

ETHICS

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CONTINUING PSYCHOLOGY EDUCATION

6 CONTINUING EDUCATION HOURS

“The ability to reason with the ethical principles and arrive at a decision for which we are willing to be accountable is what makes counseling practice ethical.”

W. Lanning (1997)

Course Objective

The purpose of this course is to provide an understanding of the concept of ethics as related to therapists. Major topics include client rights and therapist responsibilities, confidentiality, managing boundaries and dual relationships, marital and family therapy issues, multicultural counseling, therapist competence, and legal/ethics case studies.

Accreditation

Continuing Psychology Education is approved by the Illinois Department of Financial and Professional Regulation as a continuing education sponsor for LCSWs and LSWs (license # 159-000806), and for LCPCs and LPCs (license # 197-000108). This course is approved by the Illinois Department of Financial and Professional Regulation for 6 hours of continuing education for LCSWs, LSWs, LCPCs and LPCs.

Mission Statement

Continuing Psychology Education provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives

Upon completion, the participant will be able to:

1. Discuss the meaning and purpose of ethics.
2. Explain ethical standards pertaining to informed consent and record keeping.
3. Understand managed care ethical issues and various malpractice liabilities.
4. Acknowledge ethical guidelines of confidentiality.
5. Clarify relevance of managing boundaries and avoiding dual relationships.
6. Expound upon ethical issues and therapist values in marital and family therapy.
7. Communicate suggested response to a subpoena.
8. Interpret various codes of ethics.
9. Reiterate ethics of therapist competence.

Faculty

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INTRODUCTION

Ethics codes are created to protect the public and offer guidance to professionals in servicing their clientele. Various mental-health organizations have formulated codes of ethics, including the National Association of Social Workers (NASW, 1999), the American Counseling Association (ACA, 1995), the American Association for Marriage and Family Therapy (AAMFT, 2001), and the American Psychological Association (APA, 2002). Though each of these professional organizations professes a different set of codes, highlighting different themes, Herlihy and Corey (1996a) believe that codes of ethics accomplish three common objectives. The basic purpose is to educate professionals about proper ethical conduct; practitioners who understand the standards may experience expanded awareness, values-clarification, and problem-solving capabilities. Second, ethical standards promote accountability, in fact, therapists must maintain ethical conduct and encourage such from colleagues as well. Third, codes of ethics assist in improving practice by offering answers to difficult questions and situations.

Ethics are moral principles embraced by an individual or group designed to provide rules for right conduct. Bersoff (1996) identifies *ethical conduct* as the result of knowledge and an understanding of the philosophical principles which underlie an ethics code; such conduct originates from sound character leading to behavior exemplified by maturity, judgment, and prudence. Ethical issues in mental-health are governed by professional codes and laws. *Law* defines the minimum standards of performance which society will tolerate and these standards are enforced by government. *Ethics* illustrates maximum or ideal standards of performance set by the profession and are managed by professional associations, national certification boards, and government boards which regulate professions (Remley, 1996).

To practice psychotherapy ethically is to further the welfare and best interests of the client and awareness of ethics codes facilitates this goal, however, there are limitations to the codes as assessed by the *Code of Ethics* of the National Association of Social Workers (NASW, 1999):

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes, or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather a code of ethics sets forth values, ethical principles and ethical standards to which professionals aspire and by which their actions can be judged.

Clearly, the therapist must utilize judgment, reasoning, and deliberation in striving to transcend the community standard (what professionals actually do) and reach the ethical standard (what professionals should do).

Ethics codes for mental-health organizations are revised as new concerns arise. The first ACA ethics code, instituted in 1961, underwent revisions in 1974, 1981, 1988, and 1995. The first *Code of Ethics for Marriage Counselors* was developed in

1962, and the eighth revision of the *Code of Ethics of the American Association for Marriage and Family Therapy* was established in 1991; the current revision is dated 2001. The need for revisions underscores the sentiment that client welfare is of paramount significance.

CLIENT RIGHTS AND THERAPIST RESPONSIBILITIES

Therapists have legal and ethical responsibilities toward their clients, their agency, their profession, the community, members of their clients' families, and themselves. Clients have rights which ensure they are given sufficient information to make informed choices about entering and continuing the client-therapist relationship. Ethical concerns may arise given conflicts within these responsibilities, for example, when the agency's expectations differ from those of the therapist or client. Calfee (1997) reports that lawsuits brought against mental-health practitioners are few, but these cases are on the rise. To avoid opening themselves to liability, mental-health practitioners need to be aware of legal and ethical standards relating to informed consent, record keeping, managed care issues, and malpractice liability.

INFORMED CONSENT

The derivation of the doctrine of informed consent can be traced to the rights of individuals to be free from coercion and unwarranted interference. Justice Benjamin Cardozo stated the principle, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" (1914). Mental-health professionals are committed by their ethics codes to inform clients of risks, benefits, and alternatives to proposed treatment. Informed consent comprises the right of clients to be informed of their therapy and to make independent decisions regarding the process. The intent is to define and clarify the nature of the therapeutic relationship; the process begins with the intake interview and continues throughout counseling. Three ethical codes specify the parameters of informed consent as follows:

... Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent... (NASW, 1999, 1.03.a.).

When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable... (APA, 2002, 3.10).

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon client and treatment plan... (AAMFT, 2001, 1.2).

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Three factors basic to the legal definition of informed consent are capacity, comprehension of information, and voluntariness (Anderson, 1996; Crawford, 1994; Stromberg & Dellinger, 1993). *Capacity* means the client can make rational decisions; a parent or legal guardian generally is responsible for giving consent if capacity is lacking. *Comprehension of Information* indicates the therapist disclosed information in an understandable manner and confirmed the message was understood. For valid consent, the client must receive information relating to benefits and risks of procedures, possible adverse effects from treatment, risks of foregoing treatment, and available alternative procedures. *Voluntariness* means the consenting client is acting freely in the decision-making and is legally and psychologically competent to give consent.

Effective informed consent procedures minimize client misunderstanding which also tends to lower the chances of filing liability claims, therefore, Somberg, Stone, and Claiborn (1993) recommend a written, standardized informed consent form. Bennett and colleagues (1990) recommend a written consent form include the following: date of discussion about consent, name of practitioner and client, a statement indicating client understood the information, a statement of the client's right to withdraw from therapy, likely benefits and risks inherent in the therapy, a description of the type of treatment to be administered, issues of confidentiality, privilege, and their limits, and client signature. Additionally, the following may be included: therapist's theoretical orientation and its possible effect on treatment, the purpose of counseling records and how they will be kept, fees, procedures for filing insurance reimbursement, therapist's policies and procedures, and, if applicable, how managed care may affect therapy.

HMOs influence the course of therapy, including length of treatment, number of sessions, and content of therapy (Smith & Fitzpatrick, 1995), hence, clients have a right to know how their health care program is likely to affect their care, and how confidentiality may be compromised as their records are scrutinized by the reimbursing agency.

Based on the ethics codes of several professional organizations, clients should be aware of alternative helping systems. Options to traditional psychotherapy include: self-help programs, stress management, personal effectiveness training, peer self-help groups, bibliotherapy, twelve-step programs, support groups, and crisis-intervention centers.

Informed consent can become confusing when more than one client is involved in therapy, as in marriage and family counseling. Family therapists may use techniques (i.e. paradoxical interventions) which rely upon family members being uninformed of such procedures. Second, the common practice of parents providing consent for their children may be argued to violate conditions of informed consent and the rights of children. Finally, informed consent requires the consenting client is acting freely and without undue influence, however,

this may not be fulfilled when a reluctant family member is coerced into attending therapy by other family members or the therapist because the therapist will only treat families when all members are present. Potential concerns arising from these factors may be avoided by the therapist offering all family members (including children) as much information as possible about therapeutic procedures and, if necessary, referring the family to a therapist who does not require all family members be present.

The ethical codes of mental-health organizations cite the importance of informed consent; treatment without informed consent falls below the standard of care potentially resulting in liability.

RECORD KEEPING

Maintaining effective clinical notes enables the therapist to offer clientele needed therapeutic information and serves to protect the therapist confronted by lawsuit or disciplinary action. Schaffer (1997) advises that practitioners failing to maintain adequate clinical records are exposing themselves to great ethical and legal peril.

Ethical codes on record keeping indicate the following: American Association of Marriage and Family Therapists (2001):

Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards. (2.4)

National Association of Social Workers (1999):

Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided. (3.04.a.)

American Psychological Association (2002):

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals... (6.01)

The committee on Professional Practice and Standards of APA instituted guidelines for record keeping in 1993 (Appendix B of Canter et al., 1994) and suggested the following as minimal requirements for record content: client identifying information; name of client's primary care physician, or explanation for the absence of the name; intake sheet; documentation of mental status exam or assessment; signed informed consent for treatment form; existence of treatment plans, containing specific target problems and goals; statements regarding client's presenting problem; previous and present data from psychological tests; documentation of referrals to other providers, when appropriate; signed and dated progress notes; types of services provided; precise times and dates of appointments made and kept; use and completion of a discharge summary; and release of information obtained.

Therapists are ethically and legally required to store records in

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a secure manner and to protect client confidentiality. Failing to maintain adequate client records potentially could lead to a malpractice claim because it breaches the standard of care expected of a mental-health practitioner (Anderson, 1996).

ETHICAL ISSUES ASSOCIATED WITH MANAGED CARE

Mental health services, until the 1980s, were offered through a fee-for-service system whereby practitioners determined clients' issues and duration of treatment, then billed insurance carriers. Rising costs, especially in inpatient care, and various concerns for client treatment outcomes have convinced third-party payers to seek more effective cost and quality controls (Cummings, 1995; Miller, 1996). Managed care has grown from employer demand to lower care cost (Hersch, 1995). Case reviews are designed to eliminate unnecessary and costly interventions and HMOs and PPOs focusing on prevention is expected to further lower treatment costs (Karon, 1995).

The managed care model urges time-limited interventions, cost-effective methods, and focus on preventive rather than curative strategies which Miller (1996) suggests culminates in client undertreatment, underdiagnosing important conditions, restricting hospital admissions, failing to make referrals, and providing adequate follow-up. Karon (1995) believes managed care is more interested in reducing costs than quality of service. Haas and Cummings (1991) report that managed care limitations on client treatment raise ethical concerns with inherent risks being shifted to the therapist. First, issues of competence arise as therapists must maintain an eclectic orientation to work with an array of issues within a short-term intervention model. Second, Newman & Bricklin (1991) suggest a need for research to determine effective treatments within a short-term model allowing clients to make informed choices regarding their therapy, otherwise, the process of informed consent is in question. Third, practitioners are challenged to place the welfare of the client above the financial integrity of the system.

Many believe that the managed care system is and will continue to be an integral part of mental-health care delivery, in turn, therapists will benefit from training in time-efficient and cost-effective therapies.

MALPRACTICE

Malpractice is the failure to render professional services or to demonstrate skill ordinarily expected of other professionals in a similar situation; it is a legal concept involving negligence resulting in injury or loss to the client.

The law of torts is the body of law providing for monetary awards to clients of professionals who are injured resulting from malpractice. Generally, the tort of negligence creates a legal duty to act in a manner which will not create unreasonable risk of harm to others, hence, when an individual's actions creates an

unreasonable risk of harm, he or she is negligent.

In assessing negligence, the legal system essentially asks the question: Would such therapeutic conduct, under the circumstances, by a reasonably skilled, competent and experienced mental health practitioner who owes a special legal duty to this client, represent "good professional practice" or "customary or usual practice" in the community?

Malpractice is limited, generally, to six types of situations: 1) the procedure demonstrated by the practitioner was not within the realm of accepted professional practice; 2) the practitioner used a technique without proper training; 3) the therapist did not use a procedure which would have been more helpful; 4) the therapist failed to warn and protect others from a violent crime (discussed in confidentiality section); 5) informed consent to treatment was not obtained or documented; 6) the practitioner did not explain the possible consequences of the treatment (Anderson, 1996).

The following four elements of malpractice must be present for a client to succeed in a malpractice claim: *Duty* - a professional relationship existed between therapist and client. *Breach of duty* - therapist acted in a negligent or improper manner, or deviated from the "standard of care" by not providing services considered "standard practice in the community." *Injury* - client suffered harm or injury and must show proof of actual injury. *Causation* - a legally demonstrated causal relationship between practitioner's negligence or breach of duty and the claimed injury or damage of the client.

Establishing causation is thought to be one of the greatest obstacles for plaintiffs claiming psychotherapeutic malpractice. The following represents a legal argument on behalf of defendant and reinforced by testimony of an expert witness retained by defendant:

"It has often been said that medicine is not an exact science. It is for this reason that physicians do not promise patients, or enter into contracts with them, to cure or improve their condition. This is true to an even greater degree in psychotherapy. Psychotherapists can identify and evaluate psychological problems, but they cannot predict the course of an illness based upon the present knowledge of the profession. It is common for a patient's condition to worsen radically during psychotherapy.... There is no way to say that the defendant's advice had any effect on ... or that any other form of psychotherapy would have prevented If it is common for psychotherapy to have no effect, how can (plaintiff) say the defendant's failure to use a recognized therapy probably caused her injuries?" (Thompson, 1983).

Daniel Hogan's review of 300 cases of psychotherapeutic malpractice suits from 1850 to 1977 suggests that the legal obstacles to recovery in tort law are difficult to overcome. The reasons presented include:

The problems of proof involved are little short of monumental, except in instances of negligent custodial care,

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physical assault, and several other categories of negligence. Where the particular act consists of words spoken by a therapist in private session with a client, it may be impossible to prove deeds actually took place.... Where the particular acts are not in question, proof that those acts were the proximate cause of the plaintiff's distress (is) enormous....(p. 26).

Coupled with legal obstacles are psychological dynamics which discourage former clients from suing their psychotherapists. Two law professors (Feldman and Ward, 1980) suggest the following dynamic exists:

a natural reluctance on the part of the patient to parade his illness before lawyers, judges and jurors, and the emotional difficulties that might attend a suit against a therapist who once held a deep, meaningful, and trusted position in the plaintiff's eye (p. 69).

Despite client difficulties confronted in tort law, there has been an exponential increase in such suits. The American Psychological Association (1986) reports that more people are suing therapists than ever before. Swenson (1997) reports three general problem areas which yield the highest risks of malpractice lawsuits:

- a) violating clients' personal rights (commonly related to sex, privacy, or wrongful commitment).
- b) failure to protect others from clients (alleged in failure to warn, failure to commit, and wrongful release cases).
- c) incompetent treatment of clients (often alleged in suicide cases).

Benjamin Schutz (cited in Lakin, 1988) anticipated near-future trends in legal actions against therapists by the following predictions:

1. Increased use of the informed consent principle in negligence cases in verbal psychotherapies and with potentially noxious effects of cathartic therapies.
2. Malpractice suits will become more effective with directive and behavioral therapies due to the relative ease of establishing proximate cause.
3. Family therapy will produce family member suits dissatisfied with outcomes, partially due to family system approaches that focus on the family system to the potential detriment and harm of individual members.
4. Insurance peer-review actions may prompt suits in cases of rejected claims for reimbursement or payment due to inadequate treatment plans.
5. Therapist decision not to apply short-term or time-limited therapies might be interpreted as negligence in some cases.
6. A shift to strict liability or "product liability" given use of such devices as biofeedback machines; this might also be extended to verbal therapies.

One effective way to protect from liability action is to restrict practice to clients one is prepared for by virtue of education, training, and experience. Pope and Vasquez (1991) advise that even when therapists work within their specialty, they may

endeavor to work with specific populations or use certain techniques which exceed their level of competence. Another precaution against malpractice is to utilize personal and professional honesty and openness with clients.

Pope, Simpson, and Weiner (1978) suggest therapists may avoid malpractice or negligence actions in an increasingly litigious society by considering the following: keep abreast of developments in diagnosis and treatment; periodically re-examine the client to evaluate progress; effectively warn of possible consequences of suggested treatments; have sound rationale for proposed treatment; utilize consultants, peer supervision, and case conferences when in doubt, when at impasse, or when client is worsening; attempt to modify aspects of your demeanor or intervention style which irritates or frustrates client; confine your relationship to client within the therapy setting, except for situations justifying specific treatment requirements; keep hands off clients except for ordinary greetings and when promoting an acceptable therapeutic rationale; and try to find an appropriate referral if you wish to discontinue therapy.

Calfee (1997) promotes employing risk management techniques to reduce the practice of unethical behavior thus minimizing the probability of litigation. Her four-step method entails: identifying risk areas; determining whether the risk area warrants further attention; applying preventive and risk control strategies; and reviewing treatments to determine effectiveness.

Despite all precautions, given a lawsuit, Bennett and colleagues (1990) offer these recommendations:

- Contact your insurance company.
- Become familiar with your liability policy.
- Do not destroy or alter reports relevant to the client's case.
- Retain an attorney.
- Consult with professional associations, if possible.
- End the professional relationship with the client.
- Respond seriously to the lawsuit, even if it represents the client's attempt to control or punish you.
- Avoid attempting to resolve matter with client as anything you do could be used against you in litigation.

CONFIDENTIALITY: ETHICAL AND LEGAL ISSUES

A primary right of the client is that disclosures during therapy sessions are protected and kept within the boundary of the professional relationship, however, circumstances exist whereby confidentiality may be broken for ethical and legal reasons. Important court decisions have permitted therapists to warn and protect both clients and others who may be affected by a client's dangerous actions. Confidentiality may be broken to protect a client from suicide, and in cases where the client waives the right of confidentiality, but the waiver must be knowing and voluntary (Ahia & Martin, 1993).

Guidelines for confidentiality in counseling practice are summarized by the following associations:

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National Association of Social Workers (1999):

Social workers should protect the confidentiality of all information obtained in the course of professional service, except... when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person... and where disclosure of confidential information may be legally required. (1.07)

American Association for Marriage and Family Therapy (2001):

Marriage and family therapists disclose to clients... the nature of confidentiality and possible limitations of the client's right to confidentiality. (2.1)

American Psychological Association (2002):

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium... (4.01).

Related to confidentiality is the concept of *privileged communication* which ensures client disclosures of personal and sensitive information will be protected from therapist exposure during legal proceedings. Hence, therapists can refuse to answer questions or offer client records in court.

Reinforcing the value of privileged communication is a United States Supreme Court ruling, dated June, 13, 1996, indicating communications between psychotherapists and clients in the course of diagnosis and treatment are privileged and therefore protected from forced disclosure in cases arising under federal law. The Supreme Court ruling in *Jaffee v. Redmond*, written by Justice John Stevens, states, "effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make frank and complete disclosure of facts, emotions, memories, and fears" (Morrissey, 1996; Seppa, 1996). Interpretation by Newman (1996) suggests the Supreme Court's ruling acknowledges the societal value of psychotherapy and the relevance of confidentiality to successful treatment.

Another related concept to confidentiality is *privacy*, defined as the constitutional right of an individual to decide the time, place, manner, and extent of sharing oneself with others (Stromberg and colleagues, 1993). Common areas in which privacy is an issue include: an employer's access to an applicant's or employee's psychological tests, parents' access to their child's school and health records, and a third-party payer's access to a client's diagnosis and prognosis. Most professional codes of ethics comment on the need to protect a client's right to privacy.

If confidentiality must be broken, it is sound practice to inform the client and, if possible, invite the client to participate in the process. This may perpetuate the therapeutic relationship and possibly facilitate resolution between the involved parties (Mappes et al., 1985).

Conditions under which breaching confidentiality is permissible include these situations (Ahia & Martin, 1993; Herlihy & Corey, 1996b): when client poses a danger to self or others; when client discloses an intention to commit a crime; when therapist suspects abuse or neglect of a child, an elderly, or disabled person; and when a court orders a therapist to make

records available. Failure to report may involve sanctions (Ahia & Martin, 1993), whereas practitioners who report in good faith are immune from prosecution for breaching confidentiality.

Clients have a right to understand exceptions to confidentiality from the onset of therapy, otherwise, their consent to therapy is not truly informed. Breaching confidentiality unprofessionally (without recognized exception) opens the mental-health practitioner to ethical and legal sanctions, including license revocation, expulsion from a professional association, and malpractice suit. Protection from such liability is recommended by Ahia and Martin (1993) by having a written informed consent which includes confidentiality and its exceptions.

THE DUTY TO WARN AND PROTECT

Failure to diagnose or predict client dangerousness, and failure to warn potential victims and the police of violent behavior expose the counselor to lawsuit as illustrated in the case of *Tarasoff v. Board of Regents of the University of California*.

The Tarasoff case involved a client, named Poddar, who confided to his psychologist, named Moore, that he intended to kill his girlfriend, named Tatiana Tarasoff, upon her return from a trip. Moore assessed Poddar to be dangerous and informed police of such. The police questioned Poddar and released him after he showed "rational" behavior and promised he would stay away from Tarasoff. Several months later, Poddar killed Tarasoff, and her parents sued and won the case based on grounds that the victim was not notified of the threat.

The psychotherapist's duty under the Tarasoff ruling is to warn, protect, and predict when a client has communicated to the therapist a serious threat of physical violence against a reasonably identifiable victim or victims. This duty is fulfilled upon the practitioner making reasonable efforts to communicate the threat to the victim(s) and to the police.

The California Supreme Court expanded the 1974 lower court ruling indicating a "duty to warn," resulting in a "duty to protect" third parties from dangerous clients. In the words of Justice Tobriner, "Protective privilege ends where the public peril begins" (cited in Fulero, 1988).

The Tarasoff case was not a U.S. Supreme Court case, instead, a Supreme Court of California case, therefore, no other states were bound by the decision; nonetheless, Illinois and many other states embraced and codified the duty to warn requirement. Several Illinois cases after Tarasoff including *Eckhardt v. Kirts* coupled with Illinois statutory law addressing the duty to warn in two statutes, the Mental Health Code and the Mental Health and Developmental Disabilities Confidentiality Act, infer that, if challenged, Illinois courts are likely to uphold the duty to warn.

The case of *Bradley Center v. Wessner* reveals the duty not to negligently release a dangerous client. Wessner, the patient, was voluntarily admitted to a facility for psychiatric care due to being upset about his wife's extramarital affair. He repeatedly

threatened to kill his wife and lover and admitted to a therapist that he possessed a weapon in his car for that purpose. Wessner was granted an unrestricted weekend pass to visit his children - who lived with his wife - and while in the home he shot and killed his wife and her lover. The children filed a wrongful death suit claiming the psychiatric center breached a duty to exercise control over Wessner. The Georgia Supreme Court ruled that a physician has a duty to take reasonable care to prevent a potentially dangerous patient from inflicting harm (Laughran & Bakken, 1984).

The case of *Jablonski v. United States* illustrates the duty to commit a dangerous individual, and that the intended victim's knowledge of a threat does not relieve therapists of the duty to protect. Meghan Jablonski filed suit for the wrongful death of her mother, Melinda Kimball, who was killed by Philip Jablonski, whom she was living with. Philip agreed to a psychiatric exam at a hospital where physicians concluded there was no emergency nor a basis for involuntary commitment. Kimball accompanied Jablonski for a second hospital visit when she stated fear for her safety and was told by a doctor that "you should consider staying away from him." Again, doctors determined no basis for involuntary hospitalization and released him. Soon thereafter, Jablonski killed Kimball.

The Ninth U.S. Circuit Court of Appeals ruled that failure to obtain Jablonski's prior medical history constituted malpractice. This case exemplifies a negligent failure to commit (Laughran & Bakken, 1984).

The decision in *Hedlund v. Superior Court* extends the duty to warn to anyone who may be near the intended victim and accordingly, may also be in danger. LaNita Wilson and Stephen Wilson received psychotherapy from a psychological assistant, Bonnie Hedlund. During therapy, Stephen confided in the therapist that he intended to harm LaNita; later, he assaulted her in the presence of her child. The allegation indicated that the child sustained "serious emotional injury and psychological trauma."

The California Supreme Court, in keeping with the Tarasoff decision, held that breach of such a duty with respect to third persons constitutes "professional negligence," and the duty to exercise reasonable care could have been fulfilled by warning the mother that she and her child may be in danger (Laughran & Bakken, 1984).

The case of *Thompson v. Alameda* illustrates the "duty to warn" only covers situations in which there is a "reasonably identifiable victim or victims." The Supreme Court of California decided in favor of the County of Alameda when it did not notify the community at large that a youth with a history of dangerous and violent tendencies was being released from custody into a local neighborhood. The youth later killed a five-year old boy. The parents of the deceased sued the county for wrongful death but the courts ruled that their son had not been a foreseeable or identifiable victim, hence, Alameda County was

not liable for failure to notify these parents (or other parents, police, or the delinquent youth's mother) of the youth's potential for dangerous and violent actions.

Mental-health professionals working with potentially dangerous clients face ethical, legal, and moral dilemmas; they must assess risks involved to the client, the potential victim, and to themselves for breaking confidentiality. Accordingly, therapists are wise to complete thorough histories, inform clients of confidentiality limits, keep notes of client threats, record steps taken to protect others if deemed necessary, and seek consultation.

SUICIDAL CLIENTS

A breach of confidentiality is permitted when a client poses an imminent danger to him/herself. Failure of a therapist to ensure client safety within a high risk for suicide situation could end in harm or death to the client, therefore, therapists must weigh consequences of breaking confidentiality versus potential client harm. Szasz (1986) revealed that failure to prevent suicide is one of the leading causes for successful malpractice suits against mental-health professionals and institutions.

In the case of *Bellah vs. Greenson*, the California Court of Appeals determined self-inflicted harm (suicide) is not subject to the "duty to warn," additionally, it elucidated therapist need to take reasonable steps to prevent suicide. The therapist's ethical obligation is to act within reason to prevent the suicide with minimal invasion of the client's privacy. Specifically, the California court refused to find the therapist, Dr. Greenson, liable for not warning the parents of Tammy Bellah of the likelihood of her committing suicide, which she did in 1973. The court ruled that self-inflicted harm or damage to property is not a strong enough public interest to infringe upon the need for confidentiality.

Procedurally, therapist's response to suicidality can include formulating a "suicide prevention contract" with the client, informing client's family, or having client hospitalized. If possible, the counselor can discuss their intended action to resolve the situation with the client. Communication with others is best limited to information pertinent to the present situation to protect client confidentiality, in fact, based upon the level of risk, it may be sufficient to only inform client's family rather than involving hospital or emergency personnel. Essential, is protecting the client in such a situation, in turn, breaching confidentiality is permitted.

Sommers-Flanagan and Sommers-Flanagan (1995) believe consultation and documentation offer effective protection against malpractice liability in suicidal cases; these actions can demonstrate that therapist response was within legal and ethical bounds.

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CHILD ABUSE

Therapists must make a report to an appropriate authority upon knowing or suspecting the occurrence of child abuse. There are no time limits on child abuse reporting in the sense that as long as the victim is still a minor, therapists have an obligation to file a child abuse report.

In 1974, Congress enacted the National Child Abuse Prevention and Treatment Act (PL 93-247), which defined child abuse and neglect as follows:

Physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of eighteen or the age specified by the child protection law of the state in question, by a person who is responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened thereby.

The law protects reporters who acted in good faith from lawsuit.

Clearly, the obligation to maintain client confidentiality is not an absolute in all situations with all clientele, rather, situations may arise whereby therapist disclosure of client confidential information is permitted or deemed mandatory. Each case is unique with its own legal interpretations and subtleties, thus, professional judgment is needed to arrive at resolution.

MANAGING BOUNDARIES AND DUAL RELATIONSHIPS

Dual relationships exist when therapists assume two or more roles at the same time or sequentially with a client, for example, counselor and business partner, or instructor and therapist. Common examples of dual relationships include: bartering therapy for goods or services; providing therapy to a relative or a friend's relative; socializing with clients; attending a social event of a client; accepting gifts from clients; becoming emotionally or sexually involved with a client or former client; and combining the roles of supervisor and therapist. Therapists placing their personal needs above client needs by engaging in more than one role with the client is deemed unethical behavior. Pope and Vasquez (1991) believe that dual relationships impair therapist judgment resulting in greater potential for conflicts of interest, exploitation of client, and blurred boundaries that distort the therapeutic bond. The codes of ethics warn of potential concerns of dual and multiple relationships as follows:

AAMFT's Code of Ethics (2001):

... Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation... (1.3)

NASW's Code of Ethics (1999):

... In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (1.06.c.)

APA's Ethics Code (2002):

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness... or otherwise risks exploitation or harm... (3.05)

BARTERING FOR PROFESSIONAL SERVICES

A client who is unable to afford therapy may offer a good or service in exchange for counseling sessions, for example, a plumber might exchange work on a therapist's bathroom for therapy; such bartering can lead to problems for both therapist and client and damage the therapeutic relationship. Employing a sliding fee scale or referring to another therapist are possible alternatives.

Ethical codes and standards for bartering include the following:

NASW (1999):

Social workers should avoid accepting goods or services from clients as payment for professional services. ... Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship. (1.13.b.)

AAMFT (2001):

... Bartering for professional services may be conducted only if: (a) the supervisee or client requests it, (b) the relationship is not exploitative, (c) the professional relationship is not distorted, and (d) a clear written contract is established. (7.5)

American Psychological Association (2002):

Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (6.05)

SOCIAL RELATIONSHIPS WITH CLIENTS

Several reasons support the practice of avoiding becoming socially involved with clients or accepting friends as clients. Counselors may be less confrontive and challenging with clients they know for fear of losing the social tie. Second, objectivity may be lost due to the counselor's personal needs being enmeshed with those of the client. Finally, therapists may exploit clients resulting from the power differential in the therapeutic relationship.

Borys & Pope (1989) surveyed psychologists, psychiatrists, and social workers on dual relationships between therapist and client and discovered the following practices to be labeled "never ethical:"

- accepting a client's invitation to a special occasion (6.3%)
- becoming friends with a client after termination (14.8%)
- inviting clients to an office or clinic open house (26.6%)
- going out to eat with a client after a session (43.2%)
- inviting a client to a personal party or social event (63.5%)

Salisbury and Kinnier (1996) found that 70% of therapists in their study believed post-termination friendships were ethical two years after therapy termination.

Establishing friendships with former clients may be unwise

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because they may need future therapy and once a friendship is formed, the client cannot utilize the therapist's professional services. When assessing the effect of a social relationship upon the client-therapist relationship, counselors may benefit by objectively examining their own motivations and those of the client.

SEXUAL RELATIONSHIPS: ETHICAL AND LEGAL ISSUES

Sexual misconduct is considered one of the most serious ethical violations by a therapist and it is the most common allegation in malpractice suits.

The typical profile of a therapist involved in sexual boundary violations is a middle-aged male who is experiencing personal distress, is professionally isolated and over-values his healing capabilities. He practices unorthodox methods and improperly discloses personal information not relevant to therapy.

Sanders and Keith-Spiegel (1980) summarized an investigation of a psychologist accused of sexual involvement with his female client after two years of therapy which appeared in the journal, *American Psychologist*. Interestingly, this case supports the profile portrayed above. Client stated that the psychologist promptly terminated therapy without attempting to resolve unfinished issues. The sexual relationship continued on a weekly basis for approximately one year until client ended the affair due to guilt and disgust. The psychologist attempted twice to resume the affair but client refused.

Initially, the psychologist denied client charges but ultimately admitted they were true. He stated that he loved his client, that he was experiencing mid-life crisis and severe marital problems, and that he was willing to pursue personal therapy to work on his problems.

The state psychological association voted to monitor the psychologist's personal therapy and to have his practice reviewed for one year. At his hearing before the APAs ethics committee he gave a progress report of his personal therapy and attempted to convince committee members that insights gained in therapy would prevent recurrence of this ethical violation. The committee offered a stipulated resignation from the APA for five years, with opportunity to reapply given no additional ethical violations brought to the association.

The various professional associations state the following with respect to sexual contact and the therapeutic relationship:

"Sexual intimacy with clients is prohibited" (AAMFT, 2001).

"Counselors do not have any type of sexual intimacies with clients and do not counsel persons with whom they have had a sexual relationship" (ACA, 1995).

"Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced" (NASW, 1999).

"Psychologists do not engage in sexual intimacies with

current therapy clients/patients" (APA, 2002).

Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1993) studied 559 clients who became sexually involved with their therapists and concluded that 90% were adversely affected. The harm spanned from mistrust of opposite sex relationships to hospitalization to suicide. Other effects included negative feelings about the experience, a negative impact on their personality, and a deterioration of their sexual relationship with their primary partner.

Coleman and Schaefer (1986) reveal other negative outcomes of sexual contact in therapy include depression and other emotional disturbances, impaired social adjustment, substance abuse, deterioration of primary relationships, and despite increased emotional problems, difficulty in pursuing therapy because of the previous negative experience. Generally agreed upon is the awareness that sexual boundary violations remain harmful to clients no matter how much time passes after therapy-termination.

Pope (1988) describes a syndrome associated with sexual contact between therapist and client which is very similar to the rape syndrome, the battered-spouse syndrome, and responses to child abuse. This research concludes that awareness of the severity of symptoms in such cases can assist professionals to avoid acting out sexual attractions to clients and assist other helping therapists to effectively treat such abuse.

Austin, Moline, and Williams (1990) examined relevant court cases and concluded that therapists who engaged in sex with their clients had few arguments applicable in court. Courts have rejected claims of consent by clients because of the vulnerability of clients and the powerful effect of the transference relationship.

Coleman and Schaefer (1986) resolve that the counselor is responsible for setting appropriate sexual boundaries for the client, communicating these boundaries, and maintaining a professional rather than personal relationship. Despite client pathology, the therapist must uphold ethical standards in a therapy relationship (Olarie, 1997).

The American Counseling Association, the American Association for Marriage and Family Therapy, and the American Psychological Association all agree that sexual contact before two years after therapy termination is unethical. The National Association of Social Workers does not specify a time period. All four of these associations indicate that in the case of sexual relations with former clients, even after two years have elapsed, the burden of demonstrating the absence of exploitation rests with the therapist.

UNETHICAL BEHAVIOR BY COLLEAGUES

Mental-health professionals have an obligation to deal with colleagues whom they suspect of engaging in unethical conduct. Generally, it is recommended the counselor tell the colleague directly, then, depending upon the nature of the complaint and

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the outcome of discussion, reporting the colleague to the appropriate professional board is one of several options.

Ethical codes on this issue read as follows:

“Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues” (NASW, 1999, 2.11.a.).

“Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct” (AAMFT, 2001, 1.6.).

“When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved” (APA, 2002, 1.04.).

ETHICAL ISSUES IN MARITAL AND FAMILY THERAPY

Marital and family therapists view the family system as the client rather than a particular individual. Potentially, there are more ethical conflicts which may arise working with the complexity of a family unit as compared to specializing in individual therapy; these dilemmas can surface from the first session (Smith, Carlson, Stevens-Smith, & Dennison, 1995).

Green and Hansen (1989) compiled a list in rank order of areas that produced ethical concerns for family therapists: treating the entire family; having values different from those of the family; treating the entire family after one member leaves; professional development activities; imposing therapist values; manipulating the family for therapeutic benefit; payment for services; decisions on marital status; reporting child abuses; and supervision of trainees.

Family therapists generally benefit from examining their own family-of-origin and related emotional issues to improve their skill in counseling families. Getz and Protinsky (1994) profess that personal growth is important for marriage and family counselors and knowledge and skills cannot be separated from internal dynamics and use of self. Aponte (1994) reinforces this sentiment by stating, “The touching of therapists’ and clients’ lives in therapy beckons therapists to gain mastery of their personal selves in their clinical relationships” (p.4).

VALUES IN MARITAL AND FAMILY THERAPY

Family therapists who impose their values, consciously or unconsciously, on a couple or family can do more harm than good. Values regarding marriage, the preservation of family, divorce, gender roles and the delegation of responsibility within the family, lifestyles, child rearing, and extramarital affairs can influence therapist’s objectivity. Therapist bias against an individual or family whose views differ from his or her own must be guarded against. Goldenberg and Goldenberg (1996) cite three potential traps counselors must avoid: they may take sides with one family member against another; they may impose their own values on family members; and they may proselytize

for maintaining the marriage.

Most therapists believe that all people can benefit from therapy (Silber, 1976). A resulting potential concern is the attempt to prolong therapy given a family member’s reluctance to do so.

Assertiveness and autonomy are often equated with mental health by practitioners, but these characteristics may not be relevant to all family members, hence, therapists must guard against this bias.

Another therapist value that can present ethical concern is belief in preservation of the family. Though the AAMFT Code of Ethics states that the decision to separate or divorce is the sole responsibility of the client, the therapist’s value of family preservation may affect selection of an intervention, and evaluation of therapy outcome (divorce may be regarded as therapy failure).

Ethical therapeutic practice will challenge clients to clarify their values and choose a corresponding course of action rather than enacting their therapist’s values.

Additionally, it is recommended that therapists be aware of their values about gender. Effective and ethical practitioners are aware of family roles and responsibilities, child-rearing practices, multiple roles, and nontraditional vocations for men and women. Gender-aware therapy helps clients to identify and work through self-limiting gender-stereotyped values. Sexist attitudes and patriarchal assumptions are explored leading to an egalitarian model of family therapy; ultimately, the client chooses roles instead of being limited by his or her gender (Goldenberg & Goldenberg, 1996).

Margolin (1982) recommends family therapists to be nonsexist and to do so requires self-examination of unwitting comments and questions implying the husband and wife should perform specific roles and hold a specific status. Moreover, Margolin believes family therapists are vulnerable to the following biases: 1) assuming that remaining married is the best choice for the woman, 2) showing more interest in the man’s career than the woman’s, 3) encouraging the belief that child rearing is the mother’s responsibility, 4) showing a different reaction to a wife’s affair than to the husband’s, and 5) believing the husband’s need-satisfaction is more important than the wife’s.

CONFIDENTIALITY IN MARITAL AND FAMILY THERAPY

Maintaining client confidentiality can become complex when counseling multiple clients. At one extreme are therapists who believe each family member is an individual and disclosed information by one family member is never shared with another. Conversely, some therapists refuse to keep information secret that was shared individually, thus, “hidden agendas” are openly explored. Each approach has negative consequences. Upholding confidentiality can limit the therapist’s disclosure of

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critical family issues, while the position of revealing all information can inhibit family members from sharing important information openly. A moderate approach entails therapists divulging information selectively for the greatest benefit to the couple or family at the discretion of the therapist; this method allows the counselor to use professional judgment in maintaining individual confidences or not. Margolin (1982) indicates that therapists who have not promised confidentiality have more options and must contemplate therapeutic consequences of their actions. According to Margolin, the best approach is to maintain a policy consistent with one's theoretical orientation and inform all family members of this policy at the beginning of treatment. Ethically, counselors must make their stand clear to all family members so they can decide whether to participate in counseling and how much to disclose to the therapist.

SUBPOENAS

Given a therapist receiving a subpoena from the court or other litigant requesting privileged information, the therapist's response should involve the following steps (Simon, 1992; Thompson, 1990):

- 1) Determine whether the subpoena requires production of records, the appearance of the therapist in court, or both.
- 2) Regardless of which type of subpoena, in most cases, seek legal advice, and initially assert the psychotherapist-patient privilege. Failure to assert the privilege can be grounds for legal action by the client.
- 3) Therapist should contact client and/or client's attorney to assess consequences of providing the information requested by the subpoena. If client wants therapist to comply with subpoena, then therapist should get written authorization from client before sharing the requested information.
- 4) If client does not consent, therapist can continue to assert the privilege, until a court hearing which may judge the privilege should not be upheld. At this point, therapist must abide by the court order (if not, a contempt-of-court citation can be issued).

Ethical guidelines indicate that a therapist only release information relevant to the case, and subpoenaed records should be presented to the court in a sealed envelope marked "confidential." It is illegal to destroy or tamper records to avoid disclosure.

ETHICAL CODES IN MULTICULTURAL COUNSELING

Most ethics codes indicate the practitioner's responsibility to be familiar with the special needs of diverse client populations. The preamble to the Code of Ethics of ACA (1995) requires members to "recognize diversity in our society and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of each individual."

The NASW Code of Ethics (1999) states:

Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups. (1.05.b.)

Failure to include diversity factors into treatment infringes on client's basic human rights and constitutes unethical practice (Cayleff, 1986; Ivey, 1990).

THERAPIST COMPETENCE: ETHICAL AND LEGAL ISSUES

Incompetence has existed throughout human history since the first "psychotherapists" in 10,000 B.C. drilled holes in the skulls of the mentally afflicted to allow demons to escape. It was only a few hundred years ago that bloodletting, witch burning, and flagellation were accepted forms of treating people with behavioral disorders. For example, the physician in Charles II's court was consulted to promote recovery of his ailing Royal Majesty. "Tested" medications and therapeutic methods offered by this doctor included: lizard's blood, crocodile dung, hoof of ass, putrid meat, frog sperm, goat gallstones, powdered Egyptian mummy, eunuch fat, fox urine, sneezing powder, human skull extract, and forty-four other items. After administration of this solution, a pint of blood was extracted from the king's arms and legs, followed by an enema, a plaster of pitch and pigeon dung applied to his feet, and application of a bezoar stone - after which King Charles II expired (Ullmann and Krasner, 1975).

The famous Greek physician, Galen, respected as a great thinker, proclaimed that body moisture produces foolishness in a patient, dryness induces wisdom, and the ratio between these two variables reveals the state of relative sanity.

A "handbook of psychotherapy" was written by two fifteenth-century Dominican monks and titled *Hammer of the Witches*. This "handbook" recommended a diagnostic method for abnormality called "trial by swimming." The patient's right thumb was tied to their left toe and the left thumb tied to the right toe, and then she was submerged in a lake. If the patient sank, she was innocent but often dead; if she floated, she was diagnosed as "abnormal" and burned at the stake as a witch.

These historical perspectives reveal that it generally takes several decades to learn the difference between competent versus incompetent therapeutic practice and that therapists must ensure their methodologies are researched, tested, and helpful.

A mental-health practitioner must know the boundaries of his or her own competence. Periodically, even experienced therapists may wonder if they possess personal and professional abilities needed for some of their clients.

Ways to improve therapeutic skills include working with others who are more experienced than yourself, attending conferences and conventions, taking additional courses, participating in workshops, and pursuing advanced training in a specialty area.

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Professional Codes of Ethics on competence are clear: AAMFT (2001, 3.11):

Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competence.

NASW (1999):

Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. (4.01.b.)

APA (2002):

Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. (2.01.a)

Therapists need to refer clients to other professionals when the therapeutic relationship is beyond their professional training or when personal factors impede a productive working relationship.

Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully, or when social workers believe that they are not being effective or making reasonable progress with clients and additional service is required. (NASW, 1999, 2.06.a.)

LEGAL CASE STUDIES

The following court cases (cited in Austin, Moline, & Williams, 1990) illustrate nationwide legal and ethical concerns arising within psychotherapy and their accompanying court decisions.

Caesar v. Mountanos, as Sheriff of Marin County (1976) U.S. Court of Appeals, Ninth Circuit

Dr. George Caesar, a California psychiatrist, was held in contempt of court on the basis of the "patient-litigant exception" to the psychotherapist-patient privilege for refusing to answer questions regarding his former client, Joan Seebach, while giving court testimony. Ms. Seebach filed two suits to recover personal damages resulting from two car accidents in which she alleged pain and suffering not limited to her physical ailments and she sought testimony of Dr. Caesar who treated her therapeutically after the accidents. Dr. Caesar forwarded his clinical notes to Ms. Seebach's counsel but he refused to answer 11 questions concerning correlation between client's emotional condition and the accidents. He asserted, "answering further questions and revealing her confidence could be harmful to her psychologically, and detrimental to her future well-being."

The California Court of Appeals reported that "the constitution ... permits limited intrusion into the psychotherapist-patient privilege when properly justified." Further, "There is no privilege under this article as to communications relevant to an issue concerning the mental or emotional condition of the patient if such an issue has been tendered by ... the patient." In essence, plaintiff, Ms. Seebach, breached the confidential relationship with Dr. Caesar when she related her mental and emotional condition to the issue of the court case. Hence, Dr. Caesar's petition to eradicate the

contempt of court adjudication was denied.

Zipkin v. Freeman (1968) Supreme Court of Missouri

Mrs. Zipkin testified that while in treatment with Dr. Freeman, she had been his mistress and did anything he asked, including giving him money to buy personal property, stealing furniture for his sons, and suing her family for inheritance money. She stated Dr. Freeman indicated this was part of her treatment as a way to release pent-up hostility toward her family and would facilitate her need to be a man. Dr. Freeman denied the allegations.

Dr. Freeman was found liable for malpractice and liable for roughly \$18,000. His insurance company refused to pay the damages but the court compelled payment, holding that the doctor's behavior resulted from mishandling the transference phenomenon.

Roy v. Hartogs (1976) Supreme Court, Appellate Term, First Dept., New York

Julie Roy, the client, sued her psychiatrist, Dr. Hartogs, claiming he had sex with her over a 13-month period and that he indicated this was part of her prescribed therapy. Plaintiff's counsel argued that this improper treatment caused Roy to be hospitalized twice.

The initial damages awarded to plaintiff for approximately \$153,000 was lowered to an amount not to exceed \$25,000 based on defendant appeal which indicated Roy could "succeed" (hold a job), that her condition existed before becoming defendant's client, and that defendant had a condition called hydrocele which prevented him from having sexual intercourse.

Mazza v. Huffaker (1983) Court of Appeals of North Carolina

The client, Jeffrey Mazza, sued Dr. Robert Huffaker, a psychiatrist, for medical malpractice and criminal conversation. During therapy, plaintiff told Dr. Huffaker he was having marital problems, then one day found his wife in bed with Dr. Huffaker.

The court ruled that sex between a psychiatrist and the wife of a client would make previous treatment useless; trust with future therapists would be difficult to establish; harm can occur given a relationship changing from therapeutic to social; and therapy should not be terminated too abruptly or great harm may occur from such a disruption. The court awarded the plaintiff \$517,000.

Baker v. United States (1964) U.S. District Court

Mrs. Kenneth Baker, legal guardian for her husband, sued the United States due to her husband attempting suicide while under psychiatric care at an Iowa V.A. hospital. Dr. Kennedy, acting chief of the neuropsychiatric service and admitting physician, reviewed Mr. Baker's medical report indicating suicidal content was evident and he was informed by Mrs. Baker that her husband exhibited suicidal tendencies. Dr. Kennedy ordered that Kenneth be placed in an open ward and that he did not

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present a suicidal risk. Kenneth attempted suicide five days later by leaping 13 feet to the bottom of a concrete window well and sustained multiple injuries, including complete paralysis of his right side.

The U.S. district court identified the critical issue as whether Dr. Kennedy was negligent in failing to properly diagnose and it determined that “Dr. Kennedy exercised the proper standard of care required under the circumstances.” The court concluded that in the treatment of mental patients, “diagnosis is not an exact science. Diagnosis with absolute precision and certainty is impossible.”

Generally, a malpractice suit for faulty diagnosis must prove the diagnosis was incorrect, it was negligently made, and it culminated in damage to the client. Due to difficulty in diagnosing with absolute certainty, therapists are advised to make informed decisions and to seek consultation in difficult cases.

Geis v. Landau (1983)

Civil Court of the City of New York

Psychotherapist Dr. Jon Geis sued his former client of eight years, Betsy Landau, for unpaid psychotherapeutic services. Client told therapist she was experiencing divorce and it was difficult to pay for his services. Therapist decided it was unwise to refer client to a low-cost clinic and delayed payment. She knew delaying payment was a favor by therapist, but she felt “strangled” by him because of the mounting bill. Upon termination, client had an outstanding bill of \$8000 of which she paid \$4500.

The court determined that Dr. Geis exercised excessive power over an individual dependent upon him for problem-resolution. The judge felt there was another alternative (low-cost clinic) for treatment which would have resolved matters. The court approved of “extending credit to a patient,” but in a situation where therapist knows client has no means to pay, such credit is deemed unfair.

ETHICS CASE STUDIES

The following actual ethics case studies were adjudicated by the Committee on Scientific and Professional Ethics and Conduct (CSPEC) of the American Psychological Association (currently, the APA Ethics Committee adjudicates ethics cases). Each case summary highlights one of the nine principles within the 1979 revision of the *Ethical Standards of Psychologists* (APA, 1979). Cases were adjudicated either informally - CSPEC took final action because complainee (person complained against) agreed to committee’s suggestions, or formally - CSPEC filed ethics charges with APA’s Board of Directors indicating that in the committee’s opinion one or more principles of *Ethical Standards of Psychologists* was violated by complainee.

Based on CSPECs (1974) “Rules and Procedures,”

The objective of CSPEC with regard to the individual (complainee) shall in all cases be constructive and educative rather than punitive in charac-

ter, the intent being to exert a salutary influence on members found to have violated ethical principles. However, when the interests of the public or of the profession are in conflict with personal interests, the former must be of overriding concern. (p. 703)

Case 79-3-1

CSPEC received a newspaper clipping indicating a psychologist was ordered to repay money received from Medicaid claims and was placed on probation until such money was repaid. After confirming the report, CSPEC suspended the member from APA and required complainee justification to avoid APA expulsion. Complainee furnished letters from the case prosecutor and others informing all checks involved were returned before being cashed and the individual complied with authorities. CSPEC voted against expulsion, instead, it strongly censured the member and required lifting of suspension dependent upon member’s completion of one year’s tutelage from a licensed psychologist on ethics of private practice. The member accepted the arrangement (Sanders, 1979).

Case 80-1-2

A citizen wrote a letter requesting information from a psychologist whom she heard had published material relevant to her pending court case. The psychologist wrote back indicating some materials could be sent for a rather considerable amount of money and offered their services as an expert witness. The woman responded with a letter expressing disappointment and anger over feeling “solicited.” The psychologist replied with a defensive and condescending letter “diagnosing” her anger indicative of severe emotional problems requiring immediate therapy. The woman showed the letter to two psychologists who saw concern with the psychologist’s response and they, in turn, contacted the psychologist attempting to educate against offering unsolicited and unwarranted clinical statements and therapy recommendations. The two psychologists contacted CSPEC after failure to resolve the situation with the psychologist.

CSPEC learned that the psychologist had recently resigned from APA which terminated its pursuit of the case, but the committee wrote a letter stating the psychologist’s letter likely would have been viewed as unethical (Sanders & Keith-Spiegel, 1980).

Case 80-4-1

Several psychologists sent CSPEC an advertising brochure of an APA member which was being circulated due to concern it was unprofessional. The brochure contained flamboyant testimonials regarding the member’s clinical assessment, made exaggerated claims not demonstrated by proven findings, created expectations of favorable results, and implied other comparable techniques were inferior.

CSPEC asked the psychologist to stop disseminating the brochure which violated ethics relating to advertising of services (Sanders & Keith-Spiegel, 1980).

Case 80-2-2

The complainant is a former government employee who was reassigned to a less stressful job due to a psychological

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evaluation made by a clinical psychologist. Complainant showed the report to another psychologist who concluded that the MMPI test scores and 40 minute interview “do not sustain” the first evaluation. Complainant used this opinion and the second psychological evaluation as grounds for filing an ethics complaint against the original psychologist.

Complainee submitted to CSPEC requested raw data used to make the evaluation along with a psychiatric consultant report indicating that complainant “apparently suffered from a manic-depression illness approximately a year ago...” (two years before the psychological evaluation) and that complainant should not be considered for a position of higher responsibility “at this time.”

CSPEC asked the opinion of two independent diplomates in clinical psychology of the psychological evaluation quality in relation to the *Ethical Standards of Psychologists*; they resolved that complainee probably reached the right conclusions for the wrong reasons. The conclusions based on the MMPI were inaccurate, therefore, they suspected conclusions were based on the psychiatric consultant report which complainee accepted uncritically. They concluded the psychological evaluation was thoroughly unprofessional and that most graduate students would do better.

CSPEC shared the independent report with complainee and offered admonition to complete future test administration and interpretation in agreement with *Ethical Standards of Psychologists* (Sanders & Keith-Spiegel, 1980).

These cases reveal options that were available to CSPEC and are currently available to APA’s Ethics Committee to resolve ethics complaints thus assuring public protection, maintaining standards of the profession, and providing due process to complainee members.

CONCLUSION

Ethical, legal, and professional issues which therapists are likely to encounter in their counseling practice have been examined. Indeed, professional codes of ethics are fundamental for ethical practice, however, simply knowing these codes is just the beginning. The ability to think critically and apply general ethical principles to specific situations is vital.

The ethical codes of various professional organizations offer a degree of guidance, but these guidelines do not deal with every situation nor do they answer every question. At times, interpretation and application of the codes of ethics in specific cases is difficult. Thus, practitioners possess some freedom to exercise professional judgment to promote the welfare of their clients. This freedom must be tempered with informed and sound information because the mental-health professions’ codes of ethics are binding on their members. Practitioners should know the ethical codes of their specialty, be aware of consequences for actions not sanctioned by their organization, and seek consultation when in doubt.

Lanning (1997) summarizes the process of ethical decision-making as follows:

We can consult with our colleagues, call an ethics professor, read the ethics books, and more; but when we make the final decision, it is ours alone. We alone are responsible and accountable for the consequences. Nevertheless, the ability to reason with the ethical principles and arrive at a decision for which we are willing to be accountable is what makes counseling practice ethical. That is a difficult but not impossible task and one that in many ways determines the level of our professionalism.

Developing a sense of professional and ethical responsibility is an on-going process which may evolve, with proper nurturing, into the ability to resolve ethical dilemmas and consistently promote the best interest of our clients.

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TEST - ETHICS

6 Continuing Education Hours

Record your answers on the Answer Sheet (click the "Illinois Answer Sheet" link on Home Page and either click, pencil or pen your answers).

Passing is 70% or better.

For True/False questions: A = True and B = False.

TRUE/FALSE

1. **Ethics may be defined as moral principles which provide rules for right conduct.**
A) True B) False
2. **Ethics codes protect the public and provide guidance to professionals in serving their clientele.**
A) True B) False
3. **Therapy without informed consent is within the standard of care and would never result in liability.**
A) True B) False
4. **Therapists must make a report to an appropriate authority given knowledge or suspicion of child abuse.**
A) True B) False
5. **Failure to keep adequate client records breaches the standard of care expected of therapists.**
A) True B) False
6. **Consultation and documentation are recommended measures against malpractice liability in suicidal cases.**
A) True B) False
7. **Bartering therapy for goods or services is a type of dual relationship which can harm the therapy process.**
A) True B) False
8. **The therapist obligation to uphold client confidentiality applies in all situations with all clients.**
A) True B) False
9. **Sex between therapist and client may potentially result in client symptoms indicative of rape and battered-spouse syndrome.**
A) True B) False
10. **Informed consent is designed to define and clarify the therapeutic relationship.**
A) True B) False

17 Continuing Psychology Education

Continuing Psychology Education is approved by the Illinois Department of Financial and Professional Regulation as a continuing education sponsor for LCSWs and LSWs (license # 159-000806), and for LCPCs and LPCs (license # 197-000108). This course, Ethics, is approved by the Illinois Department of Financial and Professional Regulation for 6 hours of continuing education for LCSWs, LSWs, LCPCs and LPCs.

11. **Ethics promotes _____ standards of performance determined by the profession.**
A) maximum or ideal
B) the lowest
C) arbitrary
D) static
12. **Three factors relevant to the legal definition of informed consent include: capacity, voluntariness, and**
A) origin
B) comprehension of information
C) consequence
D) dispute
13. _____ **is a legal concept involving negligence and accompanying client injury or loss.**
A) Subpoena
B) Writ of habeas corpus
C) Malpractice
D) Habendum Clause
14. **Therapists working with potentially dangerous clients are recommended to _____.**
A) inform client of confidentiality limits
B) record steps taken to protect others, if necessary
C) seek consultation
D) all of the above
15. _____ **prevents therapists from revealing client confidential information during legal proceedings.**
A) privileged communication
B) Tarasoff decision
C) Thapar versus Zezulka case
D) duty to warn

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16. **Revisions to ethics codes for mental-health associations**
- A) periodically occur as new issues arise possibly affecting client-welfare.
 - B) never occur.
 - C) are amended monthly.
 - D) is viewed as unnecessary.
17. **Lawsuits brought against therapists**
- A) are never in favor of the client.
 - B) are relatively few but on the rise.
 - C) are never due to violation of client rights.
 - D) never have evidence to support the case.
18. **The U.S. Supreme Court ruling in the case of Jaffee versus Redmond highlights the importance of**
- A) the duty to warn.
 - B) protecting suicidal clients.
 - C) confidentiality toward successful treatment.
 - D) multicultural counseling.
19. **In marital and family therapy, therapists must assess their own values in order to avoid**
- A) taking sides with one family member against another.
 - B) imposing their values on family members.
 - C) persuading the marriage should be maintained.
 - D) all of the above.
20. **Effective informed consent procedures**
- A) reduce client misunderstanding and liability.
 - B) maximize odds of liability claims.
 - C) should never be in written form.
 - D) avoid discussion of therapy benefits and risks.

Please transfer your answers to the Answer Sheet (click the “Illinois Answer Sheet” link on Home Page and either click, pencil or pen your answers, then fax, mail or e-mail the Answer Sheet to us). Do not send the test pages to Continuing Psychology Education; you may keep the test pages for your records.

Press “Back” to return to “Illinois Courses” page.