ETHICS: CASE STUDIES

Presented by CONTINUING PSYCHOLOGY EDUCATION INC.

5 CONTINUING EDUCATION HOURS

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

Course Objective
The purpose of this course is to provide an understanding of the concept of ethics as related to therapists. Major topics include: competence, therapist impairment and burnout, client termination, informed consent, client right to refuse treatment, confidentiality, dual relationships, common boundary issues, sexual dual relationships, and legal/ethics case studies.

Accreditation
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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. Explain the meaning and purpose of ethical behavior.
2. Understand the ethics of therapist competence.
3. Recognize therapist impairment and burnout.
4. Discuss ethical standards pertaining to client termination.
5. Comprehend the historical development of informed consent.
6. Expound upon information to be included in informed consent material.
7. Acknowledge the ethical importance of confidentiality.
8. Describe the importance of managing boundaries and avoiding dual relationships.
9. Identify common boundary issues.
10. Emphasize the hazards of sexual dual relationships.
11. Interpret various Codes of Ethics.
12. Apply ethical standards to case studies.

Faculty
Neil Eddington, PhD, obtained his doctorate from the University of California, Berkeley. He was a research associate and assistant professor at Harvard University within the department of psychiatry, adjunct professor at Tulane University, and co-authored the book, "Urbanman: The psychology of urban survival."

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INTRODUCTION

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

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

The Codes of Ethics of the professional mental health organizations, including the National Association of Social Workers (NASW, 2008), American Association for Marriage and Family Therapy (AAMFT, 2015), American Counseling Association (ACA, 2014), and American Psychological Association (APA, 2010), serve to educate members about sound ethical conduct, professional accountability, and improved practice through mandatory and aspirational ethics. Mandatory ethics describes compliance with the "musts" and "must nots" of the ethical standards and are enforceable whereas aspirational ethics involves the highest standards of conduct to which one can aspire, implies one understands the moral fiber behind the code, suggests doing more than the minimum requirement and they are not enforceable. NASW (2008) promotes the following aspirational ethics, termed "Ethical Principles" as ideals to which social workers may aspire:

- Service – Helps people in need and addresses social problems
- Social Justice – Challenges social injustice
- Dignity and Worth of the Person – Respects the inherent dignity and worth of the person
- Importance of Human Relationships – Recognizes the central importance of human relationships
- Integrity – Acts in a trustworthy manner
- Competence – Practices within established areas of competence and evolves professional expertise

The following general principles guide the aspirational ethical conduct of ACA (2014) counselors:

> Autonomy – Counselors decrease client dependency and encourage independent decision making; they do not impose their own goals, are accepting of different beliefs and values, and are not judgmental.

> Nonmaleficence – Do no harm, hence, counselors avoid treatment that can potentially be harmful.

> Beneficence – Means to promote good and wellness, therefore, counselors foster the welfare and growth of their clientele.

> Justice – Fairness is implemented in professional relationships, including quality of care, allocation of time and resources, fees, and counseling services.

> Fidelity – A trusting and therapeutic environment is created in the absence of deceit and exploitation.

> Veracity – Counselors interact truthfully with all of their

professional contacts.

Professionals assume a fiduciary obligation with their clients, implying a "special duty to care for the welfare of one's clients or patients" (Haas & Malouf, 1995, p. 2), therefore, the professional's standard relative to moral principles is much higher than the ordinary citizen's. Meara, Schmidt and Day (1996) believe that a virtuous professional upholding a fiduciary relationship would: a) be motivated to do what is good, b) have vision and discernment, c) realize the function of emotion in judging proper conduct, d) possess a high degree of self-understanding and awareness, and e) comprehend the mores of his or her community and the legitimacy of client diversity (pp. 28-29). Contrarily, Koocher and Keith-Spiegel (2008) list characteristics of practitioners who demonstrate questionable, unethical or unprofessional behavior:

1. Are unaware or misinformed of the ethical standards
2. Offer treatment outside the scope of their practice
3. Display insensitivity to the needs of others or to situational dynamics
4. Exploit clients by putting their own needs first
5. Act irresponsibly due to stress, laziness, non-awareness, or inattention
6. React with vengeance against clients for perceived harm
7. Experience burn-out or other emotional impairment
8. Reveal interpersonal boundary issues
9. Are self-serving
10. Generally, are ethical but occasionally blunder resulting from oversight or distraction

Herlihy and Corey (1996) advise therapists to be wary of unethical or questionable behavior such as extending the number of therapy sessions to fulfill their own emotional or financial needs; being unaware of countertransference reactions to a client thereby heightening resistance and slowing growth; impressing values on clients incongruent with their cultural background; utilizing techniques or strategies comfortable for therapist but not necessarily functional for client; and practicing with apathy and little enthusiasm. Golden (1992) observed that many ambiguities may abound during therapy, thus "When we find ourselves navigating in waters that are not clearly charted by our profession's ethical codes, we must be guided by an internal ethical compass."

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

COMPETENCE

Clients disclose their most personal secrets and struggles during therapy thus placing themselves in a vulnerable position requiring therapist competence. "When clients put their trust in us as professionals, one of their most fundamental expectations is that we will be competent" (Pope & Vasquez, 1991, p. 51). Competent professionals uphold two essential ethical principles: beneficence, which is attempting to do only good for the client, and nonmaleficence, which is never doing harm. Welfel (2006) believes that competence includes a combination of knowledge, skill, and diligence. Effective practice requires intellectual and emotional competence (Pope & Brown, 1996). The intellectual component consists of attaining a knowledge base, assessing and planning effective treatment for a client or issue, and understanding one's therapeutic limitations (i.e., a child specialist may lack skills required for older adults). Emotional competence relates to managing clinical information, personal biases, and self-care (Pope, Sonne, & Greene, 2006; Welfel, 2006). The concept of competence has been difficult to define, though many efforts have manifested through the development of ethics codes, standards of practice and practice guidelines, third-party-payer quality assurance programs, state licensing and certification boards (Packard, Simon, & Vaughn, 2006), and specialized credentialing authorities. Nonetheless, uniform agreement within the mental health field on the definition of competence is lacking (Claiborn, 1982; Kaslow, 2004). Additionally, incompetence is often difficult to prove given the legal requirements of due process and supportive evidence.

Peterson and Bry (1980) studied competence by examining appraisals of 126 Ph.D. students by 102 faculty and supervisors. The dominant characteristic for "outstanding" trainees was "high intelligence" and "lack of knowledge" for incompetent trainees. Supervisors rated students the following year and determined the following four factors as central to competence: professional responsibility, interpersonal warmth, intelligence, and experience.

The minimum competence standards for therapists are based on academic training and supervised experience culminating in professional licensure. The counselor's license does not specify the type of clients, issues, or interventions he or she may address, instead, the practitioner is ethically obligated to restrict practice to areas of qualification based on training and experience. Attorneys and physicians are not competent to practice in every aspect of law and medicine, likewise, psychotherapists are not competent to treat all people for all issues (Brenner, 2006; Halderman, 2006; Maxie, Arnold, & Stephenson, 2006). The ethical codes of the mental health organizations cite the following regarding competence:

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.).

Marriage and family therapists… maintain competence in marriage and family therapy through education, training, and/or supervised experience (AAMFT, 2015, 3.1).
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.).
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.).

Competence also has legal implications because society expects practitioners to be competent and it upholds these high standards through licensing boards and the court system. Counselor incompetence is the second most often reported area of ethical complaint (dual relationships is first) as indicated by Neukrug, Millikin, & Walden (2001). Given client harm, a therapist is open to lawsuit for malpractice and can be legally responsible in a court of law; many such lawsuits focus on competence. Therapists are encouraged to be cognizant of guidelines or standards applicable to their areas of specialization as a best practice for demonstrating professional competence and lowering liability risks (Bennett et al., 2007).

Koocher & Keith-Spiegel (2008) present the following five cases:

Case 1-1: Therapist had practiced individual psychoanalysis for ten years. After completion of a four-hour continuing education workshop on family therapy, she offered family therapy sessions to some clients while reading books in this field in her spare time.

Case 1-2: Counselor treated a woman for six months with various adjustment issues following a separation and upcoming divorce. Client's attorney asked therapist to testify that client should receive child custody of her 7 year-old. Therapist lacked previous forensic experience or training but from the witness stand he offered opinions about the adjustment of client and her child. Client's husband filed an ethical complaint against therapist on the grounds that he lacked training in child work and he never interviewed the child, thus he was negligent in offering an opinion. Furthermore, this therapist did not attain information from another therapist who was seeing the child, nor from the child's father.

Case 1-3: Practitioner completed graduate training in the 1970s, before clinical neuropsychology evolved as a specialty with more advanced assessment tools. She has not studied neuroanatomy and her practice is mainly in psychotherapy. She accepted an attorney's referral to assess a client who sustained a closed head injury and resulting language, memory, and perceptual sequellae and she used her 1970s techniques.

Analysis: In each case, therapist did not identify the limit or scope of his or her practice and training which led to crossing ethical boundaries. The first case reveals a counselor lacking in minimum competence levels, training and experience. Her efficacy would only come into question if a formal complaint was filed, nonetheless, therapists have an ethical responsibility to practice in specialty areas that are new to them only after obtaining suitable education, training and supervised experience, and precautions must be taken to ensure competent work during the learning process. In the second case, practitioner was not cognizant of forensic practice or expert witness requirements that could have created negative outcomes for all involved. He violated APA's ethic code (APA 2010: 9.01.a) which states, "Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings" and ethics code (APA 2010: 9.01.b) that professes, "… Psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions." The therapist in the third instance had not kept current with newer neuropsychologial assessment techniques and appeared unaware of expert witness ethical responsibilities. In such situations, practitioners are advised to seek formal education, training, consultation or supervision with an expert in that specialty. Considering that competence is difficult to define and assess, self-monitoring is an effective method to ensure quality therapeutic service as reflected in these ethics codes:

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 continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors (ACA, 2014, C.2.d.).
While developing new skills in specialty areas, marriage and family therapists take steps to ensue the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, and/or supervised experience (AAMFT, 2015, 3.6).
Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques (NASW, 2008, 1.04.b.).

Case 1-4: Therapist performed a cognitive evaluation of an adult utilizing the Wechsler Adult Intelligence Scale-Revised (WAIS-R), four years after the revised WAIS-III was published. He responded, "They're about the same, and the new kit is too expensive."

Case 1-5: Counselor continued treating his child clients with long-term psychotherapy for secondary reactive enuresis despite significant evidence that certain behavioral treatments are very effective in a brief time. When confronted with this information, he seemed surprised and then researched the professional literature.

Analysis: Both therapists are offering below-standard treatment resulting from failure to keep abreast with advancements in the field. The first therapist rationalized his performance, combining ignorance and arrogance. The second practitioner was completely unaware but at least interested in updating his knowledge base; even if the new technique poses professional or theoretical concerns from this counselor's view, he has the ethical responsibility to inform

clients of this alternative while offering recommendations. Ethically, practitioners must maintain current skills and vigilance of progress within their areas of practice.

Case 1-6: Mr. Austin hired Dr. Dale in a child custody case in the hope of taking custody of his two sons, aged 9 and 11, from his ex-wife, Mrs. Romero, who held custody. Dr. Dale evaluated Mr. Austin, his current wife and the two children. In court, Dr. Dale testified that Mr. Austin and his wife would be better parents and should have custody of the children and Mrs. Romero should have limited visitation rights. He said the boys preferred their father over their mother. Dr. Dale never evaluated Mrs. Romero or her current husband, rather, all such information was gained secondhand. The psychologist for Mrs. Romero highlighted that she had custody of the children before the current trial, Mr. Austin infrequently saw the children, and he infrequently paid his child support. Dr. Dale ignored hospital records sent to him by Mrs. Romero indicating the fact that Mr. Austin was an alcoholic and was probably still drinking. Mrs. Romero lost custody of the children at the trial. She then received letters from her children stating that their father was drinking heavily and beating his second wife – the same reasons why Mrs. Romero divorced Mr. Austin. Mrs. Romero is Anglo but her current husband is Mexican American; she wondered if that tainted Dr. Dale's evaluation.
Analysis: Dr. Dale appears to have violated the same two ethics codes as in Case 1-2, demonstrated by his conclusions about Mrs. Romero and her current husband without previous evaluation. He also chose to ignore Mr. Austin's history of alcoholism. Whether he lacked forensic experience, was lazy in collecting information, or was biased against certain groups, the displayed incompetence produced dismal consequences for Mrs. Romero and her family (Kitchener, 2000).

Successful graduation from an accredited graduate program does not necessitate or guarantee competence (Kitzow, 2002). Determining competence with respect to various types of clients and issues is a decision requiring ethical and professional integrity often made by the individual professional. The ethics codes indicate the following concerning developing new skills:
(AAMFT, 2015, 3.6 – already cited).
When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (NASW, 2008, 1.04.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.).
(APA, 2010, 2.01.c – already cited.).

Case 1-7: A 35 year-old woman with a diagnosis of psychomotor epilepsy and multiple personality disorder filed a complaint with the APA Ethics Committee against her psychologist of four years for practicing outside her areas of competence. Client claimed that she discovered that her psychologist did not have prior training or supervised experience in her multiplicity of issues; client's condition worsened during treatment leading to hospitalization. Psychologist informed the Ethics Committee that she began treatment as an employee of a community mental health center and was under supervision of two clinic consultants: a neurologist who controlled client's medication and a psychiatrist experienced in multiple personality disorders. Psychologist started a private practice during the third year of therapy with client and was advised by psychiatrist to allow client to remain with the clinic while the clinic administrator, who was not a psychologist, recommended psychologist to work with client in private practice to avoid disruption of treatment. Psychologist continued therapy with client in private practice and kept the same psychiatrist for consultation as needed. After six months of therapy proceeding well, client began decompensating. Client called psychologist late one night threatening suicide because she felt hopeless and she blamed psychologist for not being more helpful. Psychologist called the police who took client to the county psychiatric hospital emergency room where psychologist met her and stayed with her until she was admitted. Psychologist continued therapy with client at the hospital until client refused to see psychologist. Client ultimately returned to the community mental health center for therapy with a different practitioner.

Psychologist informed the APA Ethics Committee that she acted professionally and responsibly as evidenced by her consultations with the psychiatrist and that the clinic administrator recommended she take client into her private practice.
Adjudication: The APA Ethics Committee found psychologist in violation of the principles of competence and responsibility. She tried to operate beyond the limits of her competence and used mistaken judgment in seeing the client in private practice as opposed to allowing client to continue in the more structured environment of the clinic where trained staff to deal with this issue was extant – as the psychiatrist had advised. Further, she did not take full responsibility for the consequences of her actions by transferring responsibility for her decisions to other parties – who were not psychologists. Psychologist was censured with stipulation to take two advanced courses: organic disturbances and diagnosis and treatment of borderline personality and multiple personality disorders. Psychologist accepted the censure and stipulations (APA, 1987).

Case 1-8: Psychologist A charged Psychologist B, a new Ph.D. in social psychology, with performing duties beyond his level of competence. B received a license based on two years experience performing research in a private mental hospital, and he then opened a psychotherapy practice. The private mental hospital's administrator was a businesswoman, not licensed in psychology, and she designated B as chief psychologist, a title that B used as a credential. B informed the APA Ethics Committee that his state psychology license was generic, thereby, having no limits on practice, and his two-year work experience at the

mental hospital trained him to practice psychotherapy and act as chief psychologist. He claimed psychologist A was simply professionally jealous.
Adjudication: The APA Ethics Committee declared Psychologist B was practicing outside his area of competence and was not accurately representing his education, training and experience. He was censured with the stipulation that he cease and desist from practicing psychotherapy and from utilizing the title of chief psychologist. Psychologist B did not reply to the censure and stipulation, consequently, the Committee voted that he be dropped from Association membership for violation of the above ethics standards and for failure to cooperate (APA, 1987).

Case 1-9: Mrs. A filed a complaint against her husband's therapist, Psychologist C, charging that he was disseminating outdated ideas and values regarding women and marriage. Mrs. A's husband was in therapy for a depressive reaction after the death of his father. After six months, the couple experienced marital difficulties and the husband requested his wife attend several sessions. Mrs. A suspected that Psychologist C's "old-fashioned" and patriarchal marital views were causing the marital strife. She informed the APA Ethics Committee of C's views on marriage as follows: the woman is to be subservient and obedient, only "radical feminists" believe in the women's movement, a woman's career is a marital handicap, and she quoted C's statements toward sexual relations indicating insufficient knowledge of female sexuality. The complainant reported that C helped her husband with the loss of his father but his antiquated marriage views almost destroyed her marriage and she was concerned for the welfare of future marital clients. The Ethics Committee questioned Psychologist C about his initial training and continued exposure to the themes of marriage and women. He expressed a lack of contemplating the issues, but the current situation led him to appreciate Mrs. A's criticisms culminating in his reading current books on the topics and planning to attend workshops.
Adjudication: The APA Ethics Committee found Psychologist C in technical violation of the need to undertake relevant education, training, and study yielding competence. In light of his response that he was striving to update his knowledge of these issues, a majority voted to close the case with an educative letter and no further action (APA, 1987).

In response to the awareness that society has historically misunderstood, minimized or ignored women's issues, the APA (1975) launched a task force to study potential gender-bias and gender-role stereotyping of women in psychotherapy. These four general areas of bias were recognized: a) often, therapists values were sexist and their understanding of female biology and psychological process was lacking; b) generally, therapy promoted traditional gender roles; c) therapists commonly utilized out-dated psychoanalytic concepts that devalued women; and d) therapists occasionally treated women as sex objects. Ultimately, principles for competent practice for women were endorsed by several APA divisions, including counseling, clinical, and psychotherapy stressing therapists' awareness of their personal values and ways biases limit options of female clients. The resulting "Counseling and Therapy of Women Preamble" (1979) states the following:

> Although competent counseling/therapy processes are essentially the same for all counselor/therapist interactions, special subgroups require specialized skills, abilities and knowledge. Women constitute a special subgroup.
>
> Competent counseling/therapy requires recognition and appreciation that contemporary society is not sex fair. Many institutions, test standards and attitudes of mental health professionals limit the options of women clients. Counselors/therapists should sensitize women clients to these real-world limitations, confront them with both the external and their own internalized limitations and explore with them their reactions to these constraints.

Case 1-10: Therapist D was effective in offering workshops on diagnosis and treatment planning for practitioners seeking third-party reimbursement from insurance companies. Through a referral, she agreed to provide a series of in-service consultation sessions on the above topic with ten counselors at a community mental health agency. D did not have formal training or supervision in agency consultation but she resolved that a little self-instruction would suffice. D signed a 6-month contract with the agency director to offer bi-weekly consultation with staff members to discuss cases and increase likelihood that the agency was creating diagnosis and treatment plans resulting in third-party reimbursement. D and the director did not address how D would be evaluated or how she would report to the director. D instituted a written contract with the agency indicating that staff participation was voluntary and confidential; further, agency clients were informed of D's involvement thereby addressing client confidentiality issues. All involved were pleased with D's performance but at the conclusion of the contract, D was surprised when the director asked her to evaluate the quality of each staff member's treatment plans. He said the agency was going to decrease its staff size and her opinion would be valuable in making staffing decisions. Therapist complied with this request due to feeling obligated for his hiring her, the staff reduction was to inevitably occur anyway, and she potentially might save the jobs of the most competent staff clinicians. Several months thereafter, two former employees who participated in the consultation group filed a complaint with the ACA Ethics Committee, charging ethical misconduct for disclosing to the director individual staff members' ratings of performance (Herlihy & Corey, 1996).
Analysis: Therapist complied with the ethical responsibility of having agency clients informed of her consultant role with staff members and her access to confidential client information. Codes of Ethics on informed consent reveal:

> 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 (ACA, 2014, A.2.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… (APA, 2010, 3.10.a.).

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 (NASW, 2008, 1.03.a.).
The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: …b) has been adequately informed of significant information concerning treatment processes and procedures (AAMFT, 2015, 1.2.b.).

Consultees are afforded similar rights, thus, informed consent pertaining to goals of the consultation and potential disclosure of shared information is critical, especially when a third party such as a supervisor is involved.

Therapist D declared that disclosed information during consultation meetings was confidential for clients and consultees, further, the possibility of a consultee evaluation was not mentioned. Consultees were not given the choice to participate or not with the understanding that their clinical performance might be disclosed to and evaluated by the agency director. Therapist D violated the consultees' privacy rights by disclosing information not essential to the purpose of the consultation to the director. Privacy issues are illustrated in the following codes:

Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply (NASW, 2008, 1.07.a.).
Information may be shared only to the extent necessary to achieve the purposes of the consultation (AAMFT, 2015, 2.7).
Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made (APA, 2010, 4.04.a.).
Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy (ACA, 2014, B.3.c.).

Although therapists possess broad training and experience, they have the ethical responsibility to seek education, supervision, and consultation when entering into new specialty areas. Therapist D was experienced in treatment planning and insurance reimbursement but not in agency consultation. Her attempts to study consultation on her own proved ineffective regarding consultee confidentiality and informed consent whereas having sought consultation may have prepared her to address the agency director's staff evaluation request. She unintentionally violated her consultees' rights and did not promote their welfare by divulging information that adversely affected their employment. Codes of Ethics highlighting therapist responsibility to promote client welfare state the following:

Marriage and family therapists advance the welfare of families and individuals and make reasonable efforts to find the appropriate balance between conflicting goals within the family system (AAMFT, 2015, Principle 1).
The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients (ACA, 2014, A.1.a.).
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination (APA, 2010, Principle E).
Social workers' primary responsibility is to promote the wellbeing of clients. In general, clients' interests are primary (NASW, 2008, 1.01).

Case 1-11: Therapist E was newly licensed and motivated to begin private practice. His marketing efforts were not attracting referral sources or clients but his pursuit of becoming a network provider with XYZ Corp., a managed care company, led to referrals. E was not cognizant of the impact of managed care upon private practice but he agreed to conform with XYZ Corp.'s approach to managed care. He was referred a client presenting with depression but he needed to refer client upon assessing that client was also anorexic and he lacked training and supervised experience in this disorder. E called his case manager with XYZ Corp. who arranged a referral to another provider in the network.

Over time, Therapist E became somewhat uncomfortable with several of XYZ Corp.'s policies, including having to communicate with numerous case managers (who only gave their first name) rather than only one when requesting authorization for client sessions and needing to disclose much information about the clients above and beyond the diagnosis. He understood the additional request of information was legal because clients signed XYZ Corp.'s disclosure form but E wondered if it was ethical and just what happened with this information such as clients' childhood traumas, marital concerns, addictions and other issues.

One of Therapist E's clients exhausted her insurance benefits before therapy was complete and the case manager advised E to space out the remaining three of the twenty allocated sessions over several months and to initiate a referral to a community mental health center. Therapist E informed the case manager that he disagreed with this plan because client needed continuity of care for an extended time. The case manager was not convinced which led E to see the client pro bono (with resentment toward the managed care company) and to wonder if XYZ Corp.'s case managers were qualified to make psychotherapy decisions.

Therapist E, shortly thereafter, was referred an 11 year-old boy, under the boy's father's company insurance plan administered by XYZ Corp., for fighting at school. E assessed that the boy's misbehavior resulted from conflict between the parents so therapist recommended marital counseling but this specific XYZ Corp. plan did not cover marital counseling. Therapist E felt frustrated with managed care, commenced marital counseling with the parents of the boy, and billed the sessions under the boy's name. E internally reasoned that improvement in the marital relationship would benefit the boy (Herlihy & Corey, 1996).

Analysis: Upon determining client was anorexic, Therapist E appropriately arranged for a referral to a qualified provider, thus not practicing beyond his boundaries of competence. Codes of Ethics relating to referral state:

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).
…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).
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.).
If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships.

Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship (ACA, 2014, A.11.a.).

Therapist E developed confidentiality concerns for his clients due to XYZ Corp.'s anonymous and multiple case managers and their requirement for disclosure of much client information. The limits of confidentiality are generally discussed with clients during the intake session and ethical standards respond to this issue as follows:

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.).

Social workers should not disclose confidential information to thirdparty payers unless clients have authorized such disclosure (NASW, 2008, 1.07.h.).

Psychologists discuss with persons… 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 (APA, 2010, 4.02.a.).

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

This therapist was responsible to know the type of client information that was required before agreeing to become an XYZ Corp. provider, something he may have overlooked given his frustrations and financial needs. He will need to address his concerns with XYZ Corp. and then decide whether to continue as their network provider. Upon continuing, he has an ethical responsibility to inform his clients of the information to be shared with the company because he cannot depend totally on the fact that clients have signed the company's disclosure form.

As Therapist E's concerns about XYZ Corp.'s policies and procedures progress, he is advised to decide if he can continue being their provider and also adhere to these "conflicts between ethics and organizational demands" ethical standards:

If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict 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).

The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers regarding acceptable standards of client care and professional conduct that allow for changes in institutional policy conducive to the growth and development of clients (ACA , 2014, D.1.g.).

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).

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 organizations' practices are consistent with the NASW Code of Ethics (NASW, 2008, 3.09.d.).

With resentment, Therapist E continued therapy with the client whose benefits ended, hence, E upheld the following "termination of services" ethics code:

Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary (NASW, 2008, 1.16.b.).

Nonetheless, therapist may need to self-assess his ability to offer clinical objectivity and effectiveness despite resentment toward the managed care company.

Therapist E's decision to see the parents of the 11 year-old boy and to bill the therapy under the boy's name suggests insurance fraud – a legal and ethical issue. His rationalizations may represent the onset of an "ethical slippery slope" meaning that he might continually disregard rules and condone dishonest practices in the future. Although Therapist E was qualified to establish a private practice according to state licensure laws, his actions suggest being uninformed and naïve pertaining to managed care issues, thus questioning his level of competence to begin an independent private practice. Practitioners are advised to consult their association's Code of Ethics and their state licensure laws when confronted with managed care issues. In this case, E could have emphasized his rationale to XYZ Corp.'s case manager that seeing the parents may offer the quickest and most effective way to treat the boy – instead, the therapist violated these ethics codes:

Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered (AAMFT, 2015, 8.4).

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… an identification of who is the client, the probable uses of the services provided or the information obtained… (APA, 2010, 3.07).

Psychologists do not misrepresent their fees (APA, 2010, 6.04.c.).

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis (APA, 2010, 6.06).

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided…(NASW, 2008, 3.05).

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 (NASW, 2008, 4.06.c.).

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.).

THERAPIST IMPAIRMENT and BURNOUT

Therapist impairment is a deterioration of professional abilities from a previous competent level (Kutz, 1986; Nathan, 1986; Schwebel, Skorina, Schoener, 1994) and occurs when therapists personal problems overflow into their professional activity and decreases therapeutic effectiveness. Impairment is often caused by personal vulnerabilities such as burnout, drug or alcohol abuse, depression, loneliness,

etc., and it can lead to unethical behavior, defined as causing injury or harm to a consumer during performance of a professional role (Stromberg & Dellinger, 1993). A lonely and depressed therapist, for example, may lose sight of professional boundaries and become sexually involved with a client. Therapists are obligated to identify personal emotional or physical concerns affecting professional effectiveness and to seek help for resolution. Concern for the welfare of one's clients is recommended over hesitancy to accept help. Remley and Herlihey (2007) note the following common symptoms of impairment:

1. Deterioration in personal relationships, for example, marital concerns and family dysfunction
2. Isolation and withdrawal from others
3. Sensing disillusionment with the profession
4. Exhibiting emotional distance during therapy sessions
5. Alcohol and/or drug abuse
6. Displaying changes in work style such as tardiness and absenteeism
7. Becoming moody, depressed or anxious
8. Demonstrating procedural mistakes and poor record keeping

Between 26% and 43% of practicing psychologists indicate struggling sometimes with work effectiveness issues (Guy et al., 1989; Mahoney, 1997), including episodes of emotional exhaustion, distress over the size and severity of their caseload, doubts about their therapeutic effectiveness, and disillusionment feelings (Mahoney, 1997). One study revealed 26% of psychologists identified themselves as having been impaired at a given time (Coster & Schwebel, 1997). A study of APA psychotherapy division members discovered that 71.2% disclosed having worked when too distressed to be effective and 5.9% performed therapy under the influence of alcohol (Pope et al. 1987a). A similar study of academic psychologists found that 77.2% had taught while feeling too distressed to be effective and 4.6% had taught under the influence of alcohol (Tabachnick et al., 1991). The data suggest that psychologists are similar to other groups pertaining to sometimes being too emotionally upset to be effective in work or in other areas of life.

In contrast, psychologists exhibit significant amounts of self-care behavior. Mahoney (1997) indicated that 80% of practicing psychologists read for pleasure, participate in a hobby, take vacations, and attend movies, museums or concerts for enjoyment while 75% physically exercise and socialize with peers for support. This research concluded that the average practitioner is healthy, happy, enjoys work, and takes active measures to cope with personal problems (including seeking personal therapy when appropriate). Coster and Schwebel (1997) determined that 74% of psychologists are well-functioning and Thoreson et al. (1989) found that the majority of psychologists they surveyed were healthy and satisfied with work and their interpersonal relationships.

Coster and Schwebel (1997) and Mahoney (1997) reveal the following psychologist-recommended coping mechanisms to protect psychological well-being, avoid impairment and promote client welfare:

- Maintain a strong interpersonal support system of family, friends and companions which will help buffer work-related stressors.
- Interact with a peer group facilitating exchange of objective feedback, stress-reduction, and problem-solving. Learning that your peers are challenged in similar ways as yourself and listening to their solutions can be stress-reducing.
- Spend time nurturing your personal well-being by living a balanced lifestyle encouraging fun and physical activity along with work.
- Enjoy professional development activities that foster remaining current with the field.
- Monitor your personal weaknesses and impairment danger signals such as dissatisfaction, withdrawal, depression, loss of energy, unjustified anger toward others, alcohol/drug dependence, or impulses to act on sexual feelings. Pursue self-help behavior or therapy when necessary.
- Remove yourself from professional work activities if personal issues remain unresolved that could harm consumers.

Burnout is defined as a type of emotional exhaustion due to extreme demands on energy, strength, and personal resources in the workplace (Baker, 2003; Maslach, Schaufeli, & Leiter, 2001; Shiron, 2006). Therapist burnout yields symptoms of emotional exhaustion, depersonalization, and a sense of limited personal accomplishment and "may manifest itself in a loss of empathy, respect, and positive feelings for their clients" (Skorupa & Agresti, p.281, 1993). Therapist may become withdrawn, bad-tempered and uncooperative with clients and colleagues (Mills & Huebner, 1998) which can lead to poor decision-making and disrespect of one's clients (Pope & Vasquez, 2005). Burnout is more likely for therapists with less control over work activities, excessive work hours, and many administrative tasks (Rupert & Morgan, 2005). Practitioners with smaller caseloads are less susceptible to burnout (Skorupa & Agresti, 1993). Age of therapist is inversely related to burnout (Vredenburgh et al., 1999) presumably because younger counselors experience more stress as they are developing competence and professional security.

The warning signs of burnout include the following: inappropriate anger outbursts, feeling apathetic, continual frustration, feeling depersonalized, depression, emotional and physical exhaustion, being hostile, experiencing malice or aversion toward clients, and reduced productivity or work effectiveness. Predisposing factors that can lead to burnout include: ambiguous work roles such as unclear or changing demands and expectations, work environment conflict and tension, incongruity between ideal and real job activities, unrealistic pre-employment expectations, insufficient social support at work, being a perfectionist with a feeling of being externally controlled, experiencing death or divorce in the family, consistent helplessness, permeable emotional boundaries, substance abuse, and maintaining excessively

high self-expectations (Dupree & Day, 1995; Jenkins & Maslach, 1994; Koeske & Kelly, 1995; Koocher, 1980; Lee & Ashforth, 1996; Maslach, 1993; Maslach et al., 2001; McKnight & Glass, 1995; Shiron, 2006).

Therapists can minimize burnout risk by receiving supervision and social support, especially for those working with difficult populations, feeling a strong purpose and mission in work activities, and seeking help if professional or personal stressors mount (Acker, 1999; Miller, 1998). Joining an informal peer support group can foster ventilation of pent-up stress and promote exposure to professional support and problem-solving ideas. Additional self-care strategies include taking a break or vacation from work, regular exercise, meditation, and engaging in hobbies. Work environment factors that protect therapists from burnout include: understanding your expected role, receiving positive feedback, work autonomy, opportunities to relieve stress at work, social support at the worksite, experiencing personal accomplishment, maintaining realistic criteria for client outcome, being cognizant of personal strengths and weaknesses, and remaining under internal-control (Koocher & Keith-Speigel, 2008).

The following two cases are presented by Koocher and Keith-Spiegel (2008):

Case 1-12: Therapist F worked full-time at a cancer treatment facility for several years and due to concern for his clients, made himself available "on call" beyond normal hours. His performance lessened after the death of a liked client and a personal marriage concern. F stopped returning calls to clients and staff in a timely way, sometimes missed appointments without giving notice, and exhibited distance from his clients. He was fired by the facility but performed well at his next therapeutic setting.

Case 1-13: Therapist G worked as a school psychologist in a large urban public school system. She felt under-appreciated and over-worked by clients and administrators coupled with an inability to effectively manage her work situation culminating in dislike of her position. G resigned from the job after securing another position elsewhere but she failed to give adequate notice and left several student evaluations incomplete.

Analysis: Both therapists experienced burnout resulting from stress in their jobs, personal lives, various client issues dealt with daily, and other factors. Each was subjected to learned helplessness and depression, in turn, their clients were affected. Therapist F's detachment and withdrawal was not professional and Therapist G's immediate departure probably negatively impacted several students and staff.

The Codes of Ethics express the requirement of acknowledgment and resolution of personal problems as follows:

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

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until 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.).

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.).

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

TERMINATION

Termination or referral of a client is generally based on three conditions. First, when therapy has successfully resolved client's presenting issues and treatment is no longer required. Second, if client is not gaining any benefit from therapy but is willing to continue given dependency upon the therapist. A referral is possible if therapist senses client would benefit from a different practitioner. Third, upon therapist belief that therapy continuation could be harmful to client – a referral is also possible. Additionally, therapists discuss the issue of termination with clients thoroughly along with clarifying the reasons. The decision to terminate therapy is based on the best interest of the client, hence, therapists do not abandon their clients. Codes of Ethics on terminating therapy emphasize the following:

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 (APA, 2010, 10.10.a.).

Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship (APA, 2010, 10.10.b.).

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.c.).

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 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.).

Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of treatment (AAMFT, 2015, 1.11; 1.10 already mentioned).

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.).

Case 1-14: Client has been in therapy with Therapist H weekly for six years and has already resolved her presenting issues. Her emotional status has not changed in approximately four years except she has developed a growing attachment to therapist. H has not strongly recommended termination, rather, his attitude is "If the client thinks she needs to see me, then she does" (Koocher & Keith-Speigel, 2008).
Analysis: Therapist H failed to ethically terminate treatment at the time client did not need continued services or therapy was no longer beneficial. The possibility exists that Therapist H facilitated client's dependency, prolonged needless therapy, thereby suggesting exploitation for financial or emotional fulfillment. He is wise to periodically, critically evaluate the therapy process with client and refer client to a different therapist for consultation regarding need for further therapy. The best interest of client, not therapist, determines termination and referral.

Case 1-15: Therapist I treated client for escalating anger toward his employer but therapist observed client becoming paranoid and deeply troubled. Therapist I recommended hospitalization to client several times but client rejected the thought. Therapist continued treating client, eventually developing into the object of client's paranoid anger (Koocher & Keith-Spiegel, 2008).
Analysis: Therapist I practiced beyond the scope of his competency. Upon recognition that client needed a higher level of care, possibly inpatient treatment, therapist could have refused therapy until client sought appropriate assistance. If client's behavior would have escalated to being a danger to self or others, or suggested involuntary hospitalization then therapist would be responsible to consider an effective course of action.

Case 1-16: A corporation hired Therapist J to assist in improvement of employee morale and lower product defects. Effectiveness data acquired by therapist himself validated unsuccessful results, however, Therapist J disregarded the outcome information, informed the company that a longer trial was required, and persisted to offer the unproductive services at a high fee for several more months until the corporation finally cancelled the contract (Koocher & Keith-Spiegel, 2008).
Analysis: Therapist J willfully chose to overlook his data and continue providing ineffective services rather than re-evaluating treatment plans and constructing an alternative course of action. The ethical obligation to inform management of the absence of benefit was not timely demonstrated.

Corey et al. (2007) believe that even highly experienced therapists will occasionally question whether their personal and professional competence is sufficient with some of their clients. Encountering difficulties with some clients does not necessarily imply incompetence or the need to immediately refer, instead, it is wise to balance between expanding areas of competence and referring when appropriate. Professional growth, extended competence, and avoidance of stagnation may arise by accepting clients with new issues. While learning new skills and implementing new competencies, practitioners must ensure that clients are not harmed. Broadening boundaries of competence can occur through reading, professional development activities, consultation, co-counseling with experienced colleagues in a specialty area, and receiving supervision. Whether administering experienced or inexperienced therapeutic skills, therapists would benefit by self-appraisal through peer consultation and client evaluation.

INFORMED CONSENT

The process of informed consent is a legal and ethical obligation to provide relevant information to clients regarding expectations of therapy before onset of assessment or treatment. Therapists should discuss goals, expectations, procedures, and potential risks (Becker-Blease & Freyd, 2006; Bennett et al., 2007; Everstein et al., 1980; Hare-Mustin et al., 1979; Vogel & Wester, 2003) enabling clients to make intelligent choices such as whether to receive therapy, with whom, and how the process will transpire. The essence of informed consent is designed to anticipate questions of reasonable clients thus preventing future misunderstanding and frustration yielding a "culture of safety" (Knapp & VandeCreek, 2006). Informing clients how therapy works demystifies the relationship and empowers their active involvement. Clients, generally, must rely upon and trust their practitioner to disclose information necessary to make wise treatment decisions (Handelsman, 2001). Sullivan, Martin, and Handelsman (1993) note that "clients may be more favorably disposed to therapists who take the time and effort to provide (informed consent) information" (p. 162). Further, Tryon and Winograd (2001) propose that therapist-client agreement on goals is positively correlated with improved patient outcomes and satisfaction and they advise, "to maximize the possibility of achieving a positive treatment outcome, therapist and patient should be involved throughout therapy in a process of shared decision-making, where goals are frequently discussed and agreed upon" (p. 387). Supportively, informed consent is a recurrent process because the treatment plan may be altered due to assessment results, client's reactions and his or her changing needs. The client should be informed of treatment plan changes and voluntarily agree with them. Marczyk and Wertheimer (2001) acknowledged the difficulty of mental health practitioners historically to offer comprehensive treatment choices because the discipline of counseling and psychology was "still very much a philosophy and not a science" (p. 33). They believe that mental health practitioners should be required to offer clients success rates of various mental health treatment based on empirical research-based evidence similar to physicians treating patients with conditions as cancer.

The requirement for health professionals to secure informed consent from their clientele prior to rendering services started

in the field of medicine (Appelbaum, Lidz, & Meisel, 1987). Historically, in 1767, a court in England established that physicians were responsible to acquire consent from their patients before touching them or offering treatment (*Slater v. Baker & Stapleton)*. This requirement was founded on the basic tort principle of battery emphasizing that members of a society are entitled to personal privacy, including not having their bodies touched without permission. Through history, the health care professions maintained an authoritarian position in terms of the patient's needs as it was assumed that the physician knew the best course of action and the patient lacked such knowledge – the principle of informed consent is absent from the Hippocratic Oath. This authoritarian approach was challenged in a New York case, in 1914, when Judge Benjamin Cordozo (he later became a U.S. Supreme Court Justice) wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (*Schloendorf v. Society of New York Hospital,* 1914, p. 93). The principle that the patient and not the doctor had the right to decide whether to undergo a specific treatment approach was dormant for decades. The first case in the United States to uphold the requirement that patients must be educated or informed about their medical treatment options and consequences before being able to give a valid consent to treatment that is legally binding was *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees* (1957). Appelbaum, Lidz & Meisel (1987, p. 41) conclude the Salgo case stressed that physicians must provide patients the following: "disclosure of the nature of the ailment, the nature of the proposed treatment, the probability of success, and possible alternative treatments."

In 1960, in the Kansas case of *Nathanson v. Kline*, the court endorsed the Judge Cordozo principle by stating, "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body" (p. 1104). The court expressed that the patient needs relevant information to make this determination, however, it was left to the doctors to determine what information was relevant: "The duty … to disclose … is limited to those disclosures which a reasonable … practitioner would make under the same or similar circumstances…. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation" (1960, p. 1106). This case demonstrates the "community standard" rule whereby informed consent procedures must represent that which the general community of doctors customarily do.

The case of *Canterbury v. Spence* (1972) resolved that physicians must disclose information pertaining to a proposed treatment that a reasonable person, such as the patient being treated, would require to render a decision to accept or refuse treatment. The court conveyed, "The root premise is the concept, fundamental in American jurisprudence, that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body.' True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible" (*Canterbury v. Spence*, 1972, p. 780). The patient, not the doctor, therefore, makes the final decision and the decision is based upon relevant information supplied by the doctor: "It is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential" (*Cobbs v. Grant*, 1972, p. 514).

This rationale illustrated the vital importance of trust and dependence in the delivery of health care and differentiated such trust and dependence from the less profound and intimate general marketplace transactions often reflective of the caveat emptor policy: "A reasonable revelation in these aspects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject" (*Canterbury v. Spence*, 1972, p. 782).

The *Canterbury v. Spence* case rejected the notion that doctors, resulting from their "community standards," could regulate the type of information patients should receive. It was resolved that doctors could not determine the informed consent rights of the patient or those rights indirectly by creating "customary" standards concerning the type of information to be provided. Contrarily, patients were determined to have a right to make an informed decision and the courts would guarantee patients were privy to relevant information to make the decision. The court noted, "We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition…. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves" (*Canterbury v. Spence*, 1972, pp. 783—784). Furthermore, this case requires doctors to provide relevant information whether or not patients ask the "right" questions in each area, hence, doctors could not

withhold information because a patient did not inquire. Doctors have a duty to render a sufficient full disclosure: "We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions: it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire…. Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have patients of widely divergent socioeconomic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequalities" (*Canterbury v. Spence*, 1972, p. 783).

The courts also deliberated on the possibility of patients refusing a specific assessment or treatment and concluded that patients have a right to be informed of the possible consequences of rejecting such assessment or treatment procedures. The California Supreme Court, in 1980, reaffirmed the principles of *Canterbury v. Spence* and *Cobbs v. Grant* and affirmed that patients have a right to informed refusal of treatment along with the right of informed consent to treatment: "The rule applies whether the procedure involves treatment or a diagnostic test…. If a patient indicates that he or she is going to decline a risk-free test or treatment, then the doctor has the additional duty of advising of all the material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action" (*Truman v. Thomas*, 1980, p. 312).

The court clarified that doctors need not inform patients of everything they learned during their training because patients probably would not understand such complexities, instead, patients only need relevant information presented in understandable and straightforward language so to make an informed decision: "The patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required" (*Cobbs v. Grant*, 1972, p. 515).

The courts changed the locus of control in decision-making to the patient and the duty of ensuring the decision for assessment or treatment being a result of clear and relevant doctor disclosed information. The California Supreme Court explained the derivation of informed consent as follows: "We employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm-length transactions. From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process" (*Cobbs v. Grant*, 1972, p. 513). Berner (1998) suggests that two key elements are involved with the informed consent legal standard. First, the "professional element" pertains to information which a reasonable physician would have offered a patient in similar circumstances, and "materiality," defined as the amount of information the average patient would deem adequate to decide whether to accept or reject treatment. Given Berner's interpretation, the courts will predictably require physicians to provide basic information to all patients and the information must be understandable to the particular patient.

One example of informed consent principles passing from case law into legislation is Indiana's House Enrolled Act of 1984, which articulates, "All patients or clients are entitled to be informed of the nature of treatment or habilitation program proposed, the known effect of receiving and of not receiving such treatment or habilitation, and alternative treatment or habilitation programs, if any. An adult voluntary patient or client, if not adjudicated incompetent, is entitled to refuse to submit to treatment or to a habilitation program and is entitled to be informed of this right" (section F). These informed consent principles are also clearly communicated in the ethical standards and principles of the mental health associations. Though a large portion of case law pertains to medical practice, examination of Codes of Ethics for mental health practitioners illuminates the relevance and positive transfer to clinical assessment and psychotherapy:

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 (NASW, 2008, 1.03.a.).

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 substitute 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).

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… (APA, 2010, 3.10.a.).
Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, relevant experience, and approach to counseling; continuation of services upon the incapacitation or death of a counselor; the role of technology; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis and the intended use of tests and reports. Additionally, counselors inform clients about fees and billing arrangements, including procedures for nonpayment of fees. Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality change and to be advised of the consequences of such refusal (ACA, 2014, A.2.b.).

Pondering how we would feel in the role of a client who was not given adequate information to make a decision on an informed basis can increase our sensitivity and appreciation of the ethical responsibility to provide informed consent. The following three examples of failure to provide informed consent illustrate its importance: One of the most frightening cases involved the U.S. government offering free medical care to hundreds of U.S. citizens from 1932 to 1972 in the Tuskegee syphilis study through what ultimately became the U.S. Public Health Service (J. H. Jones, 1981; Rivers, Schuman, Simpson & Olansky, 1953; U.S. Public Health Service, 1973). The participants of the study were not told that they were used to research the effects of syphilis given nontreatment. Research procedures were utilized as treatment, for example, painful spinal taps were explained to the subjects as a form of medical treatment. The Public Health Service denied any racism in this research, however, only male African Americans were admitted to the program. A second example is when hospitals may perform AIDS tests on patients without their knowledge or permission, sometimes in violation of state law (Pope & Morin, 1990). In a third case, Stevens (1990) revealed a testing center that administered the Stanford-Binet Intelligence Scale facilitating placement of students into appropriate classes at school. The schools received different information than the child's parents. One report, for example, stated the boy should be placed in a class for average students while the parents received a report stating, "David should be placed in a class for superior students" (p. 15). The testing center justified their position expressing, "The report we send to the school is accurate. The report for the parents is more soothing and positive" (p. 15).

The concern that providing relevant therapy information may yield negative client consequences has not been research-supported, instead, an array of studies demonstrate that informed consent procedures increase likelihood that clients will become less anxious, follow the treatment plan, recover more quickly, and be more alert to unanticipated negative treatment outcomes (Handler, 1990).

Therapists must strive to inform clients in understandable and unbiased language during their decision process to participate in assessment or treatment as the following Harvard University hospital study illustrates. McNeil et al. (1982) gave subjects the choice of surgical versus radiological treatment based on actuarial data of outcomes of lung cancer patients. For those who chose surgery, 10% died during the operation itself, 22% died within the first year after surgery, and another 34% died within five years. For radiation therapy, none died during the radiation treatments, 23% died within the first year, and an additional 55% died within five years. When this data was presented in terms of mortality (percentage of patients who died), 42% of participants in the study chose radiation. Given the same actuarial data presented in terms of percentage of patients who survived at each stage – for radiation, 100% survived the treatments, 77% survived the first year, and 22% survived five years – only 25% chose radiation. A shift from a mortality to survivability presentation produced a significant change in subject's perception and ultimate decision.

An informed consent form may have been composed with intimidating legalese and bureaucratic terminology to protect the organization from lawsuit, therefore, a therapist ethical responsibility exists to explain the information to client. Grundner (1980, p. 900) observed that "consent forms have valid content, but little effort has been made to ensure that the average person can read and understand them." He analyzed five forms, with two standardized readability tests, and concluded that "the readability of all five was approximately equivalent to that of material intended for upper division undergraduates or graduate school students. Four of the five forms were written at the level of a scientific journal, and a fifth at the level of a specialized academic magazine" (p. 900).

Comprehension as well as recall of information is not guaranteed by client simply reading an informed consent form. Robinson & Merav (1976) re-interviewed twenty patients four to six months after they read and signed an informed consent form and underwent therapy. All patients exhibited poor recall of all aspects of the information on the form, including the diagnosis, possible negative outcomes, and alternate types of management. Cassileth, Zupkis, Sutton-Smith, & March (1980) discovered that only 60% of patients who read and signed an informed consent form understood the purpose and nature of the procedures one day later. A mechanical and obligatory response from clients that they understand is not always reliable (Irwin et al., 1985).

Remley and Herlihey (2007) recommend the following to be included in informed consent material:

1. The purposes, goals, techniques, procedures. limitations, potential risks, and benefits of the proposed therapy
2. Therapist qualifications, including degrees, licenses and certifications, areas of specialization, and experience
3. Plans for continuation of therapy services if therapist becomes incapacitated or dies
4. Implications of the diagnosis and planned utilization of tests and reports
5. Billing information and fees
6. Confidentiality and its limitations

7. Clients' rights to receive information about their records and to participate in therapy plans
8. Clients' rights to refuse any recommended treatment services or changes and to be informed of potential consequences of refusal

Moreover, the following topics are also recommended to be included:

a) The therapist's theoretical orientation expressed in understandable language (Corey et al., 2007) or therapist's philosophy of the therapy process
b) Logistics of therapy, including length and frequency of sessions, how to make and cancel sessions, policy about telephone contact between appointments, method of contacting therapist or an alternative service in case of emergency (Haas & Malouf, 1995)
c) Insurance reimbursement information, including how client's diagnosis becomes part of client's permanent health record; description of information to be provided to insurance carriers and the resulting limits on confidentiality (Welfel, 2006); and, if appropriate, explanation of how managed care will affect the therapy process (Corey et al., 2007; Glosoff et al., 1999)
d) Information on alternatives to therapy, for example, 12-step groups, self-help groups, bibliotherapy, medications, nutritional or exercise therapy, or other pertinent options (Bray, Shepherd, & Hays, 1985)
e) If the case may be discussed with a supervisor or consultant, or videotaped/audiotaped (Corey et al., 2007)
f) Client's options if dissatisfied with therapy such as names/contact information of supervisors, and contact information of licensing boards and professional organizations (Welfel, 2006)

Furthermore, the eight potential legal concerns listed below are recommended to be discussed in informed consent material because they could lead to lawsuit if client believes therapist has enacted any of the following (Remley & Herlihy, 2007):

→ Failure to include HIPAA elements – For example, not informing clients of their right to look at their therapy records.

→ Providing a guarantee of an outcome resulting from therapy – Therapist states, "Therapy will save your marriage" but divorce ensues leading to a breach of contract lawsuit.

→ Offering a guarantee of privacy without exceptions – Therapist explains the ethical and legal responsibility of protecting privacy to a client who is concerned about privacy issues. Client perceives that therapist will not disclose any information under any circumstance. Soon after, therapist breaks confidentiality by informing client's wife that client reveals suicidal ideation. Client sues therapist for breach of contract, malpractice, and deliberately inflicting emotional distress.

→ Agreeing to a fee that is changed later – Agreement of a $50 per hour rate is raised to $75 after several months. Client expresses that the new rate is excessive and therapist replies that therapy will be terminated without the new fee. Client sues for breach of contract and abandonment.

→ Touching a client without implied or actual permission – During group therapy, therapist directs clients to catch one another as they fall backward as a sign of trust. A female client with various sexual issues reluctantly participates but leaves session early and visibly distraught. Client sues therapist for breach of contract, breach of fiduciary duty, assault, battery, and sexual assault.

→ Misrepresenting one's credentials – Client receives therapy from a master's level licensed therapist and writes the checks to "Dr. Smith" while noting fee is for "psychological services" and the checks are cashed. After eight sessions, client calls therapist "Dr. Smith" and is corrected by therapist. Client is upset to learn he is seeing a master's level therapist and not a psychologist. Client sues for breach of contract and fraudulent misrepresentation.

→ Failure to indicate the nature of therapy – Client initiates therapy to overcome public-speaking anxiety. Therapist assesses the anxiety results from low self-esteem and treatment targets the delivery of positive reinforcement of client's positive attributes. After five sessions yielding no change, client conveyed she expected to learn ways to give public presentations without feeling anxious through receiving advice on managing anxiety, reading books on the subject, and practicing speaking with therapist. Client sues for breach of contract and malpractice.

→ Failure to warn client about possible stigma – Therapist completes an insurance form after first session, at client's request, indicating client had a single episode of depression and designated the appropriate diagnosis. Therapy continued for ten sessions and terminated due to client moving away. Client called therapist two years later complaining that he was denied security clearance for a job he applied for because therapist diagnosed him with a mental disorder, without his knowledge or agreement. Client sues for breach of contract, malpractice, and defamation.

These situations demonstrate the significance of therapist and client understanding expectations of therapy before the process begins. The above issues were avoidable given therapists fully informing clients of the therapy relationship.

The Health Insurance Portability and Accountability Act (HIPAA) became effective on April 15, 2003, in turn, therapists must give their clients written informed consent documents to sign. HIPAA requires all health care providers who transmit records electronically (which probably includes all providers) to conform with procedures that will ensure consumer privacy. Practitioners must inform health care recipients in detail of their established rights regarding privacy and records. This federal law has evolved a previous vague notion of informed consent to a concrete format, including steps taken to ensure client privacy and clients' signature of a document that they were informed of their rights. Some essential HIPAA elements for informed consent documents indicating clients have been informed about

proposed treatment and agreeing to the arrangements and treatment are illustrated below (Remley & Herlihy, 2007):

- Indicate that your client's personal information may be used and disclosed in order to complete treatment, and information may be presented to health care companies in relation to payment of your services.
- Have a complete written description of your procedures for keeping and disclosing your clients' personal information.
- Advise your client that you have a more complete description of how you will keep or disclose their personal information and it is available to view. Inform that client has a right to see the complete description before signing the consent form. State that your practice may change over time and client can review those revisions by requesting such in writing.
- Explain to clients that they may request that you restrict how their personal information is used or disclosed, that you will consider their requests, and will inform them whether you have agreed to them.
- Acknowledge that client has the right to revoke his or her consent in writing, except for actions that you have already taken which were based on prior consent.
- Have client sign and date the form.
- Keep the form for a minimum of six years.

CLIENT RIGHT TO REFUSE TREATMENT

Clients who disapprove of a therapist's proposed treatment plans may generally choose to not receive treatment or to pursue alternative care, however, clients confined in mental hospitals, and minors brought to therapy by their parents or guardians may not have such a choice. Several court rulings have offered direction in this area, for example, in the landmark case of *O'Connor v. Donaldson* (1975), the U.S. Supreme Court identified, for the first time, a constitutional basis for the "right to treatment" for the nondangerous mentally ill patient. Mr. Donaldson was schizophrenic and his father committed him to a hospital for psychiatric care. Mr. Donaldson refused somatic treatments due to his Christian Science religious beliefs. He was not deemed a danger to self or others, yet, he was confined in the hospital for refusing medication. Mr. Donaldson was not offered alternative treatment such as verbal or behavioral therapy. The ruling indicated that the state could not confine such patients without treatment being provided.

Case 2-1: Charles Sell, a dentist, practiced in Missouri and had a long history of mental illness. He was hospitalized, treated with antipsychotic medication, and discharged, in 1982, after advising doctors that the gold used in his fillings was contaminated by communists. Through the years, Dr. Sell experienced several documented episodes of visual and auditory hallucinations followed by a U.S. government charge, in 1997, of Medicaid, insurance, and mail fraud, alleging he submitted multiple false claims. A court-ordered psychiatric examination assessed Dr. Sell "currently competent" but stated "a psychotic episode" was possible in the future. In 1998, during a bail revocation hearing, the judge said Dr. Sell was "totally out of control" as he yelled, insulted and ultimately spat in the judge's face. Several months later, the grand jury charged Dr. Sell with attempted murder of the Federal Bureau of Investigation agent who arrested him and a past employee who was to testify against him in the fraud case. While incarcerated before trial, another court-ordered examination found Dr. Sell "mentally incompetent to stand trial," hence, the judge ordered him "hospitalized for treatment" up to four months "to determine whether there was a substantial probability that Sell would attain the capacity to allow his trial to proceed." After two months, the medical staff recommended Dr. Sell take antipsychotic medication but he refused. The medical staff pursued permission to administer the medication against Dr. Sell's will.

In a 6-3 vote, the U.S. Supreme Court ruled that the government can involuntarily administer antipsychotic mediations to a mentally ill defendant thus allowing the defendant to stand trial, "but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trail and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests." The Supreme Court also stated that a) in deciding if the government maintains an important interest in bringing a defendant to trial, a trial court must determine whether the defendant will be civilly committed or has been detained already for a lengthy period; b) the government must show that the intended medication is considerably likely to render the defendant competent to stand trial; c) the court must recognize the absence of a less intrusive approach or alternative as likely to attain the same result of leading a defendant to competency; and d) the medication must be in the patient's best interest, including efficacy and side effects (*Sell v. United States*, 2003). The Supreme Court's decision agreed with the American Psychological Association's request that courts should consider "alternative, less intrusive means" before forcibly treating mentally ill criminal defendants with medication. Nathalie F. P. Gilfoyle, General Counsel for the APA, stated, "The bottom line is that – the Court has specifically required that trial courts consider and rule out nondrug alternatives before ordering involuntary drug treatment."

Case 2-2: Nancy Hargrave had a history of paranoid schizophrenia and many admissions to the Vermont State Hospital. At a time of emotional stability, Ms. Hargrave completed an advance directive through a durable power of attorney (DPOA) designating a substitute decision maker if she again became psychotic and incompetent by reason of psychosis and she chose to reject "any and all anti-psychotic, neuroleptic, psychotropic, or psychoactive medications" upon any future involuntary commitment.

The 1998 Vermont state legislature, however, passed Act 114, a statute allowing hospital (or prison) personnel to seek court permission to treat incompetent involuntarily

committed patients, despite any advance directives requesting otherwise. Ms. Hargrave argued that the new law violated her rights under the Americans With Disabilities Act. The U.S. District Court and the Second Circuit Court of Appeals agreed with Ms. Hargrave rather than with the state. Addressing the argument that Hargrave and other involuntarily committed patients represent a direct threat, the three-judge panel countered that all committed patients do not pose a threat to others, as required by the Americans With Disabilities Act, because many became hospitalized only due to danger to themselves. Additionally, the court stated that those people designated as dangerous to others at the time of commitment cannot still be presumed as dangerous when seeking to override their advance directives. The court resolved that the state statute violated the Americans With Disabilities Act (Appelbaum, 2004).

CASE STUDIES

Case 2-3: A 13 year-old walks into a Mental Health Center and asks to talk to someone. Therapist K sees client who indicates many personal and family problems, including severe physical abuse at home. Client asks therapist not to discuss the case with anyone, especially his parents. Therapist explains his options with client, states that he cannot offer treatment to anyone under the age of 18 without parental consent, and expresses his duty to report suspected child abuse to Child Protective Services. Client feels betrayed.

Analysis: Generally, with the exception of a small number of states (i.e., the Commonwealth of Virginia), a parent's permission is needed to provide psychotherapy with a minor client (Koocher, 1995, 2003). In fact, a child generally cannot refuse treatment authorized by a parent, even if the proposed treatment is inpatient confinement (Koocher, 2003; Melton et al., 1983; Weithorn, 1987, 2006). The courts have assumed that the mental health practitioner treating the child at the parents request represents an unbiased third party capable of assessing that which is best for the child (J.L. v. Parham, 1976; Parham v. J.R., 1979).

Therapist K understood that he could not legally accept client's request for therapy and client could not provide competent informed consent with all such implications, including payment for services. Therapist did not, however, explain limits of confidentiality to client from the start, as required by HIPAA (Health Insurance Portability and Accountability Act, 1996). Practitioner knew of the need to report suspected child abuse to the proper authorities as is the statutory obligation in all states. He also respected child's rights as a person and client by discussing his action plan (Koocher & Keith-Spiegel, 2008).

Case 2-4: A 30 year-old woman called by phone and requested therapy for depression and marital dissatisfaction. In the first session, client disclosed that she was a victim of sexual trauma as an adolescent. It appeared that client's symptoms were linked to her adolescent trauma.

Analysis: It is recommended that the informed consent process address possible negative effects of therapy upon the marriage and the spouse. Common trauma symptoms include disrupted relationships with significant others such as emotional detachment, lack of intimacy, and impaired sexual functioning. Therapist wisely informed client that some of her negative feelings about her marriage may be caused by the impact of the trauma, unrelated to the marriage itself (Knapp & VandeCreek, 2006).

Case 2-5: Therapist, working in a mental health agency, gave client a personalized, pre-made informed consent form before the session began. During session, the client, a young mother, revealed that her husband gets angry when their infant daughter cries and severely shakes the child to stop the crying. Therapist advised client that he must report her husband's actions as possible child abuse, along with potential outcomes of the report, and that he will continue counseling her. Client responded that she would not have revealed this situation had she known it would be reported. Therapist reminded client that she signed the informed consent form which clearly stated therapists are legally obligated to report incidents of suspected child abuse. Client admitted to not having read the document, instead, she signed it along with the other paperwork for insurance purposes. Client chose to discontinue therapy because she lost trust in therapist.

Analysis: Therapists should make the effort to ensure clients understand that which they have read in disclosure statements. Informed consent forms can be used to correct misunderstandings before therapy begins, additionally, written rather than verbal disclosure statements are more effective in addressing questions or issues because the intent of the parties is clearly expressed. Pope and Vasquez (1998) believe that counselors cannot rely exclusively on standard forms to complete the purpose of informed consent, regardless of the quality of the form. Dialogue is required to ensure client and therapist understand their upcoming shared encounter. In the case of clients who lack the capacity to give informed consent, for example, minors, developmentally disabled, severe thought-disorders, or those not speaking the primary language, therapists take additional steps to promote understanding as indicated in these Codes of Ethics:

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 (APA, 2010, 3.10.b.).

When counseling minors, incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf (ACA, 2014, A.2.d.).

(AAMFT, 2015, 1.2 - already cited).

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 (NASW, 2008, 1.03.b.).
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 the clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent (NASW, 2008, 1.03.c.).

Case 2-6: A 38 year-old woman, experiencing postpartum depression, chronic pain in her lower back resulting from a two year-old injury, and worry over her infant's unusual health concerns, contacted therapist for psychotherapy and nonmedical interventions for her pain. Due to media misconceptions and a close friend who was experiencing very fast therapeutic progress, client expected relief from her back pain with one hypnotic session and only a few sessions to remedy her depression. In their first telephone contact, therapist clarified that the process would probably take longer than she anticipated, involving history taking, possible psychological testing, relaxation, biofeedback or self-hypnotic training, psychotherapy, and perhaps other interventions. He described the importance of each stage and how collectively they maximize treatment, and that other practitioners may work differently but his method has proven effective through years of experience with chronic pain and depression. Counselor explained that he used cognitive-behavioral principles that are research-tested for improving pain disorders and associated symptoms, and he would coordinate treatment with her physician and specialists through consent forms to permit communication. Therapist addressed client's concern over fees and expected duration of therapy because she was previously told by another therapist that significant pain relief would occur in two or three sessions. Client felt enlightened by the discussion and appreciative of therapist taking time to explain fundamental issues and answer her questions, at no cost; she chose this therapist and was pleased with the outcome.

Upon arrival at her first session, therapist gave client a printed disclosure statement explaining other aspects of informed consent in detail, including confidentiality and its limitations, fees and third-party reimbursement, duration of therapy, cancellations and missed appointments, telephone availability and emergencies, collaboration with other health care professionals or psychologists, and interruptions to therapy such as vacations. Since therapist's practice was HIPAA compliant, he issued client a second handout indicating her rights and other relevant information required by law.
Analysis: Therapist effectively obtained informed consent before the onset of treatment and informed about the nature of the therapy and how it would likely proceed. He discussed financial matters, third-party involvement (which could include previous therapists, family members, and physicians), and confidentiality rules and exceptions. Therapists can view the informed consent process as though they are enlightening a friend or family member about the nature and expected path of treatment in an unhurried manner while addressing questions and concerns (Nagy, 2005).

Case 2-7: Therapist created a new program for overweight people to lose weight for which supporting research in the literature was scarce. The written informed consent material clearly described the procedure and the information was explained again at the first consultation. Counselor informed clients of very specific risks potentially associated with this protocol, that no weight loss might occur even with compliance to treatment, and the method was too new to assure long-term results. He reported the availability of many weight loss programs in the area, and in writing and verbally, expressed that participation was voluntary and could be withdrawn at any time; with such termination, he would refer to three other practitioners using different methods. Clients felt well informed about the novel approach given the printed handouts and verbal explanation provided at the outset.
Analysis: Therapist informed his clients about the novel techniques, interventions, strategies and procedures for which supportive research was lacking and not generally accepted by the mental health community. Informed consent regarding novel treatment includes these elements:

- Explain the experimental or evolving nature of the treatment, for example, that you have achieved good outcomes, if true, but the procedure is yet to be scientifically researched.
- Inform clients of possible risks such as the treatment may not be successful, symptoms may increase, or new symptoms or side effects might develop.
- Enlighten clients of available alternative treatments for their issues, regardless of whether you will offer them.
- State that participation is completely voluntary and may be withdrawn at any time (Nagy, 2005).

The APAs Ethical Standard relating to informing clients of new methodology states:
When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation (APA, 2010, 10.01.b.).

Case 2-8: By telephone, Therapist L told a prospective client, who was depressed and anorectic, that individual psychotherapy would rapidly relieve her symptoms and improve her work performance within nine sessions – coinciding with the number of managed care sessions allotted. Therapist L did not mention that: depression is sometimes exacerbated during therapy, treatment may last longer than expected, a managed care request for additional sessions may be needed, there may be a need for psychiatrist assessment for antidepressant medication or a need to coordinate treatment with her referring primary care physician. Therapist used complex terms in describing her theoretical orientation, which client did not comprehend, and she omitted discussion of confidentiality, possible need for

hospitalization, fees or frequency of sessions. When client arrived for the first session, she was disappointed to learn that the fees were $175.00 per session and three sessions per week was recommended. Client ended the encounter, felt betrayed and ashamed, and delayed contacting another therapist for several months.
Analysis: Therapist L did not inform client of the relevant aspects of the proposed treatment or the business arrangements, and she presented the therapy unrealistically through potentially false promises of efficacy and timeframe. Generally, clients should understand what therapist has planned through a) clear description of the proposed treatment, b) explanation of significant aspects of the services, c) a willing consent to services, and d) therapist documents the consent (Nagy, 2000).

Case 2-9: Psychologist M conducted a pre-sentencing psychological evaluation of Mr. A which would assist the court in determining whether to sentence Mr. A to death for conviction of murder of two children. Psychologist M informed Mr. A that the judge asked her to complete an evaluation to acquire information that might affect whether or not he would receive the death penalty. She clarified that in their state, the courts could deem certain psychological problems or histories as either mitigating or aggravating factors which would decease or increase, respectively, the probability of the death penalty. The psychologist illuminated that her job was to provide psychological data to the court which the judge would use to decide and that it was difficult to gage the judge's interpretation of the data. Psychologist M stated that she would not administer projective tests because people may not be aware of how much they are revealing on such tests and she wanted Mr. A to choose the information to disclose in the evaluation. The district attorney, who referred the case to Psychologist M, was so upset that she disclosed such detailed information to Mr. A about the sentencing and evaluation procedures that he filed a complaint with the Ethics Committee.
Adjudication: The Ethics Committee determined that Psychologist M was ethical and actually exemplary in clarifying her role and offering fully informed consent. The Committee explained that informed consent obligations are always important but are intensified when vital and irrevocable consequences for the client's life are involved. Important civil and legal rights are involved when conducting an evaluation for the death penalty, a custody or competency hearing, therefore, therapists should fully inform clients of the practitioner's role and purpose of the evaluation (APA, 1987).

Case 2-10: Psychologist N performed a divorce mediation with a couple, Mr. and Mrs. B, regarding the custody of their child. Psychologist N informed the couple of the goals and methods of mediation such that they would meet for eight sessions to arrive at an agreeable custody arrangement. They did not reach an agreement as conflict mounted, hence, the case was returned to the court for adjudication. Psychologist N then voluntarily issued a psychological evaluation report to the court which recommended Mr. B to be granted custody of the child, partly due to his more acquiescent presentation during mediation, perhaps facilitating allowance of the child to have unobstructed visitation rights. Mrs. B filed a complaint about the report with the Ethics Committee. Psychologist N told the Committee that it was her general practice to submit evaluation reports to the court after failed mediation attempts and that there is nothing wrong with doing so.
Adjudication: The Ethics Committee declared Psychologist N violated informed consent standards by not clarifying her role in the process and not informing the couple of the purpose and nature of their eight sessions. She did not indicate, from the beginning, that her role was as mediator and evaluator, further, she failed to explain to the couple that the mediation evaluation information might be used in the custody adjudication, if needed. The Committee determined that Psychologist N also breached confidentiality by releasing information from the sessions without either a court order or the couple's permission. The Ethics Committee censured the psychologist and ordered her forensic practice under the supervision of a board-certified forensic psychologist, selected by the Committee (APA, 1987).

Case 2-11: The director of a firm referred an ineffective employee of the firm to Psychologist O for evaluation. The firm director and psychologist agreed before the employee's first consultation that the psychologist would tell the director whether the evaluation suggested the employee's job continuation and if remedial training might improve his performance. Employee saw psychologist for several sessions involving interviews and testing, under the impression that all shared information was confidential. Psychologist O never informed employee of the arrangement with the firm. The director fired the employee upon receipt of psychologist's report. The employee deduced the psychologist's involvement and filed charges with the Ethics Committee. Psychologist O told the Committee that he thought the employer would advise employee of the purpose and possible implications of the evaluation, thus, he did not feel a need to raise the issue.
Adjudication: The Ethics Committee found Psychologist O in violation of informed consent standards based on his failure to clarify with client the nature of involvement between the three parties. Practitioner had the ethical responsibility to be explicit with client unrelated to psychologist's understanding of the employer's plans. The Committee censured Psychologist O (APA, 1987).

Case 2-12: A clinical agency hired Psychologist P as a researcher to design an evaluation study comparing the effectiveness of two depression-treatment therapeutic modalities: a behavioral group program and a psychotropic medication program with supportive psychotherapy. The clinic preferred to randomly assign clients to either treatment and psychologist expressed that informed consent is needed

for randomization and participation in the intervention and evaluation process. The clinic director, not an APA member, countered that there was no need for the clinic to inform clients they were participating in a research study. Psychologist P was uncomfortable with this decision and with the thought of endangering her position; she requested guidance from the Ethics Committee.
Opinion: The Ethics Committee instructed Psychologist P of her responsibility to conform with the Ethical Principles and any relevant state or federal regulations. Continued involvement in the study was deemed contingent upon Psychologist P convincing the clinic to abide by informed consent obligations or forcing compliance through filing a complaint with APA or proper state body (APA, 1987).

Case 2-13: A psychologist began therapy with a client at the agreed-upon rate of $70.00 per session. After several weeks of therapy, client called on the morning of a scheduled appointment stating he was in court and would have to miss that session. Client was very angry to see the missed session was charged on his monthly statement and upon questioning the psychologist was told that this is standard practice and that he, being an educated person, would understand this. Client filed a complaint with the Ethics Committee explaining he gave ample notice for the missed session and that no mutual agreement of required payment for cancelled sessions was ever made. The psychologist issued the Committee the same rationale as given to the client.
Adjudication: The Ethics Committee determined that the psychologist violated informed consent requirements by not ensuring all financial arrangements were clear to client before therapy began. The committee reprimanded the psychologist, authorized the missed session charge be cancelled, and required more open communication with her clients in the future (APA, 1987).

Weinrach (1989) suggested that the two most frequent problems for private practitioners involve fees and billing, and late cancellations or no-shows, thus, practitioners will want to be clear regarding payment methods and missed appointments.

Ethically, informed consent is a recurring process rather than a single event and documenting discussion of informed consent throughout the therapy process is advised. As therapy moves forward, goals, concerns, risks, and benefits may evolve to a different level, hence, logic dictates that clients require updated information to facilitate continued sound decisions (Handelsman, 2001).

Glosoff (1998) recommends therapists to expand informed consent information to clients in managed care systems compared to other clients; discussion would include how clients' specific plan will affect length of treatment, types of available treatment, confidentiality limits, development of treatment plans, and how diagnoses are made and used. Practitioners are encouraged to know the requirements of their clients' managed care company, but if this proves impractical, to advise their clients to understand the terms and limits of their coverage.

Obtaining informed consent is research validated to be a worthy endeavor. Studies show that clients want information about their prospective therapists (Braaten, Otto, & Handelsman, 1993; Hendrick, 1988); and they perceive therapists who offer informed consent information to be more professional and trustworthy (Sullivan, Martin, & Handelsman, 1993). Moreover, informed consent forms can help prevent some legal problems if allegations of nondisclosure occur as the client-signed disclosure statement may exonerate a falsely accused therapist.

CONFIDENTIALITY

The confidential bond between mental health professionals and their clients represents an important professional obligation and enduring foundation within the helping profession. Some have argued that therapy might be ineffective without the trust that confidentiality breeds (Epstein, Steingarten, Weinstein, & Nashel, 1977). In referring to the amicus briefs of the American Psychological and Psychiatric Associations, Justice Stevens states, "Effective psychotherapy … depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment" (*Jaffe v. Redmond*, 1996). Cullari (2001) surveyed clients on their most important expectations and demands of therapy and two of the highest ratings were "a feeling of safety and security" and "the chance to talk to someone in a safe environment and without fear of repercussion" (p. 104). Interestingly, research reveals only mixed support for the assumption that confidentiality is required for effective therapy. Some studies support that privacy assurances are necessary (McGuire, Toal, & Blau, 1985; Merluzzi & Brischetto, 1983; Miller & Thelan, 1986), while other findings show such assurances have minimal effect on encouraging disclosures (Muehleman, Pickens, & Robinson, 1985; Shuman & Weiner, 1982; Schmid, Appelbaum, Roth & Lidz, 1983), and that limits to confidentiality affect only some clients in some circumstances (Taube & Elwork, 1990; VandeCreek, Miars, & Herzog, 1987). Even without indisputable evidence, confidentiality is a cornerstone in the mental health field.

The historical origin of the mental health field sheds insight into the norm of confidentiality. Until approximately the dawn of the 19th century, mental illness was perceived as being supernatural, demonic and associated with visions of "lunatics" bound in chains in asylums. Relevant progress in understanding mental illness began in the 1800s and it was not until the 1960s that deinstitutionalization of the mentally ill brought this population back into society. Further, the development of psychoanalysis in the early to middle 1900s

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

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

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

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

Complex computer networks may be used in some settings to manage records of assessment, treatment, billing, and other health care features. Gellman & Frawley (1996) advise that a secure computer system: 1) disallows unauthorized users access to information, 2) maintains ongoing integrity of data by preventing alteration or loss, verifies the source of information to confirm its authenticity, and keeps a record of communication to and from the system, and 3) recovers quickly and effectively from unanticipated disruptions. Koocher and Keith-Spiegel (2008) suggest the following to manage electronic records:

- Use encryption software to protect data transmission; protect stored information with complex passwords, and Internet firewalls.
- Consult on security measures with professionals when storing files with a common server or backing them up on an institutional system or hub.
- Keep removable data storage media in secure places or use complex passwords to encrypt them.
- Do not share passwords with others and frequently change

the passwords.
- Be alert to security concerns when using wireless devices.
- Avoid revealing confidential information in e-mail or instant messaging without encryption.
- Protect the physical security of portable devices such as laptops, smaller computers, personal digital assistants, and smart phones.
- Use privacy screens to shield monitors and other screens from observation by others.
- Update virus protection software and other security systems.
- Remove all information when disposing old computers, which may require professional assistance, because some information may remain after erasing files or reformatting disks.

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

If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers (APA, 2010, 6.02.b.).

Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards (AAMFT, 2015, 2.5).

Social workers documentation should protect clients' privacy to the extent that is possible and appropriate… (NASW, 2008, 3.04.c.).

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them (ACA, 2014, B.6.d.).

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

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

Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant (APA, 2010, 4.02.b.; APA, 2010, 4.02.a. - already cited).

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). (NASW, 2008, 1.07.e. - already cited).

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

Sometimes it is permitted to share client information with others with the goal of promoting client welfare, and client has given consent, these situations include:
- When therapist consults with experts or peers
- When therapist is under supervision
- When other mental health practitioners request information

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

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

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

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

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

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

Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed (NASW, 2008, 1.07.c.).

Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to 1) provide needed professional services; 2) obtain appropriate professional consultations; 3) protect the client/patient, psychologist, or others from harm; or 4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose (APA, 2010, 4.05.b.).

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues (ACA, 2014, B.2.a.).
(AAMFT, 2015, 2.1 - already cited).

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

In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties regarding the confidentiality of information. In the absence of an agreement to the contrary, the couple or family is considered to be the client. (ACA, 2014, B.4.b.).

Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibit by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual (AAMFT, 2015, 2.2).

When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset 1) which of the individuals are clients/patients and 2) the relationship the psychologists will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained (APA, 2010, 10.02.a.).

When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements (NASW, 2008, 1.07.f.).

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

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

Koocher and Keith-Speigel (2008) indicate a particular therapist's statement to clients concerning the issue of disclosure to insurance companies: "If you choose to use your coverage, I shall have to file a form with the company telling them when our appointments were and what services I performed (i.e., psychotherapy, consultation, or evaluation). I will also have to formulate a diagnosis and advise the company of that. The company claims to keep this information confidential, although I have no control over the information once it leaves this office. If you have questions about this, you may wish to check with the company providing the coverage. You may certainly choose to pay for my services out of pocket and avoid the use of insurance altogether, if you wish." Clients lack much control because refusal to authorize release of information results in the insurer's refusal to pay the claim. Some clients feel unaffected by this process whereas others, perhaps in a sensitive work position, may consider not informing a third party of their treatment involvement. Further, some employers use self-insurance programs that may send claim forms or information to that company's headquarters thus alerting management. It may benefit some clients to learn the channels through which their personal information will travel.

> Managed care companies generally ask for much more information than third parties have traditionally requested from clinicians. The ethical explanations given for such requests generally have fallen into two categories. One is based on the known history of some clinicians to distort information on forms… Then managed care companies began to discover that some clinicians charged for sessions not provided or approved. A more general reason applicable to all clinicians is to make sure that the intended treatment meets criteria of medical necessity as designated in the third-party benefits. In addition to treatment plans, managed care companies will often ask for copies of any

notes kept on patients; they sometimes do on-site reviews of charts in hospitals, and on occasion they even talk directly to the patient to try to verify information (Moffic, 1997, p. 97).

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

Case 3-1: In 2007, Blue Cross and Blue Shield of Massachusetts (BCBSMA) declared that it planned to utilize an outcomes measurement program using the Behavioral Health Laboratories Treatment Outcomes Package (BHL TOP) for voluntary usage with all of their subscribers who sought mental health services. Therapists would ask their clients at the outset of treatment to voluntarily complete the form and intermittently thereafter. The forms would be sent electronically to BHL for scoring and data storage and feedback reports would be sent to the therapists and BCBSMA; data security was promised. Therapists were instructed that they would receive increased reimbursement rates given large numbers of their clients completing the form. Some of the form questions included sexual orientation, family income, religion, detailed usage patterns for alcohol, cocaine, crack, PCP, heroin, and other illegal substances, and arrest/incarceration history.
Analysis: Several professional organizations indicated the following ethical concerns with this plan: 1) Therapists would be asking clients to voluntarily relinquish their privacy and would be financially rewarded for obtaining completed forms, 2) Client data would be stored in electronic databases without explanation of its use or affect upon the participants, 3) Though data storage security is mentioned, concerns exist due to recent breaches by private institutions and federal agencies, 4) Client disclosure of such personal information, including admittance to illegal behavior, represented potential risk to clients. The forms would become part of their permanent record and open to discovery in some legal proceedings, and 5) BCBSMA originally did not plan to inform their subscribers of these risks, instead, practitioners were given sample text of a highly self-serving nature. The Massachusetts Psychological Association helped practitioners by suggesting objective text for informing clients about the form highlighting its voluntary nature, that form-completion refusal would not affect their care, practitioners could not control the information after transmittal to BCBSMA, and that financial incentives were presented to practitioners. Amidst professional criticism, BCBSMA made some modifications to their public information, without admitting to any ethical issues or how the information will be used (Koocher & Keith-Spiegel, 2008).

Case 3-2: Client alleged that psychologist sent copies of his case notes to the insurance carrier responsible for reimbursement and that therapist should not have revealed this information. Client reported psychologist to the APA Ethics Committee for violating confidentiality principles. Psychologist explained to Ethics Committee that any client understands that their confidentiality may be breached when using an insurance company for third-party reimbursement due to administrative and professional peer review. Nonetheless, psychologist never informed client of this risk before therapy began, rather, he assumed client "must understand" the protocol.
Adjudication: The Ethics Committee determined that psychologist violated the confidentiality ethical standard by not informing client of the limits of confidentiality prior to treatment. The Committee reprimanded the psychologist and advised him to construct and implement an effective informed consent process for the future (APA, 1987).

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

Case 3-4: Theresa Marie Squillacote and her husband, Kurt Stand, were convicted of espionage. Squillacote had a law degree and worked for the U.S. Department of Defense performing duties requiring security clearance. In 1996, the FBI secured a warrant to conduct secret electronic surveillance of Squillacote's conversations at home and work. Using these monitored conversations coupled with discussions with her psychotherapists, an FBI Behavioral Analysis Program team (BAP) made a report of her personality for use in the investigation. The BAP report stated that she experienced depression, took antidepressant medications, and manifested a "cluster of personality

characteristics often loosely referred to as 'emotional and dramatic.' " The BAP team recommended taking advantage of Squillacote's "emotional vulnerability" by describing the type of individual that she could have a relationship with and, in turn, disclose classified information. Eventually, she did reveal national defense secrets to a government official who pretended to be a foreign agent and employed strategies presented by the BAP team (United States v. Squillacote, 2000). This case, and the next, show the potential intrusion of government security agencies into psychotherapy.

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

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

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

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

Case 3-8: Psychotherapist evaluated an 8 year-old boy at his family's request due to school problems. The evaluation involved a developmental and family history, meeting with both parents, assessing school progress reports, and administering cognitive and personality tests. Therapist observed that client had a mild perceptual learning disability and was not coping well with several family stressors, including his mother's response to paternal infidelity, his father's recent learning that the boy is not his child, and other relevant family secrets. Therapist recommended counseling which the boy had begun. Some weeks later, therapist received a signed release form from the boy's school asking for "any" information available concerning the boy's problem. Therapist sent a letter to the school explaining the cognitive test results and referring only in general terms to "emotional stresses in the family that are being attended to."
Analysis: Therapist correctly responded to the school's need to learn information that could benefit this student, and did so by discriminating between relevant versus irrelevant information for the school's purpose. Despite the school's vague request for "any" information, therapist assessed that some of the family disclosures were not relevant to the school's role (Koocher & Keith-Spiegel, 2008). The Codes of Ethics support "minimal disclosure" as follows:
When consulting with colleagues, … psychologists disclose information only to the extent necessary to achieve the purposes of the consultation (APA, 2010, 4.06).

To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed (ACA, 2014, B.2.e.).
… Information may be shared only to the extent necessary to achieve the purposes of the consultation (AAMFT, 2015, 2.7).
(NASW, 2008, 1.07.c. - previously cited).

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

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

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

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

Case 3-13: Counselor bought twelve new desktop computers for the clinic that she managed and kindly donated the older clinic computers to a local community center. She diligently deleted all the word processing and billing files she could find before sending the older computers.
Analysis: Therapists are recommended to consider confidentiality issues when utilizing modern technology. In the first case, usage of readily available encryption technology for confidential files would have protected the contents. The second case required determining the security and accuracy of recipient's e-mail address and carefully executing such as is advised whenever transmitting confidential material by e-mail, fax, or any electronic means. In the third case, only deleting files on a hard drive will not permanently remove the information, and in some instances, reformatting a drive may not prevent some information from being recovered. Professional computer consultation is advised when disposing computer equipment containing client data. Ethical principles and codes remain the same as technology changes: Therapists are responsible for protecting the privacy of information disclosed to them in confidence. Practitioners may consider using conservative communication methods to protect client welfare if uncertain of new technology. The Ethical Standards relative to transmitting confidential information are clear:
Counselors take precautions to ensure the confidentiality of all information transmitted through the use of any meduim (ACA, 2014, B.3.e.).
Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium (APA, 2010, 6.02.a.).
Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible (NASW, 2008, 1.07.m.).
It is the therapist's or supervisor's responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and

protections offered by the therapist's or supervisor's technology (AAMFT, 2015, 6.3).

Case 3-14: Client filed an ethics complaint against therapist who purportedly "made my problems worse instead of better." He highlighted one specific session that "caused me strong mental anguish and insomnia for several weeks." Client stated that the other twelve sessions were irrelevant and he would only consent to allow therapist to discuss the single "traumatic session."
The Ethics Committee declined to investigate the case without a more complete client authorization because the one-session-only limitation would restrict an adequate therapist response. Client did not accept broader authorization (Koocher & Keith-Spiegel, 2008).

Case 3-15: An unmarried 17 year-old student filed a complaint with the APA Ethics Committee against a psychologist employed by a university counseling service. The psychologist supervised the student's counselor who was a predoctoral intern at the counseling service. Psychologist was an APA member whereas the intern was not. The complainant alleged that the supervising psychologist breached the confidentiality of his client-therapist relationship by alerting the client's parents of his suicide threat. The intern informed his supervising psychologist of client's suicide threat after client refused to seek intern-recommended voluntary hospitalization. Client attempted suicide several years earlier and currently was agitated and depressed. The supervisor required intern to give her the student's name and identifying information so she could notify the parents. Upon notification, the parents arrived at the campus and hospitalized their son. Client filed the confidentiality violation complaint against the psychologist after his brief hospitalization. Psychologist informed the Ethics Committee that she acted in accordance with the Ethical Principles of confidentiality. Based on her intern's information, clear danger or harm to the student was present. Psychologist stated that she notified student's parents to protect his welfare because a) state law allowed immediate relatives to request involuntary hospitalization, b) client rejected voluntary admission, and c) the psychologist and intern did not want to proceed unilaterally.
Adjudication: The Ethics Committee found no substantial evidence for violation of confidentiality. The psychologist encountered a conflict between the principle of confidentiality, protecting client's welfare, and the parents' interest with involvement in treatment decisions for their dependent minor child. The Committee agreed with the reasonable judgment of psychologist that potentially losing the student to suicide justified informing the parents and revealing information about their son's therapy (APA, 1987).

Case 3-16: A social service agency staff member registered a complaint with the APA Ethics Committee that a psychologist on the agency staff often verbalized, at lunch and other informal gatherings, information from his private practice therapy sessions. The complainant advised psychologist several times that this behavior is unprofessional but he responded that it is okay since he never identifies a client's name. One day, complainant realized that psychologist was discussing a client who had worked for the agency and his shared information allowed for easy recognition. After complainant's previous unsuccessful attempts to enlighten psychologist, she filed a formal complaint. Psychologist explained to the Committee that he never revealed a client's name, and informally seeking advice of peers was ethical and beneficial to his clients.
Adjudication: The Ethics Committee found the psychologist guilty of violating the Ethical Principles of confidentiality on these grounds: There is no relevant connection between agency staff members and private practice clients. Discussions about agency clients should not occur in public or semi-public places such as a lunchroom, further, in privacy, only appropriately involved agency staff members should participate. Anonymity is not ensured in the absence of a client's name. A private practitioner who requests a consult with another therapist must secure client's permission for such. Therapists working in a supervised setting or with clients using third-party payment should inform client of confidentiality limits at the outset. The Ethics Committee censured the psychologist, ordered him to cease this behavior, and instructed that another such reported and confirmed violation would yield a harsher Committee response (APA, 1987).

Case 3-17: Several psychologists complained to the APA Ethics Committee about an APA member who appeared on radio and television talk shows with past and present clients, all being known entertainment industry stars. The psychologist encouraged clients to discuss why they sought treatment and their experiences in therapy. The complainants urged that these programs violated the psychologist-client confidentiality principle as it was unprofessional, and disclosed client identity and treatment details. The psychologist responded that her clients suggested these programs. She discussed the risks and benefits of such self-disclosure and all agreed that the advantages to the general public outweighed any risks. Psychologist secured written informed consent agreements, and all clients were willing to authorize statements to explain the course of events.
Adjudication: The Committee determined, based on the available information, that insufficient evidence existed to sustain an ethical violation of confidentiality. Several members concluded the psychologist did not act in good taste but not enough to support an ethical charge (APA, 1987).

Case 3-18: Psychologist O was a tenured faculty member of the psychology department and a counselor at the health services center of a small university. She taught an undergraduate abnormal psychology course and often used hypothetical case studies to demonstrate various syndromes. During a lecture on love and depression, Psychologist O

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

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

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

DUAL RELATIONSHIPS

In researching dual relationships, Gabbard (1994) quoted a well-known psychiatrist on the challenge of maintaining boundaries: "Harry Stack Sullivan … once observed that psychotherapy is a unique profession in that it requires therapists to set aside their own needs in the service of addressing the patient's needs. He further noted that this demand is an extraordinary challenge for most people, and he concluded that few persons are really suited for the psychotherapeutic role. Because the needs of the psychotherapists often get in the way of the therapy, the mental health professions have established guidelines, often referred to as boundaries, that are designed to minimize the opportunity for therapists to use their patients for their own gratification" (p. 283). Likewise, in revealing his difficulty with maintaining a professional role with a certain client, Kovacs (1974) noted:

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

A boundary can be visualized as a frame or membrane surrounding the therapeutic dyad that identifies a set of roles for those involved in the therapy process (Smith & Fitzpatrick, 1995). Katherine (1991) defines a boundary as a "limit that promotes integrity" (p. 3) which also conveys the purpose of boundary setting. Boundaries protect the well-

being of clients who disclose intimate personal information in the therapeutic relationship. Boundary issues involve the theme of dual relationships, also called multiple-role relationships, which occur when the mental health practitioner assumes two or more roles, either concurrently or sequentially, with a help seeker (Herlihy & Corey, 1997). The second role is commonly social, financial or professional, for example, therapist and, friend, employer or professor. The Ethical Standards clearly define a multiple relationship as follows:

A multiple relationship occurs when a psychologist is in a professional role with a person and 1) at the same time is in another role with the same person, 2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or 3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical (APA, 2010, 3.05.a.).

Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.) (NASW, 2008, 1.06.c.).

Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions of multiple roles, therapists document the appropriate precautions taken (AAMFT, 2015, 1.3).

Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. Examples include attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs (ACA, 2014, A.6.b.).

If counselors extend boundaries as described… they must officially document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. When unintentional harm occurs to the client or former client, or to an individual significantly involved with the client, the counselor must show evidence of an attempt to remedy such harm (ACA, 2014, A.6.c.).

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

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

Some inherent concerns with multiple-role relationships include the following: To begin, the dual relationship can deteriorate the professional nature of the therapeutic bond which is based on predictable boundaries. The essential professional nature of the therapeutic relationship is altered and compromised when therapist is also client's employer, friend, or teacher. Second, dual relationships may establish conflicts of interest thus jeopardizing the objectivity and neutrality required for professional judgment. Therapists promote the client's best interests but a second set of interests may encourage therapists to fulfill their own needs. A therapist treating someone who is also offering a service may become critical of the rendered service thus harming the therapy process. Third, multiple-role relationships can negatively affect cognitive processes that are known to facilitate the therapy process and the maintenance of therapy's benefits after termination (Gabbard & Pope, 1989). Fourth, client does not have equal power in a business or secondary association due to the nature of the therapist-client relationship (Pope, 1988). A client who feels mistreated in a financial or social exchange with a therapist faces extraordinary barriers in legal redress because therapist can use client's shared secrets in creating a defense; further, therapist can utilize false diagnostic labels to discredit client – which is a common practice (Pope, 1988). Fifth, if dual relationships became ethically acceptable, therapists could screen clients for later fulfillment of therapists' social, sexual financial, or professional needs which would change the nature of psychotherapy. Likewise, clients would become aware of therapists seeking extracurricular activities and could change their behavior accordingly. Sixth, a therapist's court testimony concerning a dual relationship client, for

example, in personal injury lawsuits, custody hearings, criminal trials, and other legal proceedings would be suspect. Seventh, Pipes (1997) illustrates formal complaints that potentially can ensue:

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

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

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

Borys and Pope (1989) surveyed 1600 psychiatrists, 1600 psychologists, and 1600 social workers (with a 49% return rate) examining an array of beliefs and behaviors pertaining to dual relationships such as therapist gender, profession (psychiatrist, psychologist, social worker), therapist age, experience, marital status, region of residence, client gender, practice setting (i.e., solo, group private practice, outpatient clinics), practice locale (size of community), and therapeutic orientation. Results indicated: 1) There was not a significant difference between the three professions relative to sexual intimacies with clients before or after termination, nonsexual dual professional roles, social involvements, or financial involvements with clients, 2) More therapists rated each dual relationship behavior as "never ethical" or "ethical under only some or rare conditions" than a rating of "ethical under most or all conditions," and 3) Psychiatrists, as a whole, rated such dual relationships as less ethical than psychologists or social workers. In a separate interpretation of this study, Borys (1988, p. 181) utilized a systems theory orientation to investigate the relationship between nonsexual and sexual dual relationships and concluded:

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

> therapeutic relationship, just as those in the family, serve a protective function that serves to prevent exploitation (p. 182).

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

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

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

COMMON BOUNDARY ISSUES

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

Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship (NASW, 2008, 1.13.b.).

Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract (ACA, 2014, A.10.e.).

Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: a) the supervisee or client requests it, b) the relationship is not exploitative, c) the professional relationship is not distorted, and d) a clear written contract is established (AAMFT, 2015, 7.5).

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if 1) it is not clinically contraindicated, and 2) the resulting arrangement is not exploitative (APA, 2010, 6.05).

Establishing a friendship with client produces a conflict of interest that impairs the required objectivity for professional judgment (Pope & Vasquez, 1998). The friendship dual relationship forms a new set of interests beyond those of client, namely those of the therapist. Therapist, for example, may hesitate to raise a certain issue with client who is also a friend due to concern of endangering the friendship. Two

factors that affect therapists' decision to socialize with clients are the clinician's theoretical orientation and the nature of the social function. Borys (1988) suggested that psychodynamic practitioners might refrain from social interactions with clients due to the importance of "maintaining the frame of counseling" and consideration of transference and countertransference issues; relationship-oriented counselors and systems theorists might be more amenable to broader client interaction. Results from Borys' study revealed that only 33% of respondents thought it was never or only rarely ethical to attend a client's special occasion while 92% rejected the idea of inviting client to a personal party.

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

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

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

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

Physical contact with clients such as touching or hugging can be therapeutic but such behavior can be misunderstood as a sexual advance or violation of client's personal space. Smith and Fitzpatrick (1995) observe that physical contact was prohibited when "talk therapy" was initiated in the Freudian era because it presumably negatively affected transference and countertransference. In the 1960s and 1970s, in the human potential movement, touching was accepted practice. Holroyd & Brodsky (1977) determined that 30% of humanistic practitioners, compared to 6% of psychodynamic therapists viewed touching as potentially helpful to clients. Pope, Tabachnick, and Keith-Spiegel (1987b) examined mental health practitioners' beliefs on three types of physical contact and found that 85% viewed kissing a client as "never" or "only rarely ethical," 44% disapproved of hugging, and 94% believed handshakes are ethical. Generally, at present, therapists are trained to be cautious regarding physical contact, for instance, they are recommended to hug a client only upon client-request or after attaining client's permission. Professional liability insurance

carriers have shown concern that clients may bring suit against their practitioners for even well-intentioned physical contact. Some malpractice insurance applications ask, "Do you ever touch a client beyond a routine handshake?" A response of "yes" requires an explanation and such therapists are at risk of being classified as a risky applicant and their insurance application being rejected. Therapeutic touch, in the final analysis, is a function of professional judgment. Therapists are advised to be aware of their motivations in touching a client and to ensure that touching serves client's and not therapist's needs.

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

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

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

SEXUAL DUAL RELATIONSHIPS

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

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

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

Approximately 90% of clients who experienced sexual intimacies with their therapist are damaged by the relationship, based on their succeeding therapists (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Clients are likely to suffer with reactions similar to victims of rape, spouse battering, incest and posttraumatic stress disorder. Feelings of guilt, rage, isolation, confusion, and impaired ability to trust often ensue along with symptoms of posttraumatic stress disorder, including attention and

concentration issues, reexperiencing of overwhelming emotional reactions upon sexual involvement with a partner, nightmares and flashbacks. Such harm is currently well-recognized, in turn, there are no credible opinions in the profession defending therapist-client sexual relationships.

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

Psychologists do not engage in sexual intimacies with current therapy clients/patients (APA, 2010, 10.05).

Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy (APA, 2010, 10.08.a.).

Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including 1) the amount of time that has passed since therapy terminated; 2) the nature, duration, and intensity of the therapy; 3) the circumstances of termination; 4) the client's /patient's personal history; 5) the client's/patient's current mental status; 6) the likelihood of adverse impact on the client/patient; and 7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient (APA, 2010, 10.08.b.).

Sexual and/or romantic counselor-client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in-person and electronic interactions or relationships (ACA, 2014, A.5.a.).

Sexual and/or romantic counselor-client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship (ACA, 2014, A.5.c.).

Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced (NASW, 2008, 1.09.a.).

Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers – not their clients – who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally (NASW, 2008, 1.09.c.).

Sexual intimacy with current clients or with known members of the client's family system is prohibited (AAMFT, 2015, 1.4).

Sexual intimacy with former clients or with known members of the client's family system is prohibited (AAMFT, 2015, 1.5).

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

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

From 1983 to 1992, thirteen states instituted legislation that made it a crime for mental health professionals to have sexual relationships with their clients – punishable by jail-time. Kane (1995) listed these states, at the time of the review, as follows: California, Colorado, Connecticut, Florida, Georgia, Iowa, Maine, Michigan, Minnesota, New Mexico, North Dakota, South Dakota, and Wisconsin. The following professionals are included in some of the laws: psychotherapists, counselors, marriage and family counselors, clergy, social workers, psychiatrists, and psychologists. Some of these statutes are unusually strict, for example, the Colorado statute allows prosecutors to file injunctions to prevent mental health professionals from practicing before a guilty verdict has been reached, if the professional is considered a risk to clients. Roberts-Henry (1995) reported that the law essentially states, "any psychotherapist who perpetrates sexual penetration or intrusion on a client commits a felony" (p. 340). The law prohibits accused mental health professionals from using client consent as a defense. Though the rate of therapist-client sexual exploitation has decreased every decade (Pope, 2001), the issue continues, even in the states that legislated such misconduct a criminal offense.

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

Welfel (2006) determined that between 22% and 65% of mental health professionals will encounter clients reporting sexual exploitation by a previous counselor; other research suggests approximately 50% will encounter such clients, with only a small percentage of false allegations (Pope, 1994; Pope & Vetter, 1991). Though therapist's initial reaction might be to take action against the wrongdoer, it is recommended to be respectful of the client's wishes in the situation. Clients who pursue the matter will proceed

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

CASE STUDIES

Case 4-1: A renowned and outspoken therapist had a tendency of verbal attacks against anyone who criticized her theoretical foundation of the therapy orientation that she initiated in the 1970s as being outdated. Therapist maintained a successful private practice in her fashionable condominium and her clients were the focus of her life – she was a widow. Therapist hosted social events in her home for her clients and accompanied clients on vacations. Colleagues were concerned that therapist created a cult of high-paying, ongoing clients who also provided her adoration, loyalty, and "family."
Analysis: Professional or personal isolation can impair practitioners' judgments, facilitate exploitation of clients, and lower standards of care. Many boundary blurring cases occur among clinicians in solo practice, frequently in isolated offices away from other mental health professionals. Lacking people to confer with regarding therapeutic predicaments tends to increase the probability of unethical decisions. Therapists can acquire collegial involvement through peer supervision groups, consultation, participation in professional associations and numerous other ways (Koocher and Keith-Spiegel, 2008).

Case 4-2: Client worked as a records clerk for a community mental health center and Therapist A supervised her work. Client experienced some personal problems for which she asked therapist to treat – he agreed. Client ultimately filed an ethics complaint against Therapist A charging that he blocked her promotion based on evaluations of her as a client rather than as an employee.
Analysis: It is difficult to determine exact cause and effect in this situation but client can now interpret the cause of any work-related negative outcomes as related to the therapy. Dual relationships with client/employee can become problematic in many ways and can produce career and economic hardships for client. Therapist A violated ethical standards due to clear and foreseeable risk of harm to client (Koocher and Keith-Spiegel, 2008).

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

therapist could have recommended an Internet site with a far reach and little cost (Koocher and Keith-Spiegel, 2008).

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

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

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

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

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

Case 4-7: A wealthy client gave his recently licensed therapist a new car for Christmas and a card indicating, "To the only man who ever helped me." Therapist came to believe that the gift was warranted because client expressed having many past unproductive therapists. Over time, client found fault with the therapy and ultimately sued therapist for manipulating him into buying an expensive gift.
Analysis: This case demonstrates therapeutic inexperience as gifts and favors beyond small one-time or proper for special occasion tokens should not be accepted. Clients, who are commonly in vulnerable situations, can declare exploitation at a later date and the charge may be justified regardless of therapist's rationalizations. Being self-serving can lead practitioners into trouble whereas maintaining a strong professional identity relative to accepting gifts and favors can avoid concerns. Unrelated to small gifts bestowing genuine appreciation, gifts have the power to control, manipulate, and symbolize more than what meets the eye. Some clients may attempt to equalize power in the therapeutic relationship by offering a gift (Knox, Hess, Williams, & Hill, 2003) (Koocher and Keith-Spiegel, 2008).

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

enough emotional intensity to have justified more caution than therapist eventually displayed (Koocher and Keith-Spiegel, 2008).

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

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

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

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

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

Case 4-10: A high-profile case, extensively covered by the media, involved a psychiatrist who was found innocent of sexual relations with the sexually-assertive side of his multiple personality client. The jury exonerated therapist despite DNA evidence of his semen on client's underwear. The defense attorney argued that client transferred therapist's semen to her own panties after stealing underwear from the psychiatrist's trash bin. Later DNA tests administered by CBS's television program "48 Hours" concluded that the patterning and large amount of semen on client's panties could not have resulted from such a transfer (CBS News, 2002).

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

diagnosis suggesting vulnerability such as currently depressed, previously abused, or various personality disorders could convince an ethics committee of therapist bad judgment sufficient to uphold an ethics charge.

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TEST - ETHICS: CASE STUDIES

5 Continuing Education hours
Record your answers on the Answer Sheet (click the "NCC Answer Sheet" link on Home Page and click your answers).
Passing is 70% or better.
For True/False questions: A = True and B = False.

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TRUE/FALSE

1. **Competent professionals uphold two essential ethical principles: beneficence and nonmaleficence.**
   A) True B) False

2. **Ethically, informed consent is a recurring process rather than a single event.**
   A) True B) False

3. **Uniform agreement within the mental health field on the definition of competence is not lacking.**
   A) True B) False

4. **Studies show that clients perceive therapists who offer informed consent information to be more professional and trustworthy.**
   A) True B) False

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

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

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

8. **The decision to terminate therapy is not based on the best interest of the client.**
   A) True B) False

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

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

11. **The Codes of Ethics of the professional mental health organizations serve to educate members about _____.**
    A) sound ethical conduct
    B) professional accountability
    C) improved practice through mandatory and aspirational ethics
    D) all of the above

12. **Therapist impairment _____.**
    A) is a deterioration of professional abilities from a previous competent level
    B) occurs when therapists' personal problems overflow into their professional activity
    C) decreases therapeutic effectiveness
    D) all of the above

13. **_____ provides relevant information to clients regarding expectations of therapy before onset of assessment or treatment.**
    A) Informed consent
    B) Empiricism
    C) Naturalistic observation
    D) Deductive reasoning

14. **The requirement for health professionals to receive informed consent from their clientele prior to rendering services started in the field of _____.**
    A) dentistry
    B) medicine
    C) communication
    D) linguistics

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

16. **Studies demonstrate that informed consent procedures increase likelihood that clients will _____.**
    A) become less anxious
    B) follow the treatment plan
    C) recover more quickly
    D) all of the above

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

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

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

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

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