# ETHICS: CASE STUDIES II

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION HOURS

"What makes an action right is the principle that guides it."
T. Remley and B. Herlihy (2007)

**Course Objective**
The purpose of this course is to provide an understanding of the concept of ethics as related to therapists. Major topics include: confidentiality, dual relationships, common boundary issues, sexual dual relationships, and legal/ethics case studies.

**Accreditation**
This course is approved by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Approved Education Provider Program (NAADAC Provider # 438), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC Provider # 1S-07-397-1013), and the California Association for Alcohol and Drug Educators (CAADE Provider # CP40 909 H 1113).

**Mission Statement**
Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of alcohol, drug, and addiction counselors. 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. Explain the meaning and purpose of ethical behavior.
2. Acknowledge the ethical importance of confidentiality.
3. Describe the importance of managing boundaries and avoiding dual relationships.
4. Identify common boundary issues.
5. Emphasize the hazards of sexual dual relationships.
6. Interpret various Codes of Ethics.
7. Apply ethical standards to case studies.

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## INTRODUCTION

The ethical considerations of therapists are becoming greater in number and complexity. Managed care requires practitioners to consider issues of confidentiality and delivery of competent treatment while other decisions may involve informed consent, multiple relationships with clients, and breaking confidentiality given clients' dangerous behavior. These deliberations are occurring within a changing culture as the populations which counselors treat are increasingly diverse raising questions of competency and availability of mental health services. Further, therapists are operating in a society that is increasingly litigious, hence, the need for codes of ethics by the various mental health professional organizations offering guidance is quite clear.

Historically, the concepts of standards of practice and accountability appear to have developed simultaneously with the description of physician duties (and other occupations) in ancient Egypt approximately 2000 B.C., as indicated in the Code of Hammurabi (American College of Physicians, 1984) in which a fee structure and punishments for poor results were recommended. The Hippocratic Oath, written roughly 400 B.C., is a well-known example of a professional code of ethics that was formulated by members of the medical profession and indicated obligations of the professional to the profession and to members of society. This physicians guide of that era professed some outdated doctrines such as forbidding removal of kidney stones but it also highlighted maintaining confidentiality and avoiding sexual relations with patients (patients of both sexes and slaves). The Hippocratic Oath promotes many of the key ethical principles and values inherent in modern codes of ethics (Sinclair et al., 1996). The American Psychological Association (APA) began development of a code of ethics following World War II given increased professional activity and public exposure of its members. The profession offered successful war-related services such as creation of group tests to help the armed services ascertain the draft eligibility of young men and delivery of mental health services to hospitalized soldiers upon returning home. The goal was to create a code that would "be effective in modifying human behavior… specifically, the behavior of psychologists" (Hobbs, 1948, p. 82). The process involved a critical incident technique of asking APA members to use firsthand knowledge in describing a situation whereby a psychologist made a decision having ethical implications and to express the accompanying ethical issues. Nicholas Hobbs chaired the committee that reviewed over 1000 such incidents and identified essential ethical themes relating to psychologists' relationships and responsibilities to others, including clients, students, research participants and other professionals. Hobbs articulated, "In a field so complex, where individual and social values are yet but ill defined, the desire to play fairly must be given direction and consistency by some rules of the game. These rules should do much more than help the unethical psychologist keep out of trouble; they should be of palpable aid to the ethical psychologist in making daily decisions" (Hobbs, 1948, p. 81). Many of the reported incidents mirrored the political atmosphere of the postwar era, for instance, the effects of McCarthyism on academic freedom, and concerns of psychologists working in industry being asked to design tests that would maintain racial segregation in the workplace. These incident reports led to drafting an ethical code which was debated in psychology departments and at state, regional and national professional meetings. The first formal APA code of ethics was adopted in 1953, and it has undergone nine revisions. Currently, the Ethics Committee adopts new standards based on contemporary complaints and issues within the profession.

This course uses cases that have been adapted from actual incidents to illustrate realistic and common ethical issues facing practitioners; the names have been omitted to protect the privacy of those involved except when cases are already public information through books, newspapers, or media. Codes of ethics, which represent moral principles created by the various mental health organizations to provide guidance for right conduct and are binding on their members, and key literature, are utilized to assist practitioners in making sound ethical decisions promoting the welfare and best interests of their clients and to avoid ethical conflicts.

## CONFIDENTIALITY

The confidential bond between mental health professionals and their clients represents an important professional obligation and enduring foundation within the helping profession. Some have argued that therapy might be ineffective without the trust that confidentiality breeds (Epstein, Steingarten, Weinstein, & Nashel, 1977). In referring to the amicus briefs of the American Psychological and Psychiatric Associations, Justice Stevens states, "Effective psychotherapy … depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment" (*Jaffe v. Redmond*, 1996). Cullari (2001) surveyed clients on their most important expectations and demands of therapy and two of the highest ratings were "a feeling of safety and security" and "the chance to talk to someone in a safe environment and without fear of repercussion" (p. 104). Interestingly, research reveals only mixed support for the assumption that confidentiality is required for effective therapy. Some studies support that privacy assurances are necessary (McGuire, Toal, & Blau, 1985; Merluzzi & Brischetto, 1983; Miller & Thelan, 1986), while other findings show such assurances have minimal effect on encouraging disclosures (Muehleman, Pickens, & Robinson, 1985; Shuman & Weiner, 1982; Schmid, Appelbaum, Roth & Lidz, 1983), and that limits to


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confidentiality affect only some clients in some circumstances (Taube & Elwork, 1990; VandeCreek, Miars, & Herzog, 1987). Even without indisputable evidence, confidentiality is a cornerstone in the mental health field.

The historical origin of the mental health field sheds insight into the norm of confidentiality. Until approximately the dawn of the 19th century, mental illness was perceived as being supernatural, demonic and associated with visions of "lunatics" bound in chains in asylums. Relevant progress in understanding mental illness began in the 1800s and it was not until the 1960s that deinstitutionalization of the mentally ill brought this population back into society. Further, the development of psychoanalysis in the early to middle 1900s required patients of Freudian analysts to work through their socially unacceptable yearnings, sexual fantasies and repressed thoughts and feelings within a culture promoting Victorian social mores. Our early conceptions of mental illness combined with our opinion about the essence of personal disclosures in analysis notably contributed to forming a social stigma. Within such an environment, clients needed complete privacy and assurance that their having pursued and received treatment would not be revealed. Finally, in the mid 1900s, several positive influences in the mental health field materialized inducing an attitude change away from therapy being only conducive for the mentally ill or sexually repressed: Carl Rogers' humanistic ideology, theorists emphasizing the natural developmental life stages that people universally move through, and the career guidance movement. Simultaneously, the health sciences started to discover the biological bases for several mental disorders and that medications could improve conditions previously thought to be untreatable; the mental illness and psychotherapy stigma was now reduced. Nevertheless, in current times, a notion still exists that it is somewhat shameful to seek the assistance of a mental health professional. As noted in the last paragraph, the U.S. Supreme Court, in its 1996 decision in *Jaffee v. Redmond* (1996, p. 8.) explained, "…disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace."

The concepts of confidentiality and privileged communication stem from society's conviction that individuals have a right to privacy. Privacy refers to the rights of people to decide what information about themselves will be shared with or withheld from others. Confidentiality is an ethical principle relating to the therapist's obligation to respect the client's privacy and to protect the information revealed during therapy from disclosure without client's explicit consent. Privileged communication is a legal concept that protects clients from having confidential information during therapy disclosed in a court of law without their permission.

Bok (1983) believes that confidentiality is based on four principles. "Respect for autonomy" means that therapists acknowledge clients' ability to be independently functioning and to make wise choices; regarding confidentiality, counselors respect the rights of clients to decide who should know what information. The second principle, "respect," applies to valuing human relationships and the intimate nature in which personal secrets are shared. Third, practitioner is obligated to offer client a "pledge of silence" in that therapist is bound to a pledge, in word and deed, to protect clients' secrets from disclosure. The final basis for confidentiality is "utility," meaning that confidentiality in therapeutic relationships is useful to society, because people would be hesitant to seek help without a pledge of privacy. In essence, society relinquishes its right to certain information and accepts the risks of not being cognizant of some problems and dangers in society in exchange for the attained advantage of its members acquiring improved mental health.

Studies indicate that only 1% to 5% of complaints registered with ethics committees and state licensing boards of counselors and psychologists pertain to confidentiality violations (Garcia, Glosoff, & Smith, 1994; Garcia, Salo, & Hamilton, 1995; Neukrug, Healy, & Herlihey, 1992; Pope & Vetter, 1992; Pope & Vasquez, 1998). It seems that practitioners honor the pledge to maintain their clients' confidentiality. Grabois (1997/1998) stated that there are only a few cases of mental health professionals having been sued for breaching confidentiality but she suspects this number will rise because more people are presently seeking counseling. Four years of annual reports by the APA Ethics Committee revealed that the violation of "Privacy and Confidentiality," including professional and scientific activities of all APA members (APA, 1992), was the fifth most frequent allegation yielding opened cases (American Psychological Association, Ethics Committee, 1994, 1995, 1996, 1997). Contrarily, statistics on formal complaints and disciplinary actions may significantly underestimate the prevalence of breaches in confidentiality. One national study found that 61.9% of psychologists reported that they had unintentionally violated their clients' confidentiality, and clients may not have been aware of the breaches (Pope, Tabachnick, & Keith-Speigel, 1987). Another national study determined that the most-often reported intentional violation of the law or ethical standards by experienced, prominent psychologists involved confidentiality (Pope & Bajt, 1988). A national survey discovered that 10% of therapists who were in therapy themselves reported that their own therapist violated their confidentiality rights (Pope & Tabachnick, 1994). The frequency of such breaches is not surprising given new technologies such as the computer, faxes, e-mail, and cellular phones which require special security considerations due to new risks for unintentional, and possibly intentional, confidentiality breaches.

Complex computer networks may be used in some settings to manage records of assessment, treatment, billing, and other health care features. Gellman & Frawley (1996) advise that a secure computer system: 1) disallows unauthorized users access to information, 2) maintains ongoing integrity of data by preventing alteration or loss, verifies the source of information to confirm its authenticity, and keeps a record of

communication to and from the system, and 3) recovers quickly and effectively from unanticipated disruptions. Koocher and Keith-Spiegel (2008) suggest the following to manage electronic records:

- Use encryption software to protect data transmission; protect stored information with complex passwords, and Internet firewalls.
- Consult on security measures with professionals when storing files with a common server or backing them up on an institutional system or hub.
- Keep removable data storage media in secure places or use complex passwords to encrypt them.
- Do not share passwords with others and frequently change the passwords.
- Be alert to security concerns when using wireless devices.
- Avoid revealing confidential information in e-mail or instant messaging without encryption.
- Protect the physical security of portable devices such as laptops, smaller computers, personal digital assistants, and smart phones.
- Use privacy screens to shield monitors and other screens from observation by others.
- Update virus protection software and other security systems.
- Remove all information when disposing old computers, which may require professional assistance, because some information may remain after erasing files or reformatting disks.

The Ethical Standards for maintenance, dissemination, and disposal of confidential records of professional and scientific work expound the following:

If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers (APA, 2002, 6.02.b.).

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 (AAMFT, 2001, 2.4).

Social workers documentation should protect clients' privacy to the extent that is possible and appropriate… (NASW, 1999, 3.04.c.).

Counselors ensure that records are kept in a secure location and that only authorized persons have access to records (ACA, 2005, B.6.a.).

Confidentiality can be a difficult ethical issue because it is not absolute in all cases – sometimes confidentiality may or must be breached. Therapists must inform clients at the beginning that limits to their confidentiality exist, as the following codes express:

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached (ACA, 2005, B.1.d.).

Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant (APA, 2002, 4.02.b.; APA, 2002, 4.02.a. - already cited).

Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contact, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures (AAMFT, 2001, 2.1).

(NASW, 1999, 1.07.e. - already cited).

Prospective clients may be unaware that confidentiality is not absolute. A survey of the general public found that 69% believed that everything disclosed to a professional therapist would be strictly confidential, and 74% thought there should not be any exceptions to upholding confidentiality (Miller & Thelan, 1986). Therapists are advised to overcome concern that explaining exceptions to confidentiality to new clients may limit their self-disclosure as some studies indicate very little evidence that describing confidentiality limits in detail inhibits client disclosures. Other research concluded that advantages of informing clients about limits prevail over disadvantages in terms of inhibited disclosure (Baird & Rupert, 1987; Muehleman et al., 1985).

Sometimes it is permitted to share client information with others with the goal of promoting client welfare, and client has given consent, these situations include:

- When therapist consults with experts or peers
- When therapist is under supervision
- When other mental health practitioners request information

Information may also be shared with clerical or other assistants who handle confidential information.

Federal and state laws mandate the reporting of suspected child abuse or neglect, and statutes often require the protection of others with reduced capacity to care for themselves such as the elderly and institutional residents. Taylor & Adelman (1995) recommend a statement, similar to the following, to inform a minor that confidentiality cannot be guaranteed:

> Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the police about it. If you tell me you have made a plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people? (p. 198).

They suggest adding a buffer statement along the lines of the following:

> Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you (p.198).

The confidentiality requirement does not apply when clear and imminent danger to the client or others exists. This duty to warn, arising from the Tarasoff case (1974), in California, applies to a number of states, but variations exist across the states regarding whether therapists may or must warn, to whom a warning is given, and under what circumstances. Therapists are advised to know their state laws regarding a duty to warn (this topic is covered in more detail in the first Ethics course by Continuing Psychology Education Inc.).

Briefly stated, 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, many other states have embraced and codified the duty to warn requirement. Practitioners are advised to know their specific state law because the duty to warn varies from state to state.

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. Essential, is protecting the client in such a situation, in turn, breaching confidentiality is permitted. As indicated in the previous section, therapists are advised to know their specific state law regarding the duty to warn and protect in a suicidal situation.

The duty to warn ethics codes are articulated below:

Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed (NASW, 1999, 1.07.c.).

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to 1) provide needed professional services; 2) obtain appropriate professional consultations; 3) protect the client/patient, psychologist, or others from harm; or 4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose (APA, 2002, 4.05.b.).

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues (ACA, 2005, B.2.a.).

(AAMFT, 2001, 2.1 - already cited).

Confidentiality cannot be guaranteed when counseling groups or families because therapists cannot guarantee the behavior of group members. Practitioners, from the outset, must inform clients of the concept of confidentiality, the parameters of the specific group, who the client is, how confidentiality matters will be addressed, how family secrets and information provided by one member may be disclosed by therapist with other members, and that confidentiality cannot be assured. Ethical Standards pertaining to therapy involving couples and families cite the following:

In couples and family counseling, counselors clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known (ACA, 2005, B.4.b.).

Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibit by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual’s confidences to others in the client unit without the prior written permission of that individual (AAMFT, 2001, 2.2).

When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset 1) which of the individuals are clients/patients and 2) the relationship the psychologists will have with each person. This clarification includes the psychologist’s role and the probable uses of the services provided or the information obtained (APA, 2002, 10.02).

When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual’s right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements (NASW, 1999, 1.07.f.).

When therapists must testify in court and their clients request them not to reveal disclosed information during therapy, therapists should ask the court not to require the disclosure and indicate the possible harm to the therapeutic relationship. If the judge still requires the disclosure then therapist should only reveal essential information; in such a case, practitioners need not worry about being sued for violation of privacy because compliance with a judge’s order is a defense to any charge of wrongdoing (Prosser, 1971). Note that a subpoena may not be valid, therefore, confidential or privileged information should not be disclosed given a subpoena until an attorney representing the therapist has advised to do so.

Clients may feel betrayed when therapy records become part of their general medical or health record in an HMO or other managed care facility, and may become privy to third parties. Confidentiality questions within managed care have surfaced because these organizations generally request more information historically considered as private to manage allocation of resources and eligibility compliance. Not all clients understand that submitting a claim for mental health services leads to the provider of services sharing information such as diagnosis, type of service offered, dates of service, duration of treatment, and so on. Sometimes, insurers or companies assigned to manage mental health benefits may be authorized to seek detailed information from case files, for example, client’s current symptom status, treatment plan specifics, or other personal material. Insurance companies may not protect such information as diligently as the provider of services, hence, confidentiality lies beyond the control of therapists in this circumstance. Some insurance companies participate in rating bureaus or other reporting services that can become accessible to other companies in the future. A public case noted how a business executive was denied an individual disability insurance policy because he received therapy for family and work stress. Disability underwriters explained this denial as very commonplace practice, additionally, some insurers may deny health or life insurance policies given a history of therapy (Bass, 1995).

Koocher and Keith-Speigel (2008) indicate a particular therapist’s statement to clients concerning the issue of disclosure to insurance companies: “If you choose to use your coverage, I shall have to file a form with the company telling them when our appointments were and what services I

performed (i.e., psychotherapy, consultation, or evaluation). I will also have to formulate a diagnosis and advise the company of that. The company claims to keep this information confidential, although I have no control over the information once it leaves this office. If you have questions about this, you may wish to check with the company providing the coverage. You may certainly choose to pay for my services out of pocket and avoid the use of insurance altogether, if you wish." Clients lack much control because refusal to authorize release of information results in the insurer's refusal to pay the claim. Some clients feel unaffected by this process whereas others, perhaps in a sensitive work position, may consider not informing a third party of their treatment involvement. Further, some employers use self-insurance programs that may send claim forms or information to that company's headquarters thus alerting management. It may benefit some clients to learn the channels through which their personal information will travel.

> Managed care companies generally ask for much more information than third parties have traditionally requested from clinicians. The ethical explanations given for such requests generally have fallen into two categories. One is based on the known history of some clinicians to distort information on forms… Then managed care companies began to discover that some clinicians charged for sessions not provided or approved. A more general reason applicable to all clinicians is to make sure that the intended treatment meets criteria of medical necessity as designated in the third-party benefits. In addition to treatment plans, managed care companies will often ask for copies of any notes kept on patients; they sometimes do on-site reviews of charts in hospitals, and on occasion they even talk directly to the patient to try to verify information (Moffic, 1997, p. 97).

The council of the National Academies of Practice (including medicine, dentistry, nursing, optometry, osteopathic and podiatric medicine, psychology, social work, and veterinary medicine) adopted the "Ethical Guidelines for Professional Care in a Managed Care Environment," and confidentiality is one of five guidelines indicated as a primary concern. The National Academies of Practice recognize that utilization and quality assurance reviews are functional in a health care system, but they also promote safeguards to protect confidentiality of patient/client data and practitioner clinical materials, and to obtain client consent. They conclude, "the rationale for this position is founded on the patient's autonomous right to control sensitive personal information. It is further based upon an historical recognition in the Oath of Hippocrates and corroborated throughout the centuries, of the enduring value of preserving confidentiality in order to enhance mutual trust and respect in the patient-provider relationship" (p.5).

Case 3-1: In 2007, Blue Cross and Blue Shield of Massachusetts (BCBSMA) declared that it planned to utilize an outcomes measurement program using the Behavioral Health Laboratories Treatment Outcomes Package (BHL TOP) for voluntary usage with all of their subscribers who sought mental health services. Therapists would ask their clients at the outset of treatment to voluntarily complete the form and intermittently thereafter. The forms would be sent electronically to BHL for scoring and data storage and feedback reports would be sent to the therapists and BCBSMA; data security was promised. Therapists were instructed that they would receive increased reimbursement rates given large numbers of their clients completing the form. Some of the form questions included sexual orientation, family income, religion, detailed usage patterns for alcohol, cocaine, crack, PCP, heroin, and other illegal substances, and arrest/incarceration history.

Analysis: Several professional organizations indicated the following ethical concerns with this plan: 1) Therapists would be asking clients to voluntarily relinquish their privacy and would be financially rewarded for obtaining completed forms, 2) Client data would be stored in electronic databases without explanation of its use or affect upon the participants, 3) Though data storage security is mentioned, concerns exist due to recent breaches by private institutions and federal agencies, 4) Client disclosure of such personal information, including admittance to illegal behavior, represented potential risk to clients. The forms would become part of their permanent record and open to discovery in some legal proceedings, and 5) BCBSMA originally did not plan to inform their subscribers of these risks, instead, practitioners were given sample text of a highly self-serving nature. The Massachusetts Psychological Association helped practitioners by suggesting objective text for informing clients about the form highlighting its voluntary nature, that form-completion refusal would not affect their care, practitioners could not control the information after transmittal to BCBSMA, and that financial incentives were presented to practitioners. Amidst professional criticism, BCBSMA made some modifications to their public information, without admitting to any ethical issues or how the information will be used (Koocher & Keith-Spiegel, 2008).

Case 3-2: Client alleged that psychologist sent copies of his case notes to the insurance carrier responsible for reimbursement and that therapist should not have revealed this information. Client reported psychologist to the APA Ethics Committee for violating confidentiality principles. Psychologist explained to Ethics Committee that any client understands that their confidentiality may be breached when using an insurance company for third-party reimbursement due to administrative and professional peer review. Nonetheless, psychologist never informed client of this risk before therapy began, rather, he assumed client "must understand" the protocol.

Adjudication: The Ethics Committee determined that psychologist violated the confidentiality ethical standard by not informing client of the limits of confidentiality prior to treatment. The Committee reprimanded the psychologist and

advised him to construct and implement an effective informed consent process for the future (APA, 1987).

Case 3-3: After the deaths of Nicole Brown Simpson and Ron Goldman (Hunt, 1999), Susan J. Forward, an LCSW who had two counseling sessions with Ms. Simpson in 1992, breached confidentiality in an unsolicited manner by stating in public that Ms. Simpson had allegedly revealed experiencing abuse by O.J. Simpson.
Analysis: The California Board of Behavioral Science Examiners barred Ms. Forward from seeing clients for 90 days and issued a 3-year probation. Deputy Attorney General Anne L. Mendoza, who represented the board, articulated, "Therapy is based on privacy and secrecy, and a breach of confidentiality destroys the therapeutic relationship" (Associated Press, 1995). Clients have some rights to confidentiality beyond their death (Koocher & Keith-Spiegel, 2008).

Case 3-4: Theresa Marie Squillacote and her husband, Kurt Stand, were convicted of espionage. Squillacote had a law degree and worked for the U.S. Department of Defense performing duties requiring security clearance. In 1996, the FBI secured a warrant to conduct secret electronic surveillance of Squillacote's conversations at home and work. Using these monitored conversations coupled with discussions with her psychotherapists, an FBI Behavioral Analysis Program team (BAP) made a report of her personality for use in the investigation. The BAP report stated that she experienced depression, took antidepressant medications, and manifested a "cluster of personality characteristics often loosely referred to as 'emotional and dramatic.' " The BAP team recommended taking advantage of Squillacote's "emotional vulnerability" by describing the type of individual that she could have a relationship with and, in turn, disclose classified information. Eventually, she did reveal national defense secrets to a government official who pretended to be a foreign agent and employed strategies presented by the BAP team (United States v. Squillacote, 2000). This case, and the next, show the potential intrusion of government security agencies into psychotherapy.

Case 3-5: Samuel L. Popkin, an assistant professor of government at Harvard University, on November 21, 1972, was imprisoned under a U.S. district court order due to refusing to answer some questions before a federal grand jury that was investigating the publication of the "Pentagon Papers." Popkin declared a First Amendment right to refuse to disclose the information gathered during his scholarly research on Vietnam and the United States involvement there. The court ordered his confinement for the duration of the grand jury's service, which lasted seven days. The U.S. Supreme Court later refused to review the order that caused his confinement (Carroll, 1973).
Analysis: Popkin taught political science but it is assumed that his confinement would have been the same had he taught, for example, psychology, while researching the psychodynamics of past political figures. Though such research generally requires some promise of confidentiality to respondents, "national security interests" was the rationale for the courts to overrule any claim of privilege or assertion of confidentiality.

Case 3-6: Therapist sent a third billing notice to a slow-to-pay client's fax machine in her office but client did not report to work that day. The bill was titled "psychological services rendered" and handwritten in large print was "Third Notice – OVERDUE!!" with client's name. This notice sat in an open access mail tray of the busy office all day.
Analysis: Therapist should have reasoned that many people have access to the fax machine in a busy place of business. Private material should not be faxed unless it is known that the intended recipient will be retrieving the information. Moreover, a creditor message forwarded to a client's workplace may violate debt collection laws (Koocher & Keith Spiegel, 2008).

Case 3-7: David Goldstein, a Ph.D. and MFT, had treated Geno Colello, a former Los Angeles policeman, for three years. Therapy centered on work-related injuries and the breakup of his 17-year relationship with Diana Williams, who began to date Keith Ewing. On June 21, 2001, by telephone, Colello allegedly told Dr. Goldstein that he was thinking suicidal thoughts. Goldstein recommended hospitalization and he asked for permission to talk with client's father, Victor Colello. Victor reportedly informed Goldstein that his son was highly depressed, had lost his desire to live, could not accept Diana dating another man, and that Geno contemplated harming Ewing. Geno signed himself in as a voluntarily patient at Northridge Hospital Medical Center on the eve of June 21, 2001. Goldstein received a phone call from Victor, the next morning, stating the hospital would soon release Geno, in turn, Goldstein called the admitting psychiatrist and urged him to maintain close observation of Geno through the weekend. The psychiatrist disagreed and discharged Geno, who did not have further contact with Dr. Goldstein. On June 23, 2001, Geno Colello shot Keith Ewing to death then killed himself with the same handgun.

Keith Ewing's parents filed a wrongful death lawsuit naming Dr. Goldstein as one of the defendants (*Ewing v. Goldstein*, 2004), claiming he had a duty to warn their son of the risk established by Geno Colello. A judge dismissed the case against Dr. Goldstein, who asserted that his client did not disclose a threat directly to him. Ultimately, the California Court of Appeals reinstated the case, explaining, "When the communication of a serious threat of physical violence is received by the therapist from the patient's immediate family, and is shared for the purpose of facilitating and furthering the patient's treatment, the fact that the family member is not technically a 'patient,' is not crucial." The court expressed that psychotherapy does not occur in a vacuum, and that for therapy to be successful, therapists must be aware of the context of a client's history

and his or her personal relationships. The court advised that communications from clients' family members in this context comprised a "patient communication."

Case 3-8: Psychotherapist evaluated an 8 year-old boy at his family's request due to school problems. The evaluation involved a developmental and family history, meeting with both parents, assessing school progress reports, and administering cognitive and personality tests. Therapist observed that client had a mild perceptual learning disability and was not coping well with several family stressors, including his mother's response to paternal infidelity, his father's recent learning that the boy is not his child, and other relevant family secrets. Therapist recommended counseling which the boy had begun. Some weeks later, therapist received a signed release form from the boy's school asking for "any" information available concerning the boy's problem. Therapist sent a letter to the school explaining the cognitive test results and referring only in general terms to "emotional stresses in the family that are being attended to."
Analysis: Therapist correctly responded to the school's need to learn information that could benefit this student, and did so by discriminating between relevant versus irrelevant information for the school's purpose. Despite the school's vague request for "any" information, therapist assessed that some of the family disclosures were not relevant to the school's role (Koocher & Keith-Spiegel, 2008). The Codes of Ethics support "minimal disclosure" as follows:
When consulting with colleagues, … psychologists disclose information only to the extent necessary to achieve the purposes of the consultation (APA, 2002, 4.06).
To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed (ACA, 2005, B.2.d.).
(AAMFT, 2001, 2.6 - previously cited).
(NASW, 1999, 1.07.c. - previously cited).

Case 3-9: Janet Godkin underwent treatment as a voluntary mental patient several times at three different New York hospitals between 1962 and 1970. She and her husband chose to write a book about these experiences and requested access to her records to verify some of the events. The requests were denied leading to a lawsuit against the New York State Commissioner of Mental Hygiene and the directors of the involved hospitals ("Doctor and the Law," 1975).
Analysis: The judge affirmed the refusal to provide the records when the hospitals indicated their preference to release the records to a different professional as opposed to the client herself. Hospital staff argued that the records are unintelligible to the layperson; some information could be detrimental to the person's current well-being; and the records might refer to other individuals, who could be harmed by disclosure (Roth, Wolford, & Meisel, 1980). The judge expressed that records are property of the practitioner or hospital, and client consults practitioner for services, not for records ("Doctor and the Law," 1975). In a different case, the New York Supreme Court granted Matthew C. Fox, a former patient of the Binghamton Psychiatric Center, complete access to his medical records even though the center argued this would be antitherapeutic (*Fox v. Namani*, 1994). Fox sued the center for malpractice and acted as his own attorney. Currently, HIPAA grants clients access to their records.

Case 3-10: James Hess, Ph.D., treated Cindy Weisbeck from November, 1986, to June, 1987, at the Mountain Plains Counseling Center in South Dakota. He hired her as a part-time secretary at the center, which he owned, in September of 1987. Dr. Hess allegedly initiated a sexual relationship with Ms. Weisbeck twenty months after their therapy ended. James Weisbeck, Cindy's husband, sued. Mr. Weisbeck sought access to a list of Hess's patients dating back seven years and the right to depose Hess's personal therapist, Tom Terry, a social worker, in order to prove that Hess repeatedly sexually exploited vulnerable female clients (Weisbeck v. Hess, 1994).
Analysis: The South Dakota Supreme Court denied the request to view client records and the right to depose Hess's therapist. The court's rationale was not protecting client privacy, rather, the APA ethics code, at that time, did not recognize Hess's behavior as a "harmful act."

The following three cases depict confidentiality issues in using modern technology ((Koocher & Keith-Spiegel, 2008):
Case 3-11: Therapist updated various cases on her laptop computer while on a flight. While completing a treatment summary on a new client, she heard the standard flight instructions to turn off all electrical equipment and prepare for landing. She saved the file to hard disk, backed it up on a removable flash memory chip, put the stick in the seat back pocket, then packed up her computer. The plane hit some air turbulence causing practitioner to become momentarily disoriented. She ultimately left the plane without recovery of the memory chip and later called the airline for assistance but the chip was not returned.

Case 3-12: Practitioner received a faxed HIPAA-compliant release of information form from a counselor in another city requesting information about one of the practitioner's former clients. Practitioner noticed an e-mail address indicated on the new counselor's letterhead to which he transmitted the requested files. Practitioner was interrupted by a phone call during the e-mail process culminating in his sending the material to the wrong e-mail address – to 3500 subscribers on the International Poodle Fanciers list server.

Case 3-13: Counselor bought twelve new desktop computers for the clinic that she managed and kindly donated the older clinic computers to a local community center. She diligently deleted all the word processing and billing files she could find before sending the older computers.
Analysis: Therapists are recommended to consider confidentiality issues when utilizing modern technology. In the first case, usage of readily available encryption

technology for confidential files would have protected the contents. The second case required determining the security and accuracy of recipient's e-mail address and carefully executing such as is advised whenever transmitting confidential material by e-mail, fax, or any electronic means. In the third case, only deleting files on a hard drive will not permanently remove the information, and in some instances, reformatting a drive may not prevent some information from being recovered. Professional computer consultation is advised when disposing computer equipment containing client data. Ethical principles and codes remain the same as technology changes: Therapists are responsible for protecting the privacy of information disclosed to them in confidence. Practitioners may consider using conservative communication methods to protect client welfare if uncertain of new technology. The Ethical Standards relative to transmitting confidential information are clear:

Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology (ACA, 2005, B.3.e.).

Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium (APA, 2002, 6.02.a.).

Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible (NASW, 1999, 1.07.m.).

(AAMFT, 2001, 2.4 - previously cited).

Case 3-14: Client filed an ethics complaint against therapist who purportedly "made my problems worse instead of better." He highlighted one specific session that "caused me strong mental anguish and insomnia for several weeks." Client stated that the other twelve sessions were irrelevant and he would only consent to allow therapist to discuss the single "traumatic session."

The Ethics Committee declined to investigate the case without a more complete client authorization because the one-session-only limitation would restrict an adequate therapist response. Client did not accept broader authorization (Koocher & Keith-Spiegel, 2008).

Case 3-15: An unmarried 17 year-old student filed a complaint with the APA Ethics Committee against a psychologist employed by a university counseling service. The psychologist supervised the student's counselor who was a predoctoral intern at the counseling service. Psychologist was an APA member whereas the intern was not. The complainant alleged that the supervising psychologist breached the confidentiality of his client-therapist relationship by alerting the client's parents of his suicide threat. The intern informed his supervising psychologist of client's suicide threat after client refused to seek intern-recommended voluntary hospitalization. Client attempted suicide several years earlier and currently was agitated and depressed. The supervisor required intern to give her the student's name and identifying information so she could notify the parents. Upon notification, the parents arrived at the campus and hospitalized their son. Client filed the confidentiality violation complaint against the psychologist after his brief hospitalization. Psychologist informed the Ethics Committee that she acted in accordance with the Ethical Principles of confidentiality. Based on her intern's information, clear danger or harm to the student was present. Psychologist stated that she notified student's parents to protect his welfare because a) state law allowed immediate relatives to request involuntary hospitalization, b) client rejected voluntary admission, and c) the psychologist and intern did not want to proceed unilaterally.

Adjudication: The Ethics Committee found no substantial evidence for violation of confidentiality. The psychologist encountered a conflict between the principle of confidentiality, protecting client's welfare, and the parents' interest with involvement in treatment decisions for their dependent minor child. The Committee agreed with the reasonable judgment of psychologist that potentially losing the student to suicide justified informing the parents and revealing information about their son's therapy (APA, 1987).

Case 3-16: A social service agency staff member registered a complaint with the APA Ethics Committee that a psychologist on the agency staff often verbalized, at lunch and other informal gatherings, information from his private practice therapy sessions. The complainant advised psychologist several times that this behavior is unprofessional but he responded that it is okay since he never identifies a client's name. One day, complainant realized that psychologist was discussing a client who had worked for the agency and his shared information allowed for easy recognition. After complainant's previous unsuccessful attempts to enlighten psychologist, she filed a formal complaint. Psychologist explained to the Committee that he never revealed a client's name, and informally seeking advice of peers was ethical and beneficial to his clients.

Adjudication: The Ethics Committee found the psychologist guilty of violating the Ethical Principles of confidentiality on these grounds: There is no relevant connection between agency staff members and private practice clients. Discussions about agency clients should not occur in public or semi-public places such as a lunchroom, further, in privacy, only appropriately involved agency staff members should participate. Anonymity is not ensured in the absence of a client's name. A private practitioner who requests a consult with another therapist must secure client's permission for such. Therapists working in a supervised setting or with clients using third-party payment should inform client of confidentiality limits at the outset. The Ethics Committee censured the psychologist, ordered him to cease this behavior, and instructed that another such reported and confirmed violation would yield a harsher Committee response (APA, 1987).

Case 3-17: Several psychologists complained to the APA Ethics Committee about an APA member who appeared on

radio and television talk shows with past and present clients, all being known entertainment industry stars. The psychologist encouraged clients to discuss why they sought treatment and their experiences in therapy. The complainants urged that these programs violated the psychologist-client confidentiality principle as it was unprofessional, and disclosed client identity and treatment details. The psychologist responded that her clients suggested these programs. She discussed the risks and benefits of such self-disclosure and all agreed that the advantages to the general public outweighed any risks. Psychologist secured written informed consent agreements, and all clients were willing to authorize statements to explain the course of events.
Adjudication: The Committee determined, based on the available information, that insufficient evidence existed to sustain an ethical violation of confidentiality. Several members concluded the psychologist did not act in good taste but not enough to support an ethical charge (APA, 1987).

Case 3-18: Psychologist O was a tenured faculty member of the psychology department and a counselor at the health services center of a small university. She taught an undergraduate abnormal psychology course and often used hypothetical case studies to demonstrate various syndromes. During a lecture on love and depression, Psychologist O illustrated a case very similar to a junior psychology major whose affair with a basketball player had publicly ended a short time earlier. The student was in counseling briefly with Psychologist O after the relationship dissolved. Psychologist lectured about the young woman's attempted suicide and hospitalization which was not public knowledge. Several students informed the actual student of this event, who consulted with her advisor, Psychologist S, who confronted Psychologist O, who proclaimed that she always changed the circumstances when promulgating actual events. Psychologist S sided with the student's grievance and filed an APA Ethics Committee complaint. Psychologist O defended her position by insisting that she always disguised personal information regarding true cases when lecturing. Upon seeing the former client's letter submitted to the Ethics Committee indicating commonalities between Psychologist O's lecture and her actual case, psychologist stated that perhaps she could have altered the story better.
Adjudication: The Ethics Committee determined Psychologist O to be in violation of confidentiality ethical principles for failure to sufficiently disguise information acquired during the course of her professional work – she was censured (APA, 1987).

Case 3-19: Psychologist G administered an evaluation of an accused murderer in a nationwide publicized case in which six teenage girls, who disappeared over eighteen months, were found stabbed to death in an abandoned waterfront region of the city. Psychologist was with the accused for several days conducting interviews and psychometric tests and then presented the findings in court with consent of the accused. After sentencing of the now convicted murderer, Psychologist G wanted to write a book about the murderer and the underlying psychodynamics of the crimes – he asked the Ethics Committee if this undertaking was ethical. The convicted murderer refused permission to publish the psychological evaluation results in a book, however, this information was now deemed part of the public domain because it was admitted as evidence in court.
Opinion: The APA Ethics Committee informed Psychologist G that writing the proposed book was legal but unethical. Despite the material having entered the public domain or that there might have been an implied waiver of consent, still, the confidentiality Ethical Principles require obtaining prior consent before disclosing personal information acquired through the course of professional work in a public forum. The ethics code, in this instance, established a higher standard of behavior than the law required. Psychologist G did not write the book (APA, 1987).

Case 3-20: One year after therapy termination with Psychologist V, a client wrote a letter requesting her records be sent to her new therapist in the new city to which she moved. Psychologist responded that it could take several weeks because his office was burglarized and all records were in disorder. After two months, client's new therapist had not received the records or a response, hence, she sent another written request which yielded no response. Two weeks later client called long-distance to psychologist at which time he apologized for the holdup and explained that client's records disappeared in the burglary and he delayed notifying her in anticipation of their recovery by the police. After the passage of several months, he now realized the records would probably not be returned. Client filed a complaint against Psychologist V with the APA Ethics Committee, per her new therapist's advice. Psychologist admitted to the Committee that neither his office or client records were generally locked, in fact, citizens of his small town rarely locked their homes or businesses because crime was rare. From this experience, he learned that crime can occur anywhere and he would now keep all his records locked.
Adjudication: The Ethics Committee determined Psychologist V violated confidentiality ethical principles by not assuring confidentiality in storing and disposing of records. The records having been stolen from an unlocked office demonstrated Psychologist V's inadequate care of his records. Psychologist V was reprimanded and sent a "strongly worded educative letter" clarifying that good intentions do not justify his negligence (APA, 1987).

## DUAL RELATIONSHIPS

In researching dual relationships, Gabbard (1994) quoted a well-known psychiatrist on the challenge of maintaining boundaries: "Harry Stack Sullivan … once observed that psychotherapy is a unique profession in that it requires therapists to set aside their own needs in the service of addressing the patient's needs. He further noted that this

demand is an extraordinary challenge for most people, and he concluded that few persons are really suited for the psychotherapeutic role. Because the needs of the psychotherapists often get in the way of the therapy, the mental health professions have established guidelines, often referred to as boundaries, that are designed to minimize the opportunity for therapists to use their patients for their own gratification" (p. 283). Likewise, in revealing his difficulty with maintaining a professional role with a certain client, Kovacs (1974) noted:

> The style of the calling of a psychotherapist cannot be separated from the great themes of his own existence. We delude ourselves often that our task consists of our merely executing a set of well learned techniques in the service of our patients' needs. I now know that this information is nonsense. What we do with our patients – whether we do so deviously and cunningly or overtly and brashly – is to affirm our own identities in the struggle with their struggles. (p.376)

A boundary can be visualized as a frame or membrane surrounding the therapeutic dyad that identifies a set of roles for those involved in the therapy process (Smith & Fitzpatrick, 1995). Katherine (1991) defines a boundary as a "limit that promotes integrity" (p. 3) which also conveys the purpose of boundary setting. Boundaries protect the well-being of clients who disclose intimate personal information in the therapeutic relationship. Boundary issues involve the theme of dual relationships, also called multiple-role relationships, which occur when the mental health practitioner assumes two or more roles, either concurrently or sequentially, with a help seeker (Herlihy & Corey, 1997). The second role is commonly social, financial or professional, for example, therapist and, friend, employer or professor. The Ethical Standards clearly define a multiple relationship as follows:

A multiple relationship occurs when a psychologist is in a professional role with a person and 1) at the same time is in another role with the same person, 2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or 3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.
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 in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical
(APA, 2002, 3.05.a.).

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. 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. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)
(NASW, 1999, 1.06.c.).

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions of multiple roles, therapists take appropriate precautions (AAMFT, 2001, 1.3).

Counselor-client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client (ACA, 2005, A.5.c.).

When a counselor-client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization or community (ACA, 2005, A.5.d.).

Role-blurring ethics charges constitute the majority of ethics complaints and licensing board actions (Bader, 1994; Montgomery & Cupit, 1999; Neukrug, Milliken, & Walden, 2001; Sonne, 1994). Legal lawsuits and the cost incurred in defending licensing board complaints cause increased professional liability insurance rates, hence, all therapists are affected (Bennett et al., 1994). Licensing boards, which protect consumers from therapists' harm or abuse, originally focused on sexuality within dual relationships but in the past several decades they have more vigorously pursued nonsexual dual relationship issues such as bartering of professional services. The California licensing boards, for example, sent a pamphlet to all licensed therapists in the state promulgating that "hiring a client to do work for the therapist, or bartering goods or services to pay for therapy" represented "inappropriate behavior and misuse of power" (California Department of Consumer Affairs, 1990, p. 3). Some licensing boards have enforced periods of suspension and other terms in cases of nonsexual dual relationships.

Kitchener and Harding (1990) determined that three risk factors affect the potential for harm in multiple-role relationships. First, the more incompatibility of expectations in the two roles within the dual relationship then the greater the harm potential. Second, greater divergence of responsibilities and obligations associated with the dual roles leads to more potential for divided loyalties and loss of objectivity. Third, a larger power and prestige difference between therapist and client in a dual relationship culminates in greater potential for client exploitation; power is generally assigned to healers in most societies (Smith & Fitzpatrick, 1995).

Some inherent concerns with multiple-role relationships include the following: To begin, the dual relationship can deteriorate the professional nature of the therapeutic bond which is based on predictable boundaries. The essential professional nature of the therapeutic relationship is altered and compromised when therapist is also client's employer, friend, or teacher. Second, dual relationships may establish conflicts of interest thus jeopardizing the objectivity and

neutrality required for professional judgment. Therapists promote the client's best interests but a second set of interests may encourage therapists to fulfill their own needs. A therapist treating someone who is also offering a service may become critical of the rendered service thus harming the therapy process. Third, multiple-role relationships can negatively affect cognitive processes that are known to facilitate the therapy process and the maintenance of therapy's benefits after termination (Gabbard & Pope, 1989). Fourth, client does not have equal power in a business or secondary association due to the nature of the therapist-client relationship (Pope, 1988). A client who feels mistreated in a financial or social exchange with a therapist faces extraordinary barriers in legal redress because therapist can use client's shared secrets in creating a defense; further, therapist can utilize false diagnostic labels to discredit client – which is a common practice (Pope, 1988). Fifth, if dual relationships became ethically acceptable, therapists could screen clients for later fulfillment of therapists' social, sexual financial, or professional needs which would change the nature of psychotherapy. Likewise, clients would become aware of therapists seeking extracurricular activities and could change their behavior accordingly. Sixth, a therapist's court testimony concerning a dual relationship client, for example, in personal injury lawsuits, custody hearings, criminal trials, and other legal proceedings would be suspect. Seventh, Pipes (1997) illustrates formal complaints that potentially can ensue:

> Finally, from a more pragmatic perspective, there are often legal reasons for avoiding post-therapy non-sexual relationships. Because state boards vary in their interpretation of ethical standards, and because legal statutes vary from state to state, it is clear that the safest approach to post-therapy relationships is to use caution and discretion when contemplating entering one. Following a survey of state association ethics committees and state licensing boards, Gottlieb at al. (1988) noted: "One psychologist was considered in violation for an affair that began 4 years after termination. It is now quite clear that state boards are deciding that a psychologist may be held liable for his or her actions long after terminating a therapeutic relationship and that in such matters the therapeutic relationship may be assumed to never end" (p. 461). Despite the external constraints imposed on the behavior of psychologists by legal and regulatory bodies such as state boards … it is the responsibility of each psychologist to consider carefully what duty is owed former clients and what behaviors on the part of the psychologist adequately (and preferably, best) represent ethical obligations to former clients (p. 35).

Herlihy and Corey (1997) expose four problematic and complicating characteristics of dual relationships: a) potential dual relationships can be difficult to identify because they develop in subtle fashion without a clear danger sign alerting therapist that the behavior in question might lead to an unprofessional relationship. Therapist, for instance, might accept client's invitation to attend his or her wedding, b) the potential for harm broadly ranges from extremely pernicious to neutral or even beneficial. Sexual dual relationships can be extremely harmful to client whereas attending client's graduation may be benign or therapeutic, c) excluding sexual dual relationships, little consensus exists among mental health professionals concerning the appropriateness of dual relationships. Tomm (1993) proposed that dual relating engenders enhanced therapist authenticity, congruence and professional judgment because therapists' professional mask is lowered. Lazarus and Zur (2002) suggest that dual relationships with selected clients can be helpful. Conversely, St. Germaine (1993) believes that dual relationships can be harmful given loss of objectivity. Bograd (1993) emphasized how the power differential between client and therapist creates difficulty for client to give truly equal consent in an extraprofessional relationship; counselor may unconsciously or unintentionally exploit a vulnerable client. Pope and Vasquez (1998) suggest that practitioners who participate in dual relationships may rationalize their behavior by attempting to avoid the responsibility of securing alternatives to dual relationships, and d) some dual relationships cannot be avoided such as clinicians living in rural areas and small-towns. Additionally, "small worlds" exist within urban environments, for example, political affiliations, ethnic identities, pastoral counseling and substance abuse recovery status can promote dual relationships because clients may seek therapists with similar values (Lerman & Porter, 1990).

In possibly the earliest study on nonsexual dual relationships, Tallman (1981) found that roughly 33% of the 38 participating psychotherapists revealed having formed social relationships with at least some of their clients and all of these therapist respondents were male. This gender difference is consistent in sexual and nonsexual psychotherapy, and in teaching and supervision dual relationships. Borys and Pope (1989, p. 290) summarized the research in this area as follows: "First, the significant difference (i.e., a greater proportion of male than of female psychologists) that characterizes sexualized dual relationships conducted by both therapists and educators (teachers clinical supervisors, and administrators) also characterizes nonsexual dual relationships conducted by therapists in the areas of social/financial involvements and dual professional roles. Male respondents tended to rate social/financial involvements and dual professional roles as more ethical and reported engaging in these involvements with more clients that did female respondents. Second, the data suggest that male therapists tend to engage in nonsexual dual relationships more with female clients than with male clients… Third, these trends hold for psychologists, psychiatrists, and clinical social workers."

Borys and Pope (1989) surveyed 1600 psychiatrists, 1600 psychologists, and 1600 social workers (with a 49% return rate) examining an array of beliefs and behaviors pertaining to dual relationships such as therapist gender, profession (psychiatrist, psychologist, social worker), therapist age, experience, marital status, region of residence, client gender,

practice setting (i.e., solo, group private practice, outpatient clinics), practice locale (size of community), and therapeutic orientation. Results indicated: 1) There was not a significant difference between the three professions relative to sexual intimacies with clients before or after termination, nonsexual dual professional roles, social involvements, or financial involvements with clients, 2) More therapists rated each dual relationship behavior as "never ethical" or "ethical under only some or rare conditions" than a rating of "ethical under most or all conditions," and 3) Psychiatrists, as a whole, rated such dual relationships as less ethical than psychologists or social workers. In a separate interpretation of this study, Borys (1988, p. 181) utilized a systems theory orientation to investigate the relationship between nonsexual and sexual dual relationships and concluded:

> As with familial incest, sexual involvement between therapist and client may be the culmination of a more general breakdown in roles and relationship boundaries which begin on a nonsexual level. This link was predicted by the systems perspective, which views disparate roles and behaviors within a relational system as interrelated. Changes in one arena are expected to affect those in other realms of behavior. The results of the current study suggest that the role boundaries and norms in the therapeutic relationship, just as those in the family, serve a protective function that serves to prevent exploitation (p. 182).

Baer and Murdock (1995) completed a national survey of therapists on the topic of dual relationships and found that, overall, practitioners view nonerotic dual relationship behaviors as "ethical in only limited circumstances at best." They concluded that practitioners understand the importance of fulfilling their own social and financial needs (not including payment for therapy) through nonclients and that this awareness is promising (p. 143). In contrast, Gibson and Pope (1993) surveyed a large national sample of counselors and determined that at least 40% judged nonsexual dual relationships as ethical and at least 40% rated them as unethical. The data suggests that therapists disagree on the appropriateness of various nonsexual dual relationships with clients.

A boundary crossing occurs when a therapist deviates from an accepted practice for the client's benefit – the boundary is changed to assist the client at a moment in time. Such crossings have the potential for establishing a dual relationship but they are not a dual relationship in and of themselves, and they are different from a boundary violation which represents a significant breach causing harm. Boundary crossing examples are therapist attending the college graduation or marriage ceremony of client. Borys (1988) surveyed a large sample of mental health professionals regarding their views on the ethics of various boundary crossings and dual relationship behaviors and observed very little agreement on most of the behaviors.

The decision to occasionally engage in a boundary crossing may vary given the uniqueness of each client, specifically, some clients display clear interpersonal boundaries such that an infrequent crossing may produce no repercussions. Manipulative clients, however, will require firm and consistent therapeutic boundaries such as borderline personality traits or disorder who may attempt to create a "special" relationship with their therapist (Gutheil, 1989; Simon, 1989). Generally, in terms of ethics, infrequent boundary crossings are justifiable given client benefit and little risk of harm, but Herlihy and Corey (1997) advise prohibiting crossings from becoming routine, "Interpersonal boundaries are not static and my be redefined over time as counselors and clients work closely together. Nonetheless, even seemingly innocent behaviors … can, if they become part of a pattern of blurring the professional boundaries, lead to dual relationship entanglements with a real potential for harm" (p. 9). Frequent boundary crossings can produce the "slippery slope phenomenon" whereby boundaries within the therapeutic relationship become blurred taking therapists along a path of ethical violations (Gutheil & Gabbard, 1993; Pope, Sonne, & Holroyd, 1993; Sonne, 1994). A history of boundary crossings, for instance, having lunch with client after session, or asking client to babysit your child, can become the evidence that leads to an ethics committee, judge, or jury finding against a therapist. These decision-makers can resolve that the therapist does not understand or value the profession's ban against harmful multiple relationships. Remley and Herlihy (2007) advise therapists to have very few boundary crossings in their past.

## COMMON BOUNDARY ISSUES

Bartering with a client for goods or services is not ethically prohibited but it is not recommended as a customary practice. Disagreement abounds among practitioners regarding whether bartering is ethical as evidenced by Gibson and Pope's (1993) survey finding that 53% judged accepting services and 63% rated accepting goods instead of payment as ethical. Therapists generally enter bartering arrangements with clients with the good intention of offering services to those with limited finances, however, potential problems exist. Often, client services do not equal the monetary value, on an hourly basis, to that of therapy (Kitchener & Harding, 1990), hence, clients can fall further behind in the amount owed and may feel trapped or resentful. The quality of bartered services may also become problematic as therapist or client may feel short-changed resulting in resentment and therapeutic damage. The exchange of goods instead of payment may elicit the same quality issues inherent in service-exchange, and negotiating the equivalent number of therapy sessions for the bartered good can become an issue. The Codes of Ethics address bartering as follows:

> Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community,

considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. 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 (NASW, 1999, 1.13.b.).

Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract (ACA, 2005, A.10.d.).

Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. 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 (AAMFT, 2001, 7.5).

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if 1) it is not clinically contraindicated, and 2) the resulting arrangement is not exploitative (APA, 2002, 6.05).

Establishing a friendship with client produces a conflict of interest that impairs the required objectivity for professional judgment (Pope & Vasquez, 1998). The friendship dual relationship forms a new set of interests beyond those of client, namely those of the therapist. Therapist, for example, may hesitate to raise a certain issue with client who is also a friend due to concern of endangering the friendship. Two factors that affect therapists' decision to socialize with clients are the clinician's theoretical orientation and the nature of the social function. Borys (1988) suggested that psychodynamic practitioners might refrain from social interactions with clients due to the importance of "maintaining the frame of counseling" and consideration of transference and countertransference issues; relationship-oriented counselors and systems theorists might be more amenable to broader client interaction. Results from Borys' study revealed that only 33% of respondents thought it was never or only rarely ethical to attend a client's special occasion while 92% rejected the idea of inviting client to a personal party.

Postcounseling friendships also assume some inherent risks. Vasquez (1991) observed that many clients consider reentering therapy with their previous therapist but this opportunity ceases if a friendship developed. Therapeutic gains may be threatened when a friendship follows therapy due to disturbance of a healthy resolution of transference issues (Gelso & Carter, 1985; Kitchener, 1992). Moreover, the power differential extant during the therapeutic relationship may continue after therapy termination as Salisbury and Kinnier (1996) stated, "Unreciprocated knowledge of a former client's most sensitive weaknesses and most intimate secrets can render a client particularly vulnerable" (p. 495) in a friendship with a former counselor. Nonetheless, many therapists believe that postcounseling friendships with clients is ethical as evidenced by Salisbury and Kinnier' (1996) survey that indicated 70% of counselors think such behavior could be acceptable and roughly 33% of respondents had done so. Pope and Vasquez (1998) propose that although many practitioners condone or enact a practice, it does not mean the action is ethical; they recommend avoiding "prevalence" arguments as validation for multiple relationships.

The following factors should be considered before establishing a friendship with a current or former client: time-passage since termination, transference and countertransference issues, length and nature of therapy, client issues and diagnosis, circumstances of termination, client's freedom of choice, if any exploitation transpired during course of therapy, client's ego strength and mental health, feasibility of client reentering therapy, and if any client-harm can occur (Akamatsu, 1988; Kitchener, 1992; Salisbury & Kinnier, 1996). It would be difficult for therapists to demonstrate before a licensing board or court that none of these factors represented a concern, therefore, Remley and Herlihy (2007) urge the avoidance of developing friendships with current or former clients.

Periodically, clients offer gifts to their therapists and consideration of acceptance or rejection of such gifts involves several factors. The gift's monetary value is relevant as supported by Borys' (1988) survey of mental health professionals that found only 16% of respondents believe it was "never" or "only rarely" ethical to accept a gift valued less than $10 but 82% believe the same when the gift is worth more than $50. The client's motivation for offering the gift is another worthy variable as the intent to express appreciation is qualitatively different from manipulation or an effort to buy loyalty or friendship. Sometimes it can be therapeutic for therapist to explore client's motivation in gift-giving. Determining therapist's own motivation for accepting or rejecting the gift is helpful; therapists must consider client's welfare. The nature or stage of the therapeutic bond is deemed important, for example, accepting a small gift during the termination session may not become an issue whereas acceptance during an early phase of therapy before a therapeutic rapport exists could blur boundaries and lead to concerns.

The technique of self-disclosure can be an effective intervention that also may strengthen the therapeutic relationship. Therapist theoretical orientation and skill/comfort level at using self-disclosure often regulate the amount of this technique utilized during therapy. Psychodynamic therapists, trained with the Freudian belief that practitioner remains anonymous, probably will not disclose much, whereas existential therapists, who believe the therapeutic relationship is coequal may value self-disclosure. Ethically appropriate self-disclosures are executed for client's benefit (Smith & Fitzpatrick, 1995), while unethical self-disclosures occur when therapists attempt to fulfill their own needs for intimacy or understanding. Practitioners in private practice may use self-disclosure to defend against feelings of isolation (Glosoff, 1997). Unnecessary or excessive self-disclosure can create a role reversal whereby client becomes therapist's emotional caretaker. Inappropriate themes for therapists to self-disclose include current stressors, personal fantasies or dreams, and their social or financial circumstances (Borys, 1988; Gutheil & Gabbard, 1993, Simon, 1991). Inappropriate therapist

self-disclosure is the most-common type of boundary violation likely to precede therapist-client sexual intimacy (Simon, 1991).

Physical contact with clients such as touching or hugging can be therapeutic but such behavior can be misunderstood as a sexual advance or violation of client's personal space. Smith and Fitzpatrick (1995) observe that physical contact was prohibited when "talk therapy" was initiated in the Freudian era because it presumably negatively affected transference and countertransference. In the 1960s and 1970s, in the human potential movement, touching was accepted practice. Holroyd & Brodsky (1977) determined that 30% of humanistic practitioners, compared to 6% of psychodynamic therapists viewed touching as potentially helpful to clients. Pope, Tabachnick, and Keith-Spiegel (1987) examined mental health practitioners' beliefs on three types of physical contact and found that 85% viewed kissing a client as "never" or "only rarely ethical," 44% disapproved of hugging, and 94% believed handshakes are ethical. Generally, at present, therapists are trained to be cautious regarding physical contact, for instance, they are recommended to hug a client only upon client-request or after attaining client's permission. Professional liability insurance carriers have shown concern that clients may bring suit against their practitioners for even well-intentioned physical contact. Some malpractice insurance applications ask, "Do you ever touch a client beyond a routine handshake?" A response of "yes" requires an explanation and such therapists are at risk of being classified as a risky applicant and their insurance application being rejected. Therapeutic touch, in the final analysis, is a function of professional judgment. Therapists are advised to be aware of their motivations in touching a client and to ensure that touching serves client's and not therapist's needs.

Herlihy and Corey (1997) presented a decision-making model for therapists faced with a potential dual or multiple relationship. The first step is to resolve whether the dual relationship is avoidable or unavoidable. If avoidable, therapist would then explore potential problems and benefits with client. Next, therapist must judge whether benefits outweigh the risks or vice versa by assessing issues that establish potential harm, including differences in client expectations of therapist in the two roles, therapist's divergent responsibilities in the two roles, and the power differential in the therapist-client relationship. If therapist assessment concludes that client risk of harm transcends potential benefits then counselor should not enter the dual relationship and refer client if needed. Client should be informed of the rationale for therapist declining to participate in the problematic part of the dual relationship. If therapist feels that client benefits are substantial and risk of harm is low, or if the potential dual relationship is unavoidable, then the dual relationship can commence, with the following safeguards:

1) Obtain client's informed consent and initiate the dual relationship. Therapist and client should converse about potential problems and possible methods of resolution.
2) Seek ongoing consultation because therapist can easily lose objectivity in managing a dual relationship's potential for client harm.
3) Maintain ongoing communication and monitoring with client regarding potential problems and possible resolutions. This step reflects the dynamic and ongoing rather than static nature of informed consent.
4) Document the dual relationship and self-monitor throughout the process. If the dual relationship becomes a complaint before a licensure board or court of law, those adjudicating the complaint will frown upon any attempts to have hidden information. Instead, therapist is advised to document the dual relationship, illustrating vigilance toward client risks, benefits, and protection.
5) Obtain ongoing supervision – beyond consultation – during the dual relationship if risks are high, the relationship is complex, or if therapist is concerned about maintaining objectivity.

Boundary issues and dual relationships can be challenging and complex, therefore, therapists are encouraged to contemplate the consequences of their decisions, establish a comprehensible rationale for any boundary crossings, communicate relevant issues with clients who are also affected by any decisions, and consult with colleagues.

## SEXUAL DUAL RELATIONSHIPS

One of the oldest ethical mandates in the health care professions is the prohibition of sexual intimacies with help seekers – it predates the Hippocratic oath. The ethics codes of mental health professions, however, did not address this behavior until research revealed its prevalence and harm to clients (Pope & Vasquez, 1998). It is estimated that 7% of male counselors and 1.6% of female counselors reported sexual relationships with former or current clients (Salisbury & Kinnier, 1996; Thoreson, Shaughnessy, & Frazier, 1995; Thoreson, Shaughnessy, Heppner, & Cook, 1993). Holroyd and Brodsky (1977) discovered that 80% of psychologists who reported sexual contact also reported sexual intimacy with more than one client. Pope and Bouhoutsos (1986) depict some common situations and rationalizations used by offending therapists:

- A reversal of roles occurs whereby therapist's needs become the focus.
- Therapist professes that sexual intimacy with the client is legitimate treatment for sexual or other issues.
- Therapist does not manage the therapeutic relationship with professional attention and respect and claims things "just got out of hand."
- Clinician takes advantage of client's desire for nonsexual physical contact, such as a hug.
- Counselor fails to recognize that the therapeutic relationship continues beyond each session.
- Therapist establishes and exploits client dependence.
- Clinician uses drugs to facilitate the seduction.
- Counselor uses threats or intimidation.

The common profile of an offending therapist is a professionally isolated male who is experiencing concerns or crisis in his personal life (Simon, 1987; Smith & Fitzpatrick, 1995). He is representative of other impaired professionals, including attempting his own need-fulfillment through his clients and enduring burnout. Golden (in Schafer, 1990) and Schoener and Gonisorek (1988) indicate that there is much variance in this profile, ranging from practitioners who are uninformed of ethics codes to those who are sociopathic, narcissistic, or borderline and cannot understand the impact of their actions. Neither ignorance nor blaming the seductive behavior of the client is a valid excuse, rather, therapist is responsible to make certain that sexual intimacies do not develop.

Approximately 90% of clients who experienced sexual intimacies with their therapist are damaged by the relationship, based on their succeeding therapists (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Clients are likely to suffer with reactions similar to victims of rape, spouse battering, incest and posttraumatic stress disorder. Feelings of guilt, rage, isolation, confusion, and impaired ability to trust often ensue along with symptoms of posttraumatic stress disorder, including attention and concentration issues, reexperiencing of overwhelming emotional reactions upon sexual involvement with a partner, nightmares and flashbacks. Such harm is currently well-recognized, in turn, there are no credible opinions in the profession defending therapist-client sexual relationships.

The Ethical Standards on sexual relationships, including established moratorium timeframes, are as follows:

Psychologists do not engage in sexual intimacies with current therapy clients/patients (APA, 2002, 10.05).

Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy (APA, 2002, 10.08.a.).

Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including 1) the amount of time that has passed since therapy terminated; 2) the nature, duration, and intensity of the therapy; 3) the circumstances of termination; 4) the client's /patient's personal history; 5) the client's/patient's current mental status; 6) the likelihood of adverse impact on the client/patient; and 7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient (APA, 2002, 10.08.b.).

Sexual or romantic counselor-client interactions or relationships with current clients, their romantic partners, or their family members are prohibited (ACA, 2005, A.5.a.).

Sexual or romantic counselor-client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship (ACA, 2005, A.5.b.).

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, 1.09.a.).

Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers – not their clients – who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally (NASW, 1999, 1.09.c.).

Sexual intimacy with former clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. In an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients after the two years following termination or last professional contact. Should therapists engage in sexual intimacy with former clients following two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client or to the client's immediate family (AAMFT, 2001, 1.5).

The indecency of sexual contact with clients is widely acknowledged, hence, clients who sue for such have an excellent chance of winning their civil lawsuit, if allegations are true. Jorgenson (1995) lists the broad array of causes of action that victimized clients may allege in their lawsuits: malpractice, negligent infliction of emotional distress, battery, intentional infliction of emotional distress, fraudulent misrepresentation, breach of contract, breach of warranty, and spouse loss of consortium (love, companionship, and services).

Some state legislatures have passed laws that automatically make it negligence for certain categories of mental health professionals to engage in sexual relationships with their clients which encourages victimized clients to sue (for example, Cal.Civ.Code sec. 43.93, West, 1993; Ill. Ann. State, Ch. 70, secs. 801-802, Smith-Hurd, 1992; Minn. Stat. Ann. Sec. 148A, West, 1993; Texas Senate Bill 210, engrossed May 22, 1993; Wis. Stat. Ann. Sec. 895, 70(2), West, 1992). Clients who sue must still prove the sexual relationship harmed them but harm is broadly defined as emotional, financial, or physical. Some statutes have forceful aspects, for instance, the Wisconsin statute prohibits mental health professionals from settling their cases without public disclosure, in other words, they cannot agree to an out-of-court settlement that is not reported to the public.

From 1983 to 1992, thirteen states instituted legislation that made it a crime for mental health professionals to have sexual relationships with their clients – punishable by jail-time. Kane (1995) listed these states, at the time of the review, as follows: California, Colorado, Connecticut, Florida, Georgia, Iowa, Maine, Michigan, Minnesota, New Mexico, North Dakota, South Dakota, and Wisconsin. The following professionals are included in some of the laws: psychotherapists, counselors, marriage and family counselors, clergy, social workers, psychiatrists, and psychologists. Some of these statutes are unusually strict, for example, the Colorado statute allows prosecutors to file injunctions to prevent mental health professionals from practicing before a guilty verdict has been reached, if the professional is considered a risk to clients. Roberts-Henry (1995) reported that the law essentially states, "any psychotherapist who perpetrates sexual penetration or intrusion on a client commits a felony" (p. 340). The law

prohibits accused mental health professionals from using client consent as a defense. Though the rate of therapist-client sexual exploitation has decreased every decade (Pope, 2001), the issue continues, even in the states that legislated such misconduct a criminal offense.

Sexual attraction to a client is somewhat common as evidenced by research indicating that 70% to 95% of mental health professionals have been attracted to at least one client (Bernsen, Tabachnick, & Pope, 1994; Pope, Keith-Spiegel, & Tabachnick, 1986). Feeling sexually attracted to a client is not unethical, of course, acting on the attraction is. Upon feeling a sexual attraction to a client, Remley and Herlihy (2007) recommend various measures, including consulting with colleagues, ponder client welfare issues, obtain supervision, self-monitor any feelings of neediness or vulnerability, or seek counseling to help resolve your own issues.

Welfel (2006) determined that between 22% and 65% of mental health professionals will encounter clients reporting sexual exploitation by a previous counselor; other research suggests approximately 50% will encounter such clients, with only a small percentage of false allegations (Pope, 1994; Pope & Vetter, 1991). Though therapist's initial reaction might be to take action against the wrongdoer, it is recommended to be respectful of the client's wishes in the situation. Clients who pursue the matter will proceed through an arduous process, including alleging the mental health professional abused them, testifying at formal hearings, probably being cross-examined in an intimidating and accusing manner, and experiencing emotional strain throughout the process. Therapist's role is not to coerce client toward accusing the mental health professional and not to pursue "intrusive advocacy" with the hope of justice prevailing (Pope et al., 1993; Wohlberg, 1999). Instead, practitioner's function is to offer appropriate therapy services, avoid imposing his or her personal values, and facilitate clients reaching their goals. Amazingly, it will probably not be fruitful to file an ethics complaint against another mental health professional if the victim declines to participate. The majority of licensure boards, criminal prosecutors, and certification groups require a witness who was a victim before proceeding with the case. Further, therapist would violate client's privacy by divulging client's identity without his or her permission. Other options to avoiding "intrusive advocacy" with a client who is deciding whether to accuse such a mental health professional include referring client to an advocacy group, attorney, or licensing board for consultation. Therapist can offer therapeutic support during any proceedings. A few states require licensed health providers to report any instance of sexual misconduct, including confidentially disclosed information with a previously abused client or if there is reason to believe that a colleague was sexually involved with a client (Gartrell, Herman, Olarte, Feldstein, & Localio, 1988; Haspel et al., 1997). Haspel et al. (1997) noted that the following five states enacted reporting statutes regarding therapist-client sexual contact and listed their provisions: California, Wisconsin, Texas, Rhode Island, and Minnesota. The Minnesota, Wisconsin, and Texas statutes mandate a subsequent treating therapist to report the abusive therapist. Wisconsin and Texas require therapist to file an anonymous report if client withholds consent, and Minnesota requires a report, with or without client consent, if the name of the offending professional is known. In California, Rhode Island, and Wisconsin, the client determines whether to report the abusive therapist. Rhode Island and Wisconsin require therapist to ask client if he or she wants to report the offending therapist and upon client written request the therapist has thirty days to file a report. In California, subsequent treating therapist is required only to give client a brochure that encourages client reporting and to discuss the brochure with client; if client wishes to report then therapist must do so but if client chooses to not report then therapist's obligation ends. The statutes protect reporting therapists against slander or libel charges if reporter acted in good faith. State laws may change over time, therefore, therapists may wish to check their current state reporting statutes.

## CASE STUDIES

Case 4-1: A renowned and outspoken therapist had a tendency of verbal attacks against anyone who criticized her theoretical foundation of the therapy orientation that she initiated in the 1970s as being outdated. Therapist maintained a successful private practice in her fashionable condominium and her clients were the focus of her life – she was a widow. Therapist hosted social events in her home for her clients and accompanied clients on vacations. Colleagues were concerned that therapist created a cult of high-paying, ongoing clients who also provided her adoration, loyalty, and "family."

Analysis: Professional or personal isolation can impair practitioners' judgments, facilitate exploitation of clients, and lower standards of care. Many boundary blurring cases occur among clinicians in solo practice, frequently in isolated offices away from other mental health professionals. Lacking people to confer with regarding therapeutic predicaments tends to increase the probability of unethical decisions. Therapists can acquire collegial involvement through peer supervision groups, consultation, participation in professional associations and numerous other ways (Koocher and Keith-Spiegel, 2008).

Case 4-2: Client worked as a records clerk for a community mental health center and Therapist A supervised her work. Client experienced some personal problems for which she asked therapist to treat – he agreed. Client ultimately filed an ethics complaint against Therapist A charging that he blocked her promotion based on evaluations of her as a client rather than as an employee.

Analysis: It is difficult to determine exact cause and effect in this situation but client can now interpret the cause of any work-related negative outcomes as related to the therapy. Dual relationships with client/employee can become

problematic in many ways and can produce career and economic hardships for client. Therapist A violated ethical standards due to clear and foreseeable risk of harm to client (Koocher and Keith-Spiegel, 2008).

Case 4-3: Client wanted to buy a house and started selling her mother's antique jewelry to raise capital. Client showed her therapist one of the better items of jewelry for sale, therapist asked the price and client quoted a price that seemed reasonable given the quantity of rubies. Therapist bought the item for the quoted price and paid in cash. Over a year passed since successful termination of therapy when client called therapist stating that she learned the value of the item was worth $2000 more than agreed upon and she requested that amount. Therapist was astounded and she refused.
Analysis: Client took therapist to small claims court and promulgated that therapist had "taken her for a ride." Client lost the case but the local newspaper of the small town wrote a short article about the case. Therapist's practice diminished significantly and residual effects lingered after two years. Despite therapist not initiating the sale and paying the asking price, the ex-client's anguish impacted therapist's practice. When clients sell an item of true value, there is rarely a reason for their therapist to be the purchaser. Perhaps this therapist could have recommended an Internet site with a far reach and little cost (Koocher and Keith-Spiegel, 2008).

Case 4-4: Counselor presented an unemployed landscaper the option of designing and redoing his yard in exchange for psychotherapy. Counselor charged $100 per hour and credited client with $15 an hour, thus client worked over six hours for each therapy session. Client protested to therapist that the time required for the yard-work prevented his securing full-time employment. Therapist countered that client could choose to terminate therapy and resume when he could pay the full fee.
Analysis: Therapist calculated a below fair-market value for a proficient landscape artist's labor. The bartering contract is assumed to have contributed to client's difficulties. Therapist interrupted the agreement and abandoned client upon hearing client's complaint. Client sued therapist for considerable damages (Koocher and Keith-Spiegel, 2008).

Most professional liability insurance policies exclude coverage pertaining to business relationships with clients (Canter et al., 1994; Bennett et al., 2007). Liability insurance carriers may construe bartering arrangements between mental health professionals and clients as business relationships and therefore refuse to defend covered therapists if bartering complications arise. Koocher and Keith-Spiegel (2008) believe that bartering arrangements have the propensity to be problematic, actually or perceived as exploitive, and unsatisfactory in outcome to both parties and thus should be used sparingly, if at all.

Case 4-5: A professional artist complained to an Ethics Committee that therapist did not carry out her promises. The artist had been treated by therapist for over one year during which time therapist complemented his art work, attended art shows with him, and promised to introduce her art gallery contacts to client. Client began to feel so self-confident that he terminated therapy while expecting therapist's interest in his career to continue. Therapist stopped returning ex-client's phone calls leaving client frantic. An Ethics Committee contacted therapist to whom she explained that she always provided unconditional positive regard to her clients, but since this particular individual was no longer a client she felt no further obligations to him.
Analysis: The Ethics Committee found in favor of client. Therapist entwined their lives together rendering confusion in client and she did not resolve the potential consequences of the dependency she established and maintained in client (Koocher and Keith-Spiegel, 2008).

Case 4-6: Therapist and her ex-client thought they would become close friends because the past therapeutic relationship was very harmonious. Unexpectedly, ex-client perceived therapist to be controlling and overbearing and questioned therapist's overall competence to the point of distancing herself from the posttherapy friendship. Ex-client assumed that the previous therapy was inept causing her to feel exploited and lost. She sought the advice of another therapist who suggested that she press charges against the therapist.
Analysis: An Ethics Committee determined that incompetence could not be conclusively proven but both complainant and respondent were surprised at the finding of a multiple-role relationship violation. The investigation uncovered that therapist unmistakably planned their developing friendship and its longer-term continuation while client was in active therapy. Interestingly, therapist presented these facts as a defense against client's charges.

This case shows how our personas may change from one context to another and the change may not be welcomed by others as client responded well to therapist's authoritative personality in therapy but not socially. Additionally, as noted earlier, ex-clients may choose to reenter therapy and a neutral relationship combined with the positive effects of continuing transference is advised (Koocher and Keith-Spiegel, 2008).

Case 4-7: A wealthy client gave his recently licensed therapist a new car for Christmas and a card indicating, "To the only man who ever helped me." Therapist came to believe that the gift was warranted because client expressed having many past unproductive therapists. Over time, client found fault with the therapy and ultimately sued therapist for manipulating him into buying an expensive gift.
Analysis: This case demonstrates therapeutic inexperience as gifts and favors beyond small one-time or proper for special occasion tokens should not be accepted. Clients, who are commonly in vulnerable situations, can declare exploitation at a later date and the charge may be justified regardless of therapist's rationalizations. Being self-serving can lead practitioners into trouble whereas maintaining a strong

professional identity relative to accepting gifts and favors can avoid concerns. Unrelated to small gifts bestowing genuine appreciation, gifts have the power to control, manipulate, and symbolize more than what meets the eye. Some clients may attempt to equalize power in the therapeutic relationship by offering a gift (Knox, Hess, Williams, & Hill, 2003) (Koocher and Keith-Spiegel, 2008).

Case 4-8: Therapist knew after only several minutes of the first session that he could not be client's counselor because of a strong attraction to her which caused his poor concentration and sexual arousal. After ten minutes, therapist told client that he was not the right therapist for her, candidly explained the reason, and offered assistance with a referral.
Analysis: Therapist immediately recognized that his intense feelings may continue and were affecting his therapist role, as such, he correctly deduced to limit client's self-disclosure. Ultimately, therapist married client within several months but the relationship ended shortly thereafter. The flattered "almost client" and mesmerized "almost therapist" perceived few commonalities and many conflicts once the infatuation phase ended. The required moratorium period would have been required if client was a "former client" but it may be argued that ten minutes does not establish a therapist-client relationship. Still, the brief therapeutic encounter entailed enough emotional intensity to have justified more caution than therapist eventually displayed (Koocher and Keith-Spiegel, 2008).

Sexual transgressions with clients emerge as the most frequent specific cause for disciplinary action (Kirkland, Kirkland, & Reaves, 2004). Pope et al. (1986) surveyed therapists to uncover to whom they become attracted and found that "physical attractiveness" was first choice, followed by "positive mental/cognitive traits" (i.e., intelligent, well educated, articulate), "sexuality," "vulnerability" attributes (e.g., needy, childlike, sensitive, fragile) and "good personality." Other scenarios worth mentioning included attraction to clients who fulfilled their needs (i.e., improved therapist's image, lessened therapist's loneliness or pressures at home), attraction to clients who seemed attracted to them or clients who reminded them of someone else.

Case 4-9: Therapist was attracted to his client of several months and invited her to attend a lecture on eating disorders knowing that client's sister experienced anorexia nervosa. Client thought it was an appropriate professional invitation, accepted, and then agreed to have dinner after the lecture per therapist's recommendation. The next session, therapist accepted client's gift of a book authored by the lecturer from a week earlier. The following week, therapist agreed to a reciprocal dinner at client's home which culminated in several glasses of wine and a retreat to the bedroom.
Analysis: The step-by-step evolution of socialization leading to sexuality is clear in this case. An affair lasted several weeks but was ended by therapist who met someone else. Client became upset and therapist responded by terminating the therapy relationship. Client sued and won a large damage award via a civil malpractice complaint (Koocher and Keith-Spiegel, 2008).

Therapist-client sexual activity is often exploitative and harmful given abuse of power, mismanaging the transference relationship, role confusion and other variables. A charge of misconduct also devastates the therapist due to potential loss of license, job, spouse and family, economic security, and reputation. Such negative consequences outweigh the outcomes of other ethical violations. Furthermore, most malpractice insurance policies limit coverage on damages involving sexual intimacies within a range of zero to $25,000. If therapist claims innocence, the policy will cover a defense but will not pay any damages beyond the limit if therapist is found liable, thus, defendants may be accountable to pay the cost of damages which can become considerable. Ironically, most therapist-client sexual relationships do not last long and about 50% are judged afterward as not worth having (Lamb et al., 2003).

Somer and Saadon (1999) observed that almost 25% of clients who admitted to sexuality with their therapists declared that they initiated the first embrace. Nonetheless, therapists must resist their feelings of mutual attraction because the duty to uphold ethical standards cannot be assigned to the client. Pope (1989, 1994) listed an array of symptoms experienced by clients who had sexual relationships with their therapists, which included ambivalence toward therapist (similar to incest victims who feel love and negativity toward offending family members); guilt (feeling client was to blame for the event); isolation and emptiness; cognitive dysfunction (especially in attention and concentration); identity and boundary disturbances; difficulties in trusting others and themselves; confusion regarding their sexuality; lability of mood and feeling out of control; suppressed rage; and increased risk of suicide or other self-destructive behavior.

Two theories explaining the lower incidence of female therapists engaging in sex with clients than male therapists include 1) female sex roles have encouraged women to learn and practice many techniques for expressing love and nurturance that are not sexuality-based, and 2) the cultural conditioning of women to avoid taking the sexual initiative has simultaneously taught them better sexual impulse-control, and techniques for refusing to accept sexual advances (Marmor, 1972).

Case 4-10: A high-profile case, extensively covered by the media, involved a psychiatrist who was found innocent of sexual relations with the sexually-assertive side of his multiple personality client. The jury exonerated therapist despite DNA evidence of his semen on client's underwear. The defense attorney argued that client transferred therapist's semen to her own panties after stealing underwear from the psychiatrist's trash bin. Later DNA tests administered by CBS's television program "48 Hours" concluded that the patterning and large amount of semen on client's panties

could not have resulted from such a transfer (CBS News, 2002).

Case 4-11: Upon termination of four years of psychotherapy, therapist suggested to client that they keep in touch. Both exchanged letters, communicated by phone almost weekly, and periodically had lunch. After twenty months, therapist expressed that their relationship could become sexually involved if client was still interested. They were married but client sought a divorce after one year and filed a complaint with a state licensing board that therapist was "laying in wait" with hopes of securing his significant income.
Analysis: Therapist demonstrated unethical behavior by continuing an emotionally-charged relationship after termination. Unrelated to the allegation of scheming to gain financially, therapist wrongly maintained an uninterrupted relationship. Additionally, even after passage of the minimum timeframe before sexual activity may occur, therapist bears the burden of demonstrating that no exploitation occurred in light of client's current mental status and level of autonomy, how termination was executed, type of therapy that transpired, and current risks given a sexual relationship. Therapists may have difficulty in defending themselves against a claim of client harm, even after the moratorium has been fulfilled, because many factors can be presented to support an exploitation charge. Secondly, any diagnosis suggesting vulnerability such as currently depressed, previously abused, or various personality disorders could convince an ethics committee of therapist bad judgment sufficient to uphold an ethics charge.

## ADDICTION COUNSELOR ISSUES

### 42 CODE OF FEDERAL REGULATIONS

It is important for anyone directly or indirectly involved with substance abuse treatment to be familiar with the confidentiality regulations within 42 CFR. Violation of these regulations is punishable by a fine up to $500 for a first offense or up to $5000 for each subsequent offense (regulation 2.4); additionally, treatment programs could lose their federal, state or local funding.

With the exception of very limited circumstances, the regulations prohibit disclosure of records or information about any patient in a federally-assisted alcohol or drug abuse program. This rule applies whether or not the seeker of the information already has the information, has other ways of obtaining it, has official status, has secured a subpoena or warrant, or is authorized by state law. The rule applies to all those with access to the client's records, including treatment program personnel, researchers, auditors, or others, whether or not they are compensated for their work activity and it continues after they have terminated their employment or relationship with the program.

The program must keep written records in a secure room, a locked file cabinet, a safe, or other secure container. A written procedure for accessing the records is required and programs are advised to designate either the program director or a single staff member to process inquiries and requests for patient information.

A patient is defined as "any person who has applied or been assessed for, participated in, or received an interview, counseling, or any other service by a federally-assisted alcohol or drug abuse program." Patient-identifying information constitutes any information that would identify a patient as a substance abuser, either directly or indirectly.

The general rule prohibiting disclosure of patient-identifying information is broad but it does permit programs to make limited disclosures when a patient consents and it offers circumstances for disclosure given patient non-consent. To assist one in making the potentially complex decision whether a specific request for patient information is approved by an exception to the general disclosure prohibition, Lowinson, Ruiz, Millman, & Langood (1997) suggest one should ask the following questions:

1. Is the proposed communication to be made pursuant to a valid written patient consent?
2. Is the proposed communication to be made to other staff of the program or to an entity with administrative control over the program having a need for the information in connection with duties that arise out of the provision of substance abuse services?
3. Can the proposed communication be made without revealing that the person the disclosure concerns is or was an alcohol or drug abuse patient?
4. Is the proposed communication related to a medical emergency?
5. Is the proposed communication authorized by a valid court order?
6. Does the proposed communication concern a crime or a threatened crime on the premises of the program or against program personnel?
7. Is the proposed communication for purposes of research or part of an audit or an examination of a program's activities?
8. Does the proposed communication involve the reporting of child abuse or neglect?
9. Is the proposed communication to be made pursuant to a qualified service organization agreement?

The proposed communication cannot be made if the answer to all the questions is "no.," but if the answer is "yes" to one of the questions then the situation may permit a disclosure. The exceptions permitting disclosure can be complex, therefore, in situations other than routine circumstances in which patient has signed a valid consent form, it is recommended to inform staff that only the program director or a designated individual aware of confidentiality regulations can authorize disclosures. Still, certain situations, such as those involving court orders, may require the advice of counsel.

The general principle to follow when making a decision to disclose patient information as recommended by Lowenson et al. (1997) is: "Do not disclose anything about a patient, at

least without being able to state why the regulations permit the particular disclosure."

Most disclosures are allowed if the patient has signed a valid consent form that has not expired or been revoked by the patient. A valid consent form must be in writing and must include the following items contained in (reg. 2.31):

1. The name or general designation of the program(s) making the disclosure.
2. The name of the individual or organization that will receive the disclosure.
3. The name of the patient who is the subject of the disclosure.
4. The purpose or need for the disclosure.
5. How much and what kind of the information will be disclosed.
6. A statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it.
7. The date, event, or condition upon which the consent expires if not previously revoked.
8. The signature of the patient (and/or other authorized person).
9. The date on which the consent is signed (reg. 2.31(a)).

Every form presented to a program must include these nine requirements, otherwise, the program is prohibited by the regulations from making the disclosure (reg. 2.31(c)).

All disclosures are to be limited to information necessary to meet the need or purpose of the disclosure, thus, one would not disclose all information if only one specific piece of information is being requested.

The federal regulations allow patients to revoke consent at any time, orally or written, and the consent form must indicate this fact. The consent form must indicate the date upon which the approval of disclosure terminates since the regulations require that the consent is limited to the time necessary to accomplish the purpose of disclosure.

The regulations require that a disclosure include a written statement that the disclosed information is protected by federal law and the recipient cannot make any further disclosure of it unless allowed by the regulations (reg. 2.32). The regulations disallow redisclosure by a third-party payer or an entity with direct administrative control over a program. In other words, once Medicaid, for example, receives patient-identifying information on persons in drug abuse treatment, the records of these persons are subject to the regulations and can only be redisclosed under regulation rules.

Compliance with disclosure regulations may best be accomplished by disclosing only the type of information required, for the designated time-frame, and for the specific purpose of the communication.

Restrictions on disclosure of information do not apply to staff members within a program or between a program and "an entity that has direct administrative control over that program" if the recipients need "the information in connection with their duties that arise out of the provision of diagnosis, treatment or referral for treatment of alcohol or drug abuse" (2.12(c)(3)). Communication of information beyond the substance abuse unit that is not necessary to provide services to the unit's patients is not allowed.

The regulations permit a program to disclose information without patient's consent given the situation of a court issuing an order authorizing disclosure. A court may authorize disclosure of "confidential communications" only if the disclosure 1) is necessary to protect against threat to life or serious bodily injury; 2) is necessary to investigate or prosecute an extremely serious crime; or
3) connects with a proceeding at which the patient already presented evidence concerning confidential communications. A court cannot order disclosure of confidential communications outside of these parameters (reg. 2.63).

The court orders proclaimed by the regulations only authorize a program to disclose what otherwise would have been prohibited but they do not bestow upon the court the authority to compel disclosure. The program is legally bound to make the authorized disclosure if the court issues an order compelling disclosure under another source of judicial power and issues an order authorizing disclosure under the regulations, or if the order authorizing disclosure accompanies a valid subpoena. These circumstances can become complex and confusing and suggest need for counsel in this area.

Conflicting moral and legal concerns exist between the regulations' confidentiality requirements and a Tarasoff "duty to warn" situation. A program can respond in the following ways upon a patient threatening to harm self or another:

1) The program itself can inform the potential victim or law enforcement officials as long as it does not identify the person threatening to commit the crime as a patient, for example, the program can make an anonymous report which would protect the patient's identity as an alcohol or drug abuser.

2) The program can request a court order authorizing disclosure to the intended victim and to a law enforcement agency.

3) Given patient attending a treatment facility resulting from disposition of a criminal charge, the program can make the disclosure to the criminal justice agency that mandated patient into treatment, but there must be a pre-existing criminal justice consent form signed by patient with verbiage permitting such information disclosure. The criminal justice agency could then warn intended victim and notify law enforcement but must do so without revealing that patient is in alcohol or drug assessment or treatment.

4) The program can report to medical personnel if the threat presents a medical emergency posing an immediate threat to the health of any individual and demands immediate medical attention. In other words, a program can inform a private physician of a suicidal patient so medical intervention can be arranged.

5) The program can attain the patient's consent (though this is not likely unless patient is suicidal).

The program is left with a dilemma if none of the above options are viable. It is thought to be wiser to err on the side of making a report about the danger to the authorities or to the threatened individual, especially in states enforcing the Tarasoff rule. Though each case is different, it is doubtful that any prosecution or successful lawsuit under the federal confidentiality regulations would ensue against a program or counselor who believed in good faith that such a disclosure was needed to protect another from real danger. Contrarily, a civil lawsuit for failure to warn could result if the threat is carried out. The program should try to disclose the warning such that the identity of the individual as an alcohol or drug abuser is protected. Notwithstanding, programs are encouraged to consult with an attorney familiar with these issues who can offer counsel on a case-by-case basis.

## RESPONDING TO A SUBPEONA

Federal law and regulations prohibit treatment programs from disclosing verbal or written information regarding current or past patients in response to a subpoena unless: 1) the patient whose information is sought signs a valid consent form authorizing the program to release the requested information, or 2) the court orders the program to release information or written records after granting program and patient a chance to be heard and after concluding a good cause determination under the confidentiality law and regulations.

Initially, a program is notified that a court order is being sought and the program has the opportunity to appear at a hearing. The following three principles apply to programs covered by federal confidentiality regulations:

1) The program should not release information in response to a subpoena even it is signed by a judge; this type of subpoena is not the type of court order required by the confidentiality regulations.

2) Failure to respond to a subpoena in some way may be grounds for contempt of court which can result in a fine or jail term, consequently, it should not be ignored.

3) The program or person to whom the subpoena is addressed does not routinely have to testify or release the requested information, instead, the program or person can appear and object to the subpoena.

If the subpoena is signed by a lawyer who represents the patient then the solution is often easy: The program would notify the patient or the lawyer (after receiving patient's written consent) that patient must sign a valid consent form authorizing the program to comply with the subpoena.

If the subpoena is served by someone other than patient's lawyer then patient will likely not sign a consent form allowing program to release the information. The program should inform the person who signed the subpoena that federal confidentiality regulations disallow the program from obeying the subpoena in the absence of a court order abiding by the procedures and standards indicated in the regulations. The program could ask the person who signed the subpoena to withdraw it and apply for a court order.

The program is advised to seek an attorney, versed in the confidentiality regulations, if the program cannot fend off the subpoena. An attorney can clarify requirements of the federal confidentiality regulations and possibly inform the program of other ways it can object to the subpoena. For example, patient information may be protected from disclosure by a physician-patient, therapist-patient, or similar privilege enacted by state law; or an objection to a subpoena is possible if the requested information is irrelevant to the proceeding.

If the program does not enlist an attorney's assistance and does not convince the individual who issued the subpoena to either withdraw it or seek the required court order, then the person or program subpoenaed should appear in court on the designated date. The program would then ask the judge to "quash" the subpoena and it would inform the judge of the federal confidentiality regulations that the judge must follow before he or she can issue an order authorizing the program to disclose information. It is wise to show a copy of the regulations to the judge because not all judges are aware of them.

The program has fulfilled its obligations under the regulations once it appears at the court hearing and requests the court to quash the subpoena or issue a proper court order before requiring disclosure of any information. If the court does not issue any order then the program does not have to release the records, but if the court does issue an order (orally or in writing) then the program can either release the requested records to be disclosed or it can appeal. The regulations do not require a program to appeal a court's ruling, even if the ruling appears to be in error.

## TARASOFF UPDATE

Many states have adopted and even expanded upon the Tarasoff decision since its inception. In the case, Peck vs. Counseling Services of Addison Cty, Vermont (1985), the Vermont Supreme Court ruled that use of arson in an attempt to damage property was a Tarasoff mandate. Specifically, in Vermont, a 29 year-old client told his therapist that he "wanted to get back at this father" after client and father had a heated argument and when asked how he might do this, client stated, "I don't know, I could burn down his barn." Therapist and client discussed consequences of such an act which led client to promise he would not implement the plan.

Therapist assessed the situation for possible Tarasoff implications and concluded that it did not meet the threshold for a mandatory report. Later, client burned down an uninhabited area of the farm, no one was hurt. The court disagreed with therapist and ruled in favor of the father such that the father should have been given a Tarasoff. This is the only ruling with regard to the "damage to property" section of California Evidence Code 1024 in which therapists may include damage to property under the Tarasoff mandate. Given no one was hurt in this case, the rendered decision implies that the court extended the Tarasoff rule to victims of property damage.

This case highlights that the standard of care in potential harm situations is consultation with an expert (i.e., attorney, your malpractice insurance company, etc.) and to document your decision-making process before breaching or not breaching confidentiality of a client.

CHILD ABUSE MANDATED REPORTING UPDATE

Substance abuse is prevalent in over 66% of child abuse and domestic violence cases, yet, California alcoholism and drug abuse counselors, until recently, were not required to report suspected child abuse. These frontline professionals who specialize in drug and alcohol management were therefore ethically but not legally mandated to report suspected child abuse, consequently, they were not immune to lawsuit. Current mandated child abuse reporters are protected from liability claims due to their response being compelled by state law. Please note that this law varies from state to state and therapists are advised to know their specific state laws.

Assembly Bill (AB) 2337 proposes that alcohol and drug counselors be added to the list of mental health professionals who are mandated child abuse reporters. The Child Abuse and Neglect Reporting Act requires all mandated reporters to report known or suspected child abuse or neglect. Proponents for (AB) 2337 reminded us that this bill safeguards at-risk children, reduces alcoholism and drug abuse counselors' liability exposure, promotes recovery and incurs no state costs.

This bill went to hearing on March 4, 2008, in the Assembly Public Safety Committee but a final decision was not made at that time. Those in the field of alcoholism and drug abuse were optimistic of a favorable decision – they pointed out that a teamwork approach of addiction treatment and social services is time-tested and proven to facilitate long-term recovery. Fortunately, Assembly Bill (AB) 2337 passed and went into effect on September 27, 2008.

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# TEST – ETHICS: CASE STUDIES II

6 Continuing Education Credit Hours
Record your answers on the Answer Sheet (click the "NAADAC/CAADAC/CAADE 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.

This course, Ethics: Case Studies II, is approved for 6 continuing education contact hours by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Approved Education Provider Program (NAADAC Provider # 438), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC Provider # 1S-07-397-1013), and the California Association for Alcohol and Drug Educators (CAADE Provider # CP40 909 H 1113).

**TRUE/FALSE**

1. **A practical general principle to follow is: Do not disclose anything about a patient, at least without being able to state why the regulations permit the disclosure.**
   A) True B) False

2. **Statistics on formal complaints and disciplinary actions may significantly underestimate the prevalence of breaches in confidentiality.**
   A) True B) False

3. **Most disclosures are allowed if the patient has signed a valid consent form that has not expired or been revoked by the patient.**
   A) True B) False

4. **When circumstances require the disclosure of confidential information, only essential information is revealed.**
   A) True B) False

5. **Managed care companies generally do not ask for much more information than third parties have traditionally requested from clinicians.**
   A) True B) False

6. **A larger power and prestige difference between therapist and client in a dual relationship culminates in greater potential for client exploitation.**
   A) True B) False

7. **Dual relationships may establish conflicts of interest thus jeopardizing the objectivity and neutrality required for professional judgment.**
   A) True B) False

8. **Bartering with a client for goods or services is not ethically prohibited but it is not recommended as a customary practice.**
   A) True B) False

9. **Unethical therapist self-disclosures occur when therapists attempt to fulfill their own needs for intimacy or understanding.**
   A) True B) False

10. **Frequent boundary crossings cannot produce the "slippery slope phenomenon."**
    A) True B) False

11. **One of the two most important client expectations and demands of therapy is _______________.**
    A) a sliding fee scale
    B) a feeling of safety and security
    C) extending time of sessions
    D) increased therapist training

12. **The therapist's obligation to respect client's privacy and to protect the information revealed during therapy from disclosure without client's explicit consent is termed _____________.**
    A) right of entitlement
    B) right of refusal
    C) confidentiality
    D) tort of public domain

13. **Bok believes that confidentiality is based on four principles, including ______________.**
    A) the nature of communication
    B) exclusivity rights
    C) rational discernment
    D) practitioner is obligated to offer client a "pledge of silence"

14. **The percentage of complaints registered with ethics committees and state licensing boards of counselors and psychologists pertaining to confidentiality violations is ________________.**
    A) 1% to 5%
    B) 10% to 15%
    C) 16% to 20%
    D) 21% to 25%

15. **A survey of the general public found that many people believe that everything disclosed to a professional therapist would be ___________.**
    A) privy to everyone
    B) strictly confidential
    C) available only to client's immediate family
    D) available only to government officials

16. **______________ ethics charges constitute the majority of ethics complaints and licensing board actions.**
   A) Confidentiality
   B) Role-blurring
   C) Privacy
   D) Privileged communication

17. **The most-common type of boundary violation likely to precede therapist-client sexual intimacy is ______________.**
   A) establishing a friendship
   B) accepting an expensive gift
   C) inappropriate therapist self-disclosure
   D) accepting several inexpensive gifts

18. **Inappropriate themes for therapists to self-disclose to clients include ___________.**
   A) current stressors
   B) personal fantasies or dreams
   C) social or financial circumstances
   D) all of the above

19. **Clients who experience sexual intimacies with their therapists are likely to _____________.**
   A) suffer with reactions similar to victims of rape, spouse battering, incest, and posttraumatic stress disorder
   B) feel neutral about the experience
   C) feel positive about the experience
   D) resolve their issues

20. **Most therapist-client sexual relationships _________.**
   A) last at least five years
   B) do not last long and about 50% are judged afterward as not worth having
   C) result in marriage
   D) are judged afterward as worth having

Please transfer your answers to the Answer Sheet (click the "NAADAC/CAADAC/CAADE 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 Inc.; you may keep the test pages for your records.

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