice and contacting the GP independently would be. A scenario where I could imagine following that course of action would be where I did not believe the client to be capable of making an informed action, in other words that they failed the criterion of the Mental Capacity Act 2005. However, in that scenario I would also imagine the organisation recognising the situation and supporting me in contacting the GP.

That brings me to the student question about the impact of 'not knowing'. With all my clients at New Pathways, subsequent contact is not allowed. I always find this difficult and feel grief that the therapeutic relationship has ended. This ending with Alex is much harder, as there is no knowledge about whether he is alive and well, alive and disabled by the experience, or dead. In the moment I answered that I was not allowed, according to New Pathways guidelines, from contacting the client. On further thinking, I realise that to have contacted the client would have breached the contract between me and the client, as well as the GDPR. What would the benefit be to the client? It might show love and caring, but I had already shown that through caring for him as I guided him through the safeguarding procedure. To have contacted the client would have felt like nosiness–being interested in their well-being without being able to continue the therapeutic relationship that they had chosen to end. It

would be solely for my benefit and not for theirs. In my work with clients I find that a significant part of the growth within the relationship is that the relationship demonstrates what a properly boundaried relationship looks like. In knocking down a boundary for my own benefit, I could be undoing some of the therapeutic benefit of our short relationship. This uncertainty is mine to bear. Fitting in with this question is the idea of 'Ambiguous Grief' - the phenomena that group around an ending that is not clear-cut and is explored in detail by Boss (1999). Boss notes that the impact of such situations can result in effects similar to PTSD. A reminder that I am one of the people who is affected by this ethical dilemma and that I should take appropriate care of myself. I did take this situation both to personal therapy and supervision.

My other reflection is how partial this dilemma is. For instance, for the sake of brevity, I missed out taking Janice through a safeguarding procedure and creating a safety plan with her. These did happen but are not part of the presentation. My interactions with Alex are presented from my perspective. I have no idea how they landed with him and I am likely to never know.

In reflecting in detail on this ethical dilemma, I feel that I have internalised the structure given by Barnett and Johnson. I am also learning to sit with the uncomfortable feelings around a situation that has no single correct solution and consider other potential outcomes.

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