ETHICS

Presented by

CONTINUING PSYCHOLOGY EDUCATION

3 CONTINUING EDUCATION HOURS

"The ability to reason with the ethical principles and arrive at a decision for which we are willing to be accountable is what makes counseling practice ethical."
W. Lanning (1997)

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

Accreditation
Continuing Psychology Education is approved to provide continuing education by the following: Texas State Board of Social Worker Examiners (Provider # CS3329); Texas State Board of Examiners of Professional Counselors (LPC Provider # 2013); Texas State Board of Examiners of Marriage and Family Therapists; this course meets the qualifications of continuing education for Psychologists, LSSPs, LPAs, and Provisionally Licensed Psychologists as required by the Texas State Board of Examiners of Psychologists.
This course meets the qualifications for 3 hours of continuing education for SWAs, LSWs, LMSWs, LMSW-APs/ACPs, LPCs, LMFTs, Psychologists, LSSPs, LPAs, and Provisionally Licensed Psychologists as required by the above-mentioned State Boards.

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

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

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INTRODUCTION

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

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

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

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

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

Ethics codes for mental-health organizations are revised as new concerns arise. The first ACA ethics code, instituted in 1961, underwent revisions in 1974, 1981, 1988, and 1995. The first *Code of Ethics for Marriage Counselors* was developed in 1962, and the eighth revision of the *Code of Ethics of the American Association for Marriage and Family Therapy* was established in 1991; the current revision is dated 2001. The need for revisions underscores the sentiment that client welfare is of paramount significance.

CLIENT RIGHTS AND THERAPIST RESPONSIBILITIES

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

INFORMED CONSENT

Mental-health professionals are committed by their ethics codes to inform clients of risks, benefits, and alternatives to proposed treatment. Informed consent comprises the right of clients to be informed of their therapy and to make independent decisions regarding the process. The intent is to define and clarify the nature of the therapeutic relationship; the process begins with the intake interview and continues throughout counseling. Two ethical codes specify the parameters of informed consent as follows:

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

> ... counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed, and other pertinent information... (ACA, 1995).

> When psychologists conduct research or provide assessment, therapy, counseling, or consulting services... they obtain the informed consent of the individual or individuals using language that is reasonably understandable... (APA, 2002, 3.10).

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

consenting client is acting freely in the decision-making and is legally and psychologically competent to give consent.

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

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

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

Informed consent can become confusing when more than one client is involved in therapy, as in marriage and family counseling. Family therapists may use techniques (i.e. paradoxical interventions) which rely upon family members being uninformed of such procedures. Second, the common practice of parents providing consent for their children may be argued to violate conditions of informed consent and the rights of children. Finally, informed consent requires the consenting client is acting freely and without undue influence, however, this may not be fulfilled when a reluctant family member is coerced into attending therapy by other family members or the therapist because the therapist will only treat families when all members are present. Potential concerns arising from these factors may be avoided by the therapist offering all family members (including children) as much information as possible about therapeutic procedures and, if necessary, referring the family to a therapist who does not require all family members be present.

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

RECORD KEEPING

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

Ethical codes on record keeping indicate the following:

National Association of Social Workers (1999):

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

American Counseling Association (1995):

> Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures.

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

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

ETHICAL ISSUES ASSOCIATED WITH MANAGED CARE

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

The managed care model urges time-limited interventions, cost-effective methods, and focus on preventive rather than curative strategies which Miller (1996) suggests culminates in client undertreatment, underdiagnosing important conditions, restricting hospital admissions, failing to make referrals, and

providing adequate follow-up. Karon (1995) believes managed care is more interested in reducing costs than quality of service. Haas and Cummings (1991) report that managed care limitations on client treatment raise ethical concerns with inherent risks being shifted to the therapist. First, issues of competence arise as therapists must maintain an eclectic orientation to work with an array of issues within a short-term intervention model. Second, Newman & Bricklin (1991) suggest a need for research to determine effective treatments within a short-term model allowing clients to make informed choices regarding their therapy, otherwise, the process of informed consent is in question. Third, practitioners are challenged to place the welfare of the client above the financial integrity of the system.

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

MALPRACTICE

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

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

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

Swenson (1997) reports three general problem areas which yield the highest risks of malpractice lawsuits:
a) violating clients' personal rights (commonly related to sex, privacy, or wrongful commitment).
b) failure to protect others from clients (alleged in failure to warn, failure to commit, and wrongful release cases).
c) incompetent treatment of clients (often alleged in suicide cases).

One effective way to protect from liability action is to restrict practice to clients one is prepared for by virtue of education, training, and experience. Pope and Vasquez (1991) advise that even when therapists work within their specialty, they may endeavor to work with specific populations or use certain techniques which exceed their level of competence. Another precaution against malpractice is to utilize personal and professional honesty and openness with clients.

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

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

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

CONFIDENTIALITY: ETHICAL AND LEGAL ISSUES

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

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

National Association of Social Workers (1999):

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

American Counseling Association (1995):

> ... counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached.

American Association for Marriage and Family Therapy (2001):

> ... Therapists respect and guard the confidences of each individual client.

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

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

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

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

Conditions under which breaching confidentiality is permissible include these situations (Ahia & Martin, 1993; Herlihy & Corey, 1996b): when client poses a danger to self or others; when client discloses an intention to commit a crime; when therapist suspects abuse or neglect of a child, an elderly, or disabled person; and when a court orders a therapist to make records available. Failure to report may involve sanctions (Ahia & Martin, 1993), whereas practitioners who report in good faith are immune from prosecution for breaching confidentiality.

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

THE DUTY TO WARN AND PROTECT

The Texas Supreme Court has rejected Tarasoff type liability, as evidenced by the case of *Thapar versus Zezulka, 42 Tex Sup. Ct. J. 824, 1999 WL 417282 (Tex.)*, therefore, the therapist does not have a mandated duty to warn an identifiable potential victim of an actual or implied threat. The statute permits but does not require therapist breach of confidentiality "To medical or law enforcement personnel where the professional determines that there is probability of imminent physical injury by the patient/client to himself or to others, or where there is a probability of immediate mental or emotional injury to the patient/client." The court has left the decision whether to disclose confidential information in such cases to the discretion of the mental-health practitioner; such disclosure is allowed but not required. Careful deliberation and consultation with national and state organizations and attorneys is advised due to inconsistencies between ethical guidelines of national and state organizations and the state licensing laws, and litigated cases in the Supreme Courts of various states; in fact, informing the potential victim could actually be a breach of confidentiality.

Under the Tarasoff decision, practitioners have a dual responsibility to protect their clients from themselves and to protect others from potentially dangerous clients. Failure to diagnose or predict dangerousness, and failure to warn potential victims of violent behavior expose the counselor to lawsuit as illustrated in the case of *Tarasoff v. Board of Regents of the University of California.*

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

The psychotherapist's duty under the Tarasoff ruling is to warn, protect, and predict when a client has communicated to the therapist a serious threat of physical violence against a reasonably identifiable victim or victims. This duty is fulfilled upon the practitioner making reasonable efforts to communicate the threat to the victim(s) and to the police. To reiterate, unless the Texas Legislature imposes a Tarasoff duty, therapists may, but are not required, to notify medical or law enforcement personnel in such cases.

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

SUICIDAL CLIENTS

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

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

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

CHILD ABUSE

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

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

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

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

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

MANAGING BOUNDARIES AND DUAL RELATIONSHIPS

Dual relationships exist when therapists assume two or more roles at the same time or sequentially with a client, for example, counselor and business partner, or instructor and therapist. Common examples of dual relationships include: bartering therapy for goods or services; providing therapy to a relative or a friend's relative; socializing with clients; attending a social event of a client; accepting gifts from clients; becoming emotionally or sexually involved with a client or former client; and combining the roles of supervisor and therapist. Therapists placing their personal needs above client needs by engaging in more than one role with the client is deemed unethical behavior.

Pope and Vasquez (1991) believe that dual relationships impair therapist judgment resulting in greater potential for conflicts of interest, exploitation of client, and blurred boundaries that distort the therapeutic bond. The codes of ethics warn of potential concerns of dual and multiple relationships as follows:

AAMFT (2001)

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

ACA's Code of Ethics and Standards of Practice (1995):

> Counselors are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of clients. ... (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.)... (A.6.a.)

NASW's Code of Ethics (1999):

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

BARTERING FOR PROFESSIONAL SERVICES

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

Ethical codes and standards for bartering include the following:

ACA (1995):

> ... Counselors may participate in bartering only if the relationship is not exploitive, if the client requests it, if a clear written contract is established, and if such arrangements are an accepted practice among professionals in the community. (A.10.c.)

NASW (1999):

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

APA (2002):

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

SOCIAL RELATIONSHIPS WITH CLIENTS

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

Borys & Pope (1989) surveyed psychologists, psychiatrists,

and social workers on dual relationships between therapist and client and discovered the following practices to be labeled "never ethical":

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

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

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

SEXUAL RELATIONSHIPS: ETHICAL AND LEGAL ISSUES

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

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

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

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

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

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

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

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

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

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

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

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

UNETHICAL BEHAVIOR BY COLLEAGUES

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

Ethical codes on this issue read as follows:

"Counselors expect professional associates to adhere to the Code of Ethics. When counselors possess reasonable cause that raises doubts as to whether a counselor is acting in an ethical manner, they take appropriate action" (ACA, 1995, H.2.a.).

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

ETHICAL ISSUES IN MARITAL AND FAMILY THERAPY

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

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

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

VALUES IN MARITAL AND FAMILY THERAPY

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

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

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

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

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

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

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

CONFIDENTIALITY IN MARITAL AND FAMILY THERAPY

Maintaining client confidentiality can become complex when counseling multiple clients. At one extreme are therapists who believe each family member is an individual and disclosed information by one family member is never shared with another. Conversely, some therapists refuse to keep information secret that was shared individually, thus, "hidden agendas" are openly explored. Each approach has negative consequences. Upholding confidentiality can limit the therapist's disclosure of critical family issues, while the position of revealing all information can inhibit family members from sharing important information openly. A moderate approach entails therapists divulging information selectively for the greatest benefit to the couple or family at the discretion of the therapist; this method allows the counselor to use professional judgment in maintaining individual confidences or not. Margolin (1982) indicates that therapists who have not promised confidentiality have more options and must contemplate therapeutic consequences of their actions. According to Margolin, the best approach is to maintain a policy consistent with one's theoretical orientation and inform all family members of this policy at the beginning of treatment.

Ethically, counselors must make their stand clear to all family members so they can decide whether to participate in counseling and how much to disclose to the therapist.

SUBPOENAS

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

1) Determine whether the subpoena requires production of records, the appearance of the therapist in court, or both.
2) Regardless of which type of subpoena, in most cases, seek legal advice, and initially assert the psychotherapist-patient privilege. Failure to assert the privilege can be grounds for

legal action by the client.

3) Therapist should contact client and/or client's attorney to assess consequences of providing the information requested by the subpoena. If client wants therapist to comply with subpoena, then therapist should get written authorization from client before sharing the requested information.
4) If client does not consent, therapist can continue to assert the privilege, until a court hearing which may judge the privilege should not be upheld. At this point, therapist must abide by the court order (if not, a contempt-of-court citation can be issued).

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

ETHICAL CODES IN MULTICULTURAL COUNSELING

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

The NASW Code of Ethics (1999) states:

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

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

THERAPIST COMPETENCE: ETHICAL AND LEGAL ISSUES

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

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

Professional Codes of Ethics on competence are clear:

AAMFT (2001, 3.11):

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

NASW (1999):

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

ACA (1995):

> Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national credentials, and appropriate professional experience...

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

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

CONCLUSION

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

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

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

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

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

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TEST - ETHICS

3 Continuing Education Hours
Record your answers on the Answer Sheet (Click the "Texas Answer Sheet" link on Home Page and either click, pencil or pen your answers).
Passing is 70% or better.
For True/False questions: A = True and B = False.

TRUE/FALSE

1. **Ethics may be defined as moral principles which provide rules for right conduct.**
   A) True B) False

2. **Ethics codes protect the public and provide guidance to professionals in serving their clientele.**
   A) True B) False

3. **Therapy without informed consent is within the standard of care and would never result in liability.**
   A) True B) False

4. **The Texas Supreme Court has rejected Tarasoff type liability.**
   A) True B) False

5. **Failure to keep adequate client records breaches the standard of care expected of therapists.**
   A) True B) False

6. **Consultation and documentation are recommended measures against malpractice liability in suicidal cases.**
   A) True B) False

7. **Bartering therapy for goods or services is a type of dual relationship which can harm the therapy process.**
   A) True B) False

8. **The therapist obligation to uphold client confidentiality applies in all situations with all clients.**
   A) True B) False

9. **Sex between therapist and client may potentially result in client symptoms indicative of rape and battered-spouse syndrome.**
   A) True B) False

10. **Informed consent is designed to define and clarify the therapeutic relationship.**
    A) True B) False

Continuing Psychology Education is approved to provide continuing education by the following: Texas State Board of Social Worker Examiners (provider # CS3329); Texas State Board of Examiners of Professional Counselors (LPC provider # 2013); Texas State Board of Examiners of Marriage and Family Therapists; this course meets the qualifications of continuing education for Psychologists, LSSPs, LPAs, and Provisionally Licensed Psychologists as required by the Texas State Board of Examiners of Psychologists.

11. **Ethics promotes _____ standards of performance determined by the profession.**
    A) maximum or ideal
    B) the lowest
    C) arbitrary
    D) static

12. **Three factors relevant to the legal definition of informed consent include; capacity, voluntariness, and**
    A) origin
    B) comprehension of information
    C) consequence
    D) dispute

13. **_____ is a legal concept involving negligence and accompanying client injury or loss.**
    A) Subpoena
    B) Writ of habeas corpus
    C) Malpractice
    D) Habendum Clause

14. **Therapists working with potentially dangerous clients are recommended to**
    A) inform client of confidentiality limits
    B) record steps taken to protect others, if necessary
    C) seek consultation
    D) all of the above

15. **_____ prevents therapists from revealing client confidential information during legal proceedings.**
    A) Privilege
    B) Tarasoff decision
    C) Thapar versus Zezulka case
    D) duty to warn

16. **Revisions to ethics codes for mental-health associations**
    A) periodically occur as new issues arise possibly affecting client-welfare.
    B) never occur.
    C) are amended monthly.
    D) is viewed as unnecessary.

17. **Lawsuits brought against therapists**
    A) are never in favor of the client.
    B) are few but on the rise.
    C) are never due to violation of client rights.
    D) never have evidence to support the case.

18. **The U.S. Supreme Court ruling in the case of Jaffee versus Redmond highlights the importance of**
    A) the duty to warn.
    B) protecting suicidal clients.
    C) confidentiality toward successful treatment.
    D) multicultural counseling.

19. **In marital and family therapy, therapists must assess their own values in order to avoid**
    A) taking sides with one family member against another.
    B) imposing their values on family members.
    C) persuading the marriage should be maintained.
    D) all of the above.

20. **Effective informed consent procedures**
    A) reduce client misunderstanding and liability.
    B) maximize odds of liability claims.
    C) should never be in written form.
    D) avoid discussion of therapy benefits and risks.

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

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