Ethics: Cases and Commentary

Presented by CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION 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, managed care, nondiscrimination, conflict of interest, third-party requests for services, informed consent, informed consent to organizations, services to organizations, advertising and public statements, media presentations, testimonials and solicitation, in-person solicitation, record keeping and representative legal/ethics case scenarios suggesting thought-processes and actions leading to resolution of ethical dilemmas.

Accreditation
Continuing Psychology Education Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6084. Programs that do not qualify for NBCC credit are clearly identified. Continuing Psychology Education Inc. is solely responsible for all aspects of the programs. Continuing Psychology Education Inc. will award NBCC-approved continuing education clock hours for all of its listed programs.

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, personal impairment, non-improving and extremely difficult clients.
5. Understand challenges associated with managed care.
6. Articulate the importance of demonstrating nondiscrimination practices.
7. Realize that multiple relationships can be exploitative or cause harm.
8. Explain that practitioners should avoid conflicts of interest that interfere with professional judgment.
9. Understand the importance of clarifying the professional relationship with all involved in the case of a third-party request for services.
10. Recognize the essential nature of informed consent between practitioner and client.
11. Affirm that advertising and public statements must be accurate.
12. Acknowledge the restrictions of testimonials and solicitation.
13. Articulate that documentation in record keeping must be accurate and reflect the services provided.

Faculty
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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.

Rules, regulations, and a method for resolving dilemmas convey a public nature. Mental health practitioners earn a license to practice, which is a public document, through performing public acts such as completing an accredited degree program and passing various examinations. Practitioners may be required to justify their actions in a public venue, hence, their decision-making can be susceptible to public scrutiny in relation to laws, regulations, standards of care, and ethics codes. In sum, professional decisions are not limited only to therapist and client, rather, decision making can be a matter of public accountability.

The public nature of the mental health field transports decision making from subjective, personal morality to a broader public domain concern. This transition requires professionals to employ the texts of the profession as official standards of conduct, and to have a method of resolving difficulties and dilemmas that can be exposed to public scrutiny. Therefore, ethical practice entails a systematic complying with the Ethics Code rather than abiding by solely individual morality or intuition.

Many of the standards within the Ethics Code allow for a sense of reasonableness. The concepts of "reasonable" and "appropriate" grant a degree of professional judgment and deliberation which, in turn, promote a proactive, rather than reactive position. Being proactive involves looking ahead and anticipating possible benefits versus anticipating issues resulting from different actions with the intent of avoiding difficulties. Being reactive is responding after the mishap has occurred and when the danger is already present. The Introduction and Applicability section of the APA Ethics Code explains the value of the words, reasonable and appropriate:

> The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge psychologists had or should have had at the time.

The words, "reasonable" and "appropriate" instill a measure of flexibility in the Ethics Code such that along with clear expectations of conduct, practitioners can utilize professional judgment within their area of expertise.

The Ethics Code is the main text for illuminating ethical practice but other sources exist as well, as articulated by the following associations: The introductory material for NASW, in the section entitled, Purpose of the NASW Code of Ethics, states:

> For additional guidance social workers should ... seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agencybased or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

The Introduction and Applicability section of the APA Ethics Code indicates the following additional sources for assistance:

> In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field.

The Preamble of the AAMFT Code of Ethics notes these additional sources of guidance:

> Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.
>
> Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations.

The Purpose section of the ACA Code of Ethics responds to this theme as follows:

> When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application.

The development and continued implementation of ethical practice evolves over time, is a dynamic rather than static process, and endures over the entire professional life span. The associations address this concept, for example, the Preamble to the APA Ethics Code expresses:

> The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

NASW responds to this lifelong process by commenting within the section entitled, Purpose of the NASW Code of Ethics:

> Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The NASW Code of Ethics reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

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. 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.

Periodically, clinicians may feel compelled to stretch their areas of competence, despite the ensuing need to make special arrangements or alter their approach. Such an occasion can be labeled as the "compassionate exemption" which is a term used in drug trials when an experimental protocol is authorized for a patient in dire need. The following case typifies this situation (Koocher & Keith-Spiegel, 2016):

Therapist D was trained mainly in short-term behavioral treatment. She moved to a small town and began seeing clients with chronic and severe issues requiring long-term treatment, for which she was not prepared. These clients could benefit from long-term therapy but the nearest practitioners trained in such models lived 200 miles away.

A question arises regarding whether treatment by a therapist with insufficient training in certain areas is more effective than no treatment at all. A single answer for this question does not exist due to the uniqueness of each case, however, it is understood that not everyone is helped by therapy and some clients will be harmed. Therapist D must make every attempt to cause no harm. First, she must know every possible referral source in her community. Second, a possible short-term strategy is to offer supportive consultation from a distance along with a colleague who possesses the competency. Third, if the disparity between therapist competency and client need is significant, then therapeutic harm may outweigh benefit and therapist should not provide treatment.

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.).

Practitioners who believe that they have mastered everything about their specialized field may encounter risks that could have been avoided. Competent practitioners acknowledge their strengths, weaknesses, limitations, and special talents. Ignoring or disavowing our inadequacies places clients and the public at risk. The skills of evaluating our competence, motives, and the essence of our therapeutic relationships objectively and insightfully is not easily trained and rarely perfected, yet these capacities are vital to being an ethical professional.

Koocher and Keith-Spiegel (2016) believe that effective professional practice requires two disparate types of competencies: intellectual competence and emotional competence. Intellectual competence involves acquiring knowledge based on empirical research and clinical training relevant to practice with a particular client population. It also may include an ability to assess, formulate, and plan effective treatment for a particular client or problem. Equally important, intellectual competence is acknowledging what one does not know. Hence, ability to treat middle-class American Caucasian clients does not necessarily mean ability to treat other cultural or racial identities. Therapists may work with other racial or ethnic individuals but they must become informed of individual differences and obtain the necessary additional knowledge to treat such clients.

Emotional intelligence relates to practitioners' ability to emotionally tolerate clinical material arising during therapy, recognize their personal biases during treatment, and manage self-care responsibilities. All practitioners cannot competently work with every client or with all issues they encounter, but personal, social, or economic pressure may dangerously lure them into making the attempt.

Consider this example regarding intellectual competence: Therapist A finished her graduate training in the 1980's, before clinical neuropsychology became a specialty. She was trained to "assess organicity" utilizing the Wechsler Adult Intelligence Scale, House-Tree-Person drawings, and the Bender Motor Gestalt Test. She has not studied neuroanatomy and is unaware of more recent neuropsychological assessment tools. Her practice centers on psychotherapy. A lawyer called Therapist A asking for an assessment of a client who sustained a closed head injury and was experiencing language, memory, and perceptual issues. She accepted the referral and assessed the client with the techniques from her graduate school training (Koocher & Keith-Spiegel, 2016).

Therapist A was trained at a time before evidence-based neuropsychological assessment science and she did not keep abreast with this specialty. Her ethical error began upon accepting a case for which her skills were outdated and inadequate by contemporary professional standards. She also may have been unaware of ethical constraints on functioning as an expert witness.

In situations where no formal standards abound for specific types of practice or techniques, practitioners are well-served to exercise caution and be conservative in determining whether they need additional training or education before accepting the client. One source of guidance is asking colleagues who are experts in the specialty about current practice standards and adequacy of training.

In detecting competence versus incompetence in doctoral psychology students, Koocher and Keith-Spiegel (2016) describe a study in which faculty and field supervisors noted the dominant characteristics of "outstanding" and "incompetent" trainees. "High intelligence" was the most frequently reported quality for outstanding students while "lack of knowledge" was the most often indicated characteristic for incompetent trainees. Supervisors then evaluated the students one year later and their most common

28 evaluative terms were filtered down to the following four conceptualizations of competence: professional responsibility, interpersonal warmth, intelligence, and experience. An effective method to avoid unskilled or risky graduates is thorough education and training along with relevant monitoring and supervision.

Just as any endeavor can be evaluated on a bell-shaped curve, which involves a range of variability, mental health professionals will display a performance range from poor, to adequate, to superior competence. Some will have minimally passed the admission criteria, many will reside in the middle, and some will fall in the tail-end of the curve. Whereas superior competence is the goal, it is not unethical to practice in an area in which one's competence level is just "adequate" or "good enough."

Koocher and Keith-Spiegel (2016) support the concept that after approximately 10 years, one-half of psychology graduate school training and information has become outdated (an estimate for an undergraduate engineering degree is 4 to 5 years). The work of mental health professionals includes behavioral science, law, and anatomy/physiology/medicine, hence, the need arises to keep up with advances in science and changes in case law. As such, a mental health practitioner's career, spanning 30 or 40 years will require reaching out for competence, inclusive of: monitoring our awareness of personal limitations, acknowledging that our limitations can increase with the passage of time after the conclusion of formal training, and pursuing effective formal and informal remedies designed to keep abilities current.

The following two cases demonstrate the interaction between time-passage and change (Koocher & Keith-Spiegel, 2016):

Therapist B administered a cognitive evaluation of an adult using the WAIS-III, four years after the WAIS-IV was published. Upon being asked about this, he said, "they're about the same, and the new kit priced at $1200.00 is far too expensive."

Therapist C routinely recommended long-term individual psychotherapy for children with secondary reactive enuresis even though current research promoted certain behavioral treatments as being highly effective and short-term. When questioned, he appeared to be surprised and looked for information in the professional literature.

Both therapists are rendering substandard service to their clients resulting in the clients not receiving the most efficacious treatments. Therapist B uses inaccurate rationalizations and Therapist C is uninformed of proven and contemporary treatments. A saving grace is that Therapist C was willing to seek information about his area of ignorance, but concern exists over his apathetic attitude toward not doing so earlier. Therapist B is displaying resistance implying a more serious concern involving ignorance plus arrogance. Even if Therapist C does not like the new treatment for enuresis, he still has a responsibility to be aware of its existence and to advise clients of alternative treatments and choices when explaining his recommendations.

CONFLICTING VALUES IN THERAPY

Therapists avoid imposing their personal values on clients, especially in situations in which the goals and values of therapist and client differ, or when therapy results are more than client bargained for. For example, a common crucial dilemma in establishing therapy goals regards whether to encourage a client to rebel against a repressive environment or situation or simply try to adjust to it. Possible conflict areas include family values, religion, abortion choice, and sexual preference.

The following case exemplifies this theme:

Therapist J is working with a 14-year-old client for concern he is becoming increasingly depressed and socially withdrawn. Therapist observes client feeling inhibited by the close, and sometimes intrusive control of his parents while client tries to attain a degree of adolescent autonomy. After several months, therapist notes client progress but then receives telephone calls from client's parents complaining client is too assertive, overly interested in people and activities not involving the family, and that continued therapy may alienate client from the family.

Client is maturing and displaying increasingly developmentally appropriate behavior which is changing the relationship with his parents, and the parents do not condone the change. The therapeutic effects of this case are not uncommon, as sometimes, the best interest of the client may oppose the best interest of a co-client or family member. One option is for therapist to suggest an accommodation or negotiation between client and parents through a family conference or similar method, but this approach may still not be fruitful (Koocher & Keith-Spiegel, 2016).

A therapist's ethical response to treatment with family, social, religious, or political significance includes performing a thorough assessment and providing an intervention supported by proven efficacy, and fulfills client preferences and needs, unrelated to existing therapist biases.

THE EXTREMELY DIFFICULT CLIENT

Examples of extremely difficult clients include those who make frequent suicidal threats, are intimidating or dangerous, miss appointments or do not pay bills, are actively decompensating and acting out, are overly dependent and telephone often with urgent issues, or harass the therapist's family.

Therapists may, at times, experience uncomfortable feelings elicited by clients' antagonistic verbal comments or inappropriate behavior. Moreover, personality differences and disparity in values between therapist and client may arise necessitating a referral to another therapist to avoid possible harm to client or therapist.

The following 8 cases illustrate the sensitivities involved in working with extremely difficult clients (Koocher & Keith-Spiegel, 2016).

Case 1A: Therapist K strongly disliked sessions with his demanding, insulting, and flamboyant client. He tensed with dread as the session approached and felt relieved at session's end. During the ninth session, client continued with the usual critical and negative comments directed at therapist, and exhorted, "I think you need to go back to school to learn more about psychotherapy," to which therapist responded, "I think you need to go to hell. Get out of my office!"

Therapist K was found guilty of incompetent management of this client, despite his defense to excuse his behavior to an ethics committee. Therapists have the responsibility to treat clients with respect, even irritating clients. Koocher and Keith-Spiegel (2016) affirm that clinicians periodically feel an array of negative emotions toward a given client, including anger or hatred, and many therapists admit to regret for inappropriately responding to certain clients.

A client may be wrongly labeled as difficult simply because the therapist is not qualified to diagnose or treat various emotional disorders, as shown in this case.

Case 2A: Therapist L began working with a troubled young woman in an office at his home. Therapist did not observe symptoms of increasing paranoid decompensation until client acted out destructively in his office. At this juncture, therapist tried to refer client elsewhere but client reacted with increased paranoia and rage. Therapist terminated therapy and client responded by moving into an apartment across the street from therapist's home in order to spy on him, telephoned him day and night with various complaints and threats, and filed several ethical complaints against him.

Therapist L failed to recognize that his client presented with issues beyond his ability level until the situation significantly worsened, at that point, he could not gain control of the process. Though most of the client's accusations were untrue, the ethics committee assessed that therapist was practicing beyond his competence level which contributed to client's issues. Eventually, therapist needed to request police protection and obtain a court restraining order to stop his ex-client's harassment. Therapist also became aware of the potential hazard of seeing clients in one's home.

Case 3A: An ethics committee received a letter from a client of a public agency stating that Therapist M, who was the supervisor of her therapist-intern, treated her unprofessionally resulting in stress and depression. The therapist-intern was having difficulties with client during their previous 14 sessions and asked her supervisor to attend a joint session. Client had never met the supervisor. Client complained that Therapist M was very confrontational during the joint session. The ethics committee wrote to Therapist M asking for his account of the matter and he described client's "negative transference" to the intern. Client allegedly was hostile toward the intern calling him "stupid" and "a know-nothing." Therapist M said the joint session tried to "work through" the problem, that his confrontational tactics attempted to have client release some pent-up feelings, and that admittedly he had to leave the session early. Allegedly, after Therapist M left the session, the intern scolded client for her abusive behavior during the joint session and, without warning, terminated client. Therapist M tried to resolve the situation in a later meeting with client and client did state "He was a completely different person" (much nicer), but client was still very angry.

This case has a number of concerns. The client thought treatment was satisfactory for 14 weeks while the intern and his supervisor, Therapist M, considered that treatment was not progressing well. Therapist M's attempt to resolve a difficult problem in one session, which he had to leave early, illustrated questionable judgment. The ethics committee viewed Therapist M's confrontational style with client, given no therapeutic contract, bond, or previous meeting, as questionable. The ethics committee also criticized Therapist M for blaming the intern for the premature termination because as the supervisor, Therapist M was ultimately responsible. The client felt angry and hurt due to poor communication, moving too quickly in therapy, a bungled termination, and therapists needed a more sensitive approach because client was a difficult client.

Therapists are cautioned to be aware of their professional and personal limitations when working with difficult clients. This equates to not accepting clients that one is not prepared to treat, or referring clients in need of different services early rather than later when greater concerns develop. Some types of clients may elicit troubling feelings in therapists, such as clients who are verbally abusive, sarcastic, or do not speak much. Many therapists may not possess the special expertise required to work with chronic substance abusers, pedophiles, borderline personality disorder, those with histories of violence, or people involved with legal proceedings. Note that therapists are not obligated to see all potential clients, in fact, a referral elsewhere is often the best option when encountering clients beyond our scope of practice. Likewise, we can prevent the clients from experiencing undue risk or discomfort by referring appropriately and quickly if we are unprepared for their needed treatment.

Case 4A: Client was an angry 15-year-old referred to Therapist N for displaying antisocial behavior, including school vandalism. After the fourth session ended and therapist was seeing the next client, therapist smelled smoke, discovered that a fire was set in the waiting room, and he put out the fire. Therapist later called client and his parents to arrange a meeting at which time client admitted setting the fire. When therapist stated he could have been killed, client responded, "Everybody's got to go some time."

Therapist was so angry at client's fire setting and apathetic attitude that he refused to continue treating client. Assumingly, he would refer the family elsewhere while cautioning the new therapist of client's behavior. Therapist realized his strong feelings and reacted quickly and appropriately. Logically, it is difficult to focus completely on such clients when danger or threats may be imminent. The standards indicate the following:

Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help (AAMFT, 2015, 1.10).
Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment (AAMFT, 2015, 3.3).
(APA, 2010, 10.10b. - already cited)
(ACA, 2014, A.11.c. - already cited)
(NASW, 2008, 1.16.a. - already cited)

Case 5A: Client contacted Therapist O to overcome shyness and difficulty in forming new relationships. Sessions routinely had long periods of silence, except for superficial pleasantries, despite therapist's attempts to facilitate meaningful disclosure. Therapist initiated several different methods to open discussion, including asking client to write her relevant thoughts between sessions, but client continued her reticence. After the fourth session, Therapist O suggested that she should help client find another therapist with whom client felt more comfortable to communicate with, or they should discontinue therapy until client had some concerns needing address.

This client felt unable to confront her presenting concern of shyness and therapist's best efforts to engage client were unsuccessful leading to therapist frustration. Therapist did raise the issue of client not communicating and tried different self-disclosure enhancing methods. Therapist also recommended the different alternatives of another therapist and a break in treatment, but she should have done so in a manner as gentle as possible due to the chance that this issue is anxiety-producing for the client. In this case, therapist needed to overcome the common tendency of becoming angry by a client's apparent lack of participation, which led to a lack of sensitivity to the client's fears.

Another difficult client type is the individual whose attitudes, behavior or issues interact with the psychological distress of the therapist creating countertransference.
Case 6A: Client requested assistance from Therapist P regarding difficulty in controlling her rage toward her ex-husband following a recent divorce. Therapist was also recently divorced but he did not mention this fact. While listening to client's resentful, retaliatory, and vengeful attacks on her ex-spouse, Therapist P felt extremely tense and began continually biting his lip until it bled. Within several minutes, client screamed and ran out of the office. Client wrote to an ethics committee expressing that therapist was a vampire. The ethics committee sensed client was very disturbed but still contacted therapist asking for his analysis of client's perception.

Therapist P recalled the same story, explaining that he must have unconsciously bitten his lip until it bled. He realized this after client left, when he saw in a mirror the trickle of blood running from his lip to his shirt collar.

This case is laughable, except for the induced client stress, but it reminds us to be adequately self-aware when feeling anger toward a client and to avoid acting out or harming client unnecessarily. Therapists have a range of anger-management techniques relative to clientele, ranging from direct overt expression (i.e., "I am upset that you punched a hole in the wall and am going to charge you for the repair") to covert self-exploration (e.g., "This person may trigger pent-up anger toward my father because they are similar to one another, but I should manage these countertransference feelings"). Therapists should consider that clients are vulnerable to harm, a clinician's duty is to do no harm, and we must avoid using the power differential inherent in the therapist role to client's detriment. If such issues arise more than rarely in a therapist's career, it presupposes that one is practicing beyond personal competence or has a personal problem needing attention.

A very difficult type of client a therapist may encounter is one who has a challenging issue coupled with presenting issues that associate with personal concerns of the therapist.

Case 7A: A 15-year-old male saw Therapist Q to treat feelings of inadequacy and embarrassment regarding his lack of athletic ability and late pubertal development. A good therapeutic bond has developed and client is productively working on his presenting issues. As client has become more comfortable in therapy, he is exhibiting a growing amount of racial and ethnic prejudice. He classifies several classmates as "Jew bastards" and the "N-word." Client is unaware that his "White" therapist is Jewish and married to an African-American.

This case demonstrates a clash of client and therapist values. The question arises whether therapist should self-disclose with the attempted aim of inducing an attitude change in client's bigotry. Note that client did not pursue therapy to work on race relations. Koocher and Keith-Spiegel (2016) recommend therapists, in such scenarios, to retain clear personal boundaries and continue the focus of treatment upon the issues presented by client. An exception would exist if client realized his prejudices impose on the therapist, then it would be appropriate to discuss the matter in similar fashion to discussion about any therapeutic aspect. Therapist self-disclosure or therapist broaching the topic, however, would represent an inappropriate imposition on client's current treatment because client, at this time, does not perceive his biases as issues. Enlightening client of his discrimination could add emotional stress to client while overlooking his presenting issues.

Another question in such a case is whether therapist can remain empathic or whether negative countertransference and conscious anger will undermine treatment. Therapists must contemplate this question frequently when working with clients who possess conflicting values to the therapist but the issues are unrelated to the initial therapeutic goals. A recommended course of action is for therapist to seek guidance or a therapeutic consultation from an objective colleague to assess and differentiate client's versus therapist's therapeutic needs. The therapist's issues should not become the client's burden.

Case 8A: Several weeks before a state parole board appearance to request an early release, client telephoned

Therapist R from prison stating he was in the 8th year of a 20-year criminal sentence for child rape and ritualized sexual abuse of children and was eligible to apply for an early prison release. He indicated his appearance would be helped by having a psychotherapist to work with after release. Client mentioned he was innocent of all wrongdoing, despite his conviction, but he was "framed" and "railroaded" by the parents of several "oversexed kids" along with a legal system biased against his satanic religious beliefs. He admitted that he truly did not need therapy but simply wanted to show the authorities he knew "how to play their game." After Therapist R declined to accept this person as a client, the inmate filed an ethics complaint, claiming Therapist R unfairly discriminated against him by refusing to accept him as a future client or providing a referral to another therapist.

Therapist R received a self-referral from an individual whose behavior and value system she considered repulsive. Therapist did not have an ethical obligation to accept any new client calling for an appointment, and could decline such referral without need of giving a reason. Further, therapist suspected that this person was trying to manipulate the parole system rather than genuinely seeking therapy. Client admitted that he did not need therapy, therefore, probably would not appropriately utilize this resource, and he may offend again. Therapist did not have an ethical or professional obligation to this client, as such, therapist had no need to assist client in finding another therapist. Actually, therapist might do a disservice to the referred practitioner who might infer the referral is a recommendation to work with client.

CLIENTS WHO THREATEN

The worst response a therapist can make when a client becomes threatening is to do nothing. All client threats or acts of violence need to be taken seriously and one should not assume the threats will stop automatically. Threats should necessitate a reassessment of client, the diagnosis, treatment plan, and any revisions to address the new events. Verbal threats can develop into actions and violence can intensify with time. Assess client's history for violence or acting out and be aware that prior violence may predict future violence. Clarify with client that verbal abuse or threats are unacceptable and can cause therapy termination. It is recommended to document in your clinical notes, all threats, your responses, and the justification for your responses.

Clients who threaten are frequently overwhelmed with personal or family issues and many have mental illness along with impulse control, anger control, or antisocial behavior issues. Acknowledge the potential danger when accepting such clients and know you are capable of managing possible challenging outcomes. During intake interviews with new or potential clients, therapists can ask about a history of issues with these concerns, for example, "Describe the most violent or destructive thing you have done in your past."

Seek consultation with colleagues or an attorney, if needed, as soon as possible, when threats occur; in fact, it is advised to already have such a list on hand. State psychological associations may be a referral source for attorneys knowledgeable of psychological practice concerns. Contemplate a list of responses ranging from least to most intrusive, with the safety of yourself and others as central. Confirm you are not alone at your worksite when working with a potentially violent client; you may want to notify security personnel on site, if possible. Contact the police if threats or actions transpire outside of the office. When working with such a client, set rules and boundaries for threatening behavior, and possibly increase the frequency of sessions focusing on rage and fear issues.

Advanced planning is a good preventive step but may not always prevent harm by an angry client as the following case shows:

Case 9A: Client periodically failed to keep or cancel an appointment with Therapist S. Therapist reminded client of the informed consent procedure which clearly stated that a fee could be charged for missed sessions not canceled in advance. Client missed the next appointment without canceling and at the next kept appointment therapist said there would be a fee for the last missed session. Client responded that she used that time to attend a smoking cessation group, as Therapist S recommended. Therapist approved of her involvement in the smoking group but that did not resolve her failure to properly cancel the appointment. Client became angry, asked the amount she owed, wrote a check, slammed it on the desk, and raced out the office. When therapist left the office two hours later, he observed over 100 hammer dents on the hood and roof of his car. Therapist felt the client was the responsible party but had no proof.

In this case, therapist cannot do anything without evidence. In retrospect, it seems therapist missed the opportunity to address client's anger while she was still in the office. We will not know, and only be left to conjecture, if Therapist S had conversed with client about her feeling that she was treated unfairly might have prevented the mysterious car vandalism.

TERMINATING CLIENTS ETHICALLY

Therapy termination needs to occur when treatment is no longer beneficial as described by these standards:

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).

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 that additional service is required (NASW, 2008, 2.06.a.).

Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers (NASW, 2008, 2.06.b.).

(APA, 2010, 10.10.b. - previously cited)

(ACA, 2014, A.11.c. - previously cited)

Ethical issues related to the duration of therapy are not always inarguable and crystal clear because therapists' judgments are complicated by their theoretical orientations. In response to a person saying, "I'm sure I don't need therapy," some therapists might argue that this person does need therapy while others would argue to the contrary.

Koocher and Keith-Spiegel (2016) illustrate that sending the same person to two therapists might result in one assessment that the person is basically well-adjusted while the second therapist sees the need for treatment. An observer might conclude that one of the therapists is unethical, either for suggesting therapy when not needed or for withholding treatment when needed, but neither conclusion is necessarily correct. One therapist may observe mental health given the absence of symptoms and the other therapist may intuitively sense unconscious issues or the potential for enhanced functioning. These therapist perceptions may be shared with client by virtue of presenting the rationale for treatment or no treatment and a specific and valid action plan.

Termination ethical issues occur when therapist uses client fears, insecurities, or dependencies as justification for initiating or continuing unneeded treatment; Koocher and Keith-Spiegel (2016) offer the following three examples:

Case 10A: Client has been arguing with his wife about in-laws matters and resolves to see a therapist. Client sees Therapist T for 6 sessions and gains insights and problem-solving methods leading to decreased spousal conflict and an expressed desire to terminate what has been successful therapy. Therapist agrees that progress has occurred but reminds client of several stressors in his past that have "not been fully worked through," thus suggesting gloomily that problems may resurface.

Client feels therapy has been effective but Therapist T's assessment creates anxiety and doubt. Client may begin to question if improvement really occurred, if he will regress, or if his marriage will fail. It appears that therapist is abusing the power differential of his position (an expert) to hint that more therapy is required, which contradicts client's preference. Therapist raises client's anxiety and insecurity level through vagary in an unethical way rather than specifying therapist's perception of unfinished business and outlining a new treatment plan.

Case 11A: Client has been treated by Therapist U for almost 5 years. The initial presenting issue was client's unhappiness with the hostile-dependent relationship forged with her intrusive mother. Client resolved this issue a long time ago, was living independently, had a job, and was generally coping with life, though she remained emotionally needy and lonely. Therapy sessions currently centered on her activities and offering praise for Therapist U's help. Not much has changed in client's social or emotional status for approximately 2 years.

It seems that therapist and client have developed a symbiotic relationship as client has found someone to listen to her and therapist has collected an admiring client. One might argue there is nothing wrong with this arrangement and client is an adult capable of making her own decisions. Conversely and clinically, it appears that Therapist U has replaced client's mother as a dependency object. Client may not understand this process but therapist should recognize this dynamic. The emotional connection with therapist may be inhibiting client from developing more functional relationships, without a fee. Therapists are ethically obligated to help the client work toward termination if treatment issues are not raised and worked through.

Periodically, it is possible for therapists to be uncertain of a client's needs, at this time, therapist and client should communicate about the issues, and if necessary, client can be referred for consultation with another practitioner. This process may also be applied when therapist and client disagree about other important therapy issues.

Case 12A: Client had been treated by Therapist V intermittently for 3 years regarding many on-going neurotic issues and an ambivalent attitude. Client began to mildly question therapist if therapy was helping; he admitted to wanting to work on his concerns but had mixed feelings about the issues. Client wondered aloud to therapist that maybe someone else could be more helpful. Therapist interpreted this sentiment as avoidance of dealing with issues but suggested that client get a second opinion and provided several competent practitioners in the community. Client saw the clinician for two sessions and both client and clinician agreed that client should continue working with Therapist V, who knew client well and could focus the work better than a new therapist.

The client expressed justified concern, and therapist, despite clinically disagreeing with client perception, non-defensively, suggested a consultation for a second opinion on continued treatment and offered referrals to facilitate the process. Ultimately, client returned to treatment with enhanced motivation and reassured trust in Therapist V.

In sum, Koocher and Keith-Spiegel (2016) offer these key recommendations:

1. At the beginning of therapy, whether formally or informally, ensure client understands the terms of the treatment contract, including mutual discussion about treatment goals and how these goals will be attained.
2. Therapists should seek an objective view of their feelings toward each client and how these feelings could impair therapy.
3. Update treatment plans as situations change and enlist client participation in this change process.
4. Factor in the unique qualities of each client when devising the treatment plans, including diversity concerns such as race and social class that are meaningful to client.
5. Therapists should maintain awareness of their personal beliefs, values, and attributes that may limit their therapeutic efficacy and limit their practice accordingly.

6. In some cases, clients have legal rights to receive or refuse treatment. Therapists should be cognizant of these rights and honor the underlying principles, even though specific laws are not in force.
7. If you lack competence to work with a given client, or have discomfort, biases, or concerns that could interfere with care, respectfully and professionally refer client elsewhere because therapists are not obligated to work with all potential clients.
8. Do not continue therapy as usual if the client is threatening, provocative, or is not benefitting, instead, seek consultation or determine different courses of action without delay.

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, which is not addressed by AAMFT, ACA, or NASW 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.).

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.).

Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations (NASW, 2008, 2.10.b.).

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors (ACA, 2014, C.2.d.).

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.).

THE IMPAIRED PRACTITIONER
BURNOUT

Burnout is a type of emotional exhaustion caused by excessive demands on energy, strength, and personal resources in the domain of work. Job-related burnout is a known factor in the work of mental health professionals. Performing self-care activities can prevent or manage burnout while neglecting self-care can result in making poor decisions, disrespecting one's clients, loss of positive feelings, sympathy, and respect for one's clients, and loss of concern for the people one works with. Burnout risk increases when therapists have little control over work activities, are working too many hours, and are overworked with administrative tasks.

Feelings of powerlessness and emotional loss are causal factors for depression, and are components of countertransference stress. These stresses can elicit anger in the therapist and the anger manifests itself in aversion and malice. Professional values and cultural norms deter against displays of malice or sadism, however, the aversion aspect of countertransference stress can be expressed in subtle, unconscious, direct, and harmful ways. For example, therapist may tell client that the schedule will not allow for a session this week, or a client in need of help may verbalize "I don't need any help" and therapist allows client to withdraw emotionally rather than appropriately questioning client.

Burnout may occur upon therapist feeling helpless with guilt over client not making progress or client exhibiting signs of difficulty with, for example, suicidal ideation, addiction issues, or coping emotionally with an ongoing matter. Therapists failed attempts to manage their own life issues coupled with their clients failure to progress can result in therapist perceived helplessness. Therapists may conclude their efforts will not lead to resolution and both therapist and client can believe they will suffer regardless of their actions. In such a case, therapist may prevent the experiencing of strong emotions by becoming detached. Whereas some in the medical community recommend a work style of "detached concern" with patients, such a therapeutic style may have clients sensing an absence of concern or care, and an attitude of therapist unresponsiveness, possibly culminating in client failure to comply with treatment. The following cases exemplify burnout (Koocher & Keith-Spiegel, 2016):

Therapist E worked full-time at a cancer treatment facility for several years, and as a display of his motivation and concern, volunteered to be "on call" for extended service hours. After a disruption in his marriage coupled with the death of a client with whom he felt close, therapist E's work performance dropped. Specifically, he did not respond to messages from clients or colleagues, periodically missed appointments without notice, and appeared to be distant from his clients. He was fired from this job but did find another position where he performed well.

Therapist F worked as a school psychologist in a large urban public school system. She sensed being overworked and unappreciated by her clients and administrators, who frequently demanded unreasonable requests of her time. Therapist F was not able to set limits on her work schedule and the situation worsened until she dreaded going to work on a daily basis. She resigned her position after attempts to secure a different job materialized but she gave less-than-adequate notice of departure and left behind several incomplete student evaluations.

Both therapists experienced burnout resulting from an interaction between job factors, personal life stress, dealing with stressful client issues on a routine basis, and other factors. Mental health professionals who listen to the problems of people for a large part of their day are potential victims of burnout. Each therapist encountered learned helplessness and depression, without resolve, which negatively impacted their clients. Therapist E manifested avoidance and detachment, which may have not presented identifiable client injury, but likely was detrimental to some. Therapist F's abrupt departure suggests a passive-aggressive, revenge-oriented retaliation against the unappreciative employer which affected several students.

Prevention is the best way to manage many potential ethical issues, including burnout. Employers will benefit from being aware of developing problems among their employees, and mental health professionals, upon awareness of burnout symptoms in themselves or colleagues, should initiate early intervention.

Warning signs of burnout include the following: a) atypical angry outbursts, b) apathy, c) habitual frustration, d) a feeling of depersonalization, e) depression, f) physical and emotional exhaustion, g) feelings of hostility, h) a sense of malice or aversion toward clients, and i) diminished productivity or effectiveness at work (Koocher & Keith-Spiegel, 2016).

Koocher and Keith-Spiegel (2016) note that many predisposing factors for professional burnout exist, including: 1) role ambiguity, such as vague or inconsistent demands and expectations, 2) work environment conflict and tension, 3) a large disparity between ideal and real job activities, 4) unrealistic pre-employment expectations, 5) absence of social support, 6) a perfectionist personality coupled with a feeling of being externally controlled, 7) family death or divorce, 8) routine helplessness, 9) penetrable emotional boundaries, 10) chemical dependency issues, and 11) excessively high personal expectations, for example, having a "savior complex."

The above researchers list the following as variables that can help insulate professionals from burnout: a) role clarity, b) receiving positive feedback, c) a strong sense of autonomy at work, d) opportunities and resources for rehabilitation from work stress, e) workplace social support, f) personal accomplishment, g) realistic expectations for client outcome, g) accurate sense of personal strengths and weaknesses, and h) being internally controlled.

THE WOUNDED THERAPIST

In addition to burnout, therapists may also experience serious emotional problems for which they may not seek assistance or be cognizant of the negative impact on professional services. Decision making ability and other competence factors may be challenged thus placing emotionally distressed professionals at risk for unethical behavior.

Often, the impaired practitioner is professionally isolated. This implies that clinicians who maintain professional interactions with colleagues may be less vulnerable to burnout and personal decompensation, perhaps due to exposure to health-generating discussion or being made constructively aware of personal problems that could lead to ethical violations.

Practitioners who acknowledge personal problems and commit to seeking resolution have a better chance to effectively rehabilitate than those who avoid issues. In contrast, caution is recommended when expanding an ethics inquiry into the personal lives of therapists for behavior unrelated to professional competence, as the following case illustrates:

A former client issued a licensing board complaint against the therapist for improper billing practices. The complaint document included a statement that client saw, from a distance, therapist mingling at a local club where people gather for anonymous sexual encounters.

In this case, the licensing board investigated the billing complaint but justifiably ignored the allegation pointing to therapist's personal life which was not pertinent to a professional misconduct complaint (Koocher & Keith-Spiegel, 2016). If an ethics inquiry observes personal impairment or mental illness, however, an expanded investigation may be required to protect the public interest. This broadened inquiry becomes salient given therapist claiming emotional problems as a defense because the impairment might adversely affect other clients.

An inherent concern regarding impairment is that therapists may not recognize their personal distress as impairing professional competence. Even with awareness of problems, therapists may not seek assistance due to concern of being labeled imperfect or damaged. Koocher and Keith-Spiegel (2016) creatively offer two recommendations to address the troubled therapist issue: Support networks through state and local professional associations could be developed to offer consultation, and refer to therapists who have identified themselves as willing to therapeutically treat disturbed peers. Second, support groups could be arranged for therapists who work in similar stressful settings as a platform to disclose and emotionally release.

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).

RESPONSE TO NON-IMPROVING CLIENTS

Ethics codes clearly promulgate the need to terminate a therapeutic relationship when the client no longer needs services or has stopped benefiting from the professional relationship. Therapist may need to transfer client to another practitioner who can assist more effectively, or advise client that services are not needed anymore. These ethics codes offer guidance:

Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests (NASW, 2008, 1.16.a.).

Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary (ACA, 2014, A.11.c).

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service. (b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship. (c) Except where precluded by the actions of clients/ patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate (APA, 2010, 10.10.a.b.c.).

The following three cases illustrate scenarios of clients not improving (Koocher & Keith-Spiegel, 2016):

Client was in psychotherapy every week for six years with Therapist G. Client effectively resolved all initially presented issues after two years but then developed a dependency upon therapist. There was not a change in client emotional status for four years, other than an increasing attachment to therapist. Therapist G did not exert much effort to suggest termination as his approach was, "If the client thinks she needs to see me, then she does."

Therapist G apparently believes that psychotherapy is never-ending. It is uncertain exactly when therapeutic diminishing returns begin but Therapist G may be mistreating his client by perpetuating client's dependency and "apparent need" for services. Therapist should critically evaluate the therapeutic process periodically and refer client for a consultation with a different therapist if continued treatment is in question. Such action would rule out therapist having a financial or emotional blind spot preventing objectivity.

Therapist H began treating client for increasing anger toward his employer. Over time, therapist observed client becoming progressively more paranoid and troubled. Therapist proposed hospitalization several times but each time client rejected the idea. Therapist continued treating client and eventually became the object of client's paranoid anger.

Therapist H failed to acknowledge that this case was beyond his scope of practice. Upon observation that client needed more intensive treatment (i.e., inpatient service) but was declining the option, therapist could have refused to further treat until client sought appropriate care. If client presented a danger or required a commitment for involuntary hospitalization, therapist would be responsible for acting accordingly.

Therapist I, an industrial/organizational psychologist, was hired to help a company improve employee morale and lower product defects in a large factory. Based on effectiveness data that Therapist I was collecting himself, his efforts were not successful. Nevertheless, therapist opted to ignore the data, advised the company that a longer trial timeframe was indicated, and continued to provide the inadequate services at a high fee for several more months until the company canceled his contract.

Perhaps Therapist I is greedy or simply unaware of his deficiency for the present task, nonetheless, he inexcusably ignored the data. An alternative plan of action was required, instead, he chose to continue offering assistance which he knew to be ineffective. In a general therapeutic sense, Therapist I failed to reassess treatment plans given ongoing

client issues and did not re-evaluate the intervention, each being unacceptable.

Koocher and Keith-Spiegel (2016) recommend the following in relation to competence:

1) Respect standards of practice or guidelines for competent professional behavior presented by professional associations.
2) Mental health professionals should practice according to conservatively assessed indications of competence and legally authorized practice domains.
3) Be aware of burnout or exhaustion potential in specific job settings and receive help if needed.
4) Numerous specialty practice areas and novel techniques requiring special expertise for which no practice criteria have been developed abound. In such cases, consult with experienced practitioners with the specialty or technique to learn of recommended training levels before engaging in the interventions.
5) A complete agreement on course work or training for all mental health disciplines does not exist. It is the individual practitioner's responsibility to confirm she or he is operating within the scope of practice conducive to training.
6) Stop practicing given personal distress, illness, or impairment that diminishes ability to function with competence and responsibility. You may consult with colleagues for a second opinion.
7) Do not continue treating clients who show no progress or are worsening, despite employing your recommended interventions, rather, receive consultation or appropriately terminate the ineffective relationship.

MANAGED CARE

Managed care developed due to substantial escalating costs for health care services, lack of functional economic controls over prices, demand by employers who contract for employee health insurance, and legislators who manage payment for federal and state insurance plans. Essentially, managed care evolved in response to changes in health care marketplace economic realities. Some of the benefits include lowered cost of services and insurance, necessitating clinicians to carefully assess all aspects of their treatment planning resulting in improved healthcare delivery, and lowering risks of the "moral hazards" of insurance. The moral hazards of insurance involves the reality that people with insurance behave differently than those who are uninsured, and this concept is based on an *ex ante* and *ex post* basis. The ex ante paradigm corresponds to behavior before an insurance claim is made, specifically, people are generally less careful about avoiding insured perils/risks than they would be without insurance coverage. By example, a car owner whose insurance has expired may opt to avoid driving the car until insurance is renewed. The ex post model applies to behavior after the insured event, specifically, insured people often demand/consume more and higher quality services than uninsured people. For example, an uninsured car owner whose bumper is dented may choose to not pay out of pocket for the repair while an insured car owner often will obtain complete repair from the best repair shop in town. Likewise, a person with full coverage health insurance is more likely to seek more care, from the best provider, instead of bypassing some services to save money.

Insurance companies typically try to minimize the negative consequences of such moral hazards by creating strategies for policyholders to share in the risk, such as having required deductibles, copayments, and variable coverage limits. These cost controlling methods appear effective for automobile and home owner's insurance but health insurance costs have not been controlled effectively in this way. Health needs are often categorized as a survival issue, hence, individuals can delay fixing their dented car but cannot postpone bodily care, and they expect more intimate professionalism from health providers than from those we pay to fix a dented car bumper.

Within this context, along with demands from large group insurance buyers (e.g., employers), managed care organizations (MCOs) have emerged. In conjunction with policy limits, deductibles, and copayments, MCOs devised case reviews, approval requirements, and other measures to lower unnecessary, redundant, or ineffective (but costly) medical care. As such, insurance plans can, in theory, reduce coverage cost and provide cheaper benefit packages. In essence, the individual consumer has little effect on the system while the large coverage purchasers and employers use bottom-line cost as the driving force behind their decisions.

Concerns abound, however, in a health care delivery system that potentially offers incentives for providers to withhold care (i.e., in capitation models, whereby a determined fee is paid to cover all of the mental health needs of a determined number of insured people regardless of the amount of service provided), or establishes questionable barriers to reasonable treatment. Koocher and Keith-Spiegel (2016) deduce the irony involved in managed care and capitation models forming a new moral hazard by introducing an incentive to offer less service.

Not all MCOs excessively truncate care and many effectively control costs with reasonable peer review. Often times, we get what we pay for, thus, a low-cost plan will provide more limited coverage and possibly less-professional management regarding case review decisions.

The ethical threat with managed care involves therapists' allegiance to their clients versus the MCO. Under managed care, mental health professionals must often balance client needs with MCO's financial incentives to change or limit care. The MCO limits on treatment may actually be reasonable, efficient, and cost saving, but these limits may also reduce the freedom and autonomy of the therapist and client. In turn, treatment decisions that are averse to the client can be implemented without client knowledge or agreement.

Many health and mental health clinicians have argued that MCOs do not pay for complete treatment, but instead release

clients and patients "sicker and quicker." Many practitioners complain of restrictions to their professional autonomy. Managed care programs are designed to save money by eliminating unnecessary services, however, it is more cost efficient to simply cut services altogether. Such an approach often only yields short-term benefit and lacks preventive care. Case review can reduce unnecessary psychiatric hospital admissions or psychotherapy similar to second opinions eliminating unnecessary surgery, but case review and decision making in mental health care is generally not as straightforward, unambiguous, or well-defined as in physical medicine. These concerns have led to the regulation of MCOs being an important public policy concern. Practitioners who experience MCO denial of recommended services to their clients may consider the option of filing a written protest to the MCO, and forwarding a copy of the letter to their clients. This displays advocacy for one's clients and informs clients that you have their best interest in mind Koocher and Keith-Spiegel (2016).

MCOs have numerous reasons for rejecting applicant mental health providers from their service pools. They may already have enough therapists in a given locale or the denied applicants may have an ethics complaint, licensing board action, or malpractice claim in their record. Generally, practitioners not accepted to or dropped from MCO provider panels cannot easily appeal the decision. Consequently, many mental health professionals fear raising objections or challenging MCO decisions or policies that negatively impact their clients due to concern they may be terminated from the provider panel.

The following four cases typify the conflicts that health and mental health professionals increasingly encounter daily with MCOs (Koocher & Keith-Spiegel, 2016):

Case 13A: Psychotron Mental Services mailed provider renewal contracts to thousands of clinicians in three states on June 1. Most providers received the mailing on June 7, and were instructed that the renewal contracts must be returned by June 15. The contracts were lengthy and included a "hold-harmless" clause and a "gag rule." Obviously, the situation created practitioner distress. Some providers, concerned about economic loss, completed and mailed the contract without obtaining legal advice or questioning the time deadline.

Hold-harmless clauses stipulate that the clinician will not hold the MCO responsible for actions the MCO takes that may cause harm to the therapist resulting from MCO decisions regarding services to a client. By example, if the MCO denies a request to authorize psychotherapy services and therapist continues to treat client without coverage, to avoid abandonment, the therapist would be barred from recovering damages from the MCO. In another example, if the MCO denies services, causing client to end therapy, and client later commits suicide, the client's family may file a wrongful death lawsuit against the psychotherapist with or without the MCO as a codefendant. Hold-harmless clauses actually may be legally invalid due to being against public policy, nonetheless, it is advised that therapists should refuse to sign such contract conditions.

Gag rule (also called no disparagement) provisions prohibit the provider from making "critical, adverse, or negative" statements about the MCO to clients as well as in any public forum. This policy is sensible in routine business practices such as employee termination agreements but is out of context in health care. It bans practitioners' rights to free speech, might be considered a limit on client advocacy, and could be assumed to be an attempt at intimidation. Gag rule restrictions can impede therapist's ethical obligation to present clients with information about benefits, risks, and costs of conducive interventions. Still, many practitioners signed the Psychotron renewal contract thinking they had no choice and no time to waste. Thankfully, many states have now banned such contract provisions.

Some MCOs have been extremely aggressive and controlling in contract offers. Providers have reported the following MCO problematic clauses in contracts stating that the provider will be solely responsible in any legal actions undertaken by any party; take no legal action against the MCO under any circumstances; deal exclusively with the MCO; agree to abide by all of the MCOs utilization review processes and decisions; agree not to bill clients for noncovered services without advance written consent; agree not to bill clients for covered services except for copayment and deductibles; agree to provide services when benefits are exhausted, and amazingly, agree to abide by future contract provisions that the therapist has not even seen as yet. Many such provisions are not enforceable, however, no therapist ideally wants to test the legal system.

Therapists who agree with such clauses may experience voided coverage in related cases by their professional liability insurance and may hinder their ability to defend themselves given a lawsuit. These types of clauses attempt to shift unreasonable responsibility for MCO actions onto uninformed or coerced providers. Providers are advised to have such contracts reviewed by an attorney knowledgeable of mental health practice. State professional associations may be able to indicate such attorneys or suggest you speak with practitioners in your area familiar with the MCOs contracts. Be cautious if you are coerced to sign a contract hurriedly.

Case 14A: Client feels depressed; his child died of cancer several months ago, he is experiencing marital tension, and he was just informed that his employer will be downsizing the company. Therapist W has developed a treatment plan for individual and couples therapy over the next several weeks and acknowledges that antidepressant medication may be helpful, but he initially wants to see if therapy alone will suffice. Therapist informs the case manager overseeing client's benefits of the treatment plan and is instructed instead to refer client to a specific psychiatrist for a medication consultation. The case manager clarifies that the company's policy is to initially treat with generic antidepressant medication before recommending verbal psychotherapy

because "a lot of patients get better with just a little medicine."

Case 15A: Client, age 13, was brought to the office of Therapist X by her mother because client was caught smoking marijuana at school. Her father has a history of alcohol problems and has allegedly been threatening to his wife. Additionally, client has a history of learning disabilities and depression. Therapist's treatment plan recommends family therapy at least once per week to address the multiple family issues. The MCO overseeing the family's benefits only authorizes four visits each for the mother and child during a 3-month period and asserts placing both on antidepressant drugs.

These two cases show therapist careful treatment planning being overturned by case managers with the presumed agenda of management to reduce costs. Koocher and Keith-Spiegel (2016) agree that some managed care companies prefer to prescribe medication instead of therapy, and often the medications are prescribed by an internist, pediatrician, or nurse practitioner and not a psychiatrist. The ideal therapist ethical response is similar in both cases. In a firm and respectful manner, clarify the reasons for the recommended treatment plan. Present research and factual data that supports your plan. If the case manager still rejects your plan, respectfully inquire about the appeals process or request to speak with a supervisor. Once again, present your plan in a documented, empirical manner, highlighting the potential negative consequences of not enacting the treatment plan (i.e., not addressing the relevant family relationship issues may prevent permanent change and result in hospitalization or more in-depth and expensive interventions later). If your plan is still denied, therapist should meet with client(s) and state their recommendations and the MCO's response. Clients should be informed of their recourse if they so desire, such as complaining to the MCO, their employer, or contacting regulatory agencies. The three essential ethical principles involved are promoting the best interests of the client, offering client advocacy in a professional manner, and involving client in the decision-making process.

These recommendations represent "ideal" responses but many psychotherapists concern themselves with being reported as a therapist who incessantly appeals decisions or recommends clients to do so, which could result in a "no-cause termination" for the therapist. This means the MCO may execute a standard contract option to cancel a provider without need of giving a specific reason. As expressed earlier, some MCOs have contract provisions that prevent clinicians from speaking critically of the MCO's practices or advocating strenuously for clients. Significant financial pressures also abound.

Case 16A: Therapist Y was effective in focal short-term therapy and the MCO often referred to him. At a later date, the MCO informed all providers, including Therapist Y, that it was preparing to minimize its provider pool to those who could work up to 30 hours a week. The MCO subscribers quickly became the essence of Therapist Y's practice. Then, the MCO started offering special incentives, including cash bonuses, paid quarterly, for fulfilling a designated quota of cases "successfully terminated in fewer than eight sessions."

Therapist Y has become the victim of a seduction scheme; he is now dependent upon the MCO as an income source and has been propositioned with a bonus plan that puts corporate profit goals atop client welfare. This places Therapist Y on an ethical slippery slope. Therapist Y may find it difficult to advocate for a client in need of more services or who wanted to appeal an MCO decision; he could encounter a no-cause termination. This case does not imply that the majority of MCOs conduct business in this manner, rather, mental health professionals should be forewarned of this business model and the ensuing risks.

One frequent ethical question posed by therapists practicing in MCOs is: If I abide by an MCOs model that only offers coverage for medication and short-term therapy, can my client charge me with wrong or inappropriate treatment? If an MCO operates with a "one-size-fits-all" model for psychotherapy and their insurance policy infers that the treatment plan is already established independent of a thoughtful diagnostic assessment or treatment plan conducive to client's needs, then a therapist who agrees to this policy may face trouble. The treatment plan between therapist and client, which is discussed at the outset of the relationship, helps client to understand and agree with how therapy will proceed and the costs incurred. This process includes assisting clients in determining what mental health coverage their insurance provides and does not provide, and that out-of-pocket costs may arise.

Another common ethical concern raised by therapists who practice in MCOs is: If the company concludes that my treatment is not necessary, and since the company can stop making payments abruptly and my client cannot pay out-of-pocket, would I be at risk of abandonment charges? Initially, therapist can advocate for client using competent and understandable treatment plans and records. Given third party's decline for payment and client cannot or does not choose to pay out-of-pocket, therapist should seek resolution compatible with client's needs, such as providing a reduced fee or offering a referral to a more affordable agency. There is not an obligation to continue therapy indefinitely in this situation but some appropriate interim coverage should be provided. Note that clients should not be abandoned in the midst of a crisis situation.

Koocher and Keith-Spiegel (2016) remind us that some charges against for-profit MCOs have been made by the American Psychological Association (APA) and its state affiliates and have become court cases. Litigation against Humana in Florida, in 2006, alleging conspiracy to reduce, delay, and deny provider payments ended in a $3.5 million settlement. A settlement with Cigna, in 2005, led to a settlement of approximately $2.2 million covering more than

4,000 psychologists. Time will tell if these types of actions culminate in MCOs skewing their business models to favor clientele rather than cost saving. In the meantime, Koocher and Keith-Spiegel (2016) recommend therapists to be mindful of the following ethical challenges when dealing with managed care entities:

1. The needs of some clients may be compromised due to the MCOs focus being cost containment. Therapists may not find congruency between client needs and insurance-covered services causing therapist to encounter conflicting roles.
2. Providers, as individuals or groups, are increasingly being pressured by third-party payers to agree to capitation schemes such that financial incentives are offered to lower the amount of provided care. These schemes will reduce clients' trust, generalizing to situations when practitioners are justified in declining requests for added services.
3. A substantial reduction in clients' free choice under managed care is evident. Clients can be forced to work with a provider from a particular pool, necessitating them to receive care from someone with a previously negotiated arrangement with the MCO to which the client was not a party.
4. Closed provider pools may lead to the development of panels that are inadequate in working with adversity issues such as ethnic minorities and individuals with sensory impairments.
5. Confidentiality issues are increased due to MCO demands for detailed case information.
6. Restrictive contract provisions (e.g., gag rules and hold-harmless clauses) can have extensive liability consequences for practitioners.

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).

Conflict of Interest

The standard pertaining to conflict of interest requires practitioners to avoid undertaking a professional situation or responsibility given a reasonable likelihood that other interests or relationships could reduce competency or impartiality, or expose that individual or organization to harm, mistreatment, or exploitation. Trust is vital to a professional relationship and practitioners may violate that trust if they assume professional roles when competing professional, personal, financial, legal, or other interests or relationships could reasonably be anticipated to affect objectivity, competence, or proficiency to perform this professional role.

This standard also restricts practitioners from assuming a role that would subject a person or organization with which the clinician already works to harm or exploitation. Though the standard does not require rejection of the added role in all situations, caution is advised. The standard promotes avoidance of assuming responsibilities for which previous, present, or future relationships could possibly be exploitative or harmful. The conflict of interest standards are as follows:

> Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation (APA, 2010, 3.06).

Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client (NASW, 2008, 1.06.a.).
... 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).
Marriage and family therapists do not abuse their power in therapeutic relationships (AAMFT, 2015, 1.7).

Case 9: Conflict of Interest

Case Scenario - Therapist I provides assessment and treatment services to children and adolescents in an academic teaching hospital psychiatry department. She specializes in working with youth with attention deficit disorder (ADD) and she works closely with psychiatrists on a team that focuses on this population and diagnosis. Therapist I knows that several of the psychiatrists receive large research grants from a pharmaceutical manufacturer to conduct clinical trials with medications to treat ADD, and that some medications have been marketed globally. She receives no financial remuneration from the pharmaceutical company, but she is aware that her position at the hospital is supported by the large case flow of youth presenting with ADD, which is partly due to the funded research department's lofty reputation. Therapist I acknowledges that her assessment and treatment approaches over time have been positively influenced, in part, by the clinical presentations of clients engaged in the medication trials, and she believes that the medications used in the research trials have been helpful to her clients.

Therapist I is invited to give a day-long workshop to a medical school on assessment and treatment models for ADD and she will be paid well. She must complete a form which includes whether she has a financial or other commercial interest in any medication or product that will be discussed at the workshop. The form is unambiguously designed for physicians who may be receiving research support or other remuneration by medication or medical device manufacturers and does not request disclosure of any indirect financial interests or support.

Ethical Concern - Therapist I has extensive experience in the assessment and treatment of youth with ADD and will be quite informative to the workshop participants. She does not receive direct financial support through fees or research grants from commercial entities that develop ADD medications. In contrast, Therapist I works in an organization whose medication and research program has influenced her approaches to assessment and treatment. She has no direct financial interest in medication development, but her position is indirectly supported by funds provided for medication research (it is part of the department's general operating budget) along with the large case flow of youth with ADD who are referred due to the strong reputation for clinical services offered to ADD youth, partly because of the academic affiliation with a respected medical school and reputation for cutting-edge research.

Decision-Making Considerations- Standard 1.06.a. obligates social workers to "avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment." Standard 3.06 requires psychologists to "refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships" might "impair their objectivity, competence, or effectiveness" when performing the role of psychologist or may "expose the person or organization with whom the professional relationship exists to harm or exploitation."

Therapist I will need to ascertain whether her indirect financial interests emanating from the Department of Psychiatry medication research funding reasonably establishes a conflict of interest that could undermine her "professional discretion and impartial judgment" or "objectivity, competence, or effectiveness" when teaching the workshop on assessment and treatment of ADD youth, or "expose" her department or the medical school making the workshop invitation to "harm or exploitation." Further, she may consider whether her professional and/or personal relationships with her Department of Psychiatry colleagues may have impacted her "exercise of professional discretion and impartial judgment" in providing the workshop on the topic of ADD youth.

Standard 1.06.a. instructs social workers that "in some cases, protecting clients' interests may require termination of the professional relationship..." and Standard 3.06 prohibits psychologists from assuming a professional role if there can be negative impact from a conflict of interest. The standards do not indicate that practitioners can proceed given their disclosure of the conflict of interest or if the organization or person involved agrees to accept the risk of possible harm or exploitation.

Decision Options - Therapist I must determine whether her interests or relationships affect her "professional discretion and impartial judgment," or "objectivity, competence, or effectiveness" at the exact time when her objectivity in making such an evaluation is in question. Specifically, her work experience with the Department of Psychiatry, and professional and personal relationships with colleagues with direct financial interests in funded medication research, may have fundamentally molded her perception and working model of assessment and treatment of ADD youth. Therapist I may be lacking an unbiased view regarding the influence of her organization's culture and activities relative to the medication trials, similar to the possibility of a physician who receives drug company representative perquisites, incentives, or gratuities being unaware of how this determines prescription choices. Therapist I has already decided that her clients benefited from medications that underwent clinical

trials in her department, in turn, she may unmindfully favor prescribing medication for ADD as opposed to therapy.

Therapist I arranges an ethics consultation focusing on the progression of her clinical views on assessment and treatment of ADD youth within the milieu of her research-oriented psychiatry department, and ways her therapeutic perspectives may have been influenced by that department over the years.

The ethics consultation convinces Therapist I that she can provide an objective and fair workshop. She resolves to address possible bias due to undisclosed real or perceived conflicts of interest by informing the medical school representatives who hired her of her indirect financial interests in the department's funded medication research, and the possible influence of her professional and personal relationships with department colleagues who run medication trials. She decides to do so even though such information is not requested on the medical school disclosure form.

If the medical school hires her, Therapist I elects to start the workshop by announcing her indirect financial interests and possible colleague-influence on workshop content (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Third-Party Requests for Services

When a third party (e.g., a parent, teacher, court, employer, human resources office, training institution, referral source, or commanding officer) requests a mental health procedure, it is essential that both the third-party requester and the person receiving the services, be informed of the therapist's roles at the outset. Further, the AAMFT standard, Relationships with Third Parties, includes the need to clarify "the nature of the relationship with each party and the limits of confidentiality" and the APA standard, Third-Party Requests for Services, indicates the need for "an identification of who is the client." It is vital to identify who the client is, otherwise, one or more persons can wrongly believe that they are the therapist's client which can create issues (i.e., collateral contacts, employer, organization, family, school psychologist, family member).

The term "client" sometimes can relate to individuals or organizations other than the person who is the direct subject of the services. For instance, if an attorney hires a therapist to examine a defendant, the attorney is generally labeled as the "client," and the defendant is the recipient of services. The attorney provides the questions to be answered and can authorize, direct, and terminate the professional relationship, inclusive of handling the work product or any confidentiality matters. Standards such as 3.04, Avoiding Harm, reflect this concept by including phrases such as "others with whom (therapists) work" along with referring to "clients." In relation to legal minors, the client is the child, partly due to insurance procedures, despite the fact that it is the parents who authorize treatment. In situations when one or more individuals are identified as clients, that information must be clarified to all the parties, along with the therapist's role regarding all parties.

Therapists must also clarify who controls the release of a report or which parties can receive other confidential information. In turn, Standard 3.07 (indicated below) requires clarification from the beginning of the service who the client is and the possible use of the information created by the procedures, which necessitates forethought. Ethical and legal analysis is prompted by who the client is, and disclosing this information to the relevant parties involved can facilitate the avoidance of problems and productive mental health services.

Regarding confidentiality, privacy, and who will receive information, although not mandated by the standards, it is suggested to have a written release to inform clients of the nature of the information to be released and the purpose of its release, and to document the authorization - including acquiring written releases as circumstances arise. A written authorization to release information can foster clarification of the nature, extent, duration, and purpose of the information to be released or exchanged.

Standard 3.07 necessitates disclosure to all parties involved, including the third party and the recipient of services, the nature of the relationship with all involved parties. This disclosure includes information about the role of therapist, who is receiving services, who will receive information about the services, and how the use of information will be utilized. The standards for third party relationships are as follows:

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).

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).

Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality (NASW, 2008, 1.07.e.).

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.).

Case 10: Third-Party Requests for Services

Case Scenario - Therapist J provides contract testing and evaluation for the Department of Family and Child Services (DFACS). Her evaluations for DFACS involve placement or decisions to be made, such as fitness to parent, foster placement, placement in rehabilitation groups (i.e., substance abuse), and back-to-work assessment.

At Ms. B's initial client interview at DFACS, the caseworker tells her that DFACS provides counseling groups, individual counseling, vocational development, and addiction counseling. Ms. B tells the caseworker of her interest in several of these services, including parenting assistance because she acknowledges being somewhat negligent in this role, learning job interviewing skills, and receiving assistance

for her substance abuse. Therapist J contacts Ms. B to schedule an evaluation and Ms. B assumes she will be assessed for counseling for her stated goals. At the evaluation, Therapist J gives Ms. B a uniform informed consent to sign, states she works at DFACS, and that disclosures by Ms. B will not be confidential and could be included in the report. Therapist J informs every examinee of this same information. DFACS actually asked Therapist J to evaluate Ms. B for her capability to function independently, to parent effectively, and to determine if her children should be placed in foster care due to her substance abuse, neglect charges, and inability to parent.

In the completed report to DFACS, Therapist J recommends temporary foster care for the children until Ms. B receives rehabilitation. Ms. B is outraged to hear this determination because she declares that she was not informed that fitness for parenting was the purpose of the evaluation and that she would not have cooperated had she known. She blames Therapist J for not being truthful with her and she threatens to register a formal complaint with the licensing board.

Ethical Concern - It appears that Therapist J had a routine of consultation with DFACS such that she completed assessments and the informed consent and assumed that DFACS prepared clientele for evaluations or other services they would receive with all needed and appropriate information. Therapist J recognizes her role as a contract counselor for DFACS and feels she sufficiently described her role, but she also senses that she may have violated Standard 3.07, Third-Party Requests for Services. Standard 3.07 requires practitioners to clarify their roles to all persons they are working with. Therapist J did clarify her role by indicating she would be performing an evaluation. She also told Ms. B that DFACS was her client, confidentiality would be limited, and several staff members could access her report. Therapist J reviews Standard 3.07 and recognizes that she did not make clear the fact that the likely use of the services and disclosed information was for fitness to parent which could also affect custody of Ms. B's children, at this point in time. Compliance with Standard 3.07 requires that practitioners "clarify at the outset of the service the nature of the relationship with all individuals or organizations involved," and compliance with AAMFT Standard 1.13 requires practitioners to "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." Though Therapist J did discuss the nature of her relationship with DFACS and with Ms. B in that Ms. B was being evaluated by Therapist J, the probable use of the information - an essential variable for elucidation of the third-party request expectation along with appropriate informed consent - was not explained to Ms. B. It may be assumed that Ms. B was mandated for testing since the welfare of a child is involved, but practitioners must inform the individual about the nature and purpose of the evaluation in a mandated-evaluation situation.

Decision-Making Considerations - Therapist J reflects on the procedures that DFACS and herself had organized when she took the consultant position. Due to the large number of people to be tested, it was determined that Therapist J would complete the essentials of testing administration and the standard DFACS informed consent. It was understood that each client has a caseworker that performs an interview, assesses client's needs, and determines the needed action for DFACS to fulfill its responsibilities to the state. A large percent of the clients at DFACS are mandated for services and for evaluation, therefore, DFACS has in place a customary protocol for informed consent and for interacting with mandated clients in legally required ways. Therapist J now understands that she and other consultants were assuming that DFACS was providing complete informed consent and third-party request information while DFACS was assuming that consultants were fulfilling these responsibilities.

Therapist J understands the intent of the Third-Party Requests for Services standard and that her intent is to offer ethical and professional services, but she did not confirm that all aspects of the standard were enacted. She would have provided all informed consent, explanation of purpose and use of services herself if this case was within her private practice or an agency setting whereby the examinee was her client. Given her consulting role with DFACS, she had not assumed responsibility for disclosing essential elements of the services to the examinees, instead she deferred to DFACS. Therapist J recognizes that DFACS did not dictate to her a required level of thoroughness of the explanation of services to clients, rather, she made assumptions that contributed to the present dilemma.

Decision Options - Therapist J assesses her options in relation to three circumstances: a) addressing DFACS regarding this case and future cases, b) confronting Ms. B and her complaint, and c) determining how to improve her consulting practice in light of this experience. She first contacts the DFACS administrator with whom she worked to explore the role of DFACS, her role, and the court's role, when applicable, in evaluation cases. Therapist J reveals the ethical dilemma resulting from the communication gap between DFACS and herself. She advises that transparency and full information disclosure between herself and DFACS is needed in future cases, and a protocol is required enlightening her of what DFACS has told the clients, both mandated and voluntary, about the services they are going to receive. Therapist J tells DFACS that she will be providing a full informed consent and explanation of the purpose and use of information obtained from her evaluations even if DFACS provides such in their informed consent.

Therapist J establishes her own methodology for future consultations, including procedural steps when offering services to a third party. She realizes that a dilemma was imminent since she had not assessed the differing role responsibilities implicit in third-party request for services.

Therapist J ponders whether and how to contact Ms. B. She receives feedback from the caseworker of how to proceed and she recognizes that her determination for foster care of the children will probably be honored by the court, unrelated to the case having been mandated or not. She does not question her recommendation and would not change her clinical decision, because the welfare of the children is involved. Therapist J regrets that her management of the communication with Ms. B will likely cause suspicion in Ms. B to work with DFACS and that she may feel exploited. Therapist J hopes that Ms. B will work with DFACS on her issues of substance abuse and parenting skills culminating in a custody decision in which the welfare of the children will be ensured (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Informed Consent

Informed consent offers assurance that the trust required from the practitioner's clientele is justified, therapist power is not abused, and therapist care is understood and agreed to. The concept of and right to informed consent emphasizes respect for individual freedom, autonomy, and dignity and it is essential in relationships between practitioner and client. Informed consent is the end-result of therapist and client reaching an agreement to work together. It ensures that all parties involved sufficiently understand the collaboration, and it facilitates communication and clarification. It is a process that recurs in order to clarify or renegotiate the therapeutic process.

The informed consent standard is essentially based upon the principles of fidelity and responsibility along with respect for people's rights and dignity. Fidelity includes factors such as faithfulness, loyalty, and promise keeping, which are fundamental to trust. The professional relationship between practitioner and client relies on fidelity and honest communication and the understanding that the contract that unites the parties requires those involved to fulfill certain functions and responsibilities. Practitioners must also respect their clientele's dignity, worth, privacy, confidentiality, and self-determination to choose a course of action. The fact that clientele must consent to treatment and be informed of its consequences and implications reflects the value of respecting people's rights and dignity.

Individuals who provide their informed consent to the practitioner must have the capacity to do so, must have received information relevant to the decision, be aware of the voluntary nature of the participation, have been given the chance to ask questions about the processes and procedures, and be able to exercise a voluntary choice. The depth and nature of the communication may change depending on the person's capacity, level of sophistication, and needs. Practitioners must communicate to clients, in clear and understandable language, what they can expect before and throughout the process.

The standard also requires informed consent be obtained if the services are performed face to face, or by Internet, videoconference, or other forms of electronic communication. When using electronic forms of communication, therapists are advised to ensure that the person who gave consent is the one who received services; for example, a password can be used. Further, limits of confidentiality must be included in the information to clientele when electronic communication is involved.

Implied within the informed consent standard is that therapists should trust their client's ability level to decide what will be helpful to them, inclusive of their involvement in treatment decisions collaboratively with therapist. Having informed-consent forms, which generally include information about billing practices, scheduling appointments, cancellation policies, and common confidentiality exceptions, can be helpful. Such forms should contribute to, but not replace communication between therapist and client, and communication should allow for clients to discuss their expectations, needs, and concerns before and during the process.

When providing services to persons who cannot legally give consent, such as children, legally incompetent adults, or those who are not mentally or psychologically able to give consent, practitioners must try to communicate with the individual at a level equal with his or her capacity, and they must protect the best interest of the client.

The consent-getting process with clients generally communicates goals, expectations, procedures, potential risks, and limits of confidentiality. Additionally, clients may reasonably expect cautions and warnings about foreseeable and unforeseen treatment results (with the understanding that therapists cannot predict all possible outcomes). By example, clients presenting with marital issues may alter their attitudes, decisions, or behavior thus significantly changing the relationship dynamics, for better or worse. Clients with job-related concerns may opt to change employment. In such cases, when clients present with poorly addressed issues laden with pent-up emotions that might produce distressed feelings, therapists may choose to caution client of potential life changes stemming from the therapy.

The following case demonstrates an unexpected outcome which may have been avoidable given therapist informing client of possible unforeseen therapy effects.

Client entered psychotherapy to resolve depression, feelings of inadequacy, and a poor sexual relationship with her spouse. Therapy facilitated client becoming more self-assured, less depressed, and more active in initiating sexual activity with husband. Husband felt ambivalent about wife's transformation and increased sense of autonomy. Husband started to think that wife was observing and evaluating him during sexual activity which left husband feeling uncomfortable and increasingly frustrated. Husband started pressuring wife to terminate therapy and wife, instead, separated from husband. The husband complained to an ethics committee.

Analysis of this case suggests that despite a lack of sufficient psychodynamic information about this couple's relationship, therapy changed the marriage. Apparently,

client experienced personal growth from therapy and she has the right to separate from spouse and continue therapy. These facts yield the conclusion that therapist was not unethical. The unknown variable is whether therapist informed client that therapist's obligation was to client's mental and emotional health, not the marriage. Had therapist warned client that marital changes could occur due to her individual therapy, one ponders whether the outcome of this case would have been different (Koocher & Keith-Spiegel, 2016).

Therapists have the responsibility of providing clients with the information they need to make informed decisions about therapy, as such, a therapeutic contract is implemented verbally or in writing. Koocher and Keith-Spiegel (2016) support the idea that contracting facilitates therapists in fulfilling three fundamental functions:

1. The healing function or relieving emotional suffering through understanding, support, and reassurance.
2. The educational function, which includes stimulating growth, insight, and maturation.
3. A technological function involving application of various techniques designed to change or modify behavior.

The essential themes of a therapeutic contract, from the perspective of questions that clients consider, include the following (Koocher & Keith-Spiegel, 2016):

I. Therapists specify treatment goals by explaining:

a. Who the client is (i.e., an individual, family member, a group)
b. The goal(s) being pursued
c. How the therapy process will proceed
d. How will we work together
e. Scheduling of sessions (how often, for how long)
f. How can client contact therapist between sessions, if needed
g. Can therapist relate to client through social media
h. The client's rights and responsibilities
i. The therapist's rights and responsibilities
j. How does client's legal status affect therapy (i.e., a minor, mandated treatment)

II. Therapist and client therapy expectations:

a. The therapy process
b. Treatment risks
c. Fees, payment methods, services covered by insurance
d. Treatment techniques
e. Availability of therapist and ways to communicate (i.e., telephone, Internet, emergencies)
f. Confidentiality limits
g. What professional records are kept
h. What state or federal laws dictate client access to records
i. What are therapist's personal policies within the lawfully mandated options
j. How does the process work with minors or incompetent clients

The informed consent standards are listed below:

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, limits to services because of the requirements of a thirdparty payer, relevant costs, reasonable alternatives, clients' right to refuse of 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).

Case 11: Informed Consent

Case Scenario - Therapist K, a child specialist, is contacted by Ms. C regarding issues with her 12-year-old daughter, D.C. Therapist K completes an intake interview with Ms. C and D.C, acquires informed consent for services from Ms. C, and explains to D.C the nature of services in a manner she understands, including limits of confidentiality. Ms. C reports that D.C is experiencing bullying at school, in turn, she is hesitant to attend school, her grades are falling, and she is depressed at home. At the intake interview, Ms. C expresses that she had never married D.C's father, they permanently separated before the child was born, and she does not know of his whereabouts since the separation. Therapy with D.C begins and over time, the child is gaining benefit from the experience.

After four months of therapy, Therapist K is phoned by Mr. E, who identifies himself as the father of D.C and insists that Therapist K stop treatment until he meets with Therapist K. He demands Therapist K to email him a summary of D.C's intake information, diagnosis, and course of treatment. Therapist K immediately informs Ms. C of the phone call. The mother requests that Therapist K continue to see her daughter uninterruptedly because any break in the process would be detrimental, moreover, the child has never even met her biological father.

Ethical Concern - Therapist K began psychotherapy appropriately by ethically conducting informed consent procedures and explaining confidentiality with mother and daughter. The mother agreed to receive only general information about her daughter's progress and would not inquire about disclosures that D.C wanted kept confidential. The daughter was assured that her disclosures would not be shared with her mother, accordingly, she was open and candid.

Despite Therapist K having been ethical at the time, she is now uncertain of the biological father's legal rights regarding consent for treatment. Though D.C's parents never married, the mother did state that Mr. E is D.C's father. Therapist K realizes that she did not ask the mother if she had received custodial rights, because it appeared that Mr. E did not pursue custody rights, visitation, or any contact with his daughter over the past 12 years. Therapist K feels she upheld the informed consent standard in good faith when therapy began. She understands that if D.C's father does have a right to the records then she would be breaking the confidentiality agreement with her client and the mother if she complies with Mr. E's requests. Therapist K is also concerned about the Avoiding Harm standard because the child is at a delicate time in the therapeutic process whereby an interruption could be harmful. Therapist K thinks she also may not be honoring the principles of Beneficence and Nonmaleficence, along with Fidelity and Responsibility if she shares the requested information because she senses the client would experience harm by the invasion into her privacy and the evolving therapeutic trust would be threatened.

Decision-Making Considerations - Practitioners typically do not have a duty to perform an independent investigation regarding the legal custody of children unless there is reasonable suspicion about the information disclosed by parents on whom the therapist is relying to obtain informed consent or make professional decisions. If legal custody is an issue, for instance, after a parental marital separation or divorce, therapists would be wise to request to see a copy of a final divorce decree describing the legal custody, at least to confirm that the parent understands the decree's determination. In this case, the parent states there was no marriage so a final divorce decree does not exist. Given Ms. C's statement that the whereabouts of Mr. E are not known, it is not expected that Therapist K would seek permission to contact D.C's father, or would delay providing therapeutic services until he is contacted. Since Mr. E contacted Therapist K, however, there is reason to question the historical information shared by Ms. C on which Therapist K relied as a treatment authorization for D.C.

Therapist K wants to meet as soon as possible with Ms. C to learn of the status of the client and the custodial status of the parents. Therapist K knows that Ms. C has custodial rights but does not know the rights of Mr. E in this situation. If Therapist K learns that Mr. E does not have legal rights to D.C's psychotherapy records, Therapist K is optimistic that she could help D.C manage her father's sudden appearance in her life. If Mr. E does have the right to see the psychotherapy notes, then Therapist K will need to consider her response. She could refuse to share the records with Mr. E on the grounds of protecting the child from harm but she would have to accept the possibility of going to court if a subpoena were issued. She would then potentially also be in violation of the informed consent standard if she continued treatment with D.C against the will of the father.

Decision Options - Therapist K would contact Ms. C, as soon as possible, and express the communication by Mr. E and his demands. She would ask Ms. C to share pertinent information about Mr. E, how he became aware of D. C's therapy, and how Ms. E wants Therapist K to respond to his request for treatment suspension and an e-mailed summary of the treatment notes. Therapist K would document the communication with Ms. C in the treatment record.

Therapist K would learn how laws governing paternity and the rights of unmarried biological parents may apply in her jurisdiction. Therapist K would document in the treatment

record any legal or consultation assistance she received to address any uncertainty about relevant law.

If a relevant law indicates that Mr. E must be involved in obtaining a sufficient informed consent for continuing therapy, then Therapist K would meet Mr. E to discuss D.C's clinical needs and the course of treatment. The attempt to obtain Mr. E's informed consent for the therapy of D.C should be noted and documented in a manner compliant with the informed consent standard.

If Mr. E authorizes therapy to continue, Therapist K can continue D.C's treatment, but is required to submit records and summaries to Mr. E if he requests such. Therapist K would need to tell D.C that her disclosures may have less confidentiality than earlier and it depends on the limits of confidentiality agreed to by Mr. E.

If a relevant law requires Mr. E's informed consent for the child's therapy, but he refuses to offer informed consent and authorization for continuing therapy, then Therapist K will be in a comparable situation when two divorced parents with legal custody disagree regarding authorizing treatment of a child. Therapist K should suspend therapy until resolution of the parental conflict, unless the child's clinical status is so fragile and the risk of harm from immediately ending therapy is so severe that the child's situation would qualify for the exceptions that authorize "emergency" care without informed consent under the law. This situation may require Ms. C to go to court and seek sole legal custody or obtain a court order authorizing treatment of this minor child despite the lack of informed consent and authorization by Mr. E. If Therapist E continues therapy in the interim, she is advised to receive and document consultation in relation to the urgent need for ongoing therapy, and whether Mr. E's refusal to authorize urgent care necessitates a mandate report to the state child protection agency.

If a relevant law does not require Mr. E's informed consent, then the confidentiality of the child's therapy should continue, unless Ms. C authorizes communication between Therapist K and Mr. E, or until Mr. E obtains a court order instructing Therapist K to act otherwise (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Informed Consent to Organizations

The informed consent procedures for clients of therapy or evaluation services may differ somewhat from organizations. The standard regarding provision of services to organizations requires that the organizational client, employees, staff, or others involved in the practitioner's activities be given information about the nature, objectives, and intended recipients of the services. Practitioners must specify which individuals are the clients and the type of relationship that will exist with all who are involved. Practitioners indicate the likely uses of the obtained information, those who will have access to the information, applicable limits to privacy and confidentiality, and they provide results and conclusions to appropriate persons in a timely manner.

In situations when practitioners are not allowed to provide informed consent, or results of the work, they are required to discuss these restrictions with the involved parties. This implies that, within an organizational setting, practitioners should clearly understand their role, and any limitations to informing recipients of services the outcome of the work. Such disclosure of information restrictions generally occur in organizational or forensic environments but may arise in other settings as well. For instance, a corporation may have a policy to not disclose personality assessment results for security reasons if the assessments were requested by the corporation.

When employed by or consulting with an organization, the clients are organizational entities, not individuals, therefore, it is vital to determine the intended recipient, specify which individuals are clients, and define the relationship of the practitioner with each of these persons. A forensic setting may prohibit practitioners from sharing the report with the client, if so, practitioners must inform the individual that he or she may not have access to the written report through the practitioner. Related standards to provision of services to organizations, and consultation, include the following:

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 (APA, 2010, 3.11.a.).

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.b.).

Information shared in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy (ACA, 2014, B.7.a.).

When providing formal consultation services, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality (ACA, 2014, D.2.b.).

Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed (ACA, 2014, D.2.a.).

Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence (NASW, 2008, 3.01. a.).

Social workers who provide supervision or consultation are responsible for setting clear, appropriate and culturally sensitive boundaries (NASW, 2008, 3.01. b.).

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).

Case 12: Services To or Through Organizations

Case Scenario - Therapist L specializes in consulting with corporations for the evaluation of job-candidates for high-level management positions. The CEO of a computer company, which Therapist L has worked with several times, contacts Therapist L and indicates the company is seeking a research and development vice president, with expertise in computer software innovations and management experience in production. Over time, Therapist L has developed a reliable interview protocol for distinguishing individual traits, characteristics, and other variables relevant in high-ranking management. She has also developed some instruments that provide information about the executive-level potential of examinees, including personality type measures, workplace temperament, decision-making skills, creativity, independence versus collaboration, coping with stress, and other factors.

The company picks four individuals for Therapist L to evaluate. She informs the candidates that the CEO and other management representatives would have access to the evaluation, that the candidates are not her clients, therefore, their disclosures will not have confidentiality, and she communicates how the evaluation is used in making the vice president choice. Therapist L completes her full battery with each candidate and then gives the four evaluations to the CEO who uses the evaluations to select the vice president. Two of the other candidates are hired as well, but for different positions. Mr. F, one of the candidates, learns that he was not hired for any position.

Mr. F contacts Therapist L and demands a copy of his evaluation because he questions whether the process was objectively and fairly conducted by Therapist L and also he wants to receive feedback on improving his job application performance for future interviews. Mr. F is upset that he was not selected for any position, wants to address that "there must have been something negative conveyed about him" and is contemplating filing a complaint with the state licensing board.

Ethical Concern - Therapist L is surprised by Mr. F's response, additionally, she did not know that two candidates were hired for other positions. She is knowledgeable of the ethical requirements related to working with organizations as clients versus individuals, and with contemplating the relevant factors in organizational services. In this case, she understands that this examinee knows that management had access to the testing information and there was no confidentiality, evidently, he fails to understand that he is not privy to the information. The results and conclusions of the evaluation services were given to the appropriate persons, as required by the standard on services delivered to organizations, and such disclosure did not include the examinees.

Therapist L understands that she cannot defend herself against the allegation that she was not objective because she does not want to present the information to Mr. F. Unfortunately, the hiring of the two other candidates could strengthen Mr. F's perception that something was wrong in the evaluation process. With respect to Mr. F's second demand of receiving evaluation performance feedback, Therapist L never uses her battery as preparation for other interviews. Therapist L is concerned that if Mr. F pursues his complaint then she may have to reveal her test battery.

Decision-Making Considerations - Therapist L considers her attempts to uphold the services to organizations standard and how she communicated the evaluation conditions to each candidate. Therapist L believes that she properly expressed the nature and purpose of the service, including the persons who would receive the evaluations, the CEO was her client, ways in which the evaluation would be used to choose the vice president, and that all senior executives may access the information. Therapist L thinks she gave thorough information sufficient to uphold the services to organizations standard, but now senses that she had not explicitly told the candidates that they could not access their own evaluation. The standard requires practitioners to provide information to clients at the outset and, when appropriate, those directly affected by the services about the "probable uses of services provided and information obtained." Therapist L ponders that she did not tell the candidates that the evaluation could not be used for other purposes (i.e., feedback for instructive or corrective purposes). Further, Therapist L is concerned that her evaluations were used to choose two candidates for unrelated positions to vice president. Though some of the information is applicable to other vocational positions, her evaluations were precisely designed for the vice president position as defined by the CEO. Therapist L is uneasy over the possibility that if the two other candidates' job performance is poor, then her evaluations were used improperly.

Therapist L had an ongoing agreement with this software company that they would view her test materials as proprietary. It took years to evolve her evaluation protocol. Hence, she was anxious about the unintended repercussions of her evaluations along with the proprietary status of her evaluation battery being jeopardized.

Decision Options - Therapist L resolves to speak with the company and Mr. F. She will talk to the CEO about risks involved in using her battery for reasons other than as designed, and indicate that the evaluation needs to specifically match individual characteristics with the job. Therapist L understands that she cannot control the use of her evaluations upon their release, but she wants to clarify their exact use and to inquire about usage of her battery for choosing people for other positions.

Therapist L will contact Mr. F and discuss the use of her evaluations and the reasons for her inability to disclose the information to any of the candidates, including Mr. F. In this case, Mr. F comprehended the confidentiality limitations and that others had access to the information for decision-making purposes but he did not understand the limitations of the

examinee's personal access. Yet, it is safe to assume that this request for personal access to information when one is being assessed for specific performance reasons can arise. For instance, when examining fitness for duty or necessary skills for an executive management position, some individuals who are not selected may challenge or dispute the objectivity of the examiner and/or the accuracy of the assessment material. Hence, addressing this issue at the outset can prevent issues later. Though Therapist L had been conducting organizational work for some time, she misjudged and downplayed the necessity of thoroughly addressing the factors cited in Standard 3.11, specifically, pertaining to the use of information obtained and who will have access to the information (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Case 13: Services To or Through Organizations

Case Scenario - Therapist M is contacted by a vice president of a large corporation and hired to conduct an organizational consultation designed to improve communications between management and employees and mutual decision making among middle-level managers at a regional office managed by that vice president. The vice president hopes that Therapist M's objective perspective will improve the organizational relationships within that office resulting in better productivity and a healthier work environment. A meeting is arranged with Therapist M, the vice president who hired her, the director of the regional office, and the manager of the human resources division, at which time the nature of the organizational problem is reviewed. It is resolved that Therapist M will provide a written consultation report to the vice president, she will not discuss the consultation process or results with anyone other than the vice president, the process will be completed within 30 days, and a fee is negotiated. The vice president will then use the information as his upper-level management team had previously agreed upon. Therapist M informs the group of her consultation process which involves interviews with the regional office employees and several important employees in the vice president's office. Therapist M conducts the consultation by communicating with 14 regional office employees and 4 key central office executives, devising recommended steps to improve internal communications and management decision making, and giving a report to the vice president. The report included a synopsis of information and specific remarks that each individual disclosed during the interview to highlight their different perspectives and roles within the regional and central offices.

Several days later, Therapist M is called by a regional office employee who blames Therapist M for causing his being fired by the vice president. The disgruntled ex-employee states that after the consultation report was given to the vice president he was accused of being a "problem employee" who was "the cause of most of the problems" in the regional office "according to that (therapist)." The caller innocently declares that "her observations and complaints should have stayed confidential since 'what you tell a (therapist) is supposed to stay confidential - everybody knows that!'" Therapist M is alarmed by this phone call because she never thought the report would result in an employee termination and the intent of the report was to reveal patterns of organization perspective rather than depicting any person as a "problem employee."

Ethical Concern - The standard on Third-Party Requests for Services requires that when providing services at the request of a third party, MFTs "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" (Standard 1.13), and psychologists must clarify " 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 (Standard 3.07). In this case, Therapist M is providing services for an oversight office of the corporate organization relative to another office within the same organization. Therapist M did not comply with the requirements of Standard 3.07 by not explaining her role and the nature of her work to all parties that she interacted with. She did not explain that the vice president was her client and not the employees or the management staff of the office that she was evaluating. She did not express that the vice president was planning to use the information to improve organizational functioning and human interaction among the employees, and, most critically, she did not disclose that her individual interviews were not confidential. Standard 3.11, Psychological Services Delivered To or Through Organizations, also was not upheld because Therapist M was providing services "to or through" an organization. Standard 3.11 requires psychologists to inform others of the nature and objectives of the services, identify the intended recipients, and disclose who will have access to the information.

Therapist M acknowledges ACA Standard A.4.a., Avoiding Harm, which requires counselors to "avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm." Had Therapist M discussed with the CEO and senior managers the potential consequences to individual employees, she could have potentially prevented or minimized harm to the employees.

Decision-Making Considerations - Therapist M acknowledges that she did not consider key ethical factors of organizational consultation regarding the organizational structure she was going to work within and in upholding consultation ethical standards . Therapist M retraces her actions and their ramifications on ethical conduct and she recognizes several errors in her consultation process. Therapist M realizes that she did not comply with the standard on Third-Party Requests for Services (i.e., AAMFT, 1.13; APA, 3.07) because the nature of the confidentiality complaint and the repercussion of her omission was clearly

expressed by the ex-employee. Therapist M recognizes her breach of the principle on Fidelity and Responsibility in that people with whom she worked thought confidential disclosure was a given, and she senses her betrayal of their trust in her as a professional.

In hindsight, Therapist M acknowledges that she perceived the regional office as part of the same corporate entity and did not categorize the work a third-party request for professional services. She did not contemplate the needed action she should have taken to protect confidentiality of employee statements or to inform participants of the limits of confidentiality. Therapist M reconsiders the reasons she included employee names in the report; she initially construed that it would clarify organizational communication and work collaboration patterns.

Therapist M regrets the consequences to the employees and will seek more education and consultation on organizational consultation. Unrelated to whether her services were initiated by a third-party request, Therapist M could have been guided by the standard on Psychological Services To or Through Organizations, and the standard on limits of confidentiality (i.e. NASW, 1.07.e - previously cited). As noted earlier, the standard on delivering services to or through organizations indicates ethical requirements such as including disclosure of the identified client, the nature and objectives of the services, the probable uses of the services and information obtained, and any limits of confidentiality.

Decision Options - Therapist M feels somewhat overwhelmed by this experience and admits she is not fully aware of the ethical guidelines of consultation work. She decides that consultation and more preparation are requisite for her competency. Several of the Ethics Codes become more pronounced to Therapist M. The standards on Third-Party Requests for Services and Psychological Services Delivered to or Through Organizations foster sound decision making when the practitioner's client is not an individual or the recipient of services. She also learned that informed consent and confidentiality have different meanings and applications. By example, there is a distinction between the obligation of confidentiality and the limits of confidentiality, and there are different applications of informed consent for various recipient groups and in specific legal, health, and institutional contexts.

Therapist M writes a letter of clarification to the vice president regarding the fired employee explaining that her intent was not to label any individual as a problem employee largely responsible for the regional office problems. She articulates her view that the problems were collective, not solvable by termination of a single individual, and the statements by the terminated employee (as with all the other employees) were included in the report to simply show different ways the employees in the regional office subjectively perceived the problems. She emphasizes the integrity of an employee who discloses valuable information during the consultation, especially if the information was provocative or distressing to management. She explicitly asks the vice president to reconsider the termination of the employee if the termination was primarily based on her consultation report. She then calls the terminated employee and reveals she sent the letter to the vice president and specifies the content. Therapist M feels obligated to inform the ex-employee of her attempt to minimize the damage to him. She believes that notifying the employee of the letter allows for compliance of the agreement to not discuss facts or results of the consultation process with anyone outside of the central and regional office without the vice president's authorization. This case highlights the need for practitioner forethought and fairness in providing professional reports or other communication (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Advertising, Soliciting Clients, Media Presentations, and Other Public Statements

Practitioners are granted latitude regarding advertisements and public statements about their services and activities but the communications cannot be false, deceptive, or fraudulent. The principles of Beneficence and Nonmaleficence, Integrity, and Respect for People's Rights and Dignity underlie ethical conduct involved in advertising and other public statements. These principles reflect that professional activities that are not classified as direct service, such as advertising and media engagement, can potentially result in unintended exploitation or manipulation of others. Specifically, the principle of Beneficence and Nonmaleficence promotes nonexploitation, the principle of Integrity expresses the need to promote accuracy, honesty, and truthfulness in all public representations which fosters public trust and confidence in the field of psychology and individual practitioners,.and the principle of Respect for People's Rights and Dignity values self-determination. Also, the concept of informed consent assures that the public has sufficient information to make a fully informed decision. Public statements include everything that practitioners write, publish, broadcast, articulate, or communicate in any fashion. The standards within this concept require practitioners to attempt to "correct, whenever possible, false, misleading, or inaccurate information and representations made by others" (AAMFT, 2015, 9.8); "Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications… are accurate"… and "…should take steps to correct any inaccuracies or misrepresentations of their credentials by others" (NASW 2008, 4.06.c.); "When… representing their services to the public, counselors identify their credentials in an accurate manner…" (ACA, 2014, C.3.a.), and "Counselors… correct any known misrepresentations of their qualifications by others" (ACA, 2014, C.4.a.).

The standards relative to advertising and public statements are designed to prevent the public from making uninformed decisions and choices. Due to their positions of greater power, practitioners make reasonable efforts to inform of

services and procedures, and they do not intentionally or unintentionally cause disadvantage to others.

Regarding media presentations, the standard affirms that practitioners' statements are not sensationalized, exaggerated, or establish a misleading impression, instead, statements must be founded upon practitioners' professional knowledge, training, or experience compliant with appropriate psychological literature and practice. Further, practitioners are prohibited from expressing that a professional relationship exists with the recipients of the media presentation. Generally, practitioners should narrow their comments and advice to generic information, because little, if anything, is actually known about the individuals attending to the media presentation, the depth of his or her issues, or history, as would be prerequisite in standard assessment and treatment. Whereas disseminating general psychoeducational information is allowed, providing direct treatment via specific advice or guidance in a public venue challenges the ethics of various standards. Hence, it is misleading to tell recipients of the public information that a professional relationship exists. Practitioners can avoid confusion and misunderstanding relative to their role as media advice-giver or educator by suggesting that the recipient talk to a psychotherapist. The standards on advertising, soliciting clients, media presentations, and other public statements include the following:

Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others (NASW, 2008, 4.06.c.).

Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion (NASW, 2008, 4.07.a.).

Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence (NASW, 2008, 4.07.b.).

When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent (ACA, 2014, C.3.a.).

Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues...
ACA, 2014, C.4.a.).

When counselors provide advice or comment by means of public lectures, demonstrations, radio, or television programs, recordings, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that 1) the statements are based on appropriate professional counseling literature and practice, 2) the statements are otherwise consistent with the ACA Code of Ethics, and 3) the recipients of the information are not encouraged to infer that a professional counseling relationship has been established (ACA, 2014, C.6.c.).

Counselors do not exploit others in their professional relationships (ACA, 2014, C.6.d.).

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).

Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law (AAMFT, 2015, 9.1).

Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law (AAMFT, 2015, 9.2).

Marriage and family therapists claim degrees for their clinical services only if those degrees demonstrate training and education in marriage and family therapy or related fields (AAMFT, 2015, 9.5).

Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products (AAMFT, 2015, 9.8).

Marriage and family therapists represent themselves as providing specialized services only after taking reasonable steps to ensure the competence of their work and to protect clients, supervisees, and others from harm (AAMFT, 2015, 9.7).

Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated (APA, 2010, 5.01.a.).

Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings (APA, 2010, 5.01.b.).

Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice (APA, 2010, 5.01.c.).

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient (APA, 2010, 5.04).

Case 14: Media Presentations

Case Scenario - Therapist N, a therapist in private practice, understands that media psychology has become more popular in the public sector and she desires a public media aspect to her professional work. She genuinely enjoys being interviewed and sharing her opinion on public issues. Over time, Therapist N is called for various events, which leads to expansion of her practice in two ways. She includes her perspectives on psychological matters on her Web site and opens two-way communication through a chat feature. Secondly, she gives interviews on the radio and ultimately obtains a regular time spot on the local radio station. Therapist N appreciates the increased visibility of her private practice and fulfillment of an innate interest in media work.

Ethical Considerations - Therapist N routinely answers questions on her radio show, gives advice and professional opinions through the chat feature of her Web site, and provides articles on her Web site on different psychological subjects that she has written. Therapist N has a loyal listener named Jane who believes in this therapist's competency and understanding of her specific issues. Jane has a history of several suicide attempts the past years and is presently challenged by an abusive domestic partner and an eating

disorder. She has seen several therapists but Therapist N is her favorite.

While on the radio show, Therapist N announces her Web site and the services offered there, including that she gives advice to people who log in and ask questions. Jane reads the therapist's articles and asks questions, which Therapist N answers, and Jane calls the radio show asking questions which Therapist N always answers. Jane feels understood by the therapist and appreciates having someone who can tell her what to do.

Therapist N is aware that Jane has called the radio show several times because she identifies herself. The therapist believes this is acceptable because several people have called in more than once. Therapist N, however, does not know that Jane is also writing to her chat room, nor how, or how often, Jane is implementing the advice of the therapist.

The arguments between Jane and her partner escalate, leading to fights, despite Jane trying to implement some of Therapist N's advice for people in her situation. Then, a violent argument leads to Jane being assaulted by her partner. She is distressed and confused because following the advice of Therapist N is worsening the situation; she responds by taking an overdose of sleeping pills. Her sister finds her and takes Jane to the emergency room. The hospital intake interviewer asks Jane if she is receiving any professional care, and she replies, "Yes, Therapist N."

Decision-Making Considerations - Three criteria for making decisions regarding media activity are expressed in ACA Standard C.6.c., and APA Standard 5.04, as well as NASW Standard 4.06.c. Therapist N acknowledges that she must incorporate these criteria into her future decision making and into the current dilemma.

Therapist N is alarmed to receive the emergency room phone call. She remembers someone named Jane calling the radio show and the general issue she presented with, but Therapist N did not know how Jane exaggerated the role of the therapist in Jane's life, nor how Jane combined the therapist's radio show, articles, and chat feature into a subjectively perceived personal therapist-client relationship.

Therapist N intended to be ethically sound while expanding her scope of practice, but she did not fully contemplate the criteria for media presentations. First, she did not consistently tell her listening public that her advice and points-of-view were not designed to be direct services and she was not providing services for individuals. During her radio show, she did not infer that direct and individual services were offered, but she did not specifically tell listeners to avoid perceiving the radio show as provision of direct services to the public.

Second, Therapist N understands that her knowledge of domestic abuse and eating disorders is general and accurate, but it is not specialized expertise, and her practice does not include either of these issues. This does not comply with the first criterion of the standard for counselors on media presentations whereby, "the statements are based on appropriate professional counseling literature and practice," or for psychologists, such that "statements are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice," or for social workers, in that “representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate.” Therapist N resolves to seek consultation when providing services in a new area or activity in which she lacks established expertise.

Third, Therapist N was not aware of the boundaries of electronic services. Her intent was to have an electronic version of her radio show, comparable to a newspaper advice column. Unfortunately, she underestimated how much Jane was perceiving the radio advice as being individualized and the chat communication as even more personal advice. It is reasonable to assume that a needy, possible client, such as Jane, could view Therapist N's media communications as psychological services, and Therapist N's continual media presence as an ongoing relationship between therapist and client. This standard does not exclude conducting psychological services in public, but it does express the need to comply with all other standards in the Ethics Code. For instance, continued work of this type would probably not comply with the standards of informed consent, competence, appropriate assessment and diagnosis and treatment planning, which would do harm to Jane by depriving her of needed services.

Decision Options - Therapist N acknowledges that she needs to modify her radio show essentially by being very clear and specific in clarifying the limitations of her shared information. She needs to monitor and limit repeat callers as best she can. In the future, Therapist N must limit statements and information to areas in which she has claimed expertise, in other words, despite the fact that she is not offering a psychological service on the radio show, she should not express general statements regarding clinical diagnoses, treatment plans, or etiology of conditions that are outside her area of expertise.

Therapist N resolves to close her chat feature because the risk of misinterpretation is high, even though it increased her practice and referral sources. She will continue to upload her articles and other information on her Web site, but she chooses to limit activity to being one-directional information as opposed to interactive material.

Therapist N is aware that some of her colleagues are providing Internet services, and are conducting therapy on the Internet. Her plan, however, was to support media psychology and not expand her Internet practice.

Therapist N chooses not to see Jane as an Internet client or a conventional client and refers her to a therapist with expertise in Jane's issues. After consultation with informed colleagues, Therapist N could decide to personally meet with Jane, without a charge, to address the misunderstandings about her services and role as a media psychologist, and to correct Jane's view and expectations of Therapist N as her personal therapist; or not to meet in person but instead to

write a letter or call; or to not communicate at all. The suggested action is for Therapist N to consider a clinical decision about how, and if, to communicate with Jane. This ethical decision will evaluate risk management and Jane's best interests (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

The standards on Internet/Electronic Therapy include the following:

Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with electronically-assisted services; (c) ensure the security of their communication medium, and (d) only commence electronic therapy or supervision after appropriate education, training or supervised experience using the relevant technology (AAMFT, 2015, 6.1).

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 clients' written and electronic records and other sensitive information... (NASW, 2008, 1.07.l).

Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible (NASW, 2008, 1.07.m.).

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media (ACA, 2014, H.4.a.).

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps (ACA, 2014, H.4.c.).

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face to face. If the counselor is not able to provide fact-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services (ACA, 2014, H.4.d.).

Testimonials and Solicitation

The standard on testimonials prohibits solicitation of testimonials from all current therapy clients because such individuals may be susceptible to undue influence in the therapy relationship. Likewise, this standard forbids solicitation of testimonials from former therapy clients if their life circumstances can cause vulnerability to undue influence. The ban on solicitation of testimonials from all current therapy clients reflects that the nature of the therapeutic relationship between therapist and client creates a power differential, dependence on the therapist for treatment of issues relevant to the client, possible transference, and other factors, which could produce undue influence. The boundary that the standard on testimonials creates is functional because it prevents potential client exploitation due to unfulfilled therapist needs possibly affecting treatment. The potential for undue influence can endure after therapy ends, based on the length and intensity of treatment, and client's mental status. This implies that therapists must be cautious in asking former clients for testimonials and they must assess client's vulnerability to undue influence.

The testimonials standard does not prohibit the use of testimonials, however, proof of therapist exploitation of client would violate the Ethics Code.

The testimonials standard does not address testimonials from participants in activities unrelated to psychotherapy, therefore, testimonials in relation to a therapist's workshops, seminars, or organizational/industrial work are not prohibited by this standard.

The standard on In-Person Solicitation is meant to prohibit "ambulance chasing." The vulnerability factor includes all actual or potential therapy clients, and any other individual whose specific circumstances cause him or her to be susceptible to undue influence. The standard does not ban solicitation if the factor of vulnerability is not extant. For instance, it is prohibited to solicit mourners at a funeral home, or to visit homes of survivors identified through the obituaries. In contrast, the Federal Trade Commission (FTC) assures that this standard does not prohibit placing professional cards or flyers on tables at shopping malls.

There is an implied conflict of interest when one solicits services and profit or personal gain is involved. The standard does not prevent responding to individuals in urgent distress or when a risk to self or others exists.

The standard's prohibition only applies to contacts that are uninvited and occur in person (which includes telephone contacts, based on case law), whether by the therapist or through the therapist's agent. Contacts invited by the potential client or executed through general mailings or other methods are allowed.

The standard allows therapists to invite a collateral contact (e.g., family member, or significant other) of a current client to become involved in treatment to benefit the client, but therapists cannot solicit collaterals for treatment.

The standard allows for provision of community outreach or disaster services. For example, therapists can offer their services through a community program for the homeless, older adults, or other groups who do not generally self-refer for mental health services, and they can offer their services to people who are vulnerable due to natural disasters, such as hurricanes, tornadoes, earthquakes, or terrorist attacks. The standards on testimonials and solicitation include:

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence (APA, 2010, 5.05).

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services (APA, 2010, 5.06).

Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue

influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial (ACA, 2014, C.3.b.).
When feasible, counselors make reasonable efforts to ensure that statements made by others about them or about the counseling profession are accurate (ACA, 2014, C.3.c).
(NASW, 2008, 4.07.a. - previously cited).
(NASW, 2008, 4.07.b. - previously cited).
Marriage and family therapists ensure that advertisements and publications in any media are true, accurate, and in accordance with applicable law (AAMFT, 2015, 9.2).

Case 15: In-Person Solicitation

Case Scenario - Therapist O is in private practice and is conducting therapy with a client named David, who is working on several interpersonal and work-related issues, and most importantly, the care of his aging father. His father was very active and had continued to live in his own home after David's mother died, unfortunately, his father began showing signs of dementia several years ago and has recently been diagnosed with Alzheimer's disease and he cannot live in his home alone. David has been the primary caregiver for his father the past several years but he does not want to make key decisions alone for his father because David has two brothers whom he believes should be involved in decision-making as well. David understands that Therapist O cannot make decisions about his father, but he thinks that Therapist O can stimulate communication between the three brothers regarding care of their father.

Therapist O and David address the issue and Therapist O feels that he could be of assistance in attempting to improve communication and closeness among David and his brothers. Therapist O is aware of the difference between conducting therapy with multiple individuals as clients (i.e., families and couples) versus with an individual client with whom multiple individuals (e.g., collaterals) participate in the therapy for the welfare of the client. Therapist O's plan is to have the two brothers participate in David's sessions as collaterals, and he will explain such as well as the roles of everyone before the sessions. David talks with his brothers about joining him in session and articulates their roles and the therapist's intentions and role.

Ethical Concern - Therapist O schedules a series of three sessions with the three brothers and rapidly discovers that several unforeseen issues exist that challenge the goal of improving communication and closeness among the brothers and that necessitate complex decision making for the therapist. David's brother, Jim, is experiencing marital difficulties and behavioral problems with their teenage son, thus, he feels unable to help their father. Jim feels overwhelmed to the point he uses the sessions to talk about his own marital problems and family dynamics.

David's second brother, Tim, was diagnosed with schizophrenia ten years earlier and has lived independently with the help of his parents and he has been in a group home offering supervision of his medications and activities. For various reasons, Tim was taken out of the group home which puts his living arrangements in question and he is now homeless. Tim's social and financial resources have diminished since their mother died and their father became ill. He is very concerned about his future. David is also concerned about his brother but he cannot offer financial assistance, and he does not know how to attain public assistance or mental health treatment for Tim.

Therapist O has professional experience with couples in distress, similar to Jim's situation, and with outpatient community-based health centers that offer assistance for people in Tim's circumstances. Therapist O also knows that he arranged for the two brothers to be collaterals and not clients, and he is motivated to make an ethical decision as to how to proceed with therapy.

Decision-Making Considerations - Therapist O is aware of the standard that prohibits uninvited solicitation of business from potential clients and other individuals who are vulnerable to undue influence. The exceptions to this ban include collateral contact to benefit a current client and disaster or community outreach services. Therapist O believes that Jim and Tim need professional help for their issues. Therapist O acknowledges that if he had known of the significant issues affecting Jim and Tim, although he had the professional capability to help each of them, he would not have invited them as collaterals due to the prohibition of soliciting business from potential clients who are vulnerable. Therapist O assesses Jim and Tim as being vulnerable and perhaps unable to make an informed decision, and both might accept Therapist O's professional services because of their vulnerable circumstances.

Therapist O also considers the two exceptions of this standard - collateral inclusion for current client benefit, and community outreach service. He reflects that he is seeing Jim, who has mental and financial resources to acquire his own psychological services, under the collateral conditions. Tim is also involved in the therapy process as collateral but requires immediate help, and Therapist O believes that Tim would qualify under the exception of providing community outreach services. Therapist O will ascertain whether Tim is in current treatment and with whom, so services will be coordinated. The standard pertaining to Clients Served by Others includes:

When counselors learn that their clients are in a professional relationship with other mental health professionals, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships (ACA, 2014, A.3).
When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately (APA, 2010, 3.09).
Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligations to respect confidentiality and any exceptions related to it (NASW, 2008, 2.02).

Decision Options - Therapist O understands that he must apply the solicitation standard to each of the three involved individuals and make a separate determination for each. David is engaged in individual therapy which Therapist O believes will continue to benefit David and which complies

with the standards and his areas of expertise. Jim needs professional assistance, as David does, but Therapist O assesses that Jim is vulnerable due to his feeling desperate about his circumstances, and Therapist O is aware that providing therapy to Jim would occur within the context of Jim's vulnerability. Therapist O resolves to see Jim but solely within the accepted exception of collateral participation. Therapist O is concerned about Tim and senses that without help, or at least information, his situation will worsen. The therapist, however, believes that a multiple role conflict would exist by working with Tim on his issues under the classification of collateral participation within David's therapy. Therefore, Therapist O may decide to work pro bono with Tim to share information about available public sector resources and to offer direct services aimed at stabilizing him so he can resolve his living circumstances.

All things considered, the collateral sessions facilitate David's understanding of the current and future limitations of his brothers offering care for their father. Therapist O sees the value of having established goals and purpose for participation of family members in David's therapy (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

Record Keeping

Record keeping is a process by which practitioners demonstrate their professional purpose, values, and roles. The documentation of one's professional activities will include pertinent factors such as work setting, population served, nature of the activity, expected use of the records, jurisdiction, and client wishes. Proper record keeping helps practitioners to: respect client rights, responsibly execute their professional roles, and comply with specific documentation needs and requirements.

Record keeping standards utilize core concepts from the general ethical principles. The principle of Fidelity and Responsibility promotes the need for trust and creating records regarding clients' personal and private information. The Integrity principle expresses the importance of honesty and truthfulness in generating accurate record keeping and transparent fee arrangements. The principle of Justice upholds fairness and equal quality in how practitioners treat the records of information and in the determination of fees. Record-keeping decisions commonly address the questions of: What is the purpose of creating this record? How is the record keeping facilitating informed decision-making? and What values are served by the record?

Decision making on the type of information to include in record-keeping may consider: a) the probability that the record will be used by third parties for decision-making purposes; b) continuity of care, and urgent care needs of specific populations, for instance, older individuals and the developmentally disabled; c) likelihood of litigation with high-risk clients; and d) continuity of care to those who are geographically moving.

The record keeping standard requires practitioners to "facilitate provision of services later by them or by other professionals." A clinical record describes the essential features of a case such that the case is understood over time and among multiple professionals. Information to be included in a record may answer the questions of: a) What does the practitioner want the reader to know about the purpose, course, and outcome of treatment? b) How can the practitioner differentially describe clinical information, such as an assessment versus therapy treatment, or a custody case versus educational placement? c) How can practitioners include developmental factors that depict current information about a person that might be interpreted differently or suggest different treatment options at a future time?

Clinical record keeping has the obligation to protect client welfare and to clearly describe treatment, referral, and disposition of the case.

The standard on record keeping relative to scientific work is distinct from other documentation as it may center on the quality of data treatment for peer review purposes, replication, and content and financial accountability. Due to exploitation and abuse by some in the past, research universities, funding agencies, publishers, and government entities have adopted requirements for conducting research that specify the management of informed consent, manipulation of experimental variables, data collection and analysis, reported findings, and other variables.

When documenting scientific findings and judgment, researchers often consider the response of peer reviewers, other scientists engaged in the same research, members of the public who may make decisions based on the conclusions, readers of scientific journals who may pose research questions based on the findings, and funding agencies that are concerned with ethical and legal treatment of subjects and others in the study, financial concerns, accurate documentation of all information, and validity of the findings. Generally, institutional review board approval is required.

Practitioners who are conducting research are advised to evaluate several factors in record keeping and documentation, such as criteria of the authorizing agencies, including institutional review board requirements, treatment of subjects, sufficient study description, and compatibility of documentation across government, university, and institutional entities.

The record keeping standard obligates practitioners to "meet institutional requirements." When conducting professional activities for an organization, one will be aware of informed-consent conditions, knowing and indicating who the client is and who is receiving the services, acknowledgment of who controls the records during service provision and later in transfer or access to records, limits of confidentiality, administrative roles, and other procedural factors applicable to management and corporate systems. Institutional requirements may relate to hospitals, Veterans Affairs institutions, and educational settings in which the practitioner's role is not clinician, instead, as consultant, mediator, human resource specialist, or administrator of services. Practitioners may need to inquire of any unique

record-keeping policies that the institution or organization requires.

There is overlap in some activities between organizational and clinical roles, thus, role diffusion can arise if professional tasks are not clarified through documentation.

Further, practitioners must "ensure accuracy of billing and payments." Record keeping and documentation for billing and payment may include transactions with private insurance or managed care companies, government entities such as Medicare or Medicaid, individual client billing, organizational billing, and forms that document services rendered, date of service, treatment, diagnosis, and other requested information. Client misunderstanding of services and billing issues can be avoided by clear records that explain the key elements of rendered services.

The record keeping standard also requires practitioners to "ensure compliance with law," including federal and state. Additionally, working in forensic settings requires awareness of jurisdictional implications, court proceedings, and regulations that affect one's practice. In such settings, practitioners' records may have several purposes, their clinical records, evaluations, consultations and all actions may be reviewed by others, and other individuals may have a specific interest in the practitioners' findings. Forensic records often have a level of specificity, focus, and treatment of content that may differ from clinical records, and practitioners should understand the protocols and procedures within court jurisdictions. The standards below apply to record keeping:

Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies (ACA, 2014, A.1.b.).

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law (APA, 2010, 6.01).

Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided (NASW, 2008, 3.04.a.).

Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future (NASW, 2008, 3.04.b.).

Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services (NASW, 2008, 3.04.c.).

Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law (AAMFT, 2015, 3.5).

Case 16: Record Keeping

Case Scenario - Therapist P works in a large interdisciplinary organization which receives referrals for the general practice as well as for individual professionals. Therapist P maintains a practice within the organization and also has the administrative role of assigning the general referrals to individual therapists. The referrals are disseminated in a fair and organized way. One day, Therapist P received two referrals from other therapists in the community but each had record-keeping problems that could impede the provision of clinical services by the clinicians in Therapist P's organization. The treating therapists need to transfer the clients for reasonable reasons, but the records of each case jeopardizes continuity of care.

Case 1 is a referral of an 87-year-old man and his record indicates considerable mental status testing, individual, and family therapy. The client was hospitalized several times for his diabetes and there is a brief statement of a psychiatric evaluation while he was hospitalized. The client's family members called Therapist P asking which therapist their father will work with. They are eager to ask the therapist why their father is being seen and the expected treatment. Therapist P observes that the records do not indicate a diagnosis, course of treatment plan, results of the hospital visit, any informed consent, power of attorney, or guardianship documents. The fees for service are well-documented, and it appears that the client wrote personal checks for all services.

Case 2 represents a 26-year-old man who applied with his local police department to become a police officer. The psychologist who conducts evaluations of police department applicants asked the man for access to any physical or psychological health records. One report reflects that when the applicant was 15 years-old, his parents were concerned about his behavior problems, such as being oppositional, loitering after school, and two occurrences of knocking over mailboxes with his friends. At the time, he was evaluated by a therapist who detailed these issues and predicted this misbehavior would escalate with age. The psychologist working for the police department read this report and rejected the applicant due to instability as evidenced in the prior psychological report. The applicant is requesting an updated evaluation from Therapist P's organization to clear his record.

Ethical Concern - The record keeping standard requires therapists to include information within the psychological record that is essential to transfer that case to a different professional with ease of continuity and that would commonly apply, given circumstances of the case. Some types of information, specifically identification, purpose and course of treatment or service, fees, and disposition of the case would generally be provided. Such specific information is relevant because an organizational, assessment, and custody case would each require some differences in content regarding specificity, duration, jurisdictional authority, and other matters.

Therapist P understands that the Case 1 record is missing vital information needed for the appropriate disposition and transfer of the case, and the record in Case 2 possesses information that probably misrepresents the applicant's current status. Therapist P ponders the application of the record-keeping standard in each case, and despite neither she

nor her colleagues having been involved in the insufficient record keeping, she contemplates her and her practice's roles in working with these clients.

Case 1 lacks a clear record of the purpose for testing, individual, and family therapy, and hospitalization. The record contains only indirect references to the client's memory problems but omits a diagnosis. Further, there is inadequacy or absence of informed consent for the family's access to client records and for authorization of mental status testing.

Regarding Case 2, Therapist P is concerned about the record-keeping standard, and considers that she might not have released the report because it could misrepresent the client. The test data are probably outdated and should not be implicated in decision making, and rather than simply releasing the report, she would have explained the results and limitations of their usage.

Decision-Making Considerations - In each case, Therapist P will need to evaluate the purpose of the record, the content and detail required for continuity of care, and how the information should be used and in what context. Therapist P would need to deliberate over contacting the therapist who saw the applicant as a teenager and the psychologist working with the police department relative to the problems in each record.

Therapist P is uncomfortable that the record in Case 1 does not offer continuity of care, potential confidentiality limitations, and proper informed consent. She senses that the client may have memory and other associated issues and has received treatment as if he had legal caretakers despite the absence of a legal transaction. Therapist P thinks that this client is vulnerable to exploitation because he has been writing checks to pay for treatment and the client's interest may not have been upheld since the therapist was conscientious about fee, but not treatment records.

The report for Case 2 may have fulfilled the purpose of testing at that time, however, it lacked clarification in the statement that treatment was recommended and that no treatment could lead to exacerbation of symptoms. The report did not express specific recommendations or elaborate upon the evaluator's assessment that "behaviors could escalate." Therapist P surmises that even if the report is correct, it does not assist provision of services at this time. Therapist P will consider the inadequacy of the report to facilitate future use, and more pivotally, to continuity of care, because this case involved developmental changes and age-related behaviors that should have been kept in context.

Decision Options - Therapist P chooses to not accept Case 1 as a referral at this time until receiving information on the central factors of purpose of treatment and current diagnosis which will illuminate the course of treatment. She is disappointed by the dearth of information provided by the previous therapist. She is reminded of the necessity to keep accurate and thorough records to enable transfer of services. Therapist P understands that despite her organization having several therapists who specialize in working with older adults, a consultation with the client is needed to explain his confidentiality rights, confidentiality limits, informed consent, and to have the client disclose what he wants. Therapist P would want a client release of information to communicate with the previous therapist and police psychologist and to request testing data. Therapist P would need to execute an informed-consent authorization if the client desires his family to have access to information. She will also need to discuss these limits and the required course of action to the family.

Regarding Case 2, Therapist P will evaluate the need for any further testing and if testing is the best way to pursue the case. She acknowledges that outdated information was used to render a decision and resolution of this breach has several options. Therapist P contemplates a consultation with the police psychologist and the evaluating therapist. A recommendation to the evaluating therapist would suggest that he or she write a qualifying letter or statement (for any future prospective employer, inclusive of the current police department) explaining the clinical and ethical problems of using outdated information. A consultation with the police psychologist could elucidate developmental factors of adolescent behaviors, especially because the behavioral, academic, and social history of the applicant contraindicate the previous behavior problems. Therapist P (or the appointed therapist to conduct the consultation) would also inform the client of the needed transactions, obtain informed consent and a release for records, and advise the client as needed regarding developing circumstances.

Therapists recognize that their professional transactions promote the welfare and best interest of the client, which supports the general principle of Respect for People's Rights and Dignity. Therapist P infers that the police psychologist and evaluating therapist may have overlooked this key concept in their judgment in these cases (Campbell, Vasquez, Behnke, & Kinscherff, 2010).

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TEST - ETHICS: CASES and COMMENTARY

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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 initiated 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

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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. **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

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

10. **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

11. **Many of the standards within the Ethics Code do not allow for the concepts of "reasonable" and "appropriate," hence a degree of professional judgment and deliberation is not granted.**
    A) True B) False

12. **If it becomes apparent that the practitioner may be called upon to perform potentially conflicting roles, the practitioner will clarify, adjust, or withdraw from roles appropriately.**
    A) True B) False

13. **Upon agreeing to provide services to a person or entity at the request of a third party, practitioners clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party.**
A) True B) False

14. **Individuals who provide their informed consent to the practitioner must have been given the chance to ask questions about the processes and procedures.**
A) True B) False

15. **The informed consent standard requires informed consent to be obtained if the services are performed face to face, or by Internet, videoconference, or other forms of electronic communication.**
A) True B) False

16. **When providing services to organizations, practitioners do not need to specify which individuals are the clients or the type of relationship that will exist with all who are involved.**
A) True B) False

17. **Practitioners are granted latitude regarding advertisements and public statements about their services and activities but the communications cannot be false, deceptive, or fraudulent.**
A) True B) False

18. **The standards relative to advertising and public statements are designed to prevent the public from making uninformed decisions and choices.**
A) True B) False

19. **The standard on testimonials prohibits solicitation of testimonials from all current therapy clients because such individuals may be susceptible to undue influence in the therapy relationship.**
A) True B) False

20. **A clinical record describes the essential features of a case such that the case is understood over time and among multiple professionals.**
A) True B) False

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