Ethics: Cases and Commentary I

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION CONTACT HOURS

"Developing an ethics code may be viewed as an important marker in the maturation of a profession."
S. Behnke and S. Jones (2012)

Course Objective
The purpose of this course is to provide an understanding of the concept of ethics as related to mental health professionals. Various standards within the Code of Ethics are presented along with commentary and case scenarios which support the standards. Major topics include: ethics principles, conflicts between ethics code and organizational policies, different aspects of competence, nondiscrimination, multiple relationships, and representative legal/ethics case scenarios suggesting thought-processes and actions leading to resolution of ethical dilemmas.

Accreditation
Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387; Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-0080, and licensed marriage and family therapists #MFT-0043; Psychology as an approved provider of continuing education for licensed psychologists #PSY-0006.

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

Learning Objectives
Upon completion, the participant will be able to:
1. Acknowledge the ethics principles to which practitioners should aspire.
2. Understand and apply the Code of Ethics to various ethical dilemmas.
3. Comprehend ways to resolve organizational conflicts such as informed consent and confidentiality.
4. Discuss ways to maintain competence in relation to new areas of practice, forensic practice, and personal impairment.
5. Articulate the importance of demonstrating nondiscrimination practices.
6. Realize that multiple relationships can be exploitative or cause harm.

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INTRODUCTION

The literature describes ethics as a process rather than a fixed set of rules, additionally, the majority of ethical dilemmas are not plain, simple, and easily resolvable. As such, mental health practitioners encounter ethical uncertainty which, on a positive note, infers that their work is complex, multi-dimensional, and deemed relevant to the society.

The "Code of Ethics" of the National Association of Social Workers (NASW; 2008), the American Association for Marriage and Family Therapy (AAMFT; 2015), the American Counseling Association (ACA; 2014), and the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct" (APA; 2010), offer guiding principles and standards for professional conduct. Interestingly, these texts largely draw upon biomedical ethics literature but the generalizability across the disciplines is logical and functional.

The principles within the Ethics Code for each of the above organizations offer ideals to which practitioners should aspire, and they form the basis of the Ethical Standards. These principles represent the ethical ceiling of professional conduct toward which one can strive - it is the equivalent of "doing your best." Their purpose is to offer guidance and motivation toward reaching the highest ethical performance. These principles, as opposed to the Ethical Standards, are not obligations, they should not be used for administering sanctions, and they are not enforceable. In contrast, the Ethical Standards indicate mandatory compliance with the "musts" and "must nots" of professional conduct and they are enforceable.

The National Association of Social Workers (NASW), for example, promotes the core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. The Ethical Principles supporting the core values of NASW are as follows:

Service - Social workers are advised to "help people in need" by transcending self-interest, "address social problems" through implementation of acquired knowledge, values, and skills, and to offer pro bono service.

Social Justice - Social workers "challenge social injustice" by attempting social change on behalf of "vulnerable and oppressed individuals and groups" with respect to "poverty, unemployment, discrimination, and other forms of social injustice" such as oppression and cultural diversity. Attempts are made to offer equal access to relevant information, resources, services, opportunity, and decision making "for all people."

Dignity and Worth of the Person - Social workers honor "the inherent dignity and worth of the person." Individual differences, diversity, and client self-determination are respected. Social workers attempt to foster clients' ability and opportunity to change and to be self-reliant. Social workers acknowledge a dual responsibility to clients and the larger society by trying to "resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession."

Importance of Human Relationships - Social Workers understand the essential significance of human relationships. Relationships between people are understood to be "important vehicles for change," and when strengthened can enhance well-being. Social workers interact with clients "as partners in the helping process."

Integrity - Social workers are trustworthy and act in accordance with the profession's values. Social workers are honest, responsible, and promote the welfare of their clientele.

Competence - Social workers function within their scope of practice and improve upon their "professional expertise." Social workers attempt to augment their professional ability in all aspects of practice.

The American Association for Marriage and Family Therapy (AAMFT) adheres to the following Ethical Principles:

Responsibility to Clients - Marriage and family therapists (MFTs) foster the welfare of families and individuals by respecting the rights of their clientele and they "make reasonable efforts to ensure that their services are used appropriately."

Confidentiality - MFTs may be challenged by confidentiality issues because the client can be more than only one person. "Therapists respect and guard the confidences of each individual client."

Professional Competence and Integrity - MFTs demonstrate "high standards of professional competence and integrity."

Responsibility to Students and Supervisees - MFTs acknowledge the required trust and dependency that exists when working with students and supervisees and they avoid exploitation.

Responsibility to Research Participants - Research investigators act in humane ways with research participants and abide by "applicable laws, regulations, and professional standards governing the conduct of research."

Responsibility to the Profession - MFTs honor the "rights and responsibilities of professional colleagues" and are interested in promoting the goals of their profession.

Financial Arrangements - MFTs conduct financial arrangements with clients, third-party payors, and supervisees in a manner that is "reasonably understandable" and corresponds to "accepted professional practices."

Advertising - MFTs promote themselves by disseminating information that allows "the public, referral sources, or others to choose professional services on an informed basis."

The General Principles of the American Psychological Association (APA) are as follows:

Beneficence and Nonmaleficence - Psychologists aspire to benefit their clientele and strive to do no harm. They protect the welfare and rights of those with whom they have direct

contact as well as other affected people. Given conflict between psychologists, they seek responsible resolution that avoids or lessens harm. Psychologists acknowledge that their professional work affects others and they avoid "misuse of their influence." They are aware of the effects of their own mental and physical health upon their clientele.

Fidelity and Responsibility - Psychologists maintain trust in their working relationships, and they recognize their responsibilities to society and their community. "Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm." They consult and work with other professionals and institutions in order to best serve their clientele. Psychologists are mindful of the ethical compliance of their colleagues. They try to offer pro bono service when possible.

Integrity - Psychologists foster "accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology," and they do not misrepresent themselves. They uphold their word and avoid "unwise or unclear commitments." In cases where ethically justifiable deception is used to maximize therapeutic benefit, psychologists strive to resolve any ensuing mistrust or harm resulting from usage of the technique.

Justice - Psychologists understand that the principles of fairness and justice entitle all persons to benefit from the field of psychology. Psychologists affirm that their potential biases, competence level, and scope of practice do not create unjust practices.

Respect for People's Rights and Dignity - "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." Psychologists are cognizant of the need to protect the rights and welfare of those with physical or psychological impairments that reduce autonomous decision making. "Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups." Psychologists strive to eliminate bias based on the factors listed above and they do not condone such prejudice by others.

The American Counseling Association (ACA) defines their Ethical Principles in the following manner:

The Counseling Relationship - "Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships." Counselors try to understand the cultural backgrounds of their clients, their own cultural identity, and how this information affects their perception of the counseling process. Counselors are encouraged to contribute to society by offering pro bono service.

Confidentiality, Privileged Communication, and Privacy - Trust is understood to be essential to the counseling relationship, and counselors enlist trust by "creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality." Counselors express the limits of confidentiality "in a culturally competent manner."

Professional Responsibility - Counselors communicate with other professionals and the public in a transparent, honest, and factually correct manner. They practice in a non-prejudiced way within the scope of their professional and personal competence and comply with the ACA Code of Ethics. Counselors participate in national, state, and local associations that further the development of counseling. They support change that fosters improved quality of life for all people and entities and they try to eliminate barriers that impede provision of services. There is an accepted public responsibility to offer counseling that is based on "rigorous research methodologies." Further, "Counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities."

Relationships With Other Professionals - Counselors establish positive working relationships and communication lines with colleagues designed to improve client services.

Evaluation, Assessment, and Interpretation - Counselors utilize assessment instruments as one tool in the counseling process, factoring in client personal and cultural context. Counselors facilitate the well-being of their clientele "by using appropriate educational, psychological, and career assessment instruments."

Supervision, Training, and Teaching - Counselors maintain purposeful and respectful professional relationships and retain appropriate boundaries with supervisees and students. "Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training."

Research and Publication - Counselors who conduct research are open to adding knowledge to the profession and clarifying the variables that contribute to "a healthy and more just society." Counselors facilitate the efforts of researchers by participating whenever possible. "Counselors minimize bias and respect diversity in designing and implementing research programs."

Resolving Ethical Issues - Counselors act "in a legal, ethical, and moral manner" in the conduct of their professional work. They understand the connection between client protection/trust and professionalism, and they expect these high standards to be upheld by other counselors. Counselors try to resolve ethical dilemmas with honest and direct communication and receive consultation with supervisors and colleagues when needed. "Counselors incorporate ethical practice into their daily professional work." They attain "ongoing professional development regarding current topics in ethical and legal issues in counseling."

The Ethical Standards are enforceable rules of conduct that may be conceptualized as the ethical floor in which practitioners must abide and not fall below. The standards set the minimum level of performance for the profession,

which assumes an expectation to comply with a standard of care in practice, research, teaching and training. Essentially, the standards set the principles into motion, clarify the profession's values, and offer guidance in daily professional functioning.

This course presents various standards within the Code of Ethics, commentary supporting the standards, and case scenarios designed to bring the standards in unison and to life.

Conflicts Between Code and Organizational Policies

Conflicts with organizations can be more difficult to resolve as compared to issues with individual clients or government policy or regulation because practitioners are working with people with whom they have different levels of rapport and relationship. The types of organizational agencies that clinicians work with is expanding and includes mental health agencies, hospitals, insurance companies, schools, corporate and business concerns, government agencies, managed care companies, correctional systems, and government, public, and private funding agencies. The clinician's working relationship with these organizations varies, partly related to whether the work role is that of employee, consultant, or affiliate (i.e., private work versus working for a company in a collaborative manner).

The Ethics Codes indicate the need to express an ethical conflict and to uphold the Ethics Code standards "to the extent feasible" or to "take reasonable steps." Taking reasonable action is often influenced by clinicians role and status in the organization, decision-making authority in the organization, communication lines of reporting authority, organizational policies that affect the nature of the ethical concern, required funding to make a change, and the extent of interpersonal relationships. Regardless of these variables, clinicians must comply with the Ethics Code, but contemplation of these factors can facilitate effective compliance. Competent compliance can enhance the role of practitioners to being educators who improve quality care, and organizational professionalism and policymaking.

Clinicians may include other Ethics Code standards to help resolve organizational conflicts such as conflict of interest, confidentiality, and informed consent. As a brief reminder regarding confidentiality, in New York, resulting from recent mass shootings, including in Aurora, Colorado, and Newtown, Connecticut, a New York law was enacted on January 15, 2013, changing from a permissive to a mandatory duty for mental health professionals to report when they have determined that a client presents a serious and imminent danger to self or others.

Additionally, mental health professionals are mandated to report clients who may pose a danger to self or others to local mental health officials with the goal of preventing gun violence. The reason(s) for the disclosure must be documented in the clinical record. Specifically, the Secure Ammunition and Firearms Security (SAFE) Act, effective March 16, 2013, is a gun control statute that regulates access to firearms and ammunition and requires mental health professionals, including physicians, psychologists, registered nurses, and licensed clinical social workers to make a report given client behavior that would yield serious harm to self or others, regardless of a legal firearm being implicated or not.

The following “SAFE Act” information is applicable to New York LCSWs and psychologists (as indicated in the first paragraph of the SAFE Act text), not to New York LMSWs, LMHCs or LMFTs.

The SAFE Act adds new provisions, entitled Mental Health Law Section 9.46 - Reporting Requirements for Mental Health Professionals, including the following:

When a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee, who shall report to the division of criminal justice services whenever he or she agrees that the person is likely to engage in such conduct. Information transmitted to the division of criminal justice services shall be limited to names and other non-clinical identifying information, which may only be used for determining whether a [gun] license issued... should be suspended or revoked...

Nothing in this section shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to a potential victim or victims.

The decision of a mental health professional to disclose or not to disclose in accordance with this section, when made reasonably and in good faith, shall not be the basis for any civil or criminal liability of such mental health professional.

Once the therapist, utilizing reasonable professional judgment, determines that a client represents a serious and imminent risk to self or others that requires a warning to law enforcement or to a potential victim, then the therapist must also submit a SAFE Act report. Procedurally, the therapist would contact law enforcement, notify a potential victim, where applicable, and send a report to the online Integrated SAFE ACT Reporting Site (ISARS) at this Web address: http://www.omh.ny.gov/omhweb/safe_act/index.html

SAFE Act reporters must be currently treating the individual being reported and the report should be made to the Director of Community Services (Mental Health Director), or the director's designee, of the County where the person being reported lives. The criterion for reporting is the standard "likelihood to result in serious harm" which is defined as threats of, or attempts at, suicide/serious bodily harm to self or homicidal/violent behavior toward others. This standard authorizes a need for immediate action,

promoting public safety and preventing harm.

The information to be reported includes:

a) Client identifying information: name, address, date of birth or approximate age, gender, race, and social security number, if available.
b) Axis I and Axis II diagnoses
c) The reason(s) the reporting therapist has concluded that the client is likely to present a serious and imminent danger to self or others.
d) The treatment relationship of the reporting therapist to the client, and the last date seen by the therapist.
e) The reporting therapist's identifying information: name, licensed profession and license number, last four digits of social security number, phone number and email address where therapist can be reached if more information is required.
f) An affirmation that you are the professional indicated as the submitter of the report, and the report is truthful to the best of your knowledge.

If the county mental health official agrees with the Section 9.46 report, then he or she will report "non-clinical identifying information" (i.e., name, gender, date of birth, social security number, race, and address) to the New York State Division of Criminal Justice Services (DCJS). The reported individual's identifying information is added to a DCJS database of persons disqualified for five years from obtaining or retaining a firearms license and from possessing a firearm. DCJS determines if the reported person holds a firearms license, if so, they inform the local licensing official who will suspend or revoke the license 'as soon as practicable.' The reported person must surrender such license and firearms to the licensing officer, and if the reported person does not voluntarily surrender the guns then the police are authorized to seize them. Hence, the SAFE Act is designed to identify and disarm licensed gun owners who have had their Section 9.46 report accepted.

The SAFE Act reporting requirement only limits access to legal firearms, as such, it does not serve to notify law enforcement or to warn that the client presents a serious and imminent danger to self or others.

The decision making process whether to submit a Section 9.46 report involves a clinical determination that the client's mindset presents either "(a) a substantial risk of physical harm to the person, as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm."

SAFE Act confidentiality and liability concerns are addressed by the following points:

1. Mental health professionals will not be subject to any civil or criminal liability when the decision to report or the decision to not report was made "reasonably and in good faith."
2. Mental health professionals are not required to report if their reasonable professional judgment concludes that reporting would endanger the mental health professional or increase danger to the potential victim(s).
3. Due to the SAFE Act report disclosure being required by law (upon the conditions for making a report being met), the mandated report can legally be submitted without requiring the client's consent. Mental health professionals may, but are not required to, inform the client of their determination to file a SAFE Act report.
4. Clients will not have access to the SAFE Act report or to the reporter's name or contact information, but clients may become aware that a report was filed upon requesting a copy of their medical record.

Given that ethical codes of associations may be different from New York law, psychologists must comply with the rules and regulations compiled by the Board of Regents and the State Education Department which are accessible at a number of websites, including:
www.nics.ny.gov/sa-guidance-documents.html

Given that ethical codes of associations may be different from New York law, LMSWs and LCSWs must comply with the rules and regulations compiled by the Board of Regents and the State Education Department which are accessible at this Website:
http://www.op.nysed.gov/prof/sw/swlaw.htm

Given that ethical codes of associations may be different from New York law, a New York State LMHC is responsible for complying with New York laws, rules and regulations. LMHCs can access the laws, rules and regulations that define the practice of mental health counseling and continuing education at this Website:
http://www.op.nysed.gov/prof/mhp/mhplaw.htm

Given that ethical codes of associations may be different from New York law, a New York State LMFT is responsible for complying with New York laws, rules and regulations. LMFTs can access the laws, rules and regulations that define the practice of marriage and family therapy and continuing education at this Website:
http://www.op.nysed.gov/prof/mhp/mhplaw.htm

The standards involving conflicts between Ethics and organizational demands include the following:

Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organization's practices are consistent with the NASW Code of Ethics (NASW, 2008, 3.09.d.).

If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights (APA, 2010, 1.03).

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is

affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and take reasonable steps to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics (AAMFT, 2015, Preamble - Ethical Decision-Making).

If the demands of an organization with which counselors are affiliated pose a conflict with the ACA Code of Ethics, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the ACA Code of Ethics and, when possible, work through the appropriate channels to address the situation (ACA, 2014, I.2.d.).

Case 1: Conflicts Between Code and Organizational Policies

Case Scenario - Therapist A is a school counselor who assesses students for behavioral management plans and special education services. She is referred students by the school guidance staff. After several months in this position, she was shocked to learn that the guidance staff does not obtain informed consent from parents before referring the students to her for psychological services. Therapist A informed the school district superintendent of the lack of informed consent and was told that parents receive a policies and procedures handbook when they enroll their child in school and the handbook states that school authorities can refer their children for educational and psychological assessment services "at their discretion and without prior notice." The school superintendent explains that the school district's attorney believes this method is acceptable for informed consent and "it would be too much of a hassle to ask parents first every time we wanted to do some psych assessments on a kid."

Therapist A wanted to continue working in this school district but was concerned about the potential hazards inherent in this school policy and realized she needed a well-deliberated plan. She wondered if other school counselors and staff in the district knew of this policy, or if they also assumed informed consent was routinely obtained by guidance staff from the parents. She acknowledged that she had not carefully read the handbook of policies and procedures, had not questioned about routine procedures or how district policies might affect her work, upon being hired.

Ethical Concern - This case represents conflicts between organizational demands and the Ethics Code. Therapist A's conflict is between her ethical responsibility regarding informed consent and the school district practices that she believes violate "the autonomy, self-determination, and decision making of parents." Therapist A needs informed consent from parents or guardians before providing professional services to students. In contrast, the school district superintendent told Therapist A that, in their opinion, it is acceptable to give parents/guardians the school handbook that includes the statement that students may be "referred for assessment services without prior or additional notice to the parents or guardians." Therapist A considered that she had no complaints from parents during her short tenure so she wondered if parents simply did not question school policy. She concluded, however, that the number of complaints is not the test of ethical behavior. Factually, the school's presumptuous position regarding testing of students bordered on potential exploitation "because the parents were not being given a choice about their children's evaluations or the consequences of placement or behavioral regimen resulting from the evaluation."

Decision-Making Considerations - Therapist A described the nature of the ethical concern and its effects on professional practice in her school counseling setting. She should be aware of the specific standard(s) involved in the conflict between organizational demands and the Ethics Code during her discussions with the school superintendent or other relevant school officials (i.e., Standard 3.09.d. for social workers or the Preamble - Ethical Decision-Making for MFTs). The standards also indicate a need to attempt resolution of the conflict. For example, social workers "take reasonable steps to ensure that their employing organization's practices are consistent with the NASW Code of Ethics," and psychologists "to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code." Therapist A will need to consider whether she believes that the school handbook sufficiently discharges her duties to obtain informed consent or whether her specialized practices are permitted under Standard 9.03 (for psychologists).

Standard 9.03 for psychologists involves informed consent in assessments and states that informed consent is required for "assessments, evaluations, or diagnostic services" unless "testing is mandated by law or governmental regulations." It could be debated that the nature of Therapist A's work, which involves psychological services for determination of special educational services, is a type of testing mandated by governmental regulations. Standard 9.03 also waives the obligation for informed consent when it is "implied because testing is conducted as a routine educational, institutional, or organizational activity." Therapist A will need to determine whether her psychological services fall under the provision of routine educational services "in particular in light of a formalized policy of notification of the provision of psychological services in the school handbook provided to parents."

If Therapist A does not believe that Standard 9.03 resolves the possible conflict involving informed-consent responsibility, then she will need to consider how she can resolve the conflict "to the extent feasible" or, for MFTs, "attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics." Feasible and reasonable is a fact-driven judgment regarding possible outcomes, accompanying risks and benefits to these outcomes, "the vulnerability of various parties to the process," and other relevant variables. The standards on informed consent state the following:

Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substituted consent is legally permissible. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client (a) has the capacity to consent;

(b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented (AAMFT, 2015, 1.2).

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship (ACA, 2014, A.2.a.).

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code.

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent (APA, 2010, 3.10).

Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional , or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers (APA, 2010, 9.03.a.).

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a thirdparty payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible. (c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party (NASW, 2008, 1.03).

Decision Options - Therapist A contemplated the situation and secured a second appointment with the school superintendent that was also attended by an attorney for the school district. She convinced the superintendent to approve the following three provisos: a) "special attention would be drawn to the provision for referral for psychological assessment in the handbook at school orientation and a mailing home to parents at the beginning of each school year," b) parents were given an "opt-out" choice for referrals for assessment without prior notification, and c) Therapist A was allowed to call the parents of students who were referred by school staff to communicate about the assessment process. They agreed that in the case of a parent disagreeing with the assessment, Therapist A would enlist the assistance of school authorities to resolve the situation before she would proceed with the assessment. Therapist A agreed to work in this manner pending more consultation from informed colleagues in school counseling, in the Ethics Code, and, if necessary, from the ethics office of her association..
(Campbell, Vasquez, Behnke, & Kinscherff, 2010)

Case 2: Conflicts Between Code and Organizational Policies

Case Scenario - Therapist B works for an organization that contracts to provide assessments of recently sentenced inmates on a correctional classification unit. Therapist B and his colleagues provide treatment to inmates who manifest significant distress or mental illness symptoms during the weeks before the inmates get transferred to other prison units. The prison administration sent managerial correction staff to inspect the assessment and treatment records overseen by the organization in response to several disruptions on the unit that yielded injury to inmates and correctional staff. Therapist B and his colleagues were told by their contracting organization that treatment records were confidential, and they so informed the inmates. The assessment records were given to prison authorities to assign inmates to various facility units, but treatment was provided with a standard informed consent that included confidentiality of treatment. Therapist B refused to provide treatment records upon their request by the correctional agency, and he was told that all records produced on the classification unit are owned by the correctional agency, and "he will be removed from the prison immediately and permanently if she does not provide access to them immediately."

Ethical Concern - Therapist B is contracted to offer clinical services in a correctional facility in which preserving physical safety is essential. The inmates were told that assessments would be made and used for assignment to prison units, and they were also informed that "any records regarding treatment provided after assessment were confidential." If all clinical records are the work product of the contracting corrections authority then the corrections

authority is the client, in turn, Therapist B may have to provide the records for inspection, despite the fact that the inmates were informed that confidentiality was afforded. Therapist B now realizes that he should have learned about the policies and status of the records before onset of inmate treatment. He acknowledges that the correctional agency is the client of his organization, hence, his client, but he assumed that the inmate informed consent was the correctional agency's agreement to uphold confidentiality. Therapist B senses justification in defending against the release of records and maintaining confidentiality of the inmates as best as he can - but he does not have time to waste.

Therapist B is knowledgeable of the Standard pertaining to "Conflicts Between Code and Organizational Policies" and the association to his predicament. He is also aware of the Standards regarding confidentiality and its limits, as indicated below:

Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification (ACA, 2014, B.1.c.).

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached (ACA, 2014, B.1.d.).

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship (APA, 2010, 4.01).

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

(b) 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.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality (APA, 2010, 4.02).

(c) 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.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship (NASW, 2008, 1.07).

Marriage and family therapists disclose to clients and other interested parties at the outset of services 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, 2015, 2.1).

Therapist B was certain that the inmates disclosed more rather than less given his understanding that confidentiality would be protected. He knew that inmate trust and openness would be jeopardized and possibly irreparably damaged if confidentiality was not honored.

Decision-Making Considerations - Therapist B must contemplate what is reasonable and feasible to do under, for example, AAMFT Preamble - Ethical Decision-Making, which indicates the need to a) make known to the organization their commitment to the AAMFT Code of Ethics, and b) attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics. He will need to consider feasible action relative to the correctional administration, the correctional facility staff, his employing organization, the inmates who have received treatment and the treated inmates whose records the prison staff are demanding. He feels ethically obligated to respond to each of these involved groups. Further, he will want to learn about the existing contract between his organization and the correctional system concerning informed consent, confidentiality, and the correctional agency's bounds of authority.

Therapist B is keenly aware of the need to make a decision regarding allowing the correction agency's access to the inmates' treatment records promptly or he will be removed from the prison where he works immediately and permanently.

Decision Options - This dilemma could have been avoided with more timely, initial contemplation of confidentiality issues of records created by Therapist B's contracting organization. Specifically, the contracting organization could have negotiated with the correctional agency over the confidentiality of inmate treatment records before treatment services began. The informed consent given to inmates when treatment began could have indicated the limits of confidentiality if, in fact, the prison authorities persisted on having on-demand access to treatment records.

Many situations that culminate in conflicts between organization demands and ethical duties can be approached proactively rather than reactively. Resulting from this dilemma, in the future, Therapist B decides to change his consulting agreements with third parties and organizations. He now concedes that communicating, negotiating, and agreeing on all of the items in Standard 3.07, Third-Party Requests for Services, and Standard 3.11, Psychological Services Delivered To or Through Organizations, with the client would reduce the likelihood of another similar dilemma in the future. These standards indicate the following:

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of

who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality (APA, 2010, 3.07).
(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.
(b) if psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service (APA 2010, 3.11).

Therapists who are employed by or affiliated with organizations are encouraged to acknowledge areas of potential conflict along with uncertainties about professional duties and organizational demands with the aim of resolving issues in advance.

Therapist B attempted resolution from several angles. Initially, he told the corrections staff that he was about to contact the correctional authorities and that he was not planning on releasing the records until further discussions occurred. He then called the chief operating officer of the clinical services organization that hired him for the contract with the correctional agency. The chief operating officer called the prison warden to arrange a discussion. In the meantime, Therapist B sought consultation from some colleagues specialized in this area in search of his options. He was open to communicating with the inmates whose confidentiality was jeopardized depending upon the results of the discussions. If Therapist B and his company could arrange to protect inmate confidentiality, then the inmate communication would not occur. Either way, he gained knowledge about confidentiality for future services under this contract and he would request a change to the informed consent to express the real position of the inmates on several ethical standards. If the discussions result in the need to release the inmate records, then Therapist B will assess, on an individual basis, the inmates he engaged in psychotherapy and will determine what to communicate to them. (Campbell, Vasquez, Behnke, & Kinscherff, 2010)

COMPETENCE

Professional competence is the essence of ethical practice for mental health professionals and the assumption of competence exists in the implementation of each ethical standard. Competence correlates with the concepts of beneficence and nonmaleficence in that practitioners strive to benefit and do no harm to their clientele. In the absence of competence, demonstrating beneficence and nonmaleficence and enacting the standards would be difficult.

Competence within the Ethics Codes can be conceived as being skill-based and relational-based. Skill-based competence involves abilities acquired through formal education and training, maintaining skills by updating new information, and receiving training in new areas of practice. Relational-based competence reflects the process abilities of self-assessment, self-monitoring, self-evaluation, and insight (intrapersonal functions), along with understanding one's influence on others, the power differential in professional relationships, use of personhood in professional interactions, and keen observation (interpersonal functions).

Skill-based incompetence frequently surfaces as scope-of-practice violations and inability to acknowledge skill deficiencies. Relational-based incompetence can manifest as loss of judgment and poor assessment of risk conditions. In contrast, observing correctly and interacting deeply with others facilitates effective professionalism, while being insightful of one's own values, beliefs, biases, and self-perception fosters effective self-monitoring and therapeutic intervention.

Examples of standards regarding competence include the following:
Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies (AAMFT, 2015, 3.10).
Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience (NASW, 2008, 1.04.a.).
Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience (APA, 2010, 2.01.a.).
Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. (ACA, 2014, C.2.a.).

Practicing outside of one's scope of practice commonly occurs when practitioners perform a professional activity that is different or new relative to their established area of expertise. Such misperceptions can arise when overlap exists between the existing area of expertise and the different or new professional activity that necessitates additional professional development. By example, a therapist with experience in assessment including psychoeducational assessment, general psychological reports, and developmental evaluations may observe that completing child custody evaluations uses some of the same assessment instruments and may misperceive that no additional training is needed for a transition into child custody. Likewise, clinicians with clinical expertise with individuals and families involving interviewing skills, school and agency consultation, and systems intervention may wrongly conclude that these skills, which are common to organizational psychology, allow complete transferability to working within organizational psychology without any additional education or consultation. Reliance on such common skills to extend one's area of established expertise or expand into a new area of practice, without additional study, can be risky.

Mental health professionals can expand their areas of expertise given the attainment of any required education, training, supervised experience, consultation, study, or professional experience. Acknowledgment of one's area of competence and when such boundaries are over-extended is a

challenge, but operating outside of accurate boundaries can lead to a slippery slope.

Displaying competence in working with diverse groups is essential and reflects APAs General Principle E: Respect for People's Rights and Dignity. When working with diverse populations, practitioners are wise to: a) be cognizant of scientific or professional knowledge relevant to the party, b) if a knowledge base exists, then acquire the needed proficiency, and c) if necessary, refer the client to a qualified provider. Utilization of scientific or professional knowledge helps therapists to self-assess their level of proficiency in working with diverse groups.

Decision making with special populations is facilitated by knowing and honoring the values of the general group as well as respecting the individuality of the client who is a group member. Assessing the client's cultural identity, degree of assimilation, family context, language, and personal goals is pertinent to comprehending the client's subjective world.

Therapist membership in their client's identified group does not necessitate a deeper understanding of the client. Clinicians who share with their client the common characteristics of similar family-of-origin and socioeconomic status, for example, and who thus adopt an apparent deep connection with the client, can make judgment errors. The assumption that shared characteristics necessarily leads to competent practice can result in countertransference, lack of objectivity, inadequate treatment planning, and inaccurate expectations of the clients and their goals.

If scientific or professional knowledge regarding a diverse group does not yet exist, then practitioners strive to be aware of potentially important factors that can affect delivery of services and they progress with respect to gain understanding of the client.

The standards regarding non-discrimination and becoming informed about diverse populations include the following:

Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability (NASW, 2008, 1.05.c.).

Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals ... (APA, 2010, 2.01.b.).

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status (AAMFT, 2015, 1.1).

Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population (ACA, 2014, C.2.a.).

The following standards refer to the need for preparation when encountering new areas of expertise:

Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study (APA, 2010, 2.01.c.).

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm (ACA, 2014, C.2.b.).

Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience. (AAMFT, 2015, 3.1).

Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques (NASW, 2008, 1.04.b.).

Case 3: Competence

Case Scenario - Therapist C was asked to evaluate a child's parents after hospital staff reported the parents to child welfare. The parents are new immigrants to America and cannot communicate effectively with the hospital staff. Hospital staff reports that the parents rely too heavily on traditional healing methods of their country-of-origin which is endangering proper care of their child's grave medical condition. Hospital staff declared this to be medical neglect and child welfare is contemplating taking custody of the child. Therapist C will have to explain to the child welfare department that the parents' refusal to give medical care at home adhering to hospital medical staff instructions is not medical neglect, otherwise, the child will be removed and placed in medical foster care pending the filing of a child abuse case in court. The child welfare department will give Therapist C and the parents three weeks until rendering a decision and, in the meantime, they place the child in a relative's home. Therapist C acknowledges that several factors exist in this case that could hinder her accurate evaluation of the parents. Therapist C routinely honors the ethical obligation to become culturally competent and to pursue training in diversity when needed, hence, she feels competent in various practice areas. She does not feel competent, however, in this case due to lack of knowledge in nontraditional healing practices and the limited time factor involved.

Ethical Concern - The standards indicate the need to comprehend diversity factors "essential for effective implementation of services" or to "obtain the training, experience, consultation, or supervision necessary to ensure the competence of services, or make appropriate referrals" unless one is providing emergency services. The 3-week time frame probably rules out this situation as an "emergency," nonetheless, Therapist C is encountering difficulty because she lacks supervision, consultation, or awareness of a referral source for the parents. The child will be placed in medical foster care and the parents will face legal action if Therapist C does not complete the assessment or submits an inaccurate assessment that projects the parents as being neglectful. Acting too slowly will exhaust the 3-week time frame, not pursuing needed consultation/supervision or an adequate referral jeopardizes

the family and leads to legal action. Such inaction could result in Therapist C's violation of the competence standard, additionally, she should consider Ethical Principle A: Beneficence and Nonmaleficence "to safeguard the welfare and rights of those with whom they interact professionally" and General Principle E: Respect for People's Rights and Dignity such that if Therapist C takes the case, she is obliged to administer an objective evaluation, and to respect the clients' privacy, confidentiality, and self-determination.

Decision-Making Considerations - Therapist C's decision on whether and how to proceed with this case involves different considerations, such as follows:

a) the chance of acquiring proper supervision or consultation expediently;
b) the probability that Therapist C, the hospital staff, or the child welfare authorities will find an appropriate professional to refer the case;
c) the consequences of performing an inaccurate assessment to the child should the parents be evaluated more favorable than is the case, and to the parents should they be viewed more neglectful than they should be, as opposed to the absence of any assessment which would result in family disruption and legal action; and
d) the chance that understanding the motive and perspective of the parents would affect the child welfare's determination.

Therapist C acknowledges Standard 2.01 (b) in that "professional knowledge establishes that an understanding of factors ... is essential for effective implementation." She considers that hospital staff and child welfare authorities are not cognizant of the family's traditional healing methods relative to their child's medical needs. Also, the parents perspective on the child's needed medical care is a question mark. Therapist C hopes to assemble the comprehensive information required to provide a reliable determination.

Decision Options - Therapist C accepted the case and asked the child welfare authorities for a time extension beyond three weeks as long as the child was not at risk during placement with the relative and progress was occurring. The time concession was granted, then she requested the hospital's interpreter service to locate an interpreter, which was found in a nearby locale. Therapist C told the interpreter of the child protection issues, explained the interview and assessment process that would occur, and obtained informed consent from the parents. Through discussion with the interpreter and Internet researching, she learned of a medical anthropologist at a college across the country who wrote several articles about the healing practices and perspectives of the parents' culture and ethnic group. Therapist C arranged a telephone consultation with the medical anthropologist and clarified that the parents' usage of traditional healing practices was not, by definition, child neglect, because the parents may not understand the hospital's home care treatment plan and may not agree with the medical model's projected cause of the illness.

The medical anthropologist recommended that the parents invite to a meeting the traditional healer who was medically advising them on their child's care. This meeting would not occur until two weeks later but child welfare authorities granted additional time for the assessment process. With the interpreter's help, Therapist C instrumentally organized a conference between herself, the traditional healer, the parents, and the physician who was initially concerned about the child. It quickly became evident that the parents showed no intent to medically neglect the child, instead, they deeply desired his recovery. In fact, the parents brought their child to the hospital after the traditional healer's failed treatment attempts. The traditional healer disclosed his healing practices, the treatment procedure instructions given to the parents, and that he accepted usage of prescribed medicines. The physician accepted usage of the traditional healer's rituals and herbs in addition to the mandatory Western medicine procedures. The physician articulated potential serious consequences of not taking the prescribed medication (which helped Therapist C's case because it revealed the medical staff's elevated concern). The physician and therapist became aware that the parents simply did not understand the prescribed medication regimen without proper interpretation. Hence, the parents were instructed to bring their child to the hospital with a child welfare caseworker when the interpreter would be present for medication regimen instructions for the child.

An interesting nuance within the competency standards is that the "training, experience, consultation or supervision necessary to ensure the competence" does not always pertain to the therapist's direct services. In this case, the instrumental consultation involved the interpreter, treating physician, medical anthropologists, and traditional healer. Each of these consultants significantly contributed to Therapist C's understanding the intent and perspective of the parents, and to a conclusion supportive of the child's well-being. She also realized that creativity and unconventional methods may be required to attain reliable results (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

As the field of psychology evolves and legal activity expands, clinicians may be called into court situations. Even practitioners who do not specialize in forensic work but who practice in areas that periodically juxtapose to forensic activity, such as marital, family therapy, and trauma, can familiarize themselves with rules of the court and applicable legal principles. Mental health professionals working in forensic psychology as expert witnesses or evaluators are responsible to understand court procedures, judicial rules and laws pertinent to their specific subject matter. The standards relevant to forensic matters indicate:

When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles (APA, 2010, 2.01.f.).

Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others (ACA, 2014, C.6.b.).

Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their

professional recommendations and opinions through testimony or other public statements (AAMFT, 2015, 3.11).
Social workers should strive to become and remain proficient in professional practice and the performance of professional functions (NASW, 2008, 4.01.b.).

Case 4: Competence

Case Scenario - Therapist D, who specializes in working with children, sent a letter of introduction to local family court judges indicating that she was available as an evaluator in divorce child custody cases. Over time, referrals were received and in one case, therapist initiated interviews with the separated parents and their child. Therapist D sensed that the custody dispute was resolvable through mediation and she, in turn, discontinued the evaluation process and began a mediation process. Therapist D utilized standard mediation practice and informed each parent that all information shared during the mediation process is confidential unless a mandated reporting obligation arose. The mediation involved negotiating financial matters and discussing visitation scheduling issues triggered by an ongoing affair of which the other parent is not aware. The mediation attempt proved unsuccessful so Therapist D restarted the custody evaluation. She told the judge and involved attorneys that all information that was disclosed during the mediation was confidential, but the judge instructed her to respond to court demands and stressed her "obligation to be forthcoming with the court." Therapist D became aware that she did not establish: a) specifically who her client was; b) to whom, if anyone, confidentiality was to be maintained; c) the difference between and purpose of a custody evaluation in contrast to mediation; and d) her role in the process and expectations of this role.

Ethical Concern - The above-mentioned standards pertinent to forensic matters specify the need for therapists to be "reasonably familiar with the judicial or administrative rules governing their roles." Practitioners who are reasonably aware of the rules that dictate their roles in legal or forensic situations can differentiate between clinical and forensic professional practices. They can identify legal and administrative procedures enough to not unintentionally compromise the interests of those involved in the legal proceedings (i.e., confidentiality and privilege violations) or slow the legal proceedings. Therapist D is a children's specialist, but her unfamiliarity with judicial and administrative proceedings in her jurisdiction relative to the role of divorce child custody evaluator has yielded misrepresentation, agreements that cannot be obliged, and uncertainty of her capability to complete a custody evaluation. She was granted responsibility to render a determination about custody, instead, Therapist D altered her service to mediation and adopted the role of negotiator, and possibly, therapist, as opposed to that of evaluator. This jeopardized the parents because they disclosed personal information in a negotiation setting which they may have chosen to withhold in an evaluative setting. Additionally, Therapist D granted confidentiality to the parents, but the court was her client, not the parents.

This case would also involve Standard 3.07, Third-Party Requests for Services, which states:
When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality (APA, 2010, 3.07).
Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality (AAMFT, 2015, 1.13).
Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others (ACA, 2014, C.6.b.).
Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship (NASW, 2008, 1.07.e.).

Irrespective of whether the case was forensic or not, the parents would not have been the clients of Therapist D, hence, they probably would not have been included in a confidentiality agreement.

Therapist D may have violated the following standards as well:

Avoiding Harm:
Social workers' primary responsibility is to promote the well-being of clients (NASW, 2008, 1.01).
Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship (AAMFT, 2015, 1.9).
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable (APA, 2010, 3.04).
Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm (ACA, 2014, A.4.a.).

Multiple Relationships:
Marriage and family therapists are aware of their influential position 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 or multiple roles, therapists document the appropriate precautions taken (AAMFT, 2015, 1.3).
When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest (NASW, 2008, 1.06.d.).

... If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately (ACA, 2014, A.8).

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.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur (APA, 2010, 3.05 a.b.c.).

Boundaries of Competence:

When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles (APA, 2010, 2.01.f.).

(ACA, 2014, C.2.b. - previously cited).

(NASW, 2008, 1.04.b. - previously cited).

Marriage and family therapists pursue appropriate consultation and training to ensure adequate knowledge of and adherence to applicable laws, ethics, and professional standards (AAMFT, 2015, 3.2).

(AAMFT, 2015, 3.10 - previously cited).

Therapist D has acquired expertise in working with children, parents, performing evaluations, and treating the harmful effects of divorce and marital strife on children. The competency and skill set specifically required in forensic work was new to her, and now she realizes the difference between these two disparate roles.

Decision-Making Considerations - To begin, Therapist D, within her jurisdiction, has a limited scope of practice as described by the conditions of her court appointment. Specifically, she has court authorization to perform an evaluation in a divorce custody proceeding but she lacks authority to go beyond this appointing court's approval.

Second, to illustrate a point, Therapist D's jurisdiction deems it to be the practice of law to perform divorce mediation that involves financial agreements or other legally significant agreements that reside outside the scope of psychological practice. Thus, she may be vulnerable to sanctions by the state bar and others for practicing law without a license.

Third, courts that are hearing divorce child custody cases generally are given authority and power to overcome privacy protections if, in the court's opinion, it would be in the best interests of the child. In therapist D's jurisdiction, this power encompasses confidentiality that is commonly afforded in mediation efforts when the case is court involved, unless the court orders confidentiality before the mediation begins. Therapist D was unaware of this protocol and wrongly offered confidentiality. Nonetheless, she will need to disclose information that was shared during the "confidential" mediation session when questioned by the attorneys - including the secret marital affair. In the role of mediation, Therapist D was prepared to not disclose the extra-marital affair, but as custody evaluator, she may have to expose the affair because it may be significant in making an effective custody decision.

Fourth, quasi-judicial immunity to court-appointed experts and evaluators is granted by many jurisdictions which protects against malpractice suits (but not licensure complaints). This immunity from being sued is limited to activities within the score of the court's appointment. Hence, Therapist D is vulnerable to a malpractice lawsuit for the mediation, including improper mediation of financial issues and granting confidentiality.

Decision Options - Therapist D now understands that different protocol exists between clinical roles versus forensic roles, and that the standard requires therapists who adopt forensic roles to become "reasonably familiar" with the related judicial or administrative rules. Being "reasonably familiar" with the rules involves understanding: a) the nuances and intricacies of the of the litigation; b) the consequences of the litigation (e.g., money damages, loss of child custody, imprisonment, execution); c) the rules of evidence governing the case and the therapist's role in the case; and d) the probability of involvement in the case leading to a licensure complaint, ethics committee complaint, or malpractice lawsuit.

In general, Therapist D is advised to avoid additional forensic-related work until becoming more knowledgeable of her jurisdictions' judicial rules. Pertaining to this case, she should inform the court of her previous actions that have hampered her involvement in the ongoing case and initiated problems for the court in proceeding with the case. She could suggest that the court find a different therapist, one with forensic knowledge, to conduct the custody evaluation. She must tell the parents that she cannot guarantee their disclosures from becoming part of the court record, further, any negotiated divorce process agreements will probably not be honored in the court proceeding because she was not appointed or authorized to conduct a mediation (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Providing Services in Emergencies

Psychologists can provide therapeutic services in an emergency situation without attempting to obtain competency and without previous training. An emergency is defined as a time-limited and immediate need for assistance in natural disasters, large-scale catastrophes, critical incidents of any scope, and when mental health services are not available. Incident response may be offered without prior emergency experience within the realm of providing psychological services, but this does not apply to being a

Good Samaritan outside the scope of practice of psychology (i.e., helping in a medical emergency involving a birth). Practitioners should strive to do no harm and assess the potential help versus harm of their treatment methods and their level of competency. The standard that applies to providing services in emergencies is as follows:

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available (APA, 2010, 2.02).

Case 5: Competence - Providing Services in Emergencies

Case Scenario - Dr. E is a neuropsychologist who lives and practices in a small, rural town. One day, the town is devastated by a tornado which caused many injuries and property damage. A sheriff, in a passing car, asked Dr. E to provide urgent care at the local school gymnasium to those in need. Upon arrival, she observed many adults and children in shock and was asked by the town physician to offer crisis intervention and psychological triage for the next several days until authorities send trained professionals. Dr. E is concerned because she never had disaster relief training nor had she ever provided general psychotherapy or psychological services beyond the scope of her practice as a neuropsychologist. Despite her hesitancy, Dr. E understands the community need and wants to help, simultaneously, she is cognizant of her limitations and wants to do no harm.

Ethical Concern - Standard 2.02 explicitly allows Dr. E to provide professional assistance in this emergency situation. She ponders the ethical ramifications of her involvement in the triage. Services would be provided outside the scope of her practice but within the bounds of Standard 2.02. She considers how competency issues may surface and how she may administer to people with whom she interacts in other ways, given the small town atmosphere (Standard 3.05, Multiple Relationships). She reflects on not wanting to do any harm (Standard 3.04, Avoiding Harm). In contrast, Dr. E considers General Principle A: Beneficence and Nonmaleficence, such that psychologists attempt "to safeguard the welfare and rights of those with whom they interact professionally and other affected persons." Also, General Principle E: Respect for People's Rights and Dignity, in that "special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making."

Dr. E regards her participation in the triage to be ethical, but she now must contemplate the depth of her role, and the length of time. She foresees the possibility of people disclosing personal issues, unresolved conflicts, and work problems not related to the present emergency but she does not want to spontaneously engage in psychotherapy or decision making for which she is not trained.

Decision-Making Considerations - The variables to assess are whether other mental health services are available (in this case, they are not) and whether there is an ongoing emergency (the tornado has passed but homes are destroyed, people are in shelters and emergency workers are still arriving). A distinction of the standard is that Dr. E is not required to offer services, instead, she may do so, despite the fact that she lacks the competency. An important consideration, even if not required by the standard, is whether services would be absent to the disaster victims should Dr. E not help. The standard also requires an appraisal of when appropriate services will become available (the assumption in this case is before the emergency ends). Generally, emergency personnel will make this determination, but Dr. E should be mindful of when trained professionals arrive, and their numbers in relation to victim needs. Dr. E could possibly continue to offer some assistance under supervision if she previously had "closely related experience or training" for the specific services to be provided under supervision (see below, Standard 2.01.d.) or
if appropriate services are still not available for the people she is working with.

When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study (APA, 2010, 2.01.d.).

Dr. E is advised to mindfully monitor her performance because the situation is uncertain and unpredictable. She may encounter puzzling behavior, demands, and attitudes. Though Standard 2.02 permits Dr. E's involvement, the manner of participation is her responsibility.

Decision Options - Dr. E is permitted to provide services to those in need until sufficient trained personnel arrive given the psychological trauma following the devastating tornado. She accepts that the disaster response coordinators will manage the volunteers based on the training, experience, and competency of the volunteers. It is predictable that volunteer ability levels will vary such that some will have more or less relative to Dr. E, therefore, her duration of needed service is unknown. She resolves to be helpful as long as the disaster response team requires her level of service and she will match her ability level with the victims' needs (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Personal Problems and Impairment:

Personal problems, conflicts, and impairment can adversely affect skill-based and relational-based competency. Such adversity can develop before or during the time that professional services are administered. Vulnerabilities include failure to recognize that a personal problem exists, the problem's effect on one's competence, and risks of insufficient response to the difficulty. Practitioners are advised to be cognizant of compromises to their competency due to interpersonal (i.e., divorce, illness of another, family, or financial stress), intrapersonal (e.g., burnout, depression,

phase of life issues), or medical problems (i.e., physical injury, fatigue due to illness, treatment response to illness). These issues can also trigger the blurring of boundaries in professional relationships that culminate in multiple role conflicts, sexual misconduct, and other unprofessional behavior.

When encountering life circumstances that would predictably be problematic for any other professional, the clinician can be wary of compromised performance and can manage the issue with self-monitoring. Consultation with other professionals can address problem resolution, how to professionally proceed, and assess the level of compromise that has already occurred. The standards applicable to personal problems include:

Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility (NASW, 2008, 4.05.a).

Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 2008, 4.05.b.).

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients (ACA, 2014, C.2.g.).

Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment (AAMFT, 2015, 3.3).

Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner (APA, 2010, 2.06.a.).

When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties (APA, 2010, 2.06.b.).

Case 6: Competence - Impairment

Case Scenario - Therapist F had a successful private practice but a physical condition necessitated several painful operations which resulted in her becoming addicted to prescription medication and alcohol. As her practice became increasingly difficult to manage, she decided to have a consultation with a colleague who suggested that she suspend her practice until completing treatment for the addiction. Therapist F followed this plan, in fact, her advanced addiction required admission into a residential program. She relapsed twice in the first 6 months after discharge and was readmitted to the facility. The unexpected relapses convinced her that recovery would be a life-long challenge and would necessitate constant vigilance and work. Therapist F has now maintained sobriety for the past 6 months, feels she can once again manage her private practice, and feels ready to work. She reasoned that her relapses occurred within a 6-month span and she has not relapsed in the past 6 months. Therapist F also acknowledged that she must earn an income to avoid loss of her health insurance and, secondly, not face financial devastation. She resolves the time has come to return to work.

Ethical Concern - Therapist F complied with the impairment standard by acknowledging that substance abuse hampered her professional functioning and accordingly, suspended practice. Presently, she has maintained sobriety for the past 6 months, further, she is experiencing substantial economic pressure to continue her private practice. Simultaneously, she relapsed twice within 6 months of discharge from a residential substance abuse treatment facility that required returning to the treatment program.

Therapist F complied with Standard 2.06 (b) by discontinuing to practice upon awareness that her problems could affect her work. Likewise, "Social workers whose personal problems... interfere with their professional judgment and performance... should immediately take appropriate remedial action by... terminating practice..." (NASW, 4.05.b). She must now address Standard 2.06 (a), specifically, "psychologists refrain from initiating an activity when... there is substantial likelihood that their problems will prevent their competent performance of professional activities." For counselors, the standard indicates the need to "... limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work (ACA, C.2.g.). Therapist F must assess whether her past problems would interfere with current performance. She feels a readiness and ability to return to work and resolves that her financial distress is not a critical deciding factor.

Decision-Making Considerations - Practitioners must minimize harm when they cannot practice competently, hence, Therapist F can contemplate the following considerations when evaluating the possibility of resuming professional practice:

1) Have life conditions changed which favor her sobriety if she returns to work? Are there changes in her social support system favoring sobriety?
2) Has she continued with her treatment program?
3) Does she continue to have the physical pain that initiated her substance abuse? Are there other anticipated stressors that could lead to relapse?
4) Does she have a relapse prevention plan?
5) Has she arranged for consultation or supervision upon return to work?

Decision Options - Therapist F has several colleagues and friends whom she confides in and she trusts their perspective on her progress. She plans on including their feedback along with her own sense of maintaining self-control. She may

schedule periodic meetings with medical consultants, therapists who specialize in substance abuse, and insightful friends. Therapist F may request feedback from select clients about her performance to determine her efficacy, but caution is advised in this self-monitoring approach.

Therapist F understands that hard work is prerequisite for her success. She is open to continued therapy addressing personal issues that could jeopardize her sobriety, consultation and coaching as needed - all of which were instituted after the last hospitalization. Therapist F will evaluate the need to limit clientele to those who are not highly vulnerable to impaired professional judgment or to her sudden unavailability if she must re-enter the residential treatment program. She will need a plan addressing client needs in case of a relapse. A relapse prevention plan is advised highlighting life circumstances that could trigger relapse, including the conditions of stress and pain that led to her substance abuse. She would benefit by being mindful of situations and events, professionally and personally, that could cause anxiety, heightened stress, or mood factors possibly leading to relapse. Therapist F is motivated to reclaim her professional life in an ethical manner. She notes that her insight was not sufficient to prevent movement along her slippery slope, but she hopes that the successful completion of treatment fostered greater self-awareness and self-regulation. Additionally, she has implemented support systems and health care monitors (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Nondiscrimination

The standards and principles discuss the responsibilities of practitioners to their clients. The driving force behind these standards emphasizes that power is not to be abused intentionally or unintentionally, activities are performed in just and fair ways, and communications are clearly understood by clientele. Further, clinicians' role, purpose, and goals should be made transparent enough so clients can make decisions regarding the nature of the professional relationship and the degree of trust and self-disclosure they will devote. Transparency and trustworthiness in the relationship are vital for the client to perceive the therapist as an ally.

In forensic situations, where the interest being served may not be the welfare of the individual client, practitioners do not harm a person by concealing their role thus leading to faulty client expectations of confidentiality, trust, and therapeutic alliance.

Nondiscrimination practices is one example of therapist responsibility to client. At times, therapists must make objective, discriminating observations or evaluations with clients' welfare in mind, but the nondiscrimination standard prohibits unlawful, malicious discrimination against individuals based on variables as age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status.

Therapists are human, as such, they can act unfairly, with or without awareness of their quality of care. For example, clinicians may feel uncomfortable or negative toward working with clients who function outside their own personal experience. Practitioners are advised to challenge their own generalized, unrealistic stereotypes so that providing benefit to clients, doing no harm, and dispensing respect, dignity, and justice prevails. The nondiscrimination standards include the following:

Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status (AAMFT, 2015, 1.1).

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law (ACA, 2014, C.5.).

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability (NASW, 2008, 4.02.).

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law (APA, 2010, 3.01).

Case 7: Nondiscrimination

Case Scenario - Therapist G promoted his private practice by marketing his services to an employee assistance department of a local factory. The clients are mainly from working-class and ethnic minority backgrounds. He pursued these referrals because he is in need of building his practice. At a particular social event for therapists, within a small group, he revealed that he found this referral source, but he did not address the relevance of acquiring training and experience to effectively work with this diverse group and he described his practice as solely driven by business conditions of client availability rather than by quality care.

In another small group, Therapist G criticized the cultures and customs of his clientele, expressed his belief that affirmative action creates unfair advantage for people of color, and that he disapproves of the factory's scholarship program for children of the employees. He disclosed a sense of entitlement and that working with the factory clientele was temporary until he would ultimately work with wealthier clients. His interest in the profession seems solely financially driven. Therapist G then boasted about having avoided a required cultural awareness course while attending graduate school. Therapist Z witnessed all of Therapist G's disclosures and felt amazed and alarmed.

Ethical Concern - Therapist Z is aware of the standards and principles regarding Nondiscrimination; Beneficence and Nonmaleficence, in that practitioners benefit clientele and they do no harm; Justice, such that fairness and justice entitle everyone to access and benefit from the contributions of

psychology and to equal quality of care; and Respect for People's Rights and Dignity, which requires avoidance of work biases that originate from diversity factors.

Therapists Z is concerned about Therapist G's stereotypes and biases and is working with these populations, for the single purpose of economic gain. Therapist Z clearly sees Therapist G's sense of entitlement and privilege relative to the working-class clients with whom he will work. Therapist Z questions whether Therapist G has the training required to obtain competence to work with this population, if not, Therapist G may be working outside the scope of his practice, which would bring the standard on competence into the picture. Likewise, the standard on Avoiding Harm may be involved, which instructs practitioners to take reasonable steps to avoid harming clientele. Therapist Z is particularly concerned that Therapist G could possibly harm due to a lack of respect and empathy and a failure to create a therapeutic bond with the clients. Along with this possible skill incompetence, Therapist Z foresaw Therapist G's possible relational incompetence in terms of interpersonal deficiency, insensitivity, and a lack of professional integrity.

Decision-Making Considerations - Therapist Z contemplates ACA Standard I.2.a., Informal Resolution, which indicates that when counselors suspect that another counselor has committed an ethical violation, they try to resolve the matter by addressing the issue with that practitioner if an informal resolution seems plausible and the intervention does not violate confidentiality. Likewise, NASW Standard 2.10 states, “Social workers who have direct knowledge of a social work colleague’s incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.” Therapist G may or may not have already committed a violation, but it is realistic to assume that he will do so given his present attitudes and biases. Even if a violation has not occurred as yet, the intent of the Informal Resolution Standard allows for active involvement in a situation which suggests an ethical violation is reasonably likely to occur. Informal Resolution Standards state:

When counselors have reason to believe that another counselor is violating or has violated an ethical standard, and substantial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved (ACA, 2014, I.2.a.).

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved (APA, 2010, 1.04).

Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action (NASW, 2008, 2.10.a.).

Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct (AAMFT, 2015, 1.6).

Greater empathy and respect for his clientele may ensue as Therapist G works with more clients, however, he intentionally avoided multicultural training in the past which further suggests that this trend is still in effect. Therapist Z senses that Therapist G's comments about training create concern that he lacks skill and competence to professionally assist the population in question, and he's demonstrating an absence of professional integrity. Therapist Z envisions that confronting Therapist G with harboring prejudicial and biased views may produce animosity, but Therapist Z has been exposed to multicultural training and has learned that interpersonal prejudice and oppressive behaviors often result from bias.

Decision Options - Therapist Z resolves to speak with Therapist G in a respectful and empathic manner. He wants to encourage Therapist G to acquire training, experience, consultation, and/or supervision offering exploration into his attitudes and sense of entitlement. He plans on suggesting that working in a multicultural competent manner is an ongoing process rather than attainable by completion of a single course. Therapist Z wants to offer Therapist G some related handouts from his past multicultural courses.

Therapist Z is prepared to suggest that Therapist G reconsider working with this clientele if he refuses to consider the recommended training. Therapist G may be competent with specific groups and issues, but Therapist Z knows that Therapist G's community comprises mainly middle- and working-class people so it is unrealistic to consider working with individuals outside of this group. Even if Therapist G avoids working with clients for whom he feels bias, his prejudice and discriminatory views will permeate onto other clients. Therapist Z is open to the possibility that if Therapist G rejects the recommendations then Therapist Z will inform the licensing board or ethics committee of his concern of harm to a client should Therapist G see working-class and ethnic minority individuals without appropriate training, supervision, and/or consultation (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Multiple Relationships

The standard on multiple relationships instructs that practitioners should maintain only one role at a time with a client, student, supervisee, research participant, consultee, or with a person close or related to the individual with whom the professional relationship exists, unless the practitioner believes that a secondary role would not impair objectivity, competence, or render harm or exploitation. Additionally, practitioners should not promise or imply, during the professional relationship, that a social or business relationship will develop after the professional relationship ends. Multiple relationships can lead to exploitative conflicts of interest with clientele.

The Ethics Code indicates that all multiple relationships are not necessarily inappropriate because some situations may not "reasonably be expected" to cause impairment, exploitation, or harm. Thus, some multiple or dual relationships are not problematic, or even avoidable, especially in small or rural communities, close ethnic or

religious groups, university communities, or periodically in large cities as well. The word, "reasonably" is essential and means that a reasonable practitioner must be cognizant of transference, countertransference, or other clinical contraindications that would render harm or exploitation foreseeable. A potential violation would be considered if reasonable practitioners would have anticipated that the multiple relationships would become problematic.

The pursuit of self-interests can lead practitioners to enter into inappropriate dual relationships. A foundation of ethical practice is that practitioners transcend their own needs while servicing their clients' professional needs. The responsibilities and expectations of a business partnership differ greatly from those of a therapist-client relationship, therefore, this incompatibility of expectations and needs increases the likelihood of misunderstanding and harm.

Multiple relationships can be exploitative or cause harm in various ways. Such relationships can: distort the nature and essence of the therapeutic relationship; create conflicts of interest that impair professional judgment; and impact clients' cognitive processes that foster therapy's benefits, even after termination. The power differential hampers clients' ability to participate in another relationship with the therapist on an equal basis; this vulnerability to exploitation remains even after therapy has ended. Some clients return to therapy with the same therapist after initial termination and a dual relationship could negate this client option. Analysis of the following factors is helpful in deciding whether to enter into a multiple relationship: length of time since therapy ended; nature and duration of the therapy; nature of the termination; client's personal history and mental health status; projected effect on client; and therapist statements during therapy inferring a future relationship. Consulting with colleagues can offer an objective and forward-thinking perspective on the feasibility of entering a multiple relationship.

The concept of "boundary crossings" relates to any deviation from traditional therapy and risk management practices or any activity that alters a neutral professional relationship between therapist and client. Maintaining boundaries promotes the principle of "do no harm" because it separates the needs of therapist versus those of client. Some boundary crossings can be helpful while others can represent mismanagement of transference and countertransference issues and be harmful. Examples of boundary crossings, that may or may not be harmful, include attending a client's wedding because therapy centered upon client's desire to marry, or attending the same church, grocery or retail store as client because therapist and client live in the same area. Further, hugs with clients, gift giving or receiving, therapist self-disclosure, and extension of therapy session beyond the scheduled duration are boundary maintenance activities that are debated as to being harmful or helpful.

Decision making about engaging in boundary crossings can include analysis of the power dynamics in the situation and therapist's assessment of client's diagnosis, needs, and issues. Practitioners can reduce risk of harm by documenting their actions, rationale, and the circumstances. By notating one's intentions, empathy, and respect for client, therapist can uphold the principle of beneficence and nonmaleficence. The purpose of avoiding harmful boundary crossings is to benefit the client and to do no harm, specifically, for therapists to not use client for their personal gratification and self-interest.

Practitioners take "reasonable steps" to resolve potential harm arising from multiple relationships. Discussion with the client about potential risks can prevent harm. Therapist can inform client of the rationale for not initiating or continuing the multiple relationship and thus eliminate client feeling rejected or disrespected. Referral to another therapist is an option if client demands the dual relationship, but practitioners are advised to not make a referral to solely enable the social, business, or other relationship. Consultation with insightful colleagues can facilitate effective resolution. The standards on Multiple Relationships are:

(AAMFT, 2015, 1.3 - previously cited).
(NASW, 2008, 1.06.d. - previously cited).
(ACA, 2014, A.8 - previously cited).
(APA, 2010, 3.05 a.b.c.. - previously cited).

Case 8: Multiple Relationships

Case Scenario - Therapist H is in private practice, and is a site clinical supervisor with the Master's-level counseling internship program at the local university. During the process of mentoring, he takes a special liking to an intern, Mr. A, who shows promise as a psychotherapist and learns that the intern also enjoys playing golf. Therapist H invites Mr. A to play several rounds of golf together. As time passes, Therapist H comments that they have developed a friendship that will exist beyond the internship. He also speaks of his connections with a mental health center that will have a therapist position become available soon and that he is willing to help Mr. A secure that position in the future. Mr. A divulges to other interns that he plays golf with Therapist H, that they have become friends, and Therapist H will be supportive for obtaining a position. Other interns sense Therapist H inappropriately favoring Mr. A in delegating case assignments, being available for supervision, and giving progress reports to the faculty in their psychology program. Interns hoping to work at the previously-mentioned mental health center are distraught. Several interns become angry at the perceived favoritism and make a formal complaint to the field placement office in their psychology program, and secondly, to the director of the clinical site that employs Therapist H.

Ethical Concern - The standard disallows "promises to enter into another relationship in the future with the person or a person closely associated with or related to the person" simultaneous to being in a professional role with that person. Therapist H maintains a professional role with Mr. A as a site clinical supervisor and concurrently has established a friendship with the intern. Therapist H spoke of his readiness to use influence to secure a future mental health center position for Mr. A. Exactly what was stated will determine if

a "promise" was made, thereby violating the standard, however, Mr. A and his colleagues presumably understood these comments as at least an implied promise by Therapist H to use his implied influence over the mental health center hiring process. The standard does not prohibit any type of additional relationship when a professional role already exists, instead, it disallows entry into a multiple relationship if that relationship could "impair professional judgment or increase the risk of exploitation, " for MFTs, or "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." The central issue in this case is: to what extent can a relationship with a trainee develop before the individual attention that generally accompanies a proper and effective mentoring relationship evolve into a potentially problematic personal relationship?

Decision-Making Considerations - This situation reflects how it is generally third parties who feel slighted and become angry upon multiple relationships being established between practitioner and a student or supervisee. Therapist H will need to establish that he can provide objective and competent supervision of Mr. A, but even if successfully shown, his efficacy as a site supervisor for Mr. A and the other interns is compromised. This compromise of professional capability often occurs when third parties perceive the special relationship between practitioner and the individual produces favoritism at a cost to themselves. Even in situations where favoritism by practitioner has not occurred, it is difficult to counter the perception of favoritism upon it becoming a historical fact, especially with a reasonable belief that the individual has been granted special rights or has a special relationship with practitioner.

A paradoxical point is that therapist H's willingness to use his influence to give the mental health center position to Mr. A can actually be harmful to Mr. A in several ways. Mental health center personnel may become privy of this situation or feel offended and may respond by reviewing Mr. A's application material with more scrutiny, to promote the integrity of the hiring process. Interns who resent Mr. A and feel that he is exploiting Therapist H, at their expense, may withdraw their support of Mr. A or disparage his name and reputation with others. The friendship may end leaving Mr. A unsure of whether his past evaluations were based on sound professional judgment or solely on the friendship. By example, if the friendship ends, Therapist H may not support Mr. A's application to the mental health center, thus creating cognitive dissonance as to whether this decision is based on professional or impaired judgment.

Decision Options - Therapist H is encountering student anger and distrust along with formal complaints to the field placement office and the director of the clinical site where he works. The social relationship with Mr. A compromised his efficacy as supervisor with other students and may threaten Mr. A's peer support group and professional reputation among his peers. To comply with ACA Standard A.4.a., Avoiding Harm, Therapist H is obligated to remedy or minimize any harm that has already resulted and to prevent any possible future harm. Similarly, NASW Standard 1.01 indicates, “Social workers’ primary responsibility is to promote the well-being of clients.” To comply with this standard, Therapist H could have a discussion with Mr. A accepting responsibility for the distress to each of them as initiated by the golf invitation. Conversation could include redefining the professional nature and boundaries of their association, explaining that, as the supervisor, he "should not have done what he did," and stating that golfing together must stop. He could inform Mr. A that he plans on meeting with the upset students to address the situation and explain his involvement. Therapist H will meet with the field placement office and his clinical director to discuss the situation. If student resentment is high, an option is to transfer supervision of the students, and Mr. A, to another supervisor. This option would be predicated not only on the level of resentment, but also on whether such would represent the best interest of the students (i.e., the new supervisor may not have enough time to work with the students thus limiting the quality of letters of recommendation). Should Therapist H be asked to write letters of recommendation for the students or Mr. A, he could have the letters read and approved by the clinical director (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

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TEST - ETHICS: CASES and COMMENTARY I

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1. **Competence within the Ethics Codes can be conceived as being skill-based and _____.**
   A) relational-based
   B) technical-based
   C) practice-based
   D) experientially-based

2. **When working with diverse populations, practitioners are wise to _____.**
   A) be cognizant of scientific or professional knowledge relevant to the party
   B) if a knowledge base exists, then acquire the needed proficiency
   C) if necessary, refer the client to a qualified provider
   D) All of the above

3. **Multiple relationships can be exploitative or cause harm because they can _____.**
   A) distort the nature and essence of the therapeutic relationship
   B) create conflicts of interest that impair professional judgment
   C) impact clients' cognitive processes that foster therapy's benefits, even after termination
   D) All of the above

4. **The standard on multiple relationships instructs that practitioners should maintain only one role at a time with clientele, unless _____.**
   A) the practitioner believes that a secondary role would not impair objectivity, competence, or render harm or exploitation.
   B) client-gain is greater than therapist-gain
   C) the client pleads for continuation of the multiple relationship
   D) the client refuses to end the multiple relationship

5. **The purpose of avoiding harmful boundary crossings is to _____.**
   A) benefit the client
   B) do no harm
   C) prevent therapists from using their clientele for their personal gratification and self-interest
   D) All of the above

TRUE/FALSE: A = True and B = False

6. **The Code of Ethics does not offer guiding principles and standards for professional conduct.**
   A) True B) False

7. **Practitioners should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice.**
   A) True B) False

8. **Informed consent generally necessitates that the client has been adequately informed of significant information concerning treatment processes and procedures.**
   A) True B) False

9. **Informed consent generally necessitates that the client has freely and without undue influence expressed consent.**
   A) True B) False

10. **Practitioners who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.**
    A) True B) False

11. **At initiation and throughout the process, practitioners do not need to inform clients of the limitations of confidentiality or seek to identify foreseeable situations in which confidentiality must be breached.**
    A) True B) False

12. **Practitioners should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required.**
A) True B) False

13. **Competence correlates with the concepts of beneficence and nonmaleficence in that practitioners strive to benefit and do no harm to their clientele.**
A) True B) False

14. **Practicing outside of one's scope of practice commonly occurs when practitioners perform a professional activity that is different or new relative to their established area of expertise.**
A) True B) False

15. **Mental health professionals can expand their areas of expertise given the attainment of any required education, training, supervised experience, consultation, study, or professional experience.**
A) True B) False

16. **While developing skills in new specialty areas, practitioners do not need to take steps to ensure the competence of their work or protect others from possible harm.**
A) True B) False

17. **Practitioners continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.**
A) True B) False

18. **Personal problems, conflicts, and impairment can adversely affect skill-based and relational-based competency.**
A) True B) False

19. **Practitioners are advised to challenge their own generalized, unrealistic stereotypes so that providing benefit to clients, doing no harm, and dispensing respect, dignity, and justice prevails.**
A) True B) False

20. **Practitioners should not promise or imply, during the professional relationship, that a social or business relationship will develop after the professional relationship ends.**
A) True B) False

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