

ETHICS: APPLIED PRINCIPLES

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3 CONTINUING EDUCATION CONTACT HOURS

Thinking positively about ethics by aspiring to the highest professional standards should always guide our actions (Koocher & Keith-Spiegel, 2016).

Course Objective

The purpose of this course is to provide an understanding of fundamental ethical standards and principles applicable to mental health professionals. Various Codes of Ethics standards and principles are presented along with representative ethics case scenarios fostering analysis and resolution strategies for ethical dilemmas. Major topics include: ethical practice, core principles within the ethics codes, ethics standards on competence, the therapeutic contract, informed consent, conflicting values in therapy, the extremely difficult client, avoiding burnout, terminating clients ethically, and New York State laws, rules, regulations, and ethical principles.

Accreditation

Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387; Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-008; Licensed Marriage and Family Therapists #MFT-0043; and Psychology as an approved provider of continuing education for Licensed Psychologists #PSY-0006.

Mission Statement

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

Learning Objectives

Upon completion, the participant will be able to:

1. Acknowledge the ethics aspirational principles which encourage striving for excellence.
2. Understand and apply the Code of Ethics to various ethical dilemmas.
3. Discern whether to give or withhold advice in therapeutic practice.
4. Indicate the essential themes to be included in a therapeutic contract.
5. Convey the consent-getting process with clients generally communicates goals, expectations, procedures, potential risks, and limits of confidentiality.
6. Accept therapists avoid imposing their personal values on clients.
7. Consider the sensitivities involved in working with extremely difficult clients.
8. Recognize professional development and self-care can lower the chance of job-related burnout arising.
9. Affirm ethics standards require termination of therapy when it becomes reasonably clear that treatment is not beneficial or is being harmful.
10. Comprehend the New York State laws, rules, regulations, and ethical principles.

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ETHICAL PRACTICE

The need for competent and ethical mental health professionals is unmistakable as approximately 25% of adults have a mental illness, and almost 50% of adults will experience at least one mental condition during their life, with anxiety and mood disorders representing the most common diagnoses. Roughly 20% of children and adolescents have a mental disorder in any given year, with mood disorders and attention deficit/hyperactivity being the most common diagnoses (Koocher & Keith-Spiegel, 2016).

Honoring the ethical principles is essential in the practice of therapy but ambiguous and problematic situations can arise leading to unclear recommended response. Managing difficult situations before they escalate is the preferred action. Awareness of the core principles within the ethics codes may result in improved professional practice and decision making and these core principles are listed below:

Do no harm (termed nonmaleficence or nonmaleficence) - Mental health practitioners attempt to benefit clientele while minimizing or preventing any potential for damage. Though we may not have the ability to help every client, we must uphold the duty to inflict no harm.

Respect autonomy - People have the right to live their lives as they wish provided that their actions do not obstruct the rights and welfare of others. Therapists respect the concept of autonomy because a latent goal of psychotherapy is to enhance clients' self-reliance and self-determination.

Act justly - Mental health professionals are fair and impartial; they treat others as they would want to be treated themselves.

Act faithfully - A fiduciary relationship is sustained replete with fidelity, loyalty, truthfulness, and promise keeping. Practitioners allow clients to feel safe and unaffected as possible by unimportant and extraneous factors.

Accord dignity - Our clientele are worthy of respect. We are open to cultural diversity and how others differ from ourselves. We strive to avoid biases affecting quality of service.

Act benevolently (beneficence) - Clients are treated with care and compassion within an atmosphere of appropriate professional roles and boundaries.

Pursue excellence - Mental health professionals maintain competence, perform their best, and take pride in their work.

Act accountably - If an error has been made, practitioners determine possible consequences, take self-responsibility for their actions or inactions, refrain from making excuses or shifting blame, and take action to minimize or undo harms and wrongs.

Act courageously - We are determined to courageously uphold ethical principles, and with true grit, to do the right thing.

Practitioners who believe that they have mastered everything about their specialized field may encounter risks

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

Knapp et al. (2024) assert that consultants can assist psychotherapists to identify cognitive biases such as confirmation bias (maintaining original impressions and minimizing or ignoring new information that negates the initial impression) or sunk cost (persisting in action that one has invested in despite evidence suggesting the behavior is not obtaining the goal; Rogerson et al., 2011). A common problematic bias for psychotherapists is the overestimation effect (the Dunning-Kruger effect) which is a type of professional narcissism (Younggren, 2007, p. 515) whereby professionals significantly overestimate their skill level. Mental health professionals exhibiting this bias risk harming clients because they lack acknowledgement of their competence limitations.

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

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

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

ETHICS: APPLIED PRINCIPLES

She accepted the referral and assessed the client with the techniques from her graduate school training (Koocher & Keith-Spiegel, 2016).

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

In situations where no formal standards abound for specific types of practice or techniques, practitioners are well-served to exercise caution and be conservative in determining whether they need additional training or education before accepting the client. One source of guidance is asking colleagues who are experts in the specialty about current practice standards and adequacy of training. Additionally, therapists may have to seek other sources of information and guidance when the standards do not offer sufficient direction such as learned texts, position articles, recommendations by other professional or scientific organizations, within consultation, or their personal conscience (Knapp et al., 2024).

In detecting competence versus incompetence in doctoral psychology students, Koocher and Keith-Spiegel (2016) describe a study in which faculty and field supervisors noted the dominant characteristics of "outstanding" and "incompetent" trainees. "High intelligence" was the most frequently reported quality for outstanding students while "lack of knowledge" was the most often indicated characteristic for incompetent trainees. Supervisors then evaluated the students one year later and their most common 28 evaluative terms were filtered down to the following four conceptualizations of competence: professional responsibility, interpersonal warmth, intelligence, and experience. An effective method to avoid unskilled or risky graduates is thorough education and training along with relevant monitoring and supervision.

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

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

monitoring our awareness of personal limitations, acknowledging that our limitations can increase with the passage of time after the conclusion of formal training, and pursuing effective formal and informal remedies designed to keep abilities current.

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

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

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

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

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

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

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

ETHICS: APPLIED PRINCIPLES

therapist competency and client need is significant, then therapeutic harm may outweigh benefit and therapist should not provide treatment.

The giving or withholding of advice in therapeutic practice is a common occurrence and thereby warrants ethical examination. Prass et al. (2021) defines advice as "suggestions or recommendations about what to do, think, or feel in response to a problem or need" which excludes assigning homework or providing information. Clinicians may feel pressure to offer advice whether client requests such or not. Practitioners often utilize their preferred theoretical orientation to guide decision-making on advice. Psychodynamic therapists are generally more hesitant to offer advice to clients (Dickerman & Auchincloss, 2016) while cognitive-behavioral therapists may be more comfortable providing advice and solutions (Beck, 2021). Prass et al. (2024) recommends advice-giving needs to involve deep self-reflection instead of reflexivity along with a thoughtful decision-making process whether to opt in or out of advice-giving.

The aspirational principles and required ethical standards of the mental health professions promote being beneficial to clients and doing no harm. Relative to advice, these directives can be upheld by the therapist asking, "What are the impacts to the therapeutic relationship if I give or withhold advice?" (Prass et al., 2024). Likewise, practitioners are advised to respect people's rights and dignity which can be included in the decision to give or withhold advice by the therapist assessing the power dynamics extant in the therapeutic relationship and how advice might affect the autonomy, positively or negatively, of the client. Therapist can also empower client to decide if advice helps them, and process client's reactions to the advice.

Ethics standards pertaining to personal problems indicate practitioners should avoid therapeutic activities in which their personal problems will negatively impact competence. With respect to advice-giving, Prass et al. (2024) encourage clinicians to contemplate how the advice they are giving or withholding relates to their own life experiences. When client's issue mirrors therapist's issue the tendency for therapist to use the "N = 1 model" (using self when giving advice) arises. This method may obscure the difference between theoretical and evidence-based advice versus one's own personal problems and conflicts (Aponte, 2021). Consultation is recommended when clinician is aware that a personal problem or conflict may negatively affect therapy (Prass et al., 2024).

The ethics standard of informed consent necessitates practitioners to obtain the informed consent of therapy clients in language that is reasonably understandable. Prass et al. (2024) recommend providing informed consent involving advice-giving and the therapist's level of comfort toward this technique. Clients may express their advice preferences and if they want therapist directives and suggestions. Clinicians are encouraged to state that provided advice is not mandatory to follow and clients possess autonomy to decide for

themselves (e.g., Value: Dignity and Worth of the Person, in the National Association of Social Worker's Ethical Principles (NASW, 2021); Principle E: Respect for People's Rights and Dignity, in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2017)). Advice comfort and expectations may deviate over time (which reflects how informed consent can be an ongoing process), therefore, revisiting the discussion during the initial informed consent process may be beneficial.

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

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

The ethics standards on competence include the following:

Social workers should accept responsibility or employment only on the basis of existing competence or the intentions to acquire the necessary competence (NASW, 2021, 4.01.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, 2017, 2.01.a.).

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience (ACA, 2014, C.2.a.).

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

PSYCHOTHERAPIST ETHICAL OBLIGATIONS

THE THERAPEUTIC CONTRACT

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

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

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

- I. Therapists specify treatment goals by explaining:
 - a. Who the client is (i.e., an individual, family member, a group)
 - b. The goal(s) being pursued
 - c. How the therapy process will proceed
 - d. How will we work together
 - e. Scheduling of sessions (how often, for how long)
 - f. How can client contact therapist between sessions, if needed
 - g. Can therapist relate to client through social media
 - h. The client's rights and responsibilities
 - i. The therapist's rights and responsibilities
 - j. How does client's legal status affect therapy (i.e., a minor, mandated treatment)
- II. Therapist and client therapy expectations:
 - a. The therapy process
 - b. Treatment risks
 - c. Fees, payment methods, services covered by insurance
 - d. Treatment techniques
 - e. Availability of therapist and ways to communicate (i.e., telephone, Internet, emergencies)
 - f. Confidentiality limits
 - g. What professional records are kept
 - h. What state or federal laws dictate client access to records
 - i. What are therapist's personal policies within the lawfully mandated options
 - j. How does the process work with minors or incompetent clients

INFORMED CONSENT

The consent-getting process with clients generally communicates goals, expectations, procedures, potential risks, and limits of confidentiality. Additionally, clients may reasonably expect cautions and warnings about foreseeable and unforeseen treatment results (with the understanding that therapists cannot predict all possible outcomes). By

example, clients presenting with marital issues may alter their attitudes, decisions, or behavior thus significantly changing the relationship dynamics, for better or worse. Clients with job-related concerns may opt to change employment. In such cases, when clients present with poorly addressed issues laden with pent-up emotions that might produce distressed feelings, therapists may choose to caution client of potential life changes stemming from the therapy.

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

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

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

The standards mandate giving clients information on informed consent to psychotherapy but many practitioners provide more than minimum informed consent information (which reflects aspirational ethics) because this will benefit clients and honor client autonomy (Knapp et al., 2024).

Gerke et al. (2024) found that explaining to clients how psychotherapy works during an optimized informed consent (OIC) consultation strengthened treatment expectations, motivation, and decision making in a nonharmful manner. The structure of the optimized informed consent consultation included addressing: a) terms and conditions of psychotherapy, techniques, and therapeutic objectives; b) efficacy, benefits, and mechanisms of action; c) risks, side effects, and respective coping strategies; and d) individualized decision-making.

In actual clinical practice, information concerning expected benefits, common factors, or risks of psychotherapy is frequently omitted due to time constraints while organizational factors may be over-represented (Gerke, Meyrose, et al., 2022). As a consequence, clients may not secure realistic treatment expectations resulting in weakened

ETHICS: APPLIED PRINCIPLES

therapeutic alliance (Zilcha-Mano & Fisher, 2022) and poorer therapy outcome (Constantino et al., 2018). Legally, clients' mere signature might be deemed appropriate informed consent, but diminishing informed consent to simply a legal obligation undervalues its ethical and clinical worth (Trachsel & Grosse Holtforth, 2019).

A comprehensive informed consent may enhance important therapy-related outcomes in the following ways. First, pertinent information about expected benefits and risks may foster realistically positive therapy expectations (Constantino et al., 2018). Second, informing clients of treatment alternatives and client rights may yield higher treatment motivation (Blease et al., 2018; Trachsel & Grosse Holtforth, 2019). Third, conveying transparent information may increase treatment credibility, thus improving treatment adherence and alliance (Blease et al., 2022). Fourth, individualizing therapy information and addressing advantages and disadvantages can facilitate consent and lower decision conflict (Stacey et al., 2017). Finally, disclosure about potential risks might help therapist and client identify and communicate adverse events, and establish coping strategies (Michnevich et al., 2022).

The informed consent codes of ethics indicate the following:

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship. (ACA, 2014, A.2.a.). 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 third-party 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, 2021, 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 on 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 except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code (APA, 2017, 3.10.a.).

CONFLICTING VALUES IN THERAPY

Therapists avoid imposing their personal values on clients, especially in situations in which the goals and values of

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

The following case exemplifies this theme:

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

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

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

THE EXTREMELY DIFFICULT CLIENT

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

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

The following 7 cases illustrate the sensitivities involved in working with extremely difficult clients (Koocher & Keith-Spiegel, 2016).

Case 1: Therapist K strongly disliked sessions with his demanding, insulting, and flamboyant client. He tensed with dread as the session approached and felt relieved at session's end. During the ninth session, client continued with the usual critical and negative comments directed at therapist, and

ETHICS: APPLIED PRINCIPLES

exhorted, "I think you need to go back to school to learn more about psychotherapy," to which therapist responded, "I think you need to go to hell. Get out of my office!"

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

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

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

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

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

Case 3: Client was an angry 15-year-old referred to Therapist M for displaying antisocial behavior, including school vandalism. After the fourth session ended and

therapist was seeing the next client, therapist smelled smoke, discovered that a fire was set in the waiting room, and he put out the fire. Therapist later called client and his parents to arrange a meeting at which time client admitted setting the fire. When therapist stated he could have been killed, client responded, "Everybody's got to go some time."

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

Marriage and family therapists respectfully assist persons in obtaining appropriate therapeutic services if the therapist is unable or unwilling to provide professional help (AAMFT, 2015, 1.10).

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, 2017, 10.10.b.).

Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary (ACA, 2014, A.11.c.).

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, 2021, 1.17.b.).

Case 4: Client contacted Therapist N to overcome shyness and difficulty in forming new relationships. Sessions routinely had long periods of silence, except for superficial pleasantries, despite therapist's attempts to facilitate meaningful disclosure. Therapist initiated several different methods to open discussion, including asking client to write her relevant thoughts between sessions, but client continued her reticence. After the fourth session, Therapist N suggested that she should help client find another therapist with whom client felt more comfortable to communicate with, or they should discontinue therapy until client had some concerns needing address.

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

Another difficult client type is the individual whose attitudes, behavior or issues interact with the psychological distress of the therapist creating countertransference.

ETHICS: APPLIED PRINCIPLES

Case 5: Client requested assistance from Therapist O regarding difficulty in controlling her rage toward her ex-husband following a recent divorce. Therapist was also recently divorced but he did not mention this fact. While listening to client's resentful, retaliatory, and vengeful attacks on her ex-spouse, Therapist O felt extremely tense and began continually biting his lip until it bled. Within several minutes, client screamed and ran out of the office. Client wrote to an ethics committee expressing that therapist was a vampire. The ethics committee sensed client was very disturbed but still contacted therapist asking for his analysis of client's perception.

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

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

A very difficult type of client a therapist may encounter is one who has a challenging issue coupled with presenting issues that associate with personal concerns of the therapist. Case 6: A 15-year-old male saw Therapist P to treat feelings of inadequacy and embarrassment regarding his lack of athletic ability and late pubertal development. A good therapeutic bond has developed and client is productively working on his presenting issues. As client has become more comfortable in therapy, he is exhibiting a growing amount of racial and ethnic prejudice. He classifies several classmates as "Jew bastards" and the "N-word." Client is unaware that his "White" therapist is Jewish and married to an African-American.

This case demonstrates a clash of client and therapist values. The question arises whether therapist should self-disclose with the attempted aim of inducing an attitude change in client's bigotry. Note that client did not pursue therapy to work on race relations. Koocher and Keith-Spiegel (2016) recommend therapists, in such scenarios, to retain clear personal boundaries and continue the focus of treatment upon the issues presented by client. An exception would exist if client realized his prejudices impose on the

therapist, then it would be appropriate to discuss the matter in similar fashion to discussion about any therapeutic aspect. Therapist self-disclosure or therapist broaching the topic, however, would represent an inappropriate imposition on client's current treatment because client, at this time, does not perceive his biases as issues. Enlightening client of his discrimination could add emotional stress to client while overlooking his presenting issues.

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

Case 7: Several weeks before a state parole board appearance to request an early release, client telephoned Therapist Q from prison stating he was in the 8th year of a 20-year criminal sentence for child rape and ritualized sexual abuse of children and was eligible to apply for an early prison release. He indicated his appearance would be helped by having a psychotherapist to work with after release. Client mentioned he was innocent of all wrongdoing, despite his conviction, but he was "framed" and "railroaded" by the parents of several "oversexed kids" along with a legal system biased against his satanic religious beliefs. He admitted that he truly did not need therapy but simply wanted to show the authorities he knew "how to play their game." After Therapist Q declined to accept this person as a client, the inmate filed an ethics complaint, claiming Therapist Q unfairly discriminated against him by refusing to accept him as a future client or providing a referral to another therapist.

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

AVOIDING BURNOUT

Burnout is a type of emotional exhaustion caused by excessive demands on energy, strength, and personal

ETHICS: APPLIED PRINCIPLES

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

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

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

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

Therapist F worked as a school psychologist in a large urban public school system. She sensed being overworked and unappreciated by her clients and administrators, who frequently demanded unreasonable requests of her time. Therapist F was not able to set limits on her work schedule and the situation worsened until she dreaded going to work on a daily basis. She resigned her position after attempts to

secure a different job materialized but she gave less-than-adequate notice of departure and left behind several incomplete student evaluations.

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

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

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

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

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

Simionato et al. (2019) propose a 5-factor model designed to prevent burnout by utilizing mutual support at every level of the psychotherapy community. Their process, entitled the "5-P network model," employs the communitarian notion of ethics which stresses the importance of community in creating ethical psychotherapy. The 5-P network model is based on the following themes:

a) Promotion of person-centered workplaces that promote well-being and ethical practice - Person-centered

- workplaces identify, for example, the most favorable number of client sessions, frequency/nature of supervision, and effective professional development opportunities that may affect burnout differently than economically based models.
- b) Prioritization of peer and collegial networks - This involves staff well-being programs that engage in non-work-related activities, including on-site mindfulness and self-compassion classes (King, 2019), positive reflective practice in the workplace (Clauss et al. 2018), nature-based interventions (Bloomfield, 2017), and entry into gym facilities or fitness classes (Hunter & Brandner, 2019).
 - c) Prioritization of professional advocacy in relation to well-being in the workplace - Professional organizations provide structure and processes when practitioners are at risk of compromised personal well-being and client care. For example, Principle A in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017; Beneficence and Nonmaleficence) states psychologists should "strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (p.3). The ethics code for social workers indicates, "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, 2021, 4.05.b.). The ethics code for counselors states, "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 (ACA, 2014,C.2.g.). The Marriage and Family Therapist ethics code specifies, "Marriage and family therapists seek appropriate professional assistance for issues that may impair work performance or clinical judgment" (AAMFT, 2015, 3.3).
 - d) Prevention of burnout through responsive training - Additional education and training in self-care can assist psychotherapists in managing the demands of the profession (Posluns & Gall, 2019).
 - e) Personalization of burnout prevention through professional development and self-care - A personal self-care approach combined with a preventative mindset can lower the chance of burnout arising (Simionato et al., 2019).
Additionally, the ability to embrace stress is enhanced by developing uncertainty and ambiguity tolerance (Iannello et al., 2017), therefore, utilizing strategies that reinforce this capacity in psychoeducational training is recommended.

TERMINATING CLIENTS ETHICALLY

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

Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship (AAMFT, 2015, 1.9).

Social workers should 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, 2021, 1.17.a.).

Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service (APA, 2017, 10.10.a.).

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, 2017, 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 (ACA, 2014, A.11.c.).

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

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

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

Case 8: Client has been arguing with his wife about in-laws matters and resolves to see a therapist. Client sees Therapist T for 6 sessions and gains insights and problem-solving methods leading to decreased spousal conflict and an expressed desire to terminate what has been successful therapy. Therapist agrees that progress has occurred but reminds client of several stressors in his past that have "not been fully worked through," thus suggesting gloomily that problems may resurface.

Client feels therapy has been effective but Therapist T's assessment creates anxiety and doubt. Client may begin to question if improvement really occurred, if he will regress, or if his marriage will fail. It appears that therapist is abusing the power differential of his position (an expert) to hint that more therapy is required, which contradicts client's

ETHICS: APPLIED PRINCIPLES

preference. Therapist raises client's anxiety and insecurity level through vagary in an unethical way rather than specifying therapist's perception of unfinished business and outlining a new treatment plan.

Case 9: Client has been treated by Therapist U for almost 5 years. The initial presenting issue was client's unhappiness with the hostile-dependent relationship forged with her intrusive mother. Client resolved this issue a long time ago, was living independently, had a job, and was generally coping with life, though she remained emotionally needy and lonely. Therapy sessions currently centered on her activities and offering praise for Therapist U's help. Not much has changed in client's social or emotional status for approximately 2 years.

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

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

Case 10: Client had been treated by Therapist V intermittently for 3 years regarding many on-going neurotic issues and an ambivalent attitude. Client began to mildly question therapist if therapy was helping; he admitted to wanting to work on his concerns but had mixed feelings about the issues. Client wondered aloud to therapist that maybe someone else could be more helpful. Therapist interpreted this sentiment as avoidance of dealing with issues but suggested that client get a second opinion and provided several competent practitioners in the community. Client saw the clinician for two sessions and both client and clinician agreed that client should continue working with Therapist V, who knew client well and could focus the work better than a new therapist.

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

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

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

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

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

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

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

Perhaps Therapist I is greedy or simply unaware of his deficiency for the present task, nonetheless, he inexcusably ignored the data. An alternative plan of action was required, instead, he chose to continue offering assistance which he knew to be ineffective. In a general therapeutic sense, Therapist I failed to reassess treatment plans given ongoing client issues and did not re-evaluate the intervention, each being unacceptable.

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

ETHICS: APPLIED PRINCIPLES

1. At the beginning of therapy, whether formally or informally, ensure client understands the terms of the treatment contract, including mutual discussion about treatment goals and how these goals will be attained.
2. Therapists should seek an objective view of their feelings toward each client and how these feelings could impair therapy.
3. Update treatment plans as situations change and enlist client participation in this change process.
4. Factor in the unique qualities of each client when devising the treatment plans, including diversity concerns such as race and social class that are meaningful to client.
5. Therapists should maintain awareness of their personal beliefs, values, and attributes that may limit their therapeutic efficacy and limit their practice accordingly.
6. In some cases, clients have legal rights to receive or refuse treatment. Therapists should be cognizant of these rights and honor the underlying principles, even though specific laws are not in force.
7. If you lack competence to work with a given client, or have discomfort, biases, or concerns that could interfere with care, respectfully and professionally refer client elsewhere because therapists are not obligated to work with all potential clients.
8. Do not continue therapy as usual if the client is threatening, provocative, or is not benefitting, instead, seek consultation or determine different courses of action without delay.

Ethics standards represent the minimum requirements that must be upheld to practice ethically whereas aspirational ethics represents a higher level of ethical behavior that transcends the minimum standards and thus encourages practitioners to strive for excellence and moral virtue. Ethics standards reflect the "bare minimum" whereas aspirational ethics refer to the pursuit of "ideal" behavior. Aspirational ethics promotes moral responsibility and a client-centered decision-making perspective.

The following case example illustrates the application of aspirational ethics in which therapist attempts to support one ethical principle while minimizing harm to client (Knapp et al., 2024):

Client indicated entering treatment due to vague concerns about adjusting to recent life changes. As therapy progressed, therapist observed client presented with more significant issues, including obsessive-compulsive disorder, which was beyond therapist's scope of practice. Therapist wanted to refer client to a practitioner with expertise in obsessive-compulsive disorder because: a) continuing treatment may not present appropriate and competent service, and, b) delivering clinically contra-indicated and harmful treatment was possible.

Ethics standards require termination of therapy when it becomes reasonably clear that treatment is not beneficial or is

harmful (NASW, 2021, 1.17.a; ACA, 2014, A.11.c; APA, 2017, 10.10.c; AAMFT, 2015, 1.9). The term, "reasonably clear" in some contexts is open to interpretation and requires aspirational-based ethics to identify therapist ethical obligations and goals.

Generally, therapist will make a referral based on client's self-identified need, but in this case, therapist needs to confirm client understands the obsessions and compulsions are the primary issue and not some minor adjustment issues.

Therapists may encounter client reluctance to accept a referral for many reasons, including, clients: a) may have developed an emotional attachment to their psychotherapist, b) are already feeling some relief due to self-disclosure about their issues, c) already spent time reaching a comfort level at sharing intimate feelings, d) might feel grief over losing a meaningful relationship, e) could feel burdened by needing to begin with a new therapist, and f) may feel they are falling farther behind goal-attainment. Nonetheless, in this case, therapist cannot grant patient autonomy (continue treating client) while simultaneously abiding by the principle of beneficence (ensuring client receives appropriate treatment).

The therapist could acknowledge client's decision-making over beneficence and continue treatment by minimizing infringement of the violated ethical principle of beneficence, for example, acquiring expertise in treating obsessive-compulsive disorder through training, reading, supervision, and consultation. Accordingly, therapist will need to consider the additional required time, effort, and expense, and whether the needed expertise level can be obtained in time to justify continued therapy. Consulting with a colleague who is knowledgeable about obsessive-compulsive disorder may inform therapist about needed additional training, education, supervision, consultation, and time to acquire competency.

In contrast, therapist could honor beneficence over client autonomy and insist on the referral by minimizing harm to the violated ethical principle of respecting client autonomy by listening to client's concerns, explaining fully the referral rationale, offering information about other possible therapists, granting time for client to assess their decision and ask questions, and providing transitional or over-lapping time while beginning with the new therapists. Hence, therapist could continue treatment until client reported the new therapist was acceptable.

Knapp et al. (2024) believe that therapists can lessen client disappointment when making a referral by highlighting in the informed consent process that therapist will focus the first sessions on understanding client's goals and either generate a treatment plan or refer client to appropriate providers elsewhere. Clients may be less disappointed upon receiving a referral to a different health care provider if informed a referral option exists. It is advised to discuss this process before therapy begins such that clients know the policies before potential conflicts happen.

Barnett et al. (2024) note that scholars have suggested changing the term of "termination" when describing the

ETHICS: APPLIED PRINCIPLES

ending of treatment, for example, Maples and Walker (2014) recommended using "consolidation." Barnett et al. (2024) agree that consolidating therapeutic treatment gains appropriately defines the ending of the treatment process as therapist prepares client for successful independent functioning. Procedurally, some practitioners designate a specific date, number of sessions, or a reduction in frequency of treatment sessions from weekly to biweekly, to monthly, to prepare client to move forward after therapy (Barnett et al., 2024).

Barnett et al. (2024) indicates clients have required responsibilities to be fulfilled for treatment to be provided such as paying agreed-upon fees for treatment and complying with treatment recommendations. Supportively, courts have consistently ruled that threats against practitioner and noncompliance with treatment are justifiable reasons for ending a client's treatment (e.g., Ensworth v. Mullvain, 1990).

Providing timely and appropriate referrals during the final phase of treatment is essential given client displaying or therapist suspecting ongoing treatment needs. Clinicians are advised to match client ongoing treatment needs with the referred professional's expertise along with geographic location, client's health insurance plan, and so forth (Barnett et al., 2024).

NEW YORK STATE LAWS, RULES, REGULATIONS, and ETHICAL PRINCIPLES

Given that ethical codes of associations may be different from New York law, psychologists (and social workers, licensed mental health counselors, and licensed marriage and family therapists) must comply with the rules and regulations compiled by the Board of Regents and the State Education Department, including rules of "Unprofessional Conduct," which are accessible at these websites: <https://www.op.nysed.gov/title8/rules-board-regents/part-29> <https://www.op.nysed.gov/professions/psychology/laws-rules-regulations>

The New York State Education Department, Office of the Professions cites the following on "Dual Relationships" on their website at: <https://www.op.nysed.gov/professions/psychology/professional-practice/dual-relationships>

Psychologists (and social workers, licensed mental health counselors, and licensed marriage and family therapists) should be aware that the objectivity and appropriateness of professional services could be jeopardized by the existence of dual relationships. Dual relationships occur when a psychologist has more than one type of relationship with a patient or client, such as:

- A professional relationship and a prior personal relationship
- A business relationship that develops during a professional relationship
- Social or personal relationships that develop during a professional relationship

- Differing professional relationships, such as performing custody evaluations with patients or clients who are in other treatment or business relationships.

Sexual relationships with patients/clients either during or within at least two years following the professional relationship may not occur (for psychologists); ACA indicates 5 years, AAMFT indicates 2 years, and NASW states social workers should never engage in sexual activity with a former client, regardless of how long ago therapy ended.

When psychologists (and social workers, licensed mental health counselors, and licensed marriage and family therapists) are involved in a mentoring, teaching or supervisory relationship with a student, the psychologist should take care to maintain appropriate boundaries so that his or her professional judgment is not jeopardized.

The relationship of psychologists who act as supervisors for persons who are gaining experience for licensure purposes is principally with the licensing agency and not with the supervisee. That is, the supervisor must attest to the licensing agency that the supervisee has completed the experience in accordance with the regulations for licensure. This means that the supervisee should not employ the supervisor when the supervisee is gaining experience for licensure. In addition, supervisors would be wise to avoid supervising relatives and close friends.

The New York State Education Department, Office of the Professions cites the following on the subject of "Maintaining Appropriate Professional Boundaries" on these websites:

<https://www.op.nysed.gov/professions/psychology/professional-practice/dual-relationships>
<https://www.op.nysed.gov/professions/social-work/maintaining-appropriate-professional-boundaries>
Guideline 5: Maintaining Appropriate Professional Boundaries

It is your responsibility, not your patient's, to maintain appropriate boundaries in your professional relationship. All complaints of inappropriate behavior by licensed professionals are taken very seriously. The Regents Rules define as unprofessional conduct a licensed professional exercising undue influence on a patient in such a manner as to exploit the patient or conduct that evidences moral unfitness to practice the profession of a licensed mental health practitioner.

You should be especially vigilant regarding any conduct that could impair your objectivity and professional judgment in serving your patient, and any conduct that carries the risk and/or the appearance of exploitation or potential harm to your patient. If a current or former patient files a complaint against you, it will be your responsibility to demonstrate that you have not exploited or coerced the patient, either intentionally or unintentionally.

The practice of the mental health professions, including counseling and psychotherapy, requires interaction with patients, which may be emotional. In most cases, it is

ETHICS: APPLIED PRINCIPLES

advisable to avoid hugging or other physical contact that could imply that you have a personal, rather than a professional, relationship with the patient. If a situation arises that leads you to believe that a hug or similar contact is appropriate, you should still seek the patient's consent before touching or hugging him or her to minimize the risk of misunderstanding or allegations of inappropriate contact.

You should recognize and avoid the dangers of dual relationships when relating to patients in more than one context, whether professional, social, educational, or commercial. Dual relationships can occur simultaneously or consecutively. Some of the types of situations that may lead to problems include, but are not limited to:

- accepting as a patient anyone with whom you have had a prior sexual relationship;
- forming a sexual relationship with a current or former patient;
- treating patients to whom you are related by blood or legal ties;
- bartering with patients for the provision of services;
- supervising applicants for licensure or other training when you are related by blood or legal ties, or when you are having or have previously had a sexual relationship with the trainee;
- referring patients to services in which you have a financial relationship, without disclosing that you may stand to benefit financially from their use of the service; and
- entering into financial relationships with patients other than their paying for your professional services.

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TEST - ETHICS: APPLIED PRINCIPLES

3 Continuing Education Contact Hours

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For True/False questions: A = True and B = False.

1. **The need for competent and ethical mental health professionals is unmistakable as approximately _____ of adults have a mental illness.**
 - A) 25%
 - B) 5%
 - C) 10%
 - D) 15%
2. **Though therapists may not have the ability to help every client, they must _____.**
 - A) not charge more than the average hourly rate within their locality
 - B) uphold the duty to inflict no harm
 - C) implement new and experimental therapeutic techniques
 - D) work with every referral they receive
3. **Research suggests that effective professional practice requires these two disparate types of competencies: _____.**
 - A) financial competence and a perfectionist drive
 - B) mastery of Gestalt therapy and Cognitive Behavioral therapy
 - C) intellectual competence and emotional competence
 - D) management capabilities and persistence
4. **Emotional intelligence relates to practitioners' ability to _____.**
 - A) emotionally tolerate clinical material arising during therapy
 - B) recognize their personal biases during treatment
 - C) manage self-care responsibilities
 - D) All of the above
5. **Research supports the concept that after approximately _____ years, one-half of psychology graduate school training and information has become outdated.**
 - A) 10
 - B) 20
 - C) 30
 - D) 40

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TRUE/FALSE: A = True and B = False

6. **All practitioners cannot competently work with every client or with all issues they encounter, but personal, social, or economic pressure may dangerously lure them into making the attempt.**
 - A) True
 - B) False
7. **In situations where no formal standards abound for specific types of practice or techniques, practitioners are well-served to exercise caution and be conservative in determining where they need additional training or education before accepting the client.**
 - A) True
 - B) False
8. **Therapists may have to seek other sources of information and guidance when the standards do not offer sufficient direction such as learned texts, position articles, recommendations by other professional or scientific organizations. within consultation, or their personal conscience.**
 - A) True
 - B) False
9. **Research recommends advice-giving needs to involve deep self-reflection instead of reflexivity along with a thoughtful decision-making process whether to opt in or out of advice-giving.**
 - A) True
 - B) False
10. **Therapists have the responsibility of providing clients with the information they need to make informed decisions about therapy, as such, a therapeutic contract is implemented verbally or in writing.**
 - A) True
 - B) False
11. **Research has found that explaining to clients how psychotherapy works during an optimized informed consent (OIC) consultation does not strengthen treatment expectations, motivation, and decision making and can be harmful.**
 - A) True
 - B) False

ETHICS: APPLIED PRINCIPLES

12. **Therapists avoid imposing their personal values on clients, especially in situations in which the goals and values of therapist and client differ, or when therapy results are more than client bargained for.**
A) True B) False
13. **Therapists are obligated to see all potential clients, in fact, a referral elsewhere is often the worst option when encountering clients beyond our scope of practice.**
A) True B) False
14. **We can prevent clients from experiencing undue risk or discomfort by referring appropriately and quickly if we are unprepared for their needed treatment.**
A) True B) False
15. **Another difficult client type is the individual whose attitudes, behavior or issues interact with the psychological distress of the therapist creating countertransference.**
A) True B) False
16. **Burnout is a type of emotional exhaustion caused by excessive demands on energy, strength, and personal resources in the domain of work.**
A) True B) False
17. **Burnout risk does not increase when therapists have little control over work activities, are working too many hours, and are overworked with administrative tasks.**
A) True B) False
18. **Prevention is the best way to manage many potential ethical issues, including burnout.**
A) True B) False
19. **Termination ethical issues occur when therapist uses client fears, insecurities, or dependencies as justification for initiating or continuing unneeded treatment.**
A) True B) False
20. **Ethics standards do not require termination of therapy when it becomes reasonably clear that treatment is not beneficial or is harmful.**
A) True B) False

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