ETHICS AND BOUNDARY ISSUES

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Learning Objectives:

Upon completion of this program, the learner will be able to:

1. Recognize common ethical dilemmas, the link between ethical and legal issues, and how ethical problems occur.
2. Explain the major ethical principles of mental and behavioral health professionals.
3. Discuss confidentiality and limits of confidentiality in varied contexts including social media, including age of consent, mandated reporting, and HIPAA.
4. Identify ethical issues related to public representations (advertising).
5. Describe the Tarasoff and Ewing rulings related to the professional duty to protect.
6. Explain the significant of competence and the steps a provider should take to maintain competence.
7. Discuss informed consent in relation to ethics and boundaries.
8. Identify the dynamics of dual relationships and the ethical violations related to sexual relationships with clients.
9. Recognize the role of ethical practice in the context of involuntary treatment.
10. Describe ethical decision-making including such important considerations as risk tolerance, cultural humility, and specific decision-making models.

Syllabus:

INTRODUCTION

While scope of practice may vary depending on a person's professional training, all mental health professionals are responsible for providing services in an ethical manner and abiding by their specific ethical standards set forth by their discipline. The responsibility for knowing one's professional code of ethics and standards falls upon each individual practitioner. Practice outcomes, the safety of clients, and professionalism depends on this knowledge; further, a lack of knowledge of ethical standards is not an excuse for unethical conduct. All training programs are mandated to provide ethics-based education for their profession and clinicians are often mandated by their state licensing boards to regularly obtain additional continuing education on this topic so that they are kept abreast of any new considerations of their particular professions ethics codes.

Most professionals have a working definition of ethics, which may simply be: "Ethics are the rules of conduct for my profession". Professional codes of ethics often add a word like "enforceable" to further delineate the importance of professional ethics. The National Association of Clinical Social Workers (2016), for example, states: "Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The NASW Code of Ethics (2017a) sets forth these values, principles, and standards to guide social workers' conduct." Similarly, the American Psychological Association (2017) states

that “This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.”

Ethical standards are generally written in broad statements and apply to varied roles and contexts. These guidelines remind us that ethical standards are not exhaustive and even when conduct is not specifically directed by an ethical standard it does not mean that the conduct is necessarily ethical or unethical. Ethics differ from values and morals, and are used to help protect both clients and professionals. Ethical dilemmas that require a clinician to make a decision based on competing ideals, values, and principles are not uncommon and clinicians need to know the appropriate actions to take when this occurs.

While this type of definition is generally clear, what sometimes becomes less clear is the comprehensive role that professional ethics play in our daily lives as psychologists, social workers, counselors, and therapists. When asked what ethical issues they have recently encountered, many professionals in these fields are unable to point to any recent ethical dilemmas. In reality, that is rarely the case and commonly these professionals have internalized ethical principles to such an extent that they don’t stop to ponder whether a decision they make has ethical ramifications.

For example, a clinician was working with an adolescent client who had been slow to connect but was now engaged. The adolescent revealed information in a session that made the clinician aware that a close friend of the client’s was also a client of the clinician. The clinician had previously seen the other client who was now in residential treatment. The client in residential treatment had the clear expectation of returning to the therapist upon discharge. The dual relationship was purely coincidental and the current client was unaware of it. Many issues are apparent here, including the ethical issue of dual relationships as well as a myriad of therapeutic issues. While it was important to consult colleagues on this issue, it was equally important to review the relevant ethical standards that applied to this scenario.

This course provides practitioners with an overview of ethical principles, serves as an ethics refresher, and asks the learner to reflect on times in which ethics concerns have arisen in the course of their professional practice.

Participants in this training are encouraged to reflect on the questions at the start of each section before reading the accompanying material. A key part of learning and reflection is to develop sound ethical judgment. Some guidelines for this are listed below:

- Familiarize oneself thoroughly with established professional standards.
- Be sensitive to ethical problems as they arise, and take into account the complexity of these issues.
- Remember that ethical decision-making is an evolutionary process that requires being continually open and self-critical.

PROFESSIONAL CODES OF ETHICS

All mental and behavioral health professionals agree to adhere to their specific profession's code of ethics. A code of ethics is a guide of standards and principles created to help practitioners and providers conduct themselves professionally in all client and client system interactions. Each organization's code defines how a professional is to approach problems, the core values and principles of that profession, and the standards to which the practitioner/provider is held. Such ethical principles as integrity then dictate such professional standards of behavior as confidentiality and informed consent. Ethical codes protect client trust and safety by delineating professional standards for mental and behavioral health professionals with the purpose of protecting the well-being and dignity of clients and client systems. The ACA (2014) sets forth guidelines that can be generalized to all helping professions by stating that all codes of ethics provide guidance to practitioners and providers, and those professionals in turn must:

- create and maintain relationships with client/client systems based on trust;
- obtain informed consent for services and collaborate with client(s) whenever possible;

- be aware of how factors of diversity including culture, values, and beliefs effect the practitioner-client relationship;
- ensure client confidentiality and privacy whenever possible including with the use of technology/social media;
- be honest in all communications and explain services to the best of their ability; and
- adhere to their specific discipline's code of ethics.

Professional associations (e.g., NASW, APA, ACA, NBCC) each have their own specific codes for the professions they represent and to which members of those professions must adhere to. These varied codes can be found in the reference section of this course. During their training, practitioners are often taught to strive for competency. Competency is commonly defined as a skill or ability, and denotes an end point. That if one gathers enough knowledge, information, and experience, they can achieve competency. With respect to professional ethics, among other topics, it is helpful to take the perspective that one can never be fully competent in ethical matters because ethics, like the contexts in which they exist, are ever changing. Thus, striving to be competent should not be the goal of learning about ethics, but rather, emphasis should be on understanding how one's code of ethics and its ethical standards apply to a variety of situations, along with having an ethical decision making model/framework that can assist the practitioner when ethical dilemmas arise.

It should be noted that the issue of competency often arises when a practitioner is working with a client from a different or specific population with whom they either are not familiar or hold different values. While the practitioner is experiencing a lack of competency with the client, it is not enough use this as a reason not work with the client. Codes of ethics for providers in all mental and behavioral health professions specifically address the difference between value conflicts and true competency issues, and terms of client termination and referrals. Later in this course, an alternative framework, cultural humility, is provided for consideration when working with clients instead of cultural competency as a way to expand one's understanding of working with diverse clients.

Ethics vs. Law

Describe a recent situation you had in which ethical and legal standards came into conflict.

Questions to Consider

1. Why are ethics important?
2. How do ethical problems occur?

Many ethical issues faced by mental health professionals involve legal issues. All mental health professionals are bound both by their professional ethical codes and by the laws of their respective states. This may be a good time to re-familiarize yourself with relevant state standards. Ethical decisions in mental health that involve legal issues do not *always* involve ethical dilemmas. In many cases such decisions are compatible with both legal and ethical standards.

However, other cases involve more difficult ethical dilemmas, particularly when clinicians' decisions are compatible with legal standards but not consistent with prevailing ethical standards or vice versa. The following training material highlights such conflicts. It is important for professionals to seek consultation with supervisors and colleagues when such conflicts arise.

How Do Ethical Problems Occur?

Both law and ethics provide boundaries through which to consider the many potential conflicts that may occur in a therapeutic relationship. Mental health professionals have a responsibility to the clients they serve. Although the scope of services may vary, the fundamental need to protect a clients' interests does not. Ethical dilemmas occur frequently; however, ethical problems can be reduced through knowledge of ethical and legal codes and vigilance on the part of the provider.

The following is a list of some common reasons that ethical problems occur. Some of these are in the providers' control and others are not.

How do ethical problems occur?

- People are human and make mistakes
- Clients misreport
- Inexperience

- Ignorance
- Unpredictable /unforeseen situations
- Foreseen, but no way to avoid them
- Inadequate agency policies
- Guidelines not adequate for situation
- Ethics in conflict with law

Another way to look at this is to be aware of basic assumptions about ethical awareness and decision-making. Several theorists have examined these issues including Koocher and Keith-Spiegel (2016) and Pope and Vasquez (2016). Their works illuminate the following:

1. Ethical awareness is a continuous, active process that involves constant questioning and personal responsibility.
2. Awareness of ethical codes and legal standards is an essential aspect of critical thinking about ethics and of making ethical decisions.
3. Awareness of the evolving research and theory in the scientific and professional literature is an important aspect of ethical competence, but the claims and conclusions emerging in the literature should not be passively accepted or reflexively applied.
4. The overwhelming majority of psychotherapists and counselors are conscientious, dedicated, caring individuals, committed to high ethical standards. But none of them are infallible.
5. It is crucial to question decisions and behavior – not just the decisions of others.
6. Psychotherapists commonly encounter ethical dilemmas without clear and easy answers.
7. Consultation is almost always helpful and sometimes crucial.

By keeping these points in mind, it is easier for the practitioner to avoid ethical pitfalls. The intersection between ethics and the law is a topic of particular interest. The following sections consider ethical and legal issues related to the practice of psychology, counseling, marriage and family therapy, and social work.

Ethical Principles

While each profession has their own code of ethics and governing bodies, the set of values and underlying framework for the standards of professional conduct that are foundation for the delivery of mental health services are highly similar among the cogent professions. These values are based upon the dominant culture in which the clinicians live and work. The overarching values include: nonmaleficence, autonomy, beneficence, competency, fidelity/integrity, and justice/equality These values are meant to provide guidelines for exemplary professional behavior and describe the ideal professional values for which clinicians should strive (APA, 2017).

Nonmaleficence

Questions to Consider

1. What does nonmaleficence mean to you?
2. In what situations might a clinician have to go against this principle?

Nonmaleficence is the foundational ethical principle in which a person agrees to do no harm. Clinicians vow that they will not cause intentional or avoidable harm to clients and client systems alike, and thus refrain from engaging in any behavior or action that may place others at risk. Harm is broadly defined and can include physical, emotional, and psychological harm, as well as violations of human rights (Beauchamp & Childress, 2013), and are culture specific and value laden. In general, clinicians from all disciplines would agree that yelling at a client, forcing them to do something against their will, or hitting a client is unacceptable. There are times when clients are in fact harmed by clinicians when it prevents a greater harm. For example, clients who are suicidal may be hospitalized involuntarily. This may be seen as an act of maleficence as it goes against a client's autonomy and right to choose, but it prevents a greater harm to the client and thus, does occur.

It becomes much more unclear when one begins to discuss 'fringe' interventions such as conversion therapy. While research indicates there is no scientific merit to conversion therapy and it in fact causes harm, some clinicians continue to engage in this practice. Ethical guidelines vary by discipline as seen by following statements. The American Psychiatric Association opposes any

psychiatric treatment such as reparative or conversion therapy (2018, para. 1), as does the National Association of Social Workers. However, the ACA Ethics Committee "suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients" (Whitman, Glosoff, Kocet, & Tarvydas, 2013, para. 10). Thus, providing conversion therapy, or even the consideration by a clinician as to whether or not to do so, can be considered an ethical dilemma, because it has been deemed harmful to clients and unacceptable due to lack of scientific evidence. Despite this, not all professions view it the same way, and some behavioral health providers continue to practice this form of intervention. Selected professional associations' views on the principle of nonmaleficence are found in table 1.

Table 1: Perspectives on Nonmaleficence by Professional Association

Association	**Ethical Code Section**	**Overview**
American Psychological Association (APA) (2017)	Principle A: Beneficence and Nonmaleficence	Psychologists work to ensure the well-being and rights of all clients and client systems. Whenever possible, they avoid and do not cause harm. Psychologists recognize the potential impact of their own physical and mental health on treatment.
	Principle D: Justice	Psychologists work to protect against unjust practices.
	2.01(e): Boundaries of Competence	Psychologists agree to training and competence in their work in order to protect clients and others with whom they work.
American Counseling Association (ACA) (2014)	Section A.4.a: Avoiding Harm	Counselors work to avoid and at least, minimize unavoidable harm.

American Association for Marriage and Family Therapy (AAMFT) (2015)	Standard III: Professional Competency and Integrity.	Practitioners participate in on-going training to ensure competency and protect clients from possible harm.
National Association of Social Workers (NASW) (2017a)	Ethical Standards Section 1.01: Commitment to Clients	Social workers promote the well-being of clients while maintaining legal obligations and responsibilities to the larger society.
	Section 1.04: Competence	Social workers should only provide services within their scope of practice and training. They agree to protect clients from harm whenever possible
	Section 1.06: Conflicts of Interest	Social workers work to avoid and/or minimize conflicts of interest whenever possible.
	Section 1.10: Physical Contact	Social workers do not engage in physical contact with clients when there is the chance it can cause harm (e.g., cradling or caressing clients). Social workers who engage in appropriate physical contact are careful to set appropriate boundaries that are clear and culturally sensitive.

When it comes nonmaleficence, clinicians must often weigh issues of maleficence, or rather acts of harm, with that is best for the client. For example, when a client is suicidal, it requires a clinician to decide which causes less harm, a mental hygiene arrest (more often than not against the will of the client) or allowing the client to remain suicidal.

Another common ethical dilemma pertaining to maleficence has to do with a client's decision to take psychotropic medication or not. Professionals and clients alike agree that that taking certain medications will cause side effects and can cause harm to a client. The effects of such medications range to mild annoyances to potentially life-threatening situations such as with polypharmaceuticals. Clients have the right to decide whether or not to take such medications, but

also are made aware of the positive, potentially life-changing aspects of taking such medications, as is the case for many individuals with schizophrenia, schizoaffective disorder, anxiety, and severe depression. It is the job of clinicians to discuss both the potential benefits and risks of taking medications with clients, and allow for clients to decide their own best course of action. This can cause ethical dilemmas for many clinicians who may believe the potential benefits of taking medication outweigh the risk for harm or disagree with a client's decision about what is best. A clinician must assess their own beliefs and values pertaining to medication, provide the most up to date information on the risks and benefits of medications, and then allow the client to decide without coercion.

In 1977 Jonsen and Jameton categorized nonmaleficence for physicians in a manner that is still applicable to behavioral health providers today. The four categories include (a) always putting the well-being of the client first (not doing harm); (b) providing adequate and appropriate care for clients; (c) properly assessing the situation including a risk/benefit analysis; and (d) make proper detriment-benefit assessments. These four guidelines can assist providers of all disciplines in making ethical decisions pertaining to nonmaleficence.

Autonomy

Describe a population with whom you work that may not have autonomy in decision making.

Questions to Consider

1. What limitations are there to autonomy?
2. How would you address this?

Clients have autonomy, or rather the right to make decisions and choices about their own lives free of coercion or pressure from providers. Autonomy is a universal principle for all behavioral health related fields, (referred to as self-determination in the field of social work) as a client strives for self-sufficiency (NASW, 2017a). Clinicians in all disciplines should strive to support and honor clients' rights to make decisions, increase clients' capacities for positive changes through appropriate interventions, discuss with clients how a decision may be perceived by others, problem solve ways

to achieve autonomy, and maintain clients' privacy and confidentiality (APA, 2017). One way many clinicians support autonomy is through adhering to specific frameworks such person (or client) centered practices that places clients in the role of decision maker toward the most competent choices possible. Providers may encounter clients who are not capable of making autonomous decisions whether due to age, developmental/cognitive ability, or other reasons. To address this, providers must consider the many different aspects of decision making and do their best to assist clients to their fullest potential. For example, in many states minors are not able to consent for mental health or substance abuse treatment, while in others, they are. Clinicians are responsible for knowing these laws and policies when working with adolescents and families to ensure their client has the utmost autonomy in decision making possible (Kerwin et al., 2015). Selected professional associations' perspectives on autonomy summarized in table 2.

Table 2: Perspectives on Autonomy by Professional Association

Association	**Code Section**	**Summary**
AAMFT (2015)	1.8 Client Autonomy in Decision Making	Practitioners respect the rights of clients to make decisions and assist clients in understanding the ramifications and consequences of their choices.
ACA (2014)	Section A.2.a	Counselors provide clients with appropriate and accurate information about the counseling process so they may choose whether to enter into or remain in a counseling relationship.
APA (2017)	Principle E: Respect for People's Rights and Dignity	Psychologists work to endorse the rights of client privacy, confidentiality, and self-determination. Considerations and attention to vulnerable populations is warranted.
NASW (2017a)	Ethical Principles, Value: Dignity and Worth of the Individual Ethical Standards Section 1.02	Social workers encourage and support client and client-systems' self-determination and work to increase clients' self-sufficiency.

Clinicians may encounter ethical dilemmas pertaining to autonomy when providing services to the aging. Most older adults would agree that maintaining autonomy as well as independent living are important aspects of a good quality of life (Smebye, Kirkevold, & Engedal (2016). Commonly when older adults experience dementia or other cognitive difficulties, they are forced into different living situations. When this occurs, it is important to ensure the highest level of autonomy when possible, as well as self-determination in decision making. The following is a case example of when the principle of autonomy may need to be considered versus nonmaleficence, or rather the need to prevent harm.

Mr. R. currently resides in his home where he and his wife, (now deceased) raised their three children. In the past few months, Mr. R has received home nursing services for a broken hip, and daily assistance with activities of daily living. It has become evident that Mr. R. is experiencing cognitive difficulties and loss of memory. Worried for his safety, his children sought the assistance of Mr. R's treatment team and he was diagnosed with early stages of dementia. Upon a daily visit, a care professional found Mr. R. sitting outside in his pajamas in the middle of afternoon in the cold. She brought Mr. R. inside and asked if he was okay, asked him to get dressed or at least wear a coat outside, and checked to see if he was disoriented. Mr. R. became agitated and said he had every right to do whatever he wanted, whenever he wanted, and that he simply didn't feel like getting dressed that day. Not wanting to be disrespectful, though concerned, the care professional documented the interaction and continued with her duties. In this example, the caregiver had to choose a course of action. Given that Mr. R is an adult who lives independently and there was no imminent danger it is reasonable to follow the principle of autonomy - Mr. R could be taken at his word that he knew what he was doing and was fine. Or, the caregiver could have been guided by the principle of non-maleficence, and attempted to persuade Mr. R to wear a coat while outside in cold weather. In this instance, the caregiver was aware that Mr. R may have been disoriented and gone out into the cold without proper attire, but that he also had the right to choose his actions. An area that the caregiver could improve upon is their knowledge of dementia, communication with other care providers/family about Mr. R's habits, thoroughly document behavioral changes or concerns as they arise, and collaborate with a supervisor to ensure proper, ethical care.

Beneficence

Questions to Consider

1. When would a clinician be going against the principle of beneficence?
2. How might they seek to change this?

Clinicians work to benefit clients by assisting in the betterment of client lives and contributing to clients' overall well-being. This is termed beneficence. It is the duty of clinicians to work towards the overall health and well-being of clients throughout the professional relationship and to assist clients in overcoming challenges and obstacles in their efforts to achieve the clients' desired results and outcomes. Through their careful actions, clinicians seek to benefit their clients' health and well-being via respectful, thought-out interactions and interventions. Coupled with the other ethical principles of nonmaleficence and autonomy, beneficence strives for the best possible care for clients with least possible harm. Thus, beneficence refers to a normative statement of a moral obligation to act for the others' benefit, helping them to further their interests, often by preventing or removing possible harms.

Beneficence should not be equated with altruism, which is a selfless act with no expectation of any direct (or indirect) compensation or benefits. For example, if a clinician continues to see a client out of a sense of financial gain when the client is ready to terminate or the clinician continues treatment out of their own need for validation, they are not acting out of beneficence. Perspectives on beneficence by select professional associations are summarized in table 3.

Table 3: Perspectives on Beneficence by Professional Association

Association	**Code Section**	**Summary**
AAMFT (2015)	Preamble	Practitioners participate in service and advocacy for the welfare of all. Marriage and family therapists embody these by participating in activities that contribute to a better community and society.

ACA (2014)	Introduction	Counselors facilitate client well-being, growth, and development in ways that foster the interest and welfare of clients.
APA (2017)	Principle A: Beneficence and Nonmaleficence	Psychologists are committed to providing services that improve the well-being of clients.
NASW (2017)	Preamble and Ethical Principles	Social workers support the quality of life of all individuals, help people in need with an additional emphasis on the lives of vulnerable, oppressed, and impoverished people, and address social problems.

Justice

Describe a recent situation you had in which ethical and legal standards came into conflict.

Questions to Consider

1. Why are ethics important?
2. How do ethical problems occur?

All mental health professionals are charged with acting in a fair and just manner. The principle of justice works to ensure that all clients have access to services, resources, and opportunities for growth despite challenges. Professions differ in how they specifically address this principle. For example, the National Association of Social Workers (NASW, 2017) charges social workers to actively challenge social injustice and work for social change on behalf of vulnerable and oppressed populations. The American Psychological Association (APA, 2018) states the principle of justice affirms that all people should have access to services, resources, benefits, and opportunities. According to the ACA (2017), justice does not necessarily ensure equal treatment, but rather in cases of difference, a specific rationale for one's course of action. Often issues of

justice occur regarding financial issues and access to services. Practitioners often serve as advocates for clients who have difficulty paying for services, finding payment alternatives, or other resources to ensure just and fair access to treatments.

CONFIDENTIALITY

Describe a recent situation you had in which confidentiality was a central issue.

Questions to Consider

1. Why is confidentiality so important?
2. Are there times in which maintaining confidentiality proves to be limiting?
3. Would you like to see additional exceptions to confidentiality mandates?

Jamal, a 16-year-old high school junior, has been in treatment with clinical social worker Alexa for the past year. She has become increasingly concerned by his depression and has noted some signs that alert her to his risk for suicide. Alexa asks that they have a family session with Jamal's parents to discuss the situation. She reminds Jamal that it is a legal and ethical mandate that she get Jamal help given the seriousness of the situation. Jamal is very resistant and leaves her office abruptly when Alexa tells him that she ***will*** *be contacting his parents. Did she handle this situation well from a therapeutic standpoint? Did Alexa handle the situation well from an ethical standpoint?*

Confidentiality is a complex therapeutic, legal and an ethical issue. Confidentiality is central to developing a trusting and productive counseling relationship and is a concrete manifestation of an essential boundary in the therapeutic relationship. Confidentiality refers to the nature of information shared in therapy sessions as well as contents of a person's medical records. Many of the factors related to confidentiality are familiar to mental health providers and it is central to a mental health professional's practice (Ferencz, Koslowsky, & Weingarten, 2017; Kahn, Bell, Walker, & Delbanco, 2014; Moss, 2017).

Confidentiality is also a leading cause of ethical complaints. Pope and Vasquez's (2007) study of ethics complaints found that failing to protect client confidentiality was the fourth most

frequent basis of disciplinary action. Kenneth Pope's (2003) review of malpractice claims also found breach of confidentiality to be a leading cause of litigation. Confidentiality breeches are also one of the common areas that result in disciplinary supervision (Thomas, 2014). This is particularly concerning because confidentiality is central to developing a trusting and productive therapeutic relationship.

Mandates related to confidentiality are found in the ethical codes of all professions:

- The American Association of Marriage and Family Therapists (2015) Code of Ethics states in Standard II: "Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

- The American Counselors Association (ACA; 2014) Code of Ethics states "Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality.

  Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared."

- The American Mental Health Counselors Association (AMHCA; 2015) Code of Ethics indicates, "Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research. Confidentiality is a right granted to all clients of mental health counseling services."

- The American Psychological Association (APA; 2017) Ethical Code similarly states that psychologists "have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship."

- The National Association of Social Workers (NASW; 2017) Code of Ethics states: “Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons, such as preventing serious, foreseeable, and imminent harm to a client or others.”

- The National Board for Certified Counselors (NBCC; 2016) Code of Ethics states: “NCCs, recognizing the potential for harm, shall not share information that is obtained through the counseling process without specific written consent by the client or legal guardian except to prevent clear, imminent danger to the client or others or when required to do so by a court order.” Additionally, the NBCC Code of Ethics also looks at the content of information shared within therapy sessions and reminds counselors that they should solicit from the client “only information that contributes to the identified counseling goals.”

The general expectation that mental health professionals 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 these instances, professionals 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. This is open to some degree of discretion on the part of the treatment professional. In the case above, for example, Alexa could disclose her concerns to Jamal’s parents, and seek their help in arranging for hospitalization, but could choose not to provide them with specifics of information shared in therapy such as the stressors that have resulted in Jamal’s suicidal ideation.

One of the primary considerations in looking at confidentiality is maintaining the privacy of client disclosures shared in therapy. Many clients are unaware of the degree of confidentiality that they can expect and it is important to let them know that although it is not permissible for a mental health professional to share their disclosures with third parties without the client’s written consent (verbal consent can be given in emergency situations only), there are exceptions to this rule. It is the mental health professional’s responsibility to define the degree of confidentiality that can be promised. Generally speaking, it may be helpful to have clients sign a written statement that includes information about limits to confidentiality. A client should understand **in advance**

the circumstances under which the therapist is allowed to disclose information. This is explored further in the section on Informed Consent.

Under most state laws there are several exceptions to the confidentiality of psychotherapy. The primary exceptions to confidentiality concern harm to self or others:

- Where there is a reasonable suspicion that a client is likely to harm him or herself unless protective measures are taken.
- Where there is a reasonable suspicion of child abuse or elder adult physical abuse (see section on Mandated Reporting);
- Where there is a reasonable suspicion of the potential for danger of violence to others (see section on Duty to Warn).

In all of the above situations, the mental health provider is legally required to break confidentiality in order to protect a client or someone they might endanger. In most states, there is no privileged communication if the therapist has reasonable cause to believe that the client is in such a mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.

Another important concern is confidentiality with regard to counseling services provided to families, couples, or groups. It is important for the provider to be specific with regard to confidentiality issues and to seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. This is particularly important if the provider will be meeting with any person on an individual basis.

In terms of group treatment, the mental health provider cannot guarantee that group members will keep information confidential and this information is important to share with all group members in advance of group psychotherapy. For an interesting discussion of group psychotherapy privilege see Morgan (2006).

In addition to confidentiality of therapeutic disclosures among clients there is the issue of third-party disclosures. Some of these issues are affected by the Health Insurance Portability and Accountability Act (HIPAA) and this will be discussed in a subsequent section. Clients must be told in advance if there is information that will be shared with third parties, such as sharing a

diagnosis or other information with an insurance company in order to receive payment for rendered services. If the provider works in an agency or group setting, there may also be information shared among members of a treatment team.

Confidentiality also extends to clinical records. *Privilege* refers to the legal right to keep clinical records confidential. Privilege is relevant with to the role of client confidentiality in legal proceedings. If the issue of a client's mental health or psychological treatment is raised during the course of a lawsuit, a mental health provider might be forced by the court to reveal the details of the client's treatment. This is a situation in which law conflicts with ethics. Codes of ethics state that clinicians should protect the confidentiality of clients during legal proceedings to the extent permitted by law. However, there may be times when a court of law or other legally authorized body orders clinicians to disclose confidential or privileged information without a client's consent. If such a court order is made, although it is ethically preferable not to reveal treatment information, the clinician may be required to comply with the court.

As with any situation in which there is an intersection between legal and ethical concerns, mental health providers can seek the consultation of a qualified colleague or legal expert to help determine a course of action.

Social Media and Confidentiality

The mental and behavioral health professions have been greatly affected by advances in technology. Practitioners understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. It is estimated that at least 70 percent of all adults use social media (Pew Research Center, 2019). Social media has created professional opportunities and challenges. Practitioners are responsible to establish effective boundaries with clients to ensure safety, confidentiality, and clear lines between public and private information. With rapid pace of advancement, ethical codes and professionals often encounter new challenges and questions of how to implement ethical principles and guidelines to everyday activities and communications. Practitioners need to be knowledgeable and open to new technology while maintaining ethical practices (Lannin & Scott, 2014). Lannin and Scott (2014) suggest some general guidelines for practitioners:

- Provide a written social media policy and consent form that clients must sign
- Use privacy settings on social media accounts whenever possible
- Check with state licensing board to stay current on rules and regulations
- Have separate social media accounts for one's professional and private life
- Become familiar with what constitutes multiple relationships
- Utilize ethical decision-making frameworks
- Document all client interactions
- Keep abreast of new technology, attend trainings to develop technological competence
- Contact professional and personal liability insurance representatives to find out whether professional and personal liability insurance covers social networking
- Avoid posting any commentary or speech that breaches client/supervisee confidentiality including disparaging comments on other's social media, anything that would disparage the reputation of one's professional practice or others, as well as comments about litigation.

Because technology is ever expanding, social networking and social media are broad terms that encompass user-generated content. Some examples include:

- Social networking sites, such as Facebook and LinkedIn.
- Publishing media, such as WordPress, Blogger and Wikipedia.
- Content sharing, such as YouTube, Flickr, Instagram, and Snapchat
- Discussion sites, such as Yahoo Messenger, Google Talk and Skype.
- Microblogging, such as Twitter, Tumblr and Posterous.
- Livestreaming, such as Zoom and Skype.
- Livecasting, such as Livestream.
- Virtual worlds, such as Second Life and There.

Lannin and Scott (2014)

For mental health professionals, participating in social media, whether for professional or personal use is replete with ethical issues and "will likely produce ethical dilemmas surrounding boundary violations related to online realities such as greater transparency, increased self-disclosure and unavoidable multiple relationships" much like those who work in rural settings. (Lannin & Scott, 2014, para. 6). In 2017, the NASW, Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE), and the Clinical Social Work Association jointly published the Standards for Technology in Social Work Practice. The standards are divided into four main sections related to the ways in which social workers use technology to "(1) provide information to the public; (2) design and deliver services; (3) gather, manage, store, and access information about clients; and (4) educate and supervise social workers" (NASW, 2017b, p 13). Prudent use of social media with an eye towards one's professional identity, using strict boundaries, outlining policies for communication and expectations before work is begun with a client, and following one's ethical principles are key to managing online ethical issues and boundaries. When considering whether to engage in social networking/media, the APA (2015) suggests the following which are applicable to any mental health professional:

1. Consider the risk and rewards of online activity for both the professional and the client
2. Use integrity and honesty with clients about potential role confusion that can occur with online transactions/communications
3. "Private" online activity may intersect with professional competence resulting in boundary violations.

The National Board of Certified Counselors (NBCC) clarifies further the professional's obligations with respect to social media in their code of ethics (2016):

> **Directive 19:** NCCs must create written practice procedures in regard to social media and digital technology, and are to be provided to clients before or at the time of the first session. these shall be incorporated with the information provided to clients before or during the initial session. Policies are to include guidelines for use of social media including personal versus professional accounts (such as "friending").

Additional information on the use of technology can be found in the informed consent section of this course.

Confidentiality and Minors (Age of Consent)

Describe a recent situation you had in which confidentiality with an underage client was a central issue.

Questions to Consider

1. What are some special considerations in treating minors?
2. At what age and under what conditions should a minor be able to consent to treatment?
3. Do parents always need to be involved in a minor's treatment? If no, when should they not be involved?

Cara, is a CSW, working for a community mental health center. During a walk-in day she assesses Dawn, a precocious 13-year-old, who shares that she is seeking treatment due to severe depression. She has had intermittent suicidal thoughts, however states that she can contract for safety at this point. Dawn states that her parents do not approve of counseling but that she feels that she will get worse without this treatment. Although Dawn is not completely forthcoming, Cara believes that her home situation is unhealthy and may be abusive, although she does not believe that Dawn is in current danger. Cara knows she must consult on this case with a supervisor, she decides to offer Dawn an appointment for outpatient therapy. Can Dawn consent to treatment? What are Cara's obligations with regard to parental notification?

Minors' rights to confidentiality and to consent to treatment are an important ethical concern. The term "age of consent" refers to laws related to the medical and legal rights of minors and is the age at which a minor can consent to medical care without being required to notify their parents or obtain authorization for care.

Most states have specific laws regarding age of consent, and it is important that practitioners know the specific laws for the state(s) in which they practice. According to Benkhe and Warner (2002) minors generally cannot consent to treatment; a parent or guardian consents on the minor's behalf. There are exceptions, however. Some states allow minors whom the law deems mature, such as those who are married or in the armed services, to consent to treatment, and sometimes minors may consent to treatment for substance abuse or sexually transmitted diseases. It is important for clinicians to be familiar with the laws in the states in which they practice (Benjamin, Ishimine, Joseph, & Mehta, 2017).

It is also important to note that while many age of consent laws refer to consent for mental health treatment, there are often different standards with regard to consent for psychotropic medication or inpatient hospitalization.

There are also confidentiality considerations. A parent who consents on the minor's behalf generally has the right to know the content of the child's treatment.

- The AAMFT Codes states that : “Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted 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.
- The AMHCA Code indicates that “The primary client owns the rights to confidentiality; however, in the case where primary clients are minors or are adults who have been legally determined to be incompetent, parents and guardians have legal access to client information.”
- The APA Ethical Guidelines, Standard 4.01, "Structuring the Relationship," states that "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship...the nature...of therapy, fees, and confidentiality." Standard 4.02, "Informed Consent to Therapy," states that when an individual cannot provide informed consent (such as a minor), psychologists "consider such person's preferences and best interests." Standard 4.03, "Couple and Family Relationships," states that psychologists "attempt to clarify at the outset (1) which of the individuals are patients or clients and (2) the relationship the psychologist will have to each person."
- The NASW Code indicates “Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of the client.”

- The NBCC Code (2016) states, "NCC's, recognizing the potential for harm, shall not share information that is obtained through the counseling process without specific written consent by the client or legal guardian except to prevent clear, imminent danger to the client or others or when required to do so by a court order."

It is generally advisable to discuss these issues with all parties (e.g. parents and adolescents). This can allow for a balance between an adolescent's need for privacy with parental needs for treatment information.

Mandated Reporting

Describe a recent situation you had in which reporting child/elder abuse was a central issue.

Questions to Consider

1. Do you always report suspected cases of child/elder abuse? Why or why not?
2. Why is mandated reporting necessary?
3. Are any professional or ethical difficulties that arise from the need to be a mandated reporter?

Vicki, a psychologist in private practice sees Eric, and 8-year-old boy for the first time. His parents described "hyperactive" behavior and a propensity to get into trouble, some classic symptoms of ADHD. The evaluation today was at the request of the school, which had also noted the difficulties expressed by Eric's parents. Vicki first meets with the family, noting that Eric actually appears quite withdrawn. There was little eye contact between Eric and his parents and at times he appeared to physically shrink away from his mother. Vicki does not see any evidence of hyperactive behavior, but she does recognize that sometimes this is not evident on first meeting a child. Vicki does note several bruises on Eric's arms and legs, which Eric's mother states are a result of rough play. They also state that Eric has been known to lie, and that he has done so in the past with school authorities. Eric's parents reluctantly agree to Vicki spending time alone with

Eric. In meeting individually with Eric, he makes reference to "hitting" and "screaming." Suspicious, but uncertain what she was seeing, Vicki decides to assess the case further without making a report. She was later alerted by a local hospital that Eric had been admitted due to multiple fractures.

Glenn is a social worker who has just started consulting with a geriatric day program. The group facilitator calls Glenn to express concerns about Adele, a 68-year-old woman who has a dementing process. The program has noted that she becomes fearful and agitated when leaving for home at the end of the day. They have attempted to express their concerns with Adele's son, Ronnie, but he has not returned their calls. They have not seen any signs of bruises, and Adele is well-nourished.

As these cases illustrate, child and elder abuse is a special area of concern for mental health professionals. The first child abuse and reporting law was enacted in California in 1963. This law pertained only to physicians, and covered the reporting of physical abuse. Since this time, the definition of mandated reporters has expanded, as has the type of abuse that must be reported. Mandated reporters are professionals who, in the ordinary course of their work and because they have regular contact with children or other identified vulnerable populations (such as the elderly), are required to report suspicions of physical, sexual or other types of abuse. In looking at this definition it is evident that mental health professionals fall under the scope of mandated reporters.

Despite these mandates many professionals are uncertain when a report is required and practitioners vary in their understanding and opinions of these laws (Ho, Bettancourt & Gross, 2017; McTavish et al., 2017; Feltner et al., 2018).

Although state laws vary, most states require that mandated reporters, such as psychotherapists, make a report of child abuse whenever a "reasonable suspicion" of abuse exists. An abuse report is mandated whenever a mental health provider learns about the abuse in his or her professional capacity.

Many states also have mandated reporting laws that pertain to elder abuse, require that the professional report physical abuse, abandonment, isolation, financial abuse, or neglect of any elder or dependent. Elder abuse is an increasing problem, especially among the frail elderly and those with disabilities (Ostaszkiewicz, 2017; Feltner et al., 2018). Elder abuse results in numerous issues and affects the elder's mental health. A report is required if the mental health professional observes or has knowledge of the abuse, or the patient reveals information about being abused.

Examples of the types of abuse covered under mandated reporting statutes include physical abuse, sexual abuse, neglect, willful cruelty, unjustifiable punishment, and unlawful, corporal punishment and injury. Some mandated reporting laws also require the reporting of instances where a child suffers, or is at substantial risk of suffering serious emotional injury.

The term "reasonable suspicion" has created some confusion among mental health providers. If a therapist does not directly observe abuse, but due to his or her training suspects that such abuse has occurred, he or she is required to report it. Some signs of child and elder abuse is explored later in this section.

There are a number of safeguards in place for professionals that report child abuse. Mandated reporters have immunity from civil and criminal liability. In addition, the reporter's name made available to only specified persons or agencies.

A mandated reporter that fails to file a report is generally subject to punishment such as misdemeanor criminal prosecution and fines. If harm comes to a child through the result of a professional's failure to report abuse, even stiffer penalties may result.

Mandated Reporting and Confidentiality

Reporting suspected child abuse brings with it some complex issues. Psychologists, social workers and counselors all have ethical guidelines that highlight mandated reporting as a key standard along with that of confidentiality.

Although the need to maintain client confidentiality is an important standard, no client can be given the guarantee of complete confidentiality. Although child abuse will be defined in more detail in the next section, this is clearly an area in which other ethical standards merit consideration. The principles of nonmaleficence (avoid harm) and beneficence (ensure people's well-being) require that psychologists break confidentiality when a client's actions pose potential harm to self or others that is, that "Psychologists disclose confidential information without the consent...to

protect the patient or client or others from harm" (Standard 5.05 [a]). Psychologists must be aware of state mandated limits and inform their clients of the exceptions to confidentiality (Standard 5.02).

Similarly, Lau, Krause and Morse (2009) discuss the role of the social worker as a mandated reporter. These authors state that the profession of social work encompasses many different professional roles, and that the primary mission of social work is to "enhance human well-being and help meet the needs of all people who are vulnerable or oppressed." In this role, social workers assist families where there are serious domestic consequences, which may involve child maltreatment. These authors acknowledge the difficult role of the social worker as a mandated reporter, stating that when making a report of suspected abuse "using their professional judgment, social workers must act by limiting the client's right to self-determination when client actions or potential actions pose a serious, foreseeable and imminent risk to themselves or others." (Lau, Krause & Morse, 2009, p. 17). The NASW Code of Ethics (2017) further clarifies for social workers that their primary responsibility is the promotion of client well-being and social workers should advise clients that there are limited occasions where the social worker's responsibility to the larger society or specific legal obligations may require that client well-being become secondary, as in the case of mandated reporting.

There has been some discussion as to whether mandated reporting laws hinder confidentiality (Ho et al., 2017). For that reason, some professionals are reluctant to report suspicions of child abuse. Koocher and Keith-Speigel (2016) suggest that when faced with the issue of disclosing suspected abuse, one must be fully aware of the legal requirements but then also consider what the client wants from the therapist. Although professionals are mandated to report abuse, the clinical aspects of the client relationship also need careful consideration. For State-specific laws pertaining to child abuse and neglect, see Child Welfare Information Gateway's State Statutes Search page at https://www.childwelfare.gov/ systemwide/laws_policies/state/.

Defining Child Abuse

Child abuse or neglect is defined as any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (usually a person under the age of 18, but a younger age may be specified in cases not involving sexual abuse) by a parent or caretaker who is responsible for the child's welfare.

Although child abuse is divided into the categories of physical abuse, neglect, sexual abuse, and emotional abuse, it is important to note that child abuse is more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected. In many states, the definition of child abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child's health or welfare. For instance, a parent who allows a child to be exposed to a known sex offender (e.g., if this person is the mother's boyfriend), may be seen as liable for child abuse even if the offender does not harm the child.

Child physical abuse is defined as the physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened. The parent or caretaker need not have intended to hurt the child for it to constitute physical abuse. Examples of physical abuse include: beating with a belt, shoe, or other object; burning a child with matches or cigarettes; hitting a child; shaking, shoving, or slapping a child. It is sometimes difficult to distinguish physical abuse from corporal punishment. McClennen (2010) suggests that various factors should be taken into account when categorizing whether an act is abusive including: 1) age of the child; 2) developmental levels of the child; 3) severity of the action; 4) frequency of the action, and 5) the "contextual" (historical or cultural) perspectives of family and community. Another form of child physical abuse is Munchausen syndrome by proxy (MBP). MBP is the intentional simulation of physical illness by a parent in his or her child, usually for the purpose of attention. This may include fabricating symptoms or actually inducing symptoms (such as causing a child to have a fever, feeding the child things he or she should not ingest, etc.)

Child neglect is defined as failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. *Physical neglect* includes refusal of or delay in seeking health care, abandonment, expulsion from the home or refusal to allow a runaway to return home, and inadequate supervision. *Educational neglect* includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. *Emotional neglect* includes such actions as marked inattention to the child's needs for affection, refusal of or failure to provide needed psychological care, spouse abuse in the child's presence, and permission of drug or alcohol use by the child. *Medical neglect* generally encompasses a parent or guardian's denial of or delay in seeking needed healthcare for children. Lack of supervision

may also fall under neglect laws. Some states specify the amount of time children of various ages can be left unsupervised or the age at which they can be left alone. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty.

One of the most difficult categories of abuse to prove and quantify is emotional abuse. Most US states and territories have mandates that include emotional abuse. What unifies these definitions is that they have two provisions 1) emotional injury and 2) a change in emotional stability of the child. California, for instance, defines emotional abuse as "an injury to the psychological capacity or emotional stability of a child evidenced by observable or substantial change in behavior, emotional response or cognition." An observable or substantial change in behavior may include anxiety, depression or aggressive behavior. Examples of emotional abuse include making fun of a child, calling a child names, and always finding fault are forms of emotional abuse. Emotional abuse is more than just verbal abuse. It is an attack on a child's emotional and social development, and is a basic threat to healthy human development.

Sexual abuse is defined as employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct; or rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. All states include sexual abuse in their definitions of child abuse. Some states specify specific acts of abuse. Sexual exploitation is defined as "the use of a child for sexual purposes in exchange for cash or in-kind favors between a customer, intermediary or agent and others who profit from the trade in children for these purposes—parent, family member, procurer, or teacher". Some common examples include child prostitution or in child pornography.

Recognizing Child Abuse and Neglect: Signs and Symptoms (see also Schilling & Christian, 2014).

It is helpful for clinicians to be aware of the signs of child abuse and neglect. The following signs are provided by the Child Welfare Information Gateway (2019).

Signs of Physical Abuse

Consider the possibility of neglect when the child:

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and cries when it is time to go home
- Shrinks at the approach of adults
- Reports abuse to you or another adult caregiver

Signs of Neglect

Consider the possibility of neglect when the child:

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently hungry and dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Signs of Sexual Abuse

Consider the possibility of sexual abuse when the child:

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

Defining Elder Abuse and Neglect: Signs and Symptoms

Elder abuse is a social problem that creates numerous ethical concerns for mental health professionals, care teams, and caregivers. According to the World Health Organization (WHO) (2017), one out of every six elderly people experiences abuse, though only 1 out of 24 abuse cases is reported. One of the challenges of defining elder abuse is that to date, there has not been an agreed upon definition and conceptualizing any "abuse" has cultural implications and contexts to be considered (Saghafi, Bahramnezhad, Poormollamirza, Dadgari, & Navab, 2019). Loosely defined, WHO that states elder abuse consists of committing an inappropriate action in a trustful relationship that causes harm to an elderly person. In addition, in the United States, not all states have the same definitions for elder abuse and therefore the laws are enacted differently depending on where a person resides (Saghafi et al., 2019; Scheiderer, 2012). Three main types of misconducts in connection with vulnerable elderly people include physical abuse, financial exploitation, and neglect. Abuse is defined as intentional harm to people. Financial exploitation is an illegal process of using vulnerable elderly people to obtain assets without their conscious consent. Neglect is the inability of an elderly person for self-care (self-neglect) or failure of a caregiver to provide appropriate care (Mohebbi, Zahednejad, Javadi, & Saki, 2016).

Signs of Elder Abuse

There are signs of abuse, neglect or exploitation that might alert professionals to the possibility of problems. Although it is important not to take any of these signs as a "definitive," they should certainly be taken seriously. There is also the difficulty that some of these things may not be signs of abuse, but of client report skewed by declining mental state.

Here are some common indicators of elder abuse (Robinson, Saisan, & Segal, 2019):

1. Sudden change in behavior such as decreased grooming, staring vacantly, fear, agitation or anxiety, unexplained crying, disorientation, depression, unusual behavior, such as biting, rocking, withdrawal or shame.

2. Discrepancies between a person's standard of living and his/her financial assets, or a depletion of assets without adequate explanation. Money or personal items that are missing without explanation, unpaid bills, reports of a new will or power of attorney.

3. Withdrawn, apathetic, fearful, or anxious behavior, particularly around certain persons. The victim may suddenly and without explanation express a desire not to visit or receive visits from family or friends.

4. Malnourishment, as evidenced by weight loss, including dehydration (cracked lips, sunken eyes), poor overall hygiene, over-sedation in session, inappropriate clothing, lack of healthcare appliances such as dentures or glasses.

5. Physical injuries, bruises, especially when not over bony prominences, unexplained or implausible injuries, multiple emergency room or physician visits, broken glasses.

6. Reports of urinary tract infection, vaginal or anal bleeding.

7. Medical needs not attended to.

6. Sudden, unexplained changes in the victim's living arrangements, such as a younger person moving in to "care for" them shortly after meeting.

It is frequently very difficult to detect abuse. Typically, abusive behavior occurs in private and the victim may be unwilling or unable to describe the attacks. When reports are made, they are frequently not believed.

The following is a list of actions by a caregiver that may be an indication of possible elder abuse. It is important to assess each situation on a case-by-case basis.

1. Caregiver not wanting elder to be seen on his/her own

2. Caregiver providing a different accounting of events (such as how elder received bruises, etc.) than elder

3. Lack of cooperation by caregiver for recommended treatment plan

4. Caregiver attempts to isolate patient from family, friends, activities.

5. Caregiver denying elder right to make decisions about care, living arrangements, etc.

6. Observable behaviors, such as anger, and substance use.

7. Dependence of caregiver on elder for financial support.

In a review of studies about elder abuse, Saghafi, et al., (2019) found that the principle of respect (dignity and autonomy) is almost always violated in psychological abuse, and the principle of non-maleficence in cases of neglect and physical or financial abuse are the most violated. Maintaining autonomy is an issue for most aging adults and includes independent decision-making without restrictions. This becomes challenging when a person begins to experience cognitive challenges or difficulties and must rely upon others to assist them. Respect for confidentiality and trust is one of the most important ethical principles that must be considered by professional and caregivers alike.

Health Insurance Portability and Accountability Act (HIPAA)

Describe a recent situation you had in which HIPAA was a central issue.

Questions to Consider

1. Do you feel that we need federal laws governing the privacy of health information?
2. Are you familiar with the Health Insurance Portability and Accountability Act (HIPAA)?
3. Are you bound by HIPAA mandates?

Luis, a social worker at a community mental health center has recently attended HIPAA training. When he returns to his office he notices a number of problems, particularly with regard to the patient file room, which is unmanned and unlocked. He discusses this with his supervisor, and is then assigned the dubious role of being the point person for HIPAA compliance.

This learning material thus far has focused on the issue of confidentiality at professional (per ethics codes) and state levels. Providers should also be aware of Federal statutes contained in the Health Insurance Portability and Accountability Act (HIPAA). This discussion is meant to provide an introduction to HIPAA, and providers are encouraged to read about HIPAA in more detail. The U.S. Department of Health and Human Services (2019) has exhaustive reference material available on their website (http://www.hhs.gov/ocr/privacy/index.html).

If you are an individual mental health provider or work for a hospital, health plan or health care clearinghouse that transmits information electronically you are affected by HIPAA. HIPAA provisions call these individuals or institutions "covered entities." If you are not currently a covered entity it is still important to be familiar with HIPAA as its scope is expected to continue to broaden.

HIPAA has several components:

- *Portability standards* that ensure the continuity of healthcare
- *Privacy standards* that govern the disclosure of protected health information
- *Security standards* that protect the development and maintenance of health information

HIPAA was established to protect the privacy of **protected health information** (PHI). Broadly defined, protected health information is any information about health status, provision of health care, or payment for health care that can be connected to a person.

The HIPAA Privacy Rule creates national standards to protect individuals' medical records and other personal health information.

- It sets boundaries on the use and release of health records.
- It gives patients the right to examine and obtain a copy of their health records and to request corrections if data is incorrect.

The Privacy Rule requires activities, such as:

- Notifying clients about their privacy rights and how their information can be used. Providers are required to notify clients about Privacy Practices during their first session (notice of privacy practices)

- Adopting and implementing privacy procedures

- Securing client records containing individually identifiable health information so that they are not readily available to those who do not need them

Access to the Patient Record

Rory and his wife had been seeing Seth, a licensed marriage and family therapist. The couple has since separated and both members of the couple desire to begin treatment with a new provider. They provide a written request to Seth, asking for copies of their psychotherapy notes. Seth responds to the couple in writing, stating that he believes that this would be detrimental to them but states that he would be willing to forward the notes to their new treatment provider. Is this legal and ethical?

Mental health professionals have long been aware of the need to keep patient records confidential and the professional codes offer guidance:

- The AMHCA Code instructs, "Mental health counselors create, maintain, store, transfer, and dispose of client records in ways that protect confidentiality and are in accordance with applicable regulations or laws."

- The APA indicates that psychologists are expected "to maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium."

- The NASW Code of Ethics states: "Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access."

- The NBCC provides guidance about client records in case of unexpected death or incapacitation of the counselor: "NCC's shall create written procedures regarding the handling of client records…these procedures shall ensure that the confidentiality of client

records is maintained and shall include the identification of individual(s) who are familiar with ethical and legal requirements …"

Although this ethical mandate continues to be applicable with HIPAA, there are additional factors that providers must take into account. First, it is important to define the *medical/patient record* and contrast this with *psychotherapy notes.* Generally speaking, minimum requirements for the patient record should consist of the dates of treatment sessions; fees and payments; clinical information such as diagnosis, treatment plan, records of any testing, and records gathered from other providers.

According to HIPAA guidelines, mental health professionals can decide whether to release their psychotherapy notes to patients, unless patients would have access to their psychotherapy notes under state laws. Though the privacy rule does afford patients the right to access and inspect their health records, psychotherapy notes are treated differently. Patients do not have the right to obtain a copy of these under HIPAA. In addition, if a clinician denies a patient access to psychotherapy notes, the denial isn't subject to a review process, as it is with other records.

It is important to note that HIPAA's definition of psychotherapy notes states that these notes are kept separate from the rest of an individual's record. So, if a clinician keeps this type of information in a patient's general chart, or if it's not distinguishable as separate from the rest of the record, access to the information doesn't require specific patient authorization. According to the Department of Health and Human Services (HHS), it is sensible to keep the notes separate.

Notice of Privacy Practices

Another change that has occurred as a result of HIPAA is the need for individual providers and hospitals that are covered under HIPAA to provide clients with a Notice of Privacy Practices. This document details client rights involving release of information. The Notice of Privacy Practices should be incorporated into the informed consent process. The content of the Privacy Practices notice will vary. In general, this document details routine uses and disclosures of protected health information as well as an individual's rights and the provider or hospital's duties with respect to protected health information. The Notice of Privacy Practices may include:

- Information about *treatment issues* (e.g., the coordination or management of PHI with a third party
- Submission of PHI for Payment
- Exceptions to Confidentiality
- How Sensitive Health Information is handled
- Right of Access to medical records.

PUBLIC REPRESENTATIONS (ADVERTISING)

Questions to Consider

1. What must you consider in advertising professional services?
2. Are there practices one should explicitly avoid?

Mental health clinicians communicate to the public through a number of means. Public communication can include: the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper, magazine, or directory, or any printed matter whatsoever, with or without any limiting qualification. Advertising refers to the use of public representation intended to attract clients (e.g., marketing). Advertising may be done through printed materials, websites and social media.

At a high level, ethical guidelines pertaining to public representation/advertising is seen as an issue mostly connected to integrity and respect to clients. Accuracy in advertising allows clients to make appropriately informed decisions about professional psychological services.

Professional ethical codes contain guidelines on public statements:

- The AAMFT states: “Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis. Marriage and family therapists accurately

represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy in accordance with applicable law.

- The AMHCA instructs, "Mental health counselors in their professional roles may be expected or required to make public statements providing counseling information about the availability of counseling products and services. In making such statements, mental health counselors accurately represent their education, professional qualifications, licenses and credentials, expertise, affiliations, and functions, as well as those of the institutions or organizations with which the statements may be associated." In addition, it includes, "Mental health counselors market the following: highest counseling-related degree, type and level of certification or license, and type and/or description of services or other relevant information concerning areas of clinical competence… Accessibility of marketing materials: mental health counselors will create marketing materials that will be accessible to individuals with disabilities and diverse cultural groups… includ[ing] websites and other promotional materials."
- The *Ethical Principles of Psychologists and Code of Conduct* (APA) focuses on providing accurate information about "research, practice and other work activities" as well as psychologist credentials.
- The *Ethical Code for Clinical Social Work* (2016) states that public statements, announcements of services, and promotional activities of clinical social workers serve the purpose of providing sufficient information to aid consumers in making informed judgments and choices. Clinical social workers state accurately, objectively, and without misrepresentation their professional qualifications, affiliations, and functions as well as those of the institutions or organizations with which they or their statements may be associated. In addition, they should correct the misrepresentations of others with respect to these matters.
- The NASW Code includes, "Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials that they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others."

- The NBCC Code provides guidance, “NCC’s shall correct known misrepresentations of their qualifications and credentials by others and shall not allow such information to be used in a misleading way.”

According to Shead and Dobson (2004) three advertising practices are still generally regarded as failing to meet expectations of professional integrity: 1) claims of unique abilities; 2) claims of comparative desirability; and 3) appeals to a client's fear and anxiety. The position is taken that psychologists cannot stay within their ethical boundaries using these types of advertising practices while promoting the welfare of clients and maintaining the profession's ethical standards.

In general, direct solicitation of individual clients by mental health professionals is inadvisable. The central issue involves the potential vulnerability of the client relative to the therapist. Vulnerability may include client insecurities, emotional problems, or lack of information about professional psychology services.

Additionally, clinicians must be accurate in advertising, and avoid misleading statements. Consider the following case:

Roberta, a licensed social worker, was in full-time private practice, but volunteered a few hours at a local college counseling center. In exchange for her time, she was given a symbolic appointment as an adjunct professor at the university. She had new stationery printed that included this new title and the university seal, and used it for all her professional correspondence, a practice that led others to believe she held a closer affiliation to the university.

Acceptable and Unacceptable Elements in Advertising:

- Any public listing should accurately list the practitioner’s credentials and licenses Citing one’s highest earned degree within the area of practice is acceptable. Where possible, spell out credentials that may be confusing to the public (e.g., use “Nationally Certified Counselor in advertising rather than NCC)
- Accurately citing affiliations only in a way that does not suggest “endorsement” by a particular entity
- Therapists should have the requisite competence to perform the services listed.

- If one maintains a web site for marketing purposes, there is an obligation to keep it current with respect to services, fees, and other relevant data of interest to potential consumers.

The AAMFT Ethical Code (2015) states that "Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements (Standard 3.13 Public Statements).

DUTY TO PROTECT (TARASOFF and EWING)

Describe a recent situation you had in which "Duty to Protect" was a central issue.

Questions to Consider

1. What is your "Duty to Protect"?
2. Do you believe that the "Duty to Protect" is beneficial? Why or Why not?
3. What information should you consider in making a report?

Begin by considering the following excerpt from the *APA Monitor on Psychology* (Volume 36, No. 7 July/August 2005):

> Geno Colello was in psychotherapy with Dr. David Goldstein and was despondent over the breakup of his long-standing relationship with Diana Williams, who had recently begun dating Keith Ewing. On June 21, 2001, Colello asked his father to loan him a gun. When his father refused, Colello said he would get another gun and "kill" the "kid" who was then dating Williams. Colello's father relayed this threat to Goldstein, who urged him to take Colello to Northridge Hospital Medical Center. Later that evening a hospital social worker evaluated Colello. Colello's father told

the evaluator about his son's threat. Colello was admitted to the hospital as a voluntary patient but discharged the next day. The following day he shot and killed Ewing and then himself.

Many professionals reading the above case are likely surprised that this discussion of the "Duty to Protect" mandate was not initially illustrated with the Tarasoff case. Most mental health professionals are familiar with *Tarasoff v.* Regents of the University of California. On October 27, 1969 Tatiana Tarasoff was killed by Prosenjit Poddar, who was an exchange student at the University of California at Berkley. Poddar had pursued a romantic relationship with Tarasoff, however, she rejected his advances. Poddar sought treatment at the school's mental health facility and was assigned to a psychologist who diagnosed him with paranoid schizophrenia. Poddar spoke about his anger at Tarasoff and his plans to murder her. The psychologist attempted to initiate commitment procedures without success, and although Poddar was questioned by police he was released after agreeing to stay away from Tarasoff. Two months later, Poddar murdered Tarasoff.

Tarasoff's parents sued the university, the therapist, and the police for negligence. The case went to the California Supreme Court who found that the defendants were negligent in not notifying Tarasoff that she had been the subject of a homicidal threat. Specifically, the court ruled that the therapist is liable if (1) they should have known about the dangerousness based on accepted professional standards of conduct, and (2) they failed to exercise reasonable care in warning the potential victim.

The Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may carry out the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Duty to Protect rules are not without controversy. Some have been concerned that the Duty to Protect mandates erode therapeutic confidentiality (see Leeman, 2004) and that it will be extended to other areas including notification in the case of potentially risky sexual behaviors (see Bersoff, 2014; Russell & Nelson, 2012).

Returning to the more recent Ewing case, Ewing's parents sued Goldstein and the hospital. They alleged that Colello posed a foreseeable danger to their son and that both Goldstein and the hospital were aware of the threat but failed to discharge their duty to warn either Ewing or a law enforcement agency. At trial, Goldstein claimed he was not liable for failure to warn because Colello had never directly disclosed any intention to seriously harm Ewing. The hospital claimed that expert testimony was required to prove a therapist's liability for failure to warn. The judge sided with the defendants.

On appeal, in Ewing v. Goldstein and Ewing v. Northridge Hospital Medical Center, the California Court of Appeal held that the plaintiffs had a right to take their claims to trial. Specifically, the court held that the defendants' duty to warn could have been triggered by the statements Collelo's father made to Goldstein and the social worker regarding his son's threats. The court did not differentiate between threats conveyed directly by the patient and those related by an immediate family member of the patient.

In California, courts have expanded Duty to Protect laws to "include family members as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn." Court documents state: "The intent of the statute is clear. A therapist has a duty to warn if, and only if, the threat which the therapist has learned - whether from the patient or a family member - actually leads him or her to believe the patient poses a risk of grave bodily injury to another person." The expanded duty from now on applies to credible threats received from the patient, or the patient's family, however, the court made clear that its decision did not go beyond "family members."

For further information, please see Zur (2019), Soulier, Maislen & Beck (2010) and Fox (2010). Also, the Board of Behavioral Sciences (California). (2019). *Statutes and regulations relating to the practice of: Professional clinical counseling, marriage and family therapy, educational psychology, clinical social work.* Retrieved from https://www.bbs.ca.gov/pdf/publications/lawsregs.pdf

ACHIEVING AND MAINTAINING COMPETENCE

Questions to Consider

1. What is professional competence?
2. Why is competence so critical for mental health professionals?
3. How do mental health professionals achieve and maintain competence?
4. Are there ever times when it is okay to practice outside the scope of one's competence?

Michael, a licensed MFT, has been working with John and Maria. He has seen the couple in counseling for 6 months, and is supporting them in managing Maria's depression. Michael receives a phone call from John, expressing concerns that his wife has started engaging in eating disordered behavior, including purging. Michael is not familiar with treating bulimia, but feels that since she has already been treating the couple and that many of their communication problems are improving, the eating disorder does not need to be the focus of treatment. Maria's symptoms continue to increase in frequency, although Michael is not aware of this. At work one day, Maria experiences severe vertigo. She consults with her primary care physician and learns that Maria's blood panels are abnormal. Michael feels badly about this, but rationalizes that Maria has not made him aware that her symptoms have worsened. Had he known he would have referred Maria to a specialist (or would he?)

The above case study focuses on the issue of professional competence. Mental health providers cannot be expected to be "experts" in all psychological disorders or in treating all populations. Professional competence is at the heart of professional practice. It is so important that NASW considers it one of the core values of their profession. The concept of professional competence, however, is not unique to social work, but is a key factor in the ethical codes and professional training of all mental health professions.

- The AMHCA code instructs, "The maintenance of high standards of professional competence is a responsibility shared by all mental health counselors in the best interests of the client, the public, and the profession…Mental health counselors: represent accurately their competence, education, training, and experience including licenses and certifications."

- The APA code links competence to "education, training, supervised experience, consultation, study, or professional experience." This may not be the case for emerging areas of treatment, however "psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm." The code recognizes that psychologists may be needed if there is an emergent situation that supersedes their normal scope of competence.
- The National Association of School Psychologists (NASP; 2019) states, "School psychologists recognize the strengths and limitations of their training and experience, engaging only in practices for which they are qualified. They enlist the assistance of other specialists in supervisory, consultative, or referral roles as appropriate in providing services. They must continually obtain additional training and education to provide the best possible services to children, families, schools, communities, trainees, and supervisees."
- The NASW Ethical Code provides a comprehensive description of the many facets of competence, and one that encompasses the lifespan of professional counselors. The code states that "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."
- The NBCC states, "NCC's shall perform only those professional services for which they are qualified by education and supervised experience."

Despite the importance of the concept of competence, it not always easy to identify what one means by this term and to define it. Pope and Vasquez (2016) offer one such schema that is particularly appropriate to for early career professionals: formal education, professional training, and supervised experience.

In looking at these provisions, it is clear that the counselor in the case, although skilled in couples work, was practicing outside the scope of competence. There are a number of potential solutions for this, including referring Maria to an individual counselor who specializes in eating disorders. Another option would have been for Michael to obtain supervision on the case with someone skilled in treating these issues.

In addition to the facets of competence described in the NASW Ethics Code, ethics theorists shed additional light on the idea of competence. Pope and Vasquez, (2016), for example, describe competence as the ability to perform according to the standards of the profession. They list three factors in competence: knowledge, technical skills and emotional competence.

Competence implies that the treating clinician has the appropriate knowledge to identify therapy goals and interventions within the context of the patient's diagnosis and presenting issues. In addition to formulating goals, it is important to have the technical expertise to apply these interventions. As in the case study, competence means that a clinician would not treat a patient who presents with an issue with which they are unfamiliar or that requires specialized skills and knowledge.

In addition to knowledge and skills, emotional competence is an important factor. Clinicians need to be aware of personal problems that may interfere with their ability to provide care. The Ethical Code of NASP, for example states: "School psychologists refrain from an activity in which their personal problems or conflicts may interfere with professional effectiveness." These problems could include issues such as a divorce, a medical or psychological illness. In terms of mental illness or substance abuse that precede licensure, some boards may refuse to issue a registration or license when it appears that an applicant may be unable to practice his or her profession safely. Should such problems be subsequent to a professional entering practice, the provider may choose to limit their practice size, not see patients whose problems mirror their own, or may take a leave of absence.

For further resources on the topic of professional competence please see (e.g., Elman, Illfelder-Kaye, & Robiner, 2005; Pope and Vasquez, 2016; Roberts, Borden, Christiansen, & Lopez, 2005.)

Cultural Competence and Non-Discrimination in Providing Services

Describe a recent situation in which cultural competence may have been an issue.

Questions to Consider

1. Are there circumstances in which a provider should refuse to provide services?
2. How can clinicians develop cultural competency?

Monique, a licensed MFT, received a phone call from a couple seeking family counseling due to problems with the 14-year-old son. In a brief phone conversation, Monique learned that the couple was from Laos, and that their son was the first generation to be raised in the United States. The mother, who had initiated the phone contact at the request of the school guidance counselor, expressed disappointment in their son, who had not been getting the grades (As) that the family expected. Monique, who felt out of her depths due to a lack of knowledge about Laotian culture, referred the family to a colleague, who had worked with other Asian families. Has Monique responded to the request for services ethically? Legally?

The idea of competence also encompasses the need for mental health professionals to be culturally competent treatment providers. Legal and ethical mandates for mental health professionals stress the need for these professionals to respect and promote the welfare of individuals and families.

What is cultural competence? Cross and colleagues (1989), defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals, that enable them to work effectively in cross-cultural situations." Included in this definition is the idea that cultural competence relies of a person's ability to accept differences, continually assess themselves regarding culture and the dynamics of difference, and the development of cultural knowledge and resources within service models to meet the needs of diverse populations. Many believe that cultural competence is the most important factor in service utilization for diverse populations.

While competence should not be the end goal for practitioners, it is important to understand how to develop cultural awareness and competency in practice. Saldana (2001) describes three important components in developing cultural competence: knowledge, professional skills, and personal attributes. The *knowledge* component consists of knowledge of the client's culture, communication styles, and help seeking behaviors. *Professional skills* include application of specific techniques that will prove effective with diverse populations, the ability to discuss racial and ethnic issues, and the ability to use resources on behalf of minority clients. Perhaps the most important of these components are the *personal attributes* of the counselor, which includes a willingness to work with diverse populations and the ability to communicate genuine warmth and empathy. Other theorists who have examined multicultural competence in counseling include Johnson & Jackson (2014) and Sehgal et al (2011).

In addition to the need to maintain cultural competency, both ethical and legal mandates look at a closely related issue: provision of nondiscriminatory practices. Ethical codes provide an exhaustive list of criteria to promote non-discriminatory practices.

- The AMHCA Code includes that counselors must "recognize the important need to be competent in regard to cultural diversity and are sensitive to the diversity of varying populations as well as to changes in cultural expectations and values over time."
- The American Association of Marriage and Family Therapists (AAMFT) Code of Ethics also stresses diversity issues and the need for nondiscriminatory provision of services: "Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation."
- The APA Code (Principle E: Respect for People's Rights and Dignity) states that "Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices."
- The NASW Code of Ethics stresses the goal of social competence and ability to work with clients of all cultural groups. It urges social workers to understand "culture and its function in human behavior and society, recognizing the strengths that exist in all cultures" and to have an adequate knowledge base from which to understand their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups."
- The National Board for Certified Counselors Code of Ethics states: "NCCs shall demonstrate multicultural competence and shall not use techniques that discriminate against or show hostility towards individuals or groups based on gender, ethnicity, race, national origin, sexual orientation, disability, religion or any other legally prohibited basis. Techniques shall be based on established theory. NCCs shall discuss appropriate considerations and obtain written consent from the client(s) prior to the use of any experimental approach.

INFORMED CONSENT

Describe a recent situation you had in which informed consent was a central issue.

Questions to Consider

1.How would you define "informed consent?"

2.Why is informed consent important therapeutically and ethically?

3.Are there ever times when informed consent is unnecessary?

Informed consent provides clients with information necessary to make educated decisions about treatment. Pope and Vasquez (2016) call informed consent "a process of communication and clarification." (p. 74). Thus, the informed consent process is important, and allows mental health professionals to structure the therapy relationship. The key factor in the success of therapy is good communication between therapist and client. One of the best ways to establish rapport and open communication with clients is to enable them to make informed choices about therapy. The process of "informed consent" is an opportunity for the therapist and client to make sure they understand their shared venture. It is a process of communication and clarification. Professional codes of ethics are generally very similar in the way that they approach the informed consent process.

For an excellent discussion of informed consent, please see Fisher & Oransky (2008) and Rosenfeld (2002).

Providing clients with the information they need to become active participants in the therapy relationship begins with the initial session and continues throughout counseling. It is challenging to balance giving clients too much information and too little. Informed consent promotes active cooperation of clients. Clients sometimes don't realize they have rights and don't think about their responsibilities in solving their problems. They seek the expertise of a counselor without realizing that the success of the therapy relationship depends largely in their own investment in the process.

The following case helps to illustrate the importance of the informed consent process:

Anna is a 36-year-old morbidly obese female. Anna has been obese most of her life, and has consulted with a surgeon regarding gastric bypass surgery. The surgeon evaluates Anna, and feels that a gastric bypass would be an appropriate option for her. He asks Anna to have a series of tests, including a psychological evaluation. The evaluator feels that Anna needs more counseling prior to undergoing weight loss surgery, and that the primary focus of this counseling should be in developing coping skills and decreasing bingeing behavior. Anna is told to seek the services of a counselor skilled in treating eating disorders. This counselor could send the surgeon a note when he or she feels that Anna has the appropriate coping skills to manage the bingeing.

Anna contacts her insurance company and receives a list of eating disorder specialists. She contacts Sarah, a social worker with 15 years of experience in treating eating disorders. In her initial session with Sarah, Anna explains why she is seeking treatment for her bingeing. Anna clearly states that her ultimate objective is to have gastric bypass surgery. She also provides Sarah with a copy of her psychological evaluation.

Sarah and Anna meet for nine months. Both agree that Anna has made good progress on her bingeing, but recognize that her weight has not changed. Anna asks when Sarah believes that she will be ready to continue with the surgery process. Sarah replies that she does not believe in gastric bypass and surgery and would not be willing to support her in this and will not provide Anna with a letter for her surgeon.

In the case Sarah did not accurately represent her position on weight loss surgery or provide Anna with information that would have allowed her to seek alternate services.

Professional codes of ethics provide that clients have the right to be presented with enough information to make informed choices about entering and continuing the therapy relationship.

- The AAMFT Ethical Code, for example, is explicit in defining the informed consent process. It states: “Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. 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. 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 AMHCA Code instructs, “Clients have the right to know and understand what is expected, how the information divulged will be used, and the freedom to choose whether, and with whom, they will enter into a counseling relationship. Mental health counselors provide information that allows clients to make an informed choice when selecting a provider. Such information includes, but is not limited to: counselor credentials, issues of confidentiality, the use of tests and inventories, diagnosis, reports, billing, and therapeutic process. Restrictions that limited clients’ autonomy are fully explained.”
- The NASW Code guides, “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.” Related to technology, “Social workers should discuss with clients the social workers’ policies concerning the use of technology in the provision of professional services.”
- The NBCC instructs, “NCC’s shall obtain a client’s consent prior to the provision of services. In private practice or other similar situations, this consent shall be documented in writing in a counseling services agreement. This counseling agreement shall become a part of the client’s record.”

Although the content of the informed consent process may vary from client to client, it generally includes the following factors (see APA Code 10.01 Informed Consent):

- Goals of therapy/psychotherapy services
- Risks and benefits of therapy
- Approximate length of the process
- Alternatives to therapy
- Fees and services
- Qualifications and background of the counselor
- Treatment procedures
- Limits of confidentiality

If the provider needs to be HIPAA compliant (transmission of information to third parties) the informed consent process must also include specific information about access to PHI (protected health information)

In general, the informed consent process may be either "formal" (i.e., in writing) or "informal" (by discussion). There are several instances in which a person must be informed in writing. These include when a client needs to undergo psychosurgery or electroconvulsive therapy or is a participant in a research study.

MULTIPLE OR NON-SEXUAL DUAL RELATIONSHIPS

Questions to Consider

1.Have you ever encountered the possibility of entering a dual/multiple relationship? What happened and how did you respond?

2.Are all multiple relationships harmful?

3.Why may some dual relationships be harmful to clients?

4.What are the potential consequences to the client?

5.Are there consequences to the therapist?

As outlined in professional codes of ethics, practitioners are to abide by professional boundaries, or rather the acceptable behaviors within a professional relationship. Boundaries are imperative because they help professional choose appropriate behaviors and prevent harm to clients. Boundaries also help the professional practice risk management and professional boundaries are designed to ensure the safety of the client and practitioner alike. The primary ethical principles underlying the identification and maintenance of professional boundaries are maleficence and beneficence.

When considering a boundary discretion, it is important to determine whether it is a boundary crossing or a boundary violation. A boundary crossing is a deviation from classical therapeutic activity that is harmless, non-exploitative, and possibly supportive of the therapy itself (Aravind, Krishnaram, & Thasneem, 2012). An example of this is when a practitioner uses self-disclosure as a way to normalize a client's experience. They may have been able to avoid the disclosure, but it was not harmful. Jain and Roberts (2009) state that behavior intended to solely benefit the well-being and interests of the client constitute an acceptable boundary crossing. A boundary violation is of greater concern and consequence. A boundary violation is a clear deviation from standard professional practice with clearly harmful consequences (Aravind et al., 2012). Sexual relationships with clients and multiple-role relationships entered into for the clinician's benefit are examples of obvious boundary violations.

Ethical codes and state laws are aware of potential conflicts of interest in relationships with clients. There are a number of potential areas that could present potential conflicts of interests, but some of the most commonly occurring ones involve sexual relationships and non-sexual dual relationships. Sexual relationships are extremely harmful and will be discussed in the next section, but it is also important to review issues related to multiple/non-sexual dual relationships. The APA Ethical Code defines a dual or multiple relationship as 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 (Standard 3.05). Psychologists are expected to refrain from entering a relationship that "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."

In writing about social work, and the issue of dual relationships, Dewane (2010) makes the point that social work is a profession that prides itself on the use of self, and that this may lead both client and therapist to know one another in an emotionally intimate way. Dewane describes two viewpoints on dual relationships which she terms the "absolutist" view (that there are never circumstances in which dual relationships should occur) and the relativist (the view that moral standards are personal, subjective, and situational and that there may be circumstances that permit a dual relationship).

Consider the following case (National Association of Social Workers as cited by Dewane, 2010):

> *An oncology client with a terminal diagnosis, widowed six months earlier, is unemployed and has a 5-year-old daughter for whom she feels incapable of providing good care. She has no next of kin, so she has decided to relinquish her daughter for adoption. The client notices that her social worker is good with her child. The client also overhears the social worker talking about her plans to try to adopt a child. The client asks the social worker if she would consider being the adoptive parent for her daughter.*

While it would appear that the ethics code would be clear on whether this is permissible, as with many ethical dilemmas it is not. Standard 1.06C of the NASW ethical code states: "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." In this situation would the social worker's decision to adopt the child bring greater peace of mind? Or would it be exploitive or harmful?

Other codes of ethics contain guidelines as well.

- The AMHCA Code indicates, "Mental health counselors make every effort to avoid dual/multiple relationships with clients that could impair professional judgment or increase the risk of harm. Examples of such relationships may include, but are not limited to: familial, social, financial, business, or close personal relationships with clients."
- The NASP guidelines state: "Dual relationships with clients are avoided. Namely, personal and business relations with clients may cloud one's judgment. School psychologists are aware of these situations and avoid them whenever possible."
  The NASW Code guides social workers to, "…not engage in dual or multiple relationships with clients or former clients in which this 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 responsibility for setting clear, appropriate, and culturally sensitive boundaries."
- The NBCC code of ethics cautions against multiple relationships, and provide guidelines on steps the NCC should take if a dual relationship develops. The code states: "NCCs shall not engage in harmful multiple relationships with clients. In the event that a harmful multiple relationship develops in an unforeseen manner, the NCC shall discuss the potential effects with the client and shall take reasonable steps to resolve the situation, including the provision of referrals. This discussion shall be documented in the client's record."

Some examples of dual/multiple relationships include counseling a friend, family member or someone previously known to the therapist, providing individual therapy to two members of the same household, providing simultaneous individual and group therapy, entering a business relationship with a client and possibly when entering a non-counseling relationship with a former client.

In a concurrent multiple relationship, the clinician has a social or business relationship with the client at the same time as he or she has a professional relationship. In a consecutive multiple relationship, the clinician had a social or business relationship with the client either before or after

the professional relationship (Knapp & VandeCreek, 2012). Again, it is important to remember that not every multiple relationship is harmful. Standard 3.05a of the APA ethics code states: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical. The main issue to consider is whether a reasonable provider would be aware of factors that would make harm foreseeable.

A multiple relationship combined with harm to the patient can result in a claim of misconduct in malpractice courts. There are several types of multiple relationships that may be considered possible "warning signs" of inappropriate behavior and misuse of power:

Entering a social relationship with a client

Hiring a patient to do work for the therapist, or bartering goods or services to pay for therapy.

Suggesting or supporting the patient's isolation from social support systems, increasing dependency on the therapist.

It is clear that some multiple relationships are extremely problematic and others are not at all problematic. For example, many therapists see clients in both individual and group therapy. Some relationships, however, are both avoidable and potentially problematic. Consider the follow case example:

Geri, clinical social worker in private practice, receives a call from Mary, an old college friend. Mary has recently discovered that her daughter, Kim, has been cutting herself, and Mary is very concerned. Kim has refused all treatment, but says she is willing to talk with Geri, whom she knows and trusts. Geri is not entirely comfortable with this, but feels that the potential benefits of treating Kim would outweigh any of the issues related to dual relationships. Geri sets up a consultation, and will reassess her stand following the meeting with Kim. Did Geri make the right decision? Why or why not?

There are many potential issues with Geri's agreement to see Kim, even for only an assessment. On the whole, dual relationships jeopardize professional judgment, clients' welfare, and the process of therapy. Pope and Vasquez (2016) discuss the difficulties inherent in dual relationships and make the following points:

1. Dual relationships erode and distort the professional nature of the therapeutic relationship, which is secured within a reliable set of boundaries upon which both therapist and client depend.
2. Dual relationships create conflicts of interest and thus compromise the disinterest necessary for sound professional judgment. Management of transference and countertransference becomes impossible.
3. There is unequal footing between therapist and client, making a truly egalitarian relationship impossible.
4. The nature of therapy would change.
5. This could affect future needs of the client. In particular, the therapist could be compelled (by court order) to provide testimony on the client's diagnosis, treatment or prognosis.

In addition to the reasons discussed above, there are some that believe that nonsexual dual relationships have the potential to develop into more intimate sexual contact. Although this is certainly not always the case it is important to consider the possible difficulties with a therapy relationship if the potential for conflict of interest may occur.

Pope and Keith-Spiegel (2008) offer the following guidelines in considering whether a specific boundary crossing is likely to be helpful or harmful, supportive of the client and the therapy or disruptive, and in using due care when crossing boundaries.

- Imagine what might be the "best possible outcome" and the "worst possible outcome" from crossing this boundary and from not crossing this boundary. Does this crossing or not crossing seem to involve significant risk of negative consequences, or any real risk of serious harm, in the short- or long term? If harm is a real possibility, are there ways to address it?

- Consider the research and published literature on this boundary crossing. Discuss concerns about specific issues at the next meeting of your professional association or making a professional contribution in the form of an article.

- Be familiar with and take into account any guidance regarding this boundary crossing offered by professional guidelines, ethics codes, legislation, case law, and other resources.

- Identify at least one colleague you can trust for honest feedback on boundary crossing questions.

- Pay attention to any uneasy feelings, doubts, or confusions -- try to figure out what's causing them and what implications, if any, they may have for your decisions. These intuitive sources of information are often invaluable to ethical decision-making.

- At the start of therapy and as part of informed consent, describe to the client exactly how you work and what kind of psychotherapy you do. If the client appears to feel uncomfortable, explore further and, if warranted, refer to a colleague who may be better suited to this individual.

- Refer to a suitable colleague any client you feel incompetent to treat or who you do not feel you could work with effectively. Some reasons to refer range from insufficient training and experience to attributes of the client that makes you extremely uncomfortable in a way that makes it hard for you to work effectively.

- Don't overlook the informed consent process for any planned and obvious boundary crossing (e.g., taking a phobic client for a walk in the local mall to window shop).

- Keep careful notes on any planned boundary crossing, describing exactly why, in your clinical judgment, this was (or will be) helpful to the client.

It is not uncommon for practitioners to experience the dilemma of multiple-role relationships; in fact, they are often considered very common, unavoidable, and completely normal (Zur, 2013). Unlike sexual relationships, nonsexual multiple-role relationships are not automatically prohibited by the professional codes. Instead, the different codes address the need to avoid harmful multiple-

role relationships that take advantage of clients. There is no clear consensus about nonsexual multiple-role relationships in mental health treatment (Herlihy & Corey, 2015), and it is ultimately the responsibility of the practitioner to protect the client (Corey, Corey, Corey, & Callanan, 2015). It has been suggested that practitioners can ask themselves questions when reflecting upon whether a potential nonsexual multiple-role relationship is ethical and in the best interest of the client including:

- Is the multiple-role relationship necessary?
- Is it likely to cause harm? If not, is it likely to be beneficial?
- What are the motivations of the clinician and client in entering the additional relationship?
- What do colleagues think about the potential relationship?

Younggren & Gottlieb, 2004; Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007)

Giving and Receiving Gifts

Giving a gift is universal way to express gratitude and appreciation. Many therapists receive gifts from clients (especially at holiday time) or chose to provide a gift to a client. Even within ethical codes there is some degree of variability with regard to how to manage gift giving and receiving, and there is also variability within therapists' practices with some therapists declining all gifts and others accepting gifts of a more nominal nature. Gifts can be appropriate or inappropriate in terms of: their type (e.g. cookies versus an item of clothing), monetary value (e.g., small versus a large gift certificate), timing (e.g., a holiday versus after missing sessions), content, frequency, intent of the giver (e.g., thanks, manipulation, or something else), perception of the receiver about the reason for the gift, and their effect on the giver, receiver or anyone else that may be touched by the gift-giving (Knox, 2008; Grandhi & Grant-Kelis 2017). Knox (2008) additionally suggests that therapists consider the client's diagnosis, stating that those involving boundary disturbances may warrant particular care regarding gifts, the stage and length of therapy. Additionally, intimate or sexual gifts should be refused and that those of great emotional value (e.g., picture of dead fiancé) may be problematic.

A major consideration with regard to giving or receiving gifts is the welfare of the patient and to respond accordingly (Knapp & VandeCreek, 2012). For example, with nominal gifts such as Christmas cookies or a hand-drawn picture, many clinicians make a decision to accept the gift

and move on. While they may discuss the gift with the client, the universality of the exchange may not provide any clinical fodder. Thus, most therapists and ethicists agree that small, inexpensive, appropriate gifts, by either therapists or clients are neither counter-clinical nor unethical. Knox (2008) suggests that it is also important to consider the gift within the context of the client's culture and states that regardless of the therapist's ethical stance on the subject of gifts, he or she must be aware that turning down a small gift may mean disrespect to an individual who comes from a culture which stresses hospitality, reciprocity or the importance of gift-giving rituals. Similarly, gifts from children may be difficult to turn down due to developmental factors in their understanding of reasons for such refusal.

Many professional codes of ethics advise professionals about giving and receiving gifts from clients:

- The American Counseling Association (ACA) ethics code takes a flexible stance of gifts. The code states: "Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift."
- The AMHCA Code states, "Mental health counselors are cognizant of cultural norms in relation to fee arrangements, bartering, and gifts. Mental health counselors clearly explain to clients, early in the counseling relationship, all financial arrangements related to counseling…Mental health counselors usually refrain from accepting goods or services from clients in return for counseling services because such arrangements may create the potential for conflicts, exploitation and distortion of the professional relationship."
- The NASW Code provides guidance, "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."
- The NBCC Code of Ethics states that: "NCCs shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant because of the potential confusion that may arise. NCCs shall consider the value of the gift and the effect on the therapeutic relationship when contemplating acceptance. This consideration shall be documented in the client's record."

Therapists' gifts to clients has been given even less attention than clients' gifts to therapists. There is nothing unethical about providing a client with a small token, such as a form of transitional object (e.g., a rock) or a therapy-related educational material (e.g., workbook), or small gifts of minimal value given to child/adolescent clients to help establish the therapy relationship. As in any clinical intervention, therapists are cautioned to be aware of their own motives when giving the gift and to be careful about the perceived meaning of the gift. Consider the following case:

Marianne is a counselor working with Brenda, a client who has experienced domestic violence. After working together for well over a year, Brenda is able to leave her abusive partner. Marianne and Brenda often discuss the symbolism of a butterfly as transformation and change. While Marianne is attending a craft show one weekend she sees a small bowl in the shape of a butterfly. She considers purchasing the bowl as a gift for Brenda. Would this be ethically and clinically appropriate? What factors should Marianne consider in purchasing and presenting the gift?

Bartering in Psychotherapy Practice

Bartering is defined as the exchange of goods and services. There are times when clients need to seek therapy or counseling but do not have the money to pay for it. Bartering is also part of the norm in cultures and communities.

Why is bartering considered in this section on dual relationships? Some experts consider bartering a boundary crossing in the example of exchanging goods (e.g., artwork) for services. Thus, the artwork would replace the payment, but would it be unethical if the client could not afford services otherwise. Some would still argue against such an arrangement, citing the idea that such bartering could be exploitive because of the power disparity between therapist and client. Another argument against bartering is that bartering of services could also lead to inadvertent self-disclosure on the part of the therapist.

Consider the following case:

Virginia, a certified counselor, has been treating Anna, and administrative assistant. Within the course of an intensive treatment including childhood trauma issues, Anna loses her job and cannot afford to pay for treatment. Virginia tries to find a referral that will do pro bono work, and ultimately decides to establish a trade whereby Anna does some typing and filing without

access to the confidential information of others in exchange for continued counseling. Did Virginia make the right decision? Why or why not?

The issue of bartering for services is one that many clinicians encounter at some point in their careers. Bartering is more often more commonly seen in rural settings, where bartering for many types of services (not just therapy) is more commonplace. In the case study above, the decision to barter or not to barter is based on a current client's inability to continue to pay for needed services. In terms of bartering, the primary question is whether accepting goods or services increases the potential for conflicts of interest.

- The AMHCA Code indicates that "…bartering may occur if the client requests it, there is no exploitation, and the cultural implications and other concerns of such practice are discussed with the client and agreed upon in writing."
- The NASW Ethical Code suggests that in limited situations, and if bartering is accepted practice, Social Workers can consider this type of arrangement. Standard 1.13 states: "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."
- Similarly, psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative."

- The NBCC Ethical Code states: "NCCs generally shall not accept goods or services from clients in return for counseling services in recognition of the possible negative effects, including perceived exploitation. NCCs may accept goods, services or other nonmonetary

compensation from clients only in cases where no referrals are possible or appropriate and if the arrangement is discussed with the client in advance, is an exchange of a reasonable equivalent value, does not place the counselor in an unfair advantage, is not harmful to the client or their treatment and is documented in the record."

In the case above, if she were following NASW ethics Virginia must ask herself: 1) Is this an accepted practice among social workers in my community (she may seek consultation to answer this); 2) Would this create a conflict of interest (for example, if Anna does not do a good enough job, then what? What files will she have access to?) and 3) Is the arrangement negotiated fairly?

The case appears to meet NBCC criteria as there was no potential or referral and continued treatment was needed.

Business Relationships with Former Clients

A related example concerns entering a business relationship with a former client. While this is not explicitly prohibited by the ethical codes, it is important to consider the appropriateness of this based on the client's vulnerabilities. Some factors to consider are the power differential, duration of treatment, and clarity of the termination as well as client-specific vulnerabilities (Knapp & VandeCreek, 2012). Many professional codes address business relationships with former clients:

- The AMHCA Code identifies examples of dual/multiple relationships to include, among others, business relationships with clients and advises that counselors avoid such relationships (see dual/multiple relationships).
- The NASW Code instructs, "Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests."
- The NBCC Code of Ethics states: "NCCs shall discuss important considerations to avoid exploitation before entering into a non-counseling relationship with a former client. Important considerations to be discussed include amount of time since counseling service termination, duration of counseling, nature and circumstances of client's counseling, the likelihood that the client will want to resume counseling at some time in the future; circumstances of service termination and possible negative effects or outcomes."

It is not always easy to foresee the potential problems of such an arrangement. For example, Knapp and VandeCreek (2012) provide the example of a therapist that borrowed money from a former client to start an unrelated business. When the business failed, and the client requested payment, there were also allegations of undue influence in soliciting the loan. Thus, careful consideration should be given any situation regarding a former client.

Unintentional Dual Relationships

As helpers, dual relationships can sometimes be the result of gestures that clinicians make to help or support a client or in terms of incidental contacts or situations beyond a therapist's control. These may or may not be harmful. For example:

Karen, a clinical social worker has been working with Michelle, and adolescent client that has struggled with suicidal thoughts and behaviors. Michelle has been doing much better, and part of the recent treatment has focused on helping Michelle to come to terms with this aspect of her adolescent years. Michelle researches things she can do to help herself, and comes up with the idea of participating in an Out of the Darkness Suicide Walk to raise money for suicide awareness. Karen is very supportive, and makes a small donation to Michelle's team. Is this beneficial? Acceptable? Why or why not?

This is an example in which boundaries are unclear. From the limited circumstances, it may be that Karen has a therapeutic reason for participating in Michelle's efforts and that there could be no potential for harm.

Incidental contacts are another form of a dual relationship. Incidental encounters occur when therapists inadvertently encounter clients outside of the therapy room, such as at the supermarket or gym. At times incidental contacts can pose interesting clinical dilemmas, but are rarely the subject of ethical complaints. In situations such as these, it may be advisable to document this contact in the medical record. For more complex examples, discussion within therapy or consultation with a colleague may be needed.

Friendships with Former Clients

There is often a close relationship that occurs within therapeutic relationship, and both clients and therapists may feel closely connected. There are a number of important things that therapists should consider before entering into any type of non-counseling relationship with a former client. This includes friendships between therapists and former therapy clients. Many professional codes address this in their ethical guidelines.

- The AMHCA identifies personal friendships in the dual/multiple relationships section and advises counselors to avoid these types of relationships with clients (see dual/multiple relationships section).
- The NASW Code advises, "Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to clients… Social workers – not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship - assume the full burden for setting clear, appropriate, and culturally sensitive boundaries."
- The NBCC ethical code outlines these, and they are pertinent to all clinicians. The code states: "NCCs shall discuss important considerations to avoid exploitation before entering into a non-counseling relationship with a former client. Important considerations to be discussed include amount of time since counseling service termination, duration of counseling, nature and circumstances of client's counseling, the likelihood that the client will want to resume counseling at some time in the future; circumstances of service termination and possible negative effects or outcomes."

It is important to note that while friendships between therapists and clients do occur following therapy, it is never ethical to terminate a therapeutic relationship for the purpose of forming a friendship.

The NASW Code of Ethics states: (Standard 1.16d Termination of Services): "Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client."

Physical Contact with Clients

In addition to the issues connected to dual relationships, a related concern is that of physical touch in treatment. The NASW Code of Ethics provides some clear guidelines on the issue of nonsexual touch. The guidelines state: "Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact."

In reviewing the ethics code, it is clear that physical contact with clients is something that the mental health professional should not engage in indiscriminately. It is important to recognize when physical touch could be distressing to a client (such as in the case of prior sexual abuse or in certain cultures where touch is not comfortable) or when it could actually be helpful to the client. Consider the following case:

Kayla is a 28-year-old client with a history of long-term sexual abuse by an uncle. She has been in treatment with Catherine, a clinical social worker with 15 years' experience in treating abuse issues. Kayla trusts Catherine, and wants to work on her fears of physical touch. Catherine consults with a colleague, and both agree that this would be beneficial to the client. Catherine develops a hierarchy of situations in which Kayla will tolerate physical touch, culminating with a hug from Catherine. Kayla is able to work through the issues and feels a great deal of relief.

In the case described above Catherine had a clear therapeutic goal and there was appropriate consultation.

Online Relationships

We live in an age in which there has been a rapid proliferation of virtual relationships through personal, social, and professional networks online. This has resulted in more potential for blurring of boundaries due to these forms of communication. While our ethical codes have attempted to keep up with these changes, it continues to be a work on progress (Giustini, Ali, Fraser, & Kamel Boulos, 2018).

While there are a number of challenges associated with online relationships, one that has been sited is the confidentiality risks associated with use of social media. It is generally considered to be inadvisable to "friend" clients on social networking sites such as Facebook and where clients

would then potentially have access to personal information about the clinician. “Friending” a client on Facebook could also inadvertently lead clients to believe that the relationship exists outside of an online forum. Additionally, it is advisable to put thought into content that is posted on online blogs, Twitter, etc. and to know that clients may be able to access these methods of communication. It may also be helpful to address potential situations like this in the informed consent statement. For example:

> Friending
>
> I do not accept friend requests from current or former clients on any social media sites such as Facebook or LinkedIn. Friending clients as friends compromises counseling and treatment boundaries.
>
> Following
>
> I do not follow former or current clients on any social media sites such as Twitter or Pinterest. I am concerned with your privacy, therefore following would compromise your confidentiality.

Challenges connected to social media are covered by a number of ethical guidelines including those related to informed consent. Consider NASW’s 1.03e stating that social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services, 1.06a: “Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment; 1.06c: “Social workers should not engage in dual or multiple relationships with clients or former clients; and •1.07a: “Social workers should respect clients’ right to privacy; and 4.03: “Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.” It is important for social workers to develop policies for many things including social networking, use of Skype, email, texting and consumer review sites.

Knapp and VandeCreek (2012) also look at the use of Facebook and other social media through the lens of therapist self-disclosure. They provide the example of Facebook friend requests but also affirm that Facebook can be utilized for advertising and that professional information may

be appropriate to share (such as education and information on areas of specialty). They suggest that therapists have appropriate privacy settings to avoid potential areas of confusion.

Consider the following scenario (excerpted from Reamer, 2013):

A social worker in private practice created a Facebook page. The social worker has been providing counseling services to a client who struggles with anxiety and borderline personality disorder. The client becomes obsessed with the social worker and was determined to find out information about the social worker's personal life. The client found the social worker's Facebook page and was able to access personal photos and information. (Reamer, 2013)

This is an example in which a social worker did not fully consider what a client had access to with regard to his/her personal information. Stricter attention to social media policies may have avoided a potential ethical and clinical dilemma.

Many professional ethical codes were updated to address online relationships with clients:

- The AAMFT Code of Ethics states: Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technologically-assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technologically-assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.
- The AMHCA Code of Ethics advises counselors that "Twitter, Facebook, LinkedIn, Google Plus and other social media should be professional profiles that are kept separate from personal profiles. Counselors should not establish connections or engage with clients through social media. In addition, counselors need to have appropriate privacy settings so that clients cannot contact them on these social media sites, or access a site in any way."
- The NASW Code states, "Social workers should respect clients' right to privacy. Social workers should not solicit private information from or about clients except for compelling professional reasons. Once private information is shared, standards of confidentiality apply." In addition, "Social workers should be aware that personal affiliations may

increase the likelihood that clients may discover the social worker's presence on Web sites, social media, and other forms of technology. Social workers should be aware that involvement in electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients. Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to clients."

- The NBCC Code advises, "NCC's shall recognize the potential harm of informal uses of social media and other related technology with clients, former clients and their families, and personal friends. After carefully considering all of the ethical implications, including confidentiality, privacy and multiple relationship, NCC's shall develop written practice procedures in regard to social medial and digital technology, and these shall be incorporated with the information provided to clients before or during the initial session. At a minimum, these social media procedures shall specify that personal accounts will be separate and isolated from any used for professional counseling purposes, including those used with prospective or current clients. These procedures shall also address 'friending' and responding to material posted." In addition, "NCC's who use digital technology (e.g., social media) for professional purposes shall limited information posted to that which does not create multiple relationships or which may threaten client confidentiality."

Related to the topic of online relationships is also topic of ethical considerations in distance counseling. Although each of the major professional codes addresses the ethical use of technology, the information in the codes often refers to the general use of technology without providing specific guidelines. As identified earlier in the learning material the joint publication put forth in 2017 by the NASW, Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE), and the Clinical Social Work Association titled *Standards for Technology in Social Work Practice* is an excellent resource for practitioners. The standards are divided into four main sections related to the ways in which social workers and cognate professionals use technology to and the second section on the design and delivery of services is especially relevant to the topic of the provision of distance counseling.

Client Role in Multiple Relationships

We have looked at a number of factors to consider in the ethics of multiple/dual relationships. While ultimately it is up to clinicians to set clear relational boundaries, it is helpful to consider some of the client-specific factors in why dual relationships occur. Consider the following case:

Maura is a newer client who has also been in treatment with Leslie, a psychologist. She and Leslie are similar ages, and through small conversations they have in therapy it seems that Maura and Leslie share several interests. Maura is also on the board of a local business woman's professional networking group and invites Leslie to a function, knowing that she will enjoy it. She lets Leslie know that it will be a great opportunity to get to know others in the community and to potentially meet referral sources. She provides Leslie with the example of a local dentist who has met a number of her clients within the group, and states how good the participation has been for her business. Maura also states that she is looking forward to getting to know Leslie better. What should Leslie do?

This is an example of a potential boundary crossing initiated by a client. While from the example it does not appear that Maura has any type of motive beyond being helpful, Leslie should decline the invitation. This is an example in which Maura may not be aware of appropriate therapeutic boundaries. Many other professions (such as dentistry, medical doctors, etc.) do not have boundaries of this type.

Other clients may push boundaries as a result of their mental illnesses, such as viewing therapists as rescuers or potential intimate partners. In some of these cases, perceived rejection by the therapist may lead to anger. In these instances, documentation and consultation with colleagues, may be very helpful.

There are also examples of times when contact with clients outside of the office setting may be helpful and therapeutic. Examples are: sharing a restaurant meal with a client with an eating disorder, in vivo exposure with a client with anxiety, OCD or panic. These are examples that are both acceptable and clinically indicated.

Therapist Consequences of Boundary Violations

As this discussion has shown, non-sexual boundary violations present a mixed picture. In some cases they fall within the parameters of ethics and patient care, and in others may prove detrimental to the client. In cases where boundary violations are unethical or are not appropriate based on clinical needs, there can be consequences to both clients and therapists. Fry (2008) describes the following consequences to therapists:

a) Less personal time with family and friends
b) Less job satisfaction
c) Co-worker frustrations
d) Burnout
e) Compassion fatigue/burnout

Fry also lists "extreme" consequences of boundary violations:

a) Loss of job
b) Loss of license
c) Loss of professional identity
d) Loss of peers
e) Loss of professional relationships

SEXUAL RELATIONSHIPS WITH CLIENTS

Questions to Consider

1. Have you ever encountered a situation in which a client reported having a sexual relationship with a former therapist? How did you handle this situation?

2. Why do you believe it is harmful for a therapist and a client to engage in sexual intimacies?

Sexual contact of any kind between a therapist and a patient is unethical and illegal in all states. Sexual contact between a therapist and a patient can also be harmful to the patient. Harm may arise from the therapist's exploitation of the patient to fulfill his or her own needs or desires, and from the therapist's loss of the objectivity necessary for effective therapy. All therapists are trained and educated to know that this kind of behavior is inappropriate and can result in the revocation of their professional license.

The issue of sexual relationships between a client and a therapist is a very important one that can result in a great deal of harm to both parties. Our professional codes of conduct have mandates that specifically prohibit sexual intimacies between clients and therapists.

- The AMHCA indicates, "Romantic or sexual relationship with clients are strictly prohibited. Mental health counselors do not counsel persons with whom they have had a previous sexual relationship." In addition, "Mental health counselors are strongly discouraged from engaging in romantic or sexual relationships with former clients. Counselors may not enter into an intimate relationship until five years post termination or longer as specified by state regulations."
- The APA Code of Ethics prohibits sexual intimacies with current therapy clients or relatives or significant others of current clients. In terms of former clients, there is a two-year rule prohibiting sexual intimacies for "at least two years after cessation or termination of therapy." Even then psychologists "bear the burden of demonstrating that there has been no exploitation" in such relationships and that sexual or romantic relationships with former clients should only occur in extremely unusual circumstances.
- The NASW ethical standards also contain strong prohibitions against therapist-client sexual relationships. Standard 1.09 states: "Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced. Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with

clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries. 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. Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries."

- The NBCC code of ethics states: "NCCs shall not engage in any form of sexual or romantic intimacy with clients or with former clients for two years from the date of counseling service termination." Counselor following ACA guidelines are directed that 5 years in the minimum posttreatment timeframe.

Despite these strong ethical mandates, estimates of sexual relationships between therapists and clients place these in the area of .9-3.6 percent for male therapists and .2-.5 percent for female therapists. The most important predictor of whether a client will become sexually involved with a therapist is prior sexual involvement on the part of the therapist (Pope & Vasquez, 2016).

There has also been research to look at clinician variables in boundary violations. MacDonald et al. (2014) studied 100 healthcare professionals attending a continuing medical education program (primarily physicians). Of those that reported patient boundary violations, one fifth of the "boundary-challenged" participants reported moderate to severe childhood abuse; sixty percent reported moderate to severe emotional neglect.

An older study that also looked at the issue of sexual intimacy between clients and therapists (Hamilton & Spruill, 1999). The focus of this study was to look at therapist trainees in order to better identify and reduce risk factors related to trainee-client sexual misconduct. The authors attempted to delineate personal and situational factors that may constitute risk factors. The authors concluded that risk was more strongly related to the training rather than inherent within the trainees. Examples they provided were the decline of concern over transference and countertransference, failure to include education about client-therapist sexual attraction and the consequences of sexual misconduct in graduate psychology curricula, and the reluctance of supervisors to deal straightforwardly with trainees' sexual feelings. This could provide an interesting direction with regard to enhancing training programs.

There is evidence that sexual attraction to clients is a common occurrence with 82 percent of therapists reporting that this has occurred for them at some point in their treatment (Pope & Vasquez, 2016). Consider the following case:

Mark is an attractive graduate social work intern in a college counseling center. During the course of his internship, he meets a number of attractive students, but sets excellent boundaries. One of the students he counsels, Lori is particularly aggressive in her pursuit of Mark. Although Mark is attracted to her, he is able to resist any urge to act on the attraction, and uses the transference/countertransference in a therapeutic way. Lori and Mark discuss this sexual pull over the course of the semester, and are able to relate Lori's sexual transference to a history of inappropriate sexual boundaries in her family of origin. Lori does well in treatment, and makes a number of gains.

Mark completes his internship at the counseling center and goes on to work at a local social services agency. Approximately two years following the termination of treatment, Mark encounters Lori at a concert. Lori stresses how well she has been doing in the two years since they have seen one another, and again makes her interest known. Mark invites her to dinner the next evening. He feels that a sufficient amount of time has elapsed since the termination of his treatment with Lori, and that the two no longer have a professional relationship.

Certainly, to many reading this case study, Mark's legal and ethical obligations are clear. To many therapists in this situation, however, professional judgment is clouded, and there are some gray areas the state law and ethics codes.

Kenneth Pope, a mental health ethicist who writes about many topics but has a particular interest in the area of sexual intimacies between therapists and clients conducted a national survey of 1,320 mental health professionals (Pope, 2018). He looked specifically at sexual relationships that had occurred between therapist and client following termination of treatment. He found that half the respondents reported assessing or treating at least one patient who had been sexually intimate with a prior therapist; a total of 958 sexual intimacy cases were reported. Most cases involved female patients. He also assessed perceptions of harm arising as a result of these intimacies and found that harm occurred in at least 80% of the instances in which therapists engaged in sex with a patient after termination.

Pope (2018) lists warning signs of therapist sexual inappropriateness:

- Telling sexual jokes or stories.
- "Making eyes at" or giving seductive looks to the patient.
- Discussing the therapist's sex life or relationships excessively.
- Sitting too close, initiating hugging, holding the patient or lying next to the patient.
- "Special" treatment by a therapist, such as inviting a patient to lunch, dinner or other social activities.
- Dating.
- Changing any of the office's business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.).
- Confiding in a patient (for example, about the therapist's love life, work problems, etc.).
- Telling a patient that he or she is special, or that the therapist loves him or her.
- Relying on a patient for personal and emotional support.
- Giving or receiving significant gifts.
- Providing or using alcohol (or drugs) during sessions.

Similarly, Dr. Robert I Simon, President of the American Academy of Psychiatry and the Law (AAPL) and a distinguished author who frequently writes about boundary violations, including sexual boundary violations, looks at the sequence and flow of client/therapist relationships that underlie sexual relationships. While this is an older resource (1999), the offers following provides a useful understanding of this progression:

1. Gradual erosion of the therapist's neutrality. The therapist begins to take special interest in the client's issues and the client's life circumstances.

2. Boundary violations begin "between the chair and the door." As the client is leaving the office and, the therapist and client may discuss personal issues that are not part of the more formal therapeutic conversation. This discussion may include things about the therapist's interest, weekend plans, etc.

3. Socialization of therapy. More therapy time is spent discussing "nontherapy" issues.

4. Disclosure of confidential information about other clients. The therapist begins to confide in the client, communicating to the client that she is special.

5. Therapist self-disclosure begins. The therapist shares more information about his own life, perhaps concerning marital or relationship problems.

6. Physical contact begins (for example, touching, hugs, kisses). Physical gestures that convey to the client that the therapist has very warm and affectionate feelings toward her.

7. Increasing client dependency. The client begins to feel more and more dependent on the therapist, and the therapist exerts more and more influence in the client's life.

8. Extra-therapeutic contacts occur. The therapist and client may meet for lunch or for a drink.

9. Therapy sessions are longer. The sessions are extended because of the special relationship.

10. Therapy sessions rescheduled for end of day. To avoid conflict with other clients' appointments, the therapist arranges to see the client as the day's final appointment.

11. Therapist stops billing client. The emerging intimacy makes it difficult for the therapist to charge the client for the time they spend together.

12. Dating begins. The therapist and client begin to schedule times when they can be together socially.

13. Therapist-client sex occurs.

Consequences to the Therapist of Sexual Boundary Violations

Certainly, therapists are human and do make mistakes. sexual boundary violations result in a great deal of emotional trauma, and can also be also extremely detrimental professionally. While these results can vary, common reactions are guilt, shame, confusion and anxiety.

Consequences to the Client of Sexual Boundary Violations

It is well established that sexual boundary violations harm the client. Simon (1999) describes the types of harm that may occur. In addition to direct causation such as relapse or worsening of symptoms there are more indirect consequences such as loss of trust and damage to self-esteem.

- Disengagement from services
- Depression
- Emotional turmoil
- Cognitive distortion

- Shame, fear or rage
- Guilt and self-blame
- Isolation and emptiness
- Identity confusion
- Emotional lability
- Mistrust of authority
- Self-harm behaviors

Clearly these negative aspects of sexual boundary violations are important. It is key that mental health providers maintain a strong therapeutic frame and consider the possible consequences of their actions. Should they have any questions they may consult with colleagues or supervisors.

While clinician-patient boundary violations are all too common, strong training programs and clinical consultation appear to be effective in helping to decrease their incidence. Molofsky (2014) describes this as "engaging the inner ethicist."

INVOLUNTARY TREATMENT

A particular area of mental health treatment that can be rife with ethical dilemmas that professionals will most likely encounter is when a clinician must address a client's suicidality or when a client must be involuntarily committed to an inpatient setting. Involuntary treatment goes against the ethical principle of autonomy (also known as self-determination) and professionals must be careful to assess all potential information when deciding what to do in these typically emergency situations. The outcomes for involuntary treatment are either community treatment, or in many cases, hospitalization. A practitioner should be aware of the laws and statutes in the jurisdictions where they practice, as well as their discipline's code of ethics to help guide them whenever the context of treatment is involuntary. When a client is at risk of harm to themselves or others, involuntary hospitalization is unavoidable. Because the issues related to "harm to others" are different from those related to "harm to self," it is best to consider them separately. Reamer (2018) suggests four considerations when determining whether involuntary treatment is necessary because of a client's potential for harm to others:

- There is evidence that the individual poses a risk of violence to someone else, where the term *violence* is defined as the use of force to harm someone else.
- The risk is foreseeable, meaning that the practitioner has evidence to suggest that there is a significant risk of violence occurring.
- There is evidence that the risk of violence is imminent, meaning that the violence is likely to occur soon.
- The identity of the potential victim(s) is known.

Practitioners should carefully weigh the options with the client (if possible), and use an ethical decision-making framework to help guide their decision. In addition to decisions about whether a client should be hospitalized involuntarily, there are considerations about the practitioner's duties to warn and protect. The duty to warn is when a provider is legally required to release confidential information to the person at risk and/or local authorities. And the duty to protect is when a provider has a legal obligation to protect the potential victim/person being threatened (National Conference of State Legislators, 2018). The ethical dilemma that arises is between a practitioner's ethical responsibilities to the client and to public safety. A practitioner must weigh the option carefully and provide documentation for their decision(s). As part of the informed consent process, providers must inform clients that they have an ethical and legal obligation to break confidentiality when they have good reason to suspect that the client is at risk of harm to others. By providing this information at the beginning of treatment and revisiting at times throughout services, the potential for a lawsuit or miscommunication with clients about the professional's role can be minimized.

Suicidal Clients

Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. It is the 10th leading cause of death in the United States, with many others who are at great risk via thoughts about or attempts at suicide (Center for Disease Control, 2019). Suicide rates vary by race/ethnicity, age, and other population and demographic characteristics. The highest rates across the life span occur among non-Hispanic American Indian/Alaska Native, non-Hispanic White populations, Veterans, and sexual minorities. Working with clients at risk for suicide is one of the most challenging situations mental health professionals encounter in their careers (Jacobson, Osteen, Sharpe, & Pastoor, 2012). The core ethical dilemma

of working with a client at risk for suicide is the conflict among the principles of autonomy, beneficence, and nonmaleficence. These three principles are often in conflict and a practitioner is responsible to decide the best course of action, knowing they will have to violate at least one if not all of these ethical principles.

According to the literature, it has been suggested that the majority of suicides are preventable (Jacobson, Osteen, Sharpe, & Pastoor, 2012; Tondo & Baldessarini, 2011). Clients who discuss suicide are seeking help and talking about suicide does not increase the risk of someone attempting or dying from suicide (Jacobson, Osteen, Sharpe, & Pastoor, 2012; Tondo & Baldessarini, 2011). By providing clients with a practitioner's policy on suicide during the informed consent process (i.e., that there is a legal requirement to take action to protect a client at risk of harm to self), the providers is supporting the safety and autonomy, as well as the ethical principles of beneficence and nonmaleficence to the best of their ability. In addition to providing information on the informed consent process, clinicians should also assess for suicide throughout the course of the client-provider relationship. Practitioners have an ethical and legal responsibility to take appropriate action. As in the case of clients at risk of harm to others, the least-intrusive and -restrictive measure possible should be used. Available options range from the use of safety plans to hospitalization, with a client having as much input and collaboration as possible. The issue of confidentiality should also be carefully considered including the question, at what point is the client's right to privacy outweighed by the need to breach confidentiality? There is no single answer other than to remind practitioners of the responsibility they hold in attempting to meet these complex ethical responsibilities.

Consider the following example.

Jan has been in therapy for several months, dealing with issues of post-partum depression, stress, and difficulty with her husband. She is agitated and sad when she arrives at her appointment with her therapist of six months. Jan believes her husband is having an affair with his administrative assistant. Jan blames herself for not feeling herself since having their third child four months ago, and including an inability to communicate what she wants. She reports that they have not had sex since she got pregnant and she has no sexual desire. Halfway through the session, Jan becomes angry and says she wants to kill her husband and his assistant. When asking additional questions, Jan breaks down in tears and states she would never kill them, but she does want to kill herself. She

describes a plan to take several bottles of prescription drugs she's been saving up for the past two months upon leaving the session. The session continues and Jan states she doesn't want to kill herself, but she feels like she has no other option. Jan's biggest concern is abandoning her three children because her "husband doesn't care about them anyway." The practitioner is worried for Jan and her children's safety. The practitioner has recently attended a suicide prevention training with a key point being that whenever a parent is experiencing any form of suicidality due in whole or in part to problems in the marriage or partnership the children's safety should also be assessed, because filicide (although rare) is linked to this context (Holland, Brown, Hall & Logan, 2018). The practitioner asks Jan if she would consider going to the local hospital for an additional evaluation. She declines stating she doesn't want other people to know how she feels.

1. What are the ethical issues raised in this vignette?

ANSWER: The first consideration is whether there is risk of harm to others or self. If yes, is it sufficient enough to warrant involuntary treatment? Issues of autonomy, nonmaleficence, and confidentiality must be considered.

2. Should the counselor let Jan leave?

Consider the following possible answers and select the one you think is most appropriate. More importantly, identify the ethical principles that informed your decision.

NOTE: Some answers may be more appropriate than others, and the best/correct answer may depend on your profession's code of ethics.

a. Yes. Although there is a potential for suicide, there is not enough evidence based on the counselor's assessment to warrant involuntary treatment.
b. Maybe. Jan made a clear threat against herself, but the practitioner feels confident in the assessment that the danger is not imminent. There is also a clear plan to mitigate any ongoing potential for harm by having Jan contract for safety (e.g., removing lethal methods of suicide from the home, increased support by trusted adults who are nearby and willing to assist), and checking-in regularly with the counselor.
c. No. The fact that Jan was not willing to voluntarily submit to evaluation at the hospital proves that she is at risk for self-harm.
d. No. There is an identifiable risk for suicide, the threat is imminent, means are available, stressors unchanged (e.g., marital issues) and the practitioner possesses knowledge of these risks. The client should be involuntary committed for additional evaluation.

DISCUSSION: Each of the options might be ethically appropriate based on the principles used to support the decision, although some options are riskier than others (see discussion on risk tolerance below). The principle of *beneficence* would apply in that all four options are intended to increase someone's well-being. However, in this vignette, any decision might also violate the principle of *nonmaleficence.* Involuntary treatment can be considered maleficence because it diminishes the client's right to autonomy and privacy. Professional guidelines and laws governing involuntary treatment must allow for some subjectivity because there will always be contextual considerations. The practitioner might seek consultation with colleagues or other mental health professionals before making a decision. They might decide to continue the session with Jan to gather additional information or persuade her to voluntarily agree to evaluation. The informed consent process should include a discussion of situations in which involuntary treatment could occur.

ETHICAL DECISION-MAKING

Types of Ethical Dilemmas

When a situation arises in practice in which a practitioner must decide one course of action among several choices, they are faced with a dilemma. An *ethical* dilemma is one in which there is a moral imperative to take *more than one* action, but the professional doesn't know which imperative takes precedence in the specific situation (McConnell, 2018). If a decision does not have to be made, there is no dilemma. If there is a clear rationale for one choice over the other, there is no dilemma. It is an ethical dilemma only when a decision must be made *and* choosing either action compromises an ethical principle (Allen, 2012).

There are two types of ethical dilemmas with which practitioners must contend: "pure" (absolute) and "approximate" (Allen, 2012). Pure ethical dilemmas are those when two (or more) ethical standards are in conflict with each other. When this occurs, a practitioner must decide to the best of their ability and with guidance from their professional association's specific code of ethics what the best outcome for the client would be. Allen (2012) provides the following example of a pure dilemma. A practitioner "in a rural community with limited mental health care services

is consulted [about] a client with agoraphobia, an anxiety disorder involving a fear of open and public spaces. Although this problem is outside of the clinician's general competence, the limited options for treatment, coupled with the client`s discomfort in being too far from home, would likely mean the client might not receive any services if the clinician declined on the basis of a lack of competence" (para. 3). In this example, a practitioner must decide which outcome does the least amount of harm, provides a viable option for the client, and is within the scope of practice. An example of "approximate" dilemma is when a practitioner is a mandated reporter and must make a report of child abuse. By doing so, they are also are releasing confidential information which goes against their desire to respect a client's confidentiality (Allen, 2012). In this instance, a practitioner can rely upon their experience, code of ethics, supervision, laws, agency policies, and a specific ethical decision-making framework to aid in deciding upon the appropriate course of action.

Risk Tolerance

While practitioners strive to do no harm, often some level of risk is unavoidable. Thus, one's comfort level with taking risks is known as risk tolerance. When working with clients, practitioners must assess their own risk tolerance when ethical dilemmas occur. Some questions a practitioner must address include:

1. How comfortable am I with uncertainty? Can I work through ambiguity in a thoughtful, logical manner?
2. How do I react in an emergent situation? What is my immediate reaction when an ethical dilemma arises?
3. Am I able to place a client's needs above my own first?
4. Can I link my understanding and ethical decision-making practices to my professional code of ethics?

While ethical dilemmas often occur expectedly, knowing in advance one's own level of risk tolerance and one's approach to making ethical decisions can be helpful.

Cultural Humility: A Framework for Understanding Ethics

In most training programs, practitioners are taught ways to move towards becoming culturally competent when working with clients. *Culture* is made up of the beliefs, attitudes, norms, and values of racial, ethnic, religious, geographic, or social groups (Office of Minority Health, 2016). According to Louw, (2016), "cultural competence is described as a dynamic, complex and continual[ly] evolving process of skill development by health care professionals to respond appropriately to their clients'/patients' unique combination of cultural variables (which may include e.g. ability, age, beliefs, customs, ethnicity, language, gender and gender identity, sexual orientation, religion etc.) to ensure efficacy in working within the cultural context of their clients/patients". And while cultural competence has been the preferred term in many mental health related professions, the notion that one can ever be competent in another's experience is being challenged. Thus, rather than work toward competence, practitioners are now increasingly being encouraged to be culturally aware and sensitive, and work to be culturally humble in their work with clients.

Cultural humility for mental and behavioral health professionals goes beyond having knowledge of the specific cultural and minority groups with whom they work. It is a way of practicing that requires practitioners have an awareness of how their own culturally embedded ideals, beliefs, and prejudices affect their interactions with diverse clients (Hook, Davis, Owen, Worthington, & Utsey, 2013; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). This requires them to continually and critically reflect on themselves and their interactions with their clients. Via reflection, professionals can improve interactions with clients through honest appraisals of how their personal biases and deficits play into each interaction/session and each relationship, allowing them to address power imbalances within the counseling relationships as well as at the institutional levels. The cultural humility framework includes four intersecting elements of ongoing self-reflection, self-critique, lifelong learning, and a commitment to advocacy and institutional change to guide their work with clients (Hook et al., 2013; Ratts et al., 2015). The cultural humility framework recognizes the concepts of power, privilege, and oppression and, thus, calls on practitioners to be agents for change and promoters of social justice (Ratts et al., 2015). Professionals with humility are able to be "other-focused" and have an accurate view of themselves, their values, their biases, and a sustain their attention upon upholding ethical principles to the highest standard (Davis et al., 2013). These qualities allow practitioners to practice as

partners with clients from various cultural, ethnic, and racial backgrounds who undoubtedly have additional dimensions of diversity as part of their biopsychosocialspiritual make up. Ethical decision-making in a culturally humble manner requires a practitioner to responded to client values, preferences, and languages, and requires understanding the role of culture in all aspects of decision-making. The delivery of culturally sensitive services to clients is a basic responsibility of all mental health professionals that requires ethical conduct and culturally appropriate actions and interventions. This is possible when a provider is trained in using the cultural humility framework coupled with specific ethical decision-making frameworks. Below are several possible ethical decision-making frameworks that can be used in conjunction with cultural humility to ensure competent practice.

Ethical Decision-Making Models

Practitioners should rely on methods or frameworks for making ethical decisions. Regardless of specific discipline (e.g., social work, psychology, marriage and family therapy, school guidance), most would agree that they would choose models that promote critical thinking, self-reflection, professional judgment, and cultural competency/humility. In addition to recognizing the ethical dilemma, a practitioner must decide a course of appropriate action. It is an ethical dilemma only when a decision must be made *and* choosing one action compromises one or more ethical principles (Allen, 2012). The on-going process of ethical decision-making often has several steps, or rather, smaller decisions before rectifying the dilemma (Dolgoff, Harrington, & Loewenberg, 2011; Reamer, 2018). According to Evans, Levitt, and Henning (2012) a practitioner must:

- systematically evaluate and analyze the information,
- rank importance of ethical principles,
- document choices, and
- work toward the best possible outcome.

There are numerous ethical decision-making models. Finding and developing an ethical decision-making model involves the consideration of professional identity, practice setting, theoretical orientation, and personality (Remley & Herlihy, 2016). Commonly practitioners use what was taught to them or what is provided by their specific profession's code of ethics. Also, it

may be relevant to consider whether clinical theoretical bases are represented when selecting a decision-making model. Decision-making should specifically consider a multitude of perspectives in order to arrive at the most ethical course of action when faced with a dilemma (Corey et al., 2015; Remley & Herlihy, 2016; Welfel, 2016). When deciding on which model to use, Ling & Hauck (2016) suggest models should be accessible and appropriate for practitioners of all experience levels (i.e., new and seasoned practitioners). Since the helping professions are ever evolving, it is important for ethical decision-making to consider recent relevant research and literature as it applies to a situation, as well as to be broadly applicable (Ling & Hauck, 2016). Authors also suggest that models be adaptable for use with multiple ethical codes or as codes are updated or modified. While there are multiple ethical decision-making models, a few select models are presented below - a practice-based model, a code specific mode, and a theoretically supported framework called the ETHICS model.

Practice Based Model

One of the most well-known ethical decision-making models was developed by Corey, Corey, Corey, and Callanan (2015) in conjunction with the American Counseling Association. This model provides eight specific steps to guide a practitioner in deciding what action to take when a complex dilemma arises. The steps are:

1. Identify/recognize the problem or dilemma.
    a. Once a practitioner recognizes there is a dilemma the nature of the problem needs to be determined.
    b. The practitioner gathers information while consulting with the client.
2. Identify the potential issues involved.
    a. The practitioner can list, describe, and keep track of progress.
    b. The practitioner gathers information and assesses the rights and responsibilities of all parties involved.
    c. The practitioner recognizes cultural considerations that may affect the situation and decision-making process.
3. Review the relevant ethical guidelines.
    a. Professional codes of ethics, standards, and how they apply to the situation are reviewed.

    b. The practitioner assesses personal values and beliefs
4. Know the applicable laws and regulations
    a. Local, state, and national law/policies that may impact the situation and outcomes are reviewed.
5. Obtain consultation
    a. The practitioner should ask colleagues and supervisors to help assess the information and apply ethical principles
6. Consider possible and probable courses of action
    a. The practitioner brainstorms, identifies, and lists possible courses of actions while considering cultural, ethical, legal, and clinical ramifications of each possible solution/outcomes
7. Enumerate the consequences of various decisions
    a. The practitioner reviews each possible solution and the consequences of going with this decision.
    b. The practitioner considers cultural factors that may affect each solution.
8. Decide on what appears to be the best course of action
    a. The practitioner reviews all of the information above and decides upon a resolution and course of action.
    b. The practitioner keeps a record of this process, how a decision was made, factors involved in that decision, and the outcomes from those decisions.

(Corey et al., 2015)

The steps above are meant to guide in the decision-making process, but are not absolute. The actual steps taken to resolve a dilemma may not always progress in the exact order and some steps may occur more than once.

The following is a brief case example to illustrate how to use the steps to make the best decision possible. This is meant as a brief exploration and not all options are presented.

Jenny, a 27-year-old woman has been receiving counseling for the past two years. Her sessions have become less frequent, though she does not feel she is ready yet to terminate. In addition to being a counselor in private practice, the counselor is also a part time employee and supervisor

of direct staff in a nearby mental health clinic for children. During Jenny's most recent session with the counselor, Jenny tells him that she is experiencing increased anxiety due to taking on a new position in the same agency in which he works. Upon asking her questions, he realizes that while he will not be her direct supervisor, but there will be occasions where they will work with each other on specific cases in the agency where he would function as her supervisor. Jenny is aware of his position at the agency and does not see it as a conflict of interest. In fact, she has asked to return to bi-weekly sessions to address her increased anxiety and is relieved to "have someone who understands what it's like at the agency." The counselor explains the ethical dilemma he encounters when they enter into a dual relationship.

1. Identify/recognize the problem or dilemma.

   The issue in this scenario is that the practitioner and the client are now experiencing the potential for multiple relationships. The problem is that in addition to seeing Jenny in private practice, the practitioner is now a colleague and potential supervisor at the agency in which they are both employed.

2. Identify the potential issues involved.

   a. *Jenny is experiencing increasing anxiety and is still appropriate for counseling services.*
   b. *The practitioner is now in the role of therapist, colleague, and potentially supervisor even though they are in different programs within the same agency.*
   c. *Jenny does not want to end therapy and, in fact, wants to increase her sessions.*
   d. *A dual relationship is the conflict that must be addressed*.

3. Review the relevant ethical guidelines.

   a. *This is where a practitioner would go to their specific code of ethics for guidelines. For example: The NASW Code of Ethics guides social workers to, "…not engage in dual or multiple relationships with clients or former clients in which this 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 responsibility for setting clear, appropriate, and culturally sensitive boundaries."

b. *And so, the question arises, is this an unavoidable dual relationship?*

4. Know the applicable laws and regulations.

    a. *There are no laws that are applicable here, though the code of ethics of different disciplines are very clear as to what is in violation.*

5. Obtain consultation.

    a. *Given that there is an established therapeutic relationship (i.e., providing Jenny with counseling services over the last two years), a practitioner may have difficulty deciding if they should end their counselling relationship based on a possible dual relationship. Would it be possible to maintain the counseling relationship and not work with Jenny at the agency? How would this even be communicated to others due to confidentiality? What is the clinical significance of Jenny only now disclosing the new position given that she knew of the counselor's role in the agency where she sought employment? What are the clinical/therapeutic consequences to Jenny of terminating and referring? The practitioner should seek out his own supervision and consultation to talk through these issues.*

6. Consider possible and probable courses of action.

    a. *This is where the practitioner can brainstorm, identify, and list possible courses of actions while considering cultural, ethical, legal, and clinical ramifications of each possible solution/outcome. For example, the practitioner could ask Jenny to request that they not work with together at the agency. They could also terminate their counseling relationship and Jenny could be referred to another provider. Jenny could inform her new supervisor of the counseling relationship and waive some*

portion of her confidentiality so that the dilemma of the dual relationship could be systematically considered and addressed within the place of employment. What are other options you can think of?

7. Enumerate the consequences of various decisions.

    a. *If the choice is to do nothing, there will be a dual relationship between the practitioner and the client/staff. The practitioner has knowledge of Jenny that others do not and this could become an issue.*
    b. *Asking Jenny to request they not work together at the agency can be an option, but it cannot be guaranteed that they would not encounter each other or have to work together. This also involves an imbalance of power for the practitioner to suggest Jenny make such a request (i.e., does Jenny feel empowered to decline the practitioner's request?) There is always the potential for a dual relationship. As a supervisor at her place of employment there will be an even more obvious power difference.*
    c. *Jenny is not in a position to quit her job, as it is her livelihood. There are numerous qualified counselors to which Jenny could be referred to upon terminating with the counselor facing the ethical dilemma. However, there may be therapeutic consequences which will need to be addressed.*

8. Decide on what appears to be the best course of action.

    a. *Because Jenny is not in a position to quit her job and there are numerous qualified counselors for Jenny to continue her therapeutic work, they decide the best option would be terminate therapy and refer to another practitioner. They agree to share the dilemma with the new practitioner and further discuss the potential of requesting a formal arrangement through the agency, where their work wouldn't overlap should it become necessary.*
    b. *Document the decision-making process and different courses of actions, as well as all communications.*

A Code Specific Model

The following is an ethical decision-making framework based on the work of Forester-Miller and Davis (1996), Haas, Malouf, & Mayerson (1986), and Kitchener (1984) and is supported by the American Counseling Association as a preferred framework. This practical, sequential, seven-step, ethical decision-making model encourages practitioners to consider the worldview of their clients and others who may be affected in each step of the decision-making model (Luke, Goodrich, & Gilbride, 2013). It can be use in various settings and adjusted to work with other professional codes of ethics by changing out the correct code of ethics for the practitioner's specific discipline in step 2. The seven steps of this ethical decision-making framework are:

1. Identify the problem.
2. Apply the *ACA Code of Ethics* (or other professional code).
3. Determine the nature and dimensions of the dilemma.
4. Generate potential courses of action.
5. Consider the potential consequences of all options and determine a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action.

The ETHICS Model

Another popular model that is also supported by the ACA (2014) and other professional organizations is the ETHICS model. This is a grounded ethical decision-making model that draws from the latest relevant literature in ethics, ACA's suggestions for good ethical decision-making models, and updates in the ACA Code of Ethics (ACA, 2014). The steps of this model are:

- E - Evaluate the Dilemma
- T - Think Ahead
- H - Help
- I - Information
- C - Calculate Risk
- S - Select an Action

E—Evaluate the Dilemma

In this step, the identification and assessment of the ethical dilemma occurs which provides the foundation for the application of the remainder of the model (Remley & Herlihy, 2016). The practitioner utilizes their code of ethics to help frame and understand the dilemma. Upon determining the dilemma, the remainder of the ETHICS model can used to decide upon a course of action.

T—Think Ahead

Once a practitioner decides on what the dilemma is, the next step is to 'think ahead' to the possible outcomes of each potential action. One will identify the option, evaluate it, consider the consequences of each, and analyze the pros and cons for each option. Ideally, the practitioner is always seeking the best possible outcome for the client while maintaining ethical boundaries and the least amount of harm possible. This step is in alignment with the beneficence and nonmaleficence principles of professional ethical behavior (ACA, 2014). This step aids in identifying potential stakeholders and how each action will affect them. This often goes beyond the client and practitioner (Ling & Hauck, 2016).

H—Help

In this step, a practitioner seeks out assistance from others such as unbiased colleagues, consultants, and supervisors to talk through the different choices and courses of actions (Remley & Herlihy, 2016). This helps to normalize the different situations and understand multiple perspectives toward the best decision possible. Practitioners seeking help can ask, "in this situation, does this aspect of the code apply?" vs. "what should I do?" (Ling & Hauck, 2016). The latter question is too vague and practitioners should decide upon a course of action that fits their best judgment and ethical considerations. Consultants provide assistance in thinking through the different aspects of the situation, but do not provide specific answers. Questions for consultations often fall with one of four groups: legal, ethical, clinical, or risk management (Behnke, 2014; Ling & Hauck, 2016). Depending on the type of question, who the consultant should be differs (e.g., supervisor, insurance company, an attorney, or colleague).

I—Information

When gathering information, a practitioner should look beyond the facts of the case and the code of ethics of their discipline to other literature, laws, agency policies, and any other written information that pertains to the dilemma (Ling & Hauck, 2016). Consulting literature pertaining to evidence-based practice, best practices, and reputable journal articles relating to ethics are possible actions a practitioner can take when gathering ideas about the best possible actions to take and potential outcomes. Once they gather information, the practitioner can weigh the pros/cons of each action. Remaining open to all possibilities is key to the success of this step (Ling & Hauck, 2016).

C—Calculate Risk

As described earlier in this course, all practitioners have some level of risk tolerance and know that work in their discipline places them at some level of risk. Recognizing the risk involved in each possible outcome is an important component in the decision-making process.

S—Select an Action

During this step of the ETHICS model, the practitioner chooses the best action based on the information gathered and its analysis. This decision should be in alignment with the person's code of ethics and best evidence gathered during all previous steps. This information is then documented and shared with the concerned parties/stakeholders.

Using the same scenario from above about Jenny and her new job, the following is an example of how to use the ETHICS model to aid in the decision-making process.

E—Evaluate the Dilemma

The ethical dilemma is the possibility of a dual relationship between the practitioner and Jenny. In all of the codes of ethics, each discipline states that a practitioner should avoid dual relationships or multiple roles with a client whenever possible. Outlined in the different codes of ethics, is the definition of what constitutes multiple relationships and potential ethical violations (i.e. confidentiality, autonomy, etc.).

T—Think Ahead

The practitioner would consider all the possible roles or interactions Jenny would have in either setting and the different potential courses of action to take.

H —Help

In this step, the practitioner could seek consultation from a supervisor to assist in understanding the application of the code of ethics, and its applicability to this specific case. He could further discuss the clinical implications of the dilemma (i.e., Jenny knowingly accepting a job where he performs a different role) and of continuing or terminating the therapeutic relationship with Jenny.

I—Information

Once consultation is obtained, a practitioner may look at the literature pertaining to multiple relationships, the consequences of participating in them, boundary discussions, etc. He must determine if he can in fact be in both roles with Jenny and stay objective and effective, as well as protect Jenny's best interest and confidentiality, and manage power imbalances.

C—Calculate Risk

What are the possible consequences to remaining Jenny's therapist and working with her at their shared place of employment? Would her confidentiality as a client be maintained? Is that possible? Can the practitioner objectively supervise Jenny, even occasionally, without allowing their therapeutic relationship to be a factor for consideration? What would be the consequences of ending treatment and providing a referral? These questions among others must be considered, as well as the level of risk for both Jenny and the practitioner.

S—Select an Action

A course of action and decision should be made based on the previous steps of the ETHICS model. In this case, because Jenny cannot seek other employment and there are other available and qualified counselors for her to work with therapeutically, the best action would be to terminate and refer Jenny to another practitioner. As part of their termination, discussions should be had about their future interactions at work, Jenny's confidentiality regarding their counseling relationship, and agreements about managing the ongoing potential for ethical issues even when their therapeutic relationship is no longer active.

The above section on the various ethical decision-making models seeks to provide brief overviews and application of the models to a specific case. In no way are these explanations exhaustive and several other courses of action may be considered when deciding which to take. These are meant as a guide to help consider the different facets of the models and to use as one begins to grapple with an ethical dilemma.

Avoiding Common Ethical Pitfalls and Dilemmas

According to Smith (2003), there are specific ways practitioners in all mental health professions can avoid common ethical pitfalls and dilemmas including:

1. Recognize what is meant by the term *multiple relationships*.
2. Protect client confidentiality.
3. Respect autonomy of clients.
4. Understand why supervision is important and what supervisory responsibilities are.
5. Distinguish specific roles (client vs. practitioner).
6. Document all interactions and communications.
7. Practice within one's competency and level of expertise.
8. Understand what constitutes termination.
9. Use all available data and evidence when making decisions.

SUMMARY

Regardless of discipline and training, all mental and behavioral health practitioners will likely encounter ethical dilemmas. Deciding how to apply one's code of ethics and choosing a particular decision-making framework takes time, skill, consultation, and knowledge. It is the duty and professional obligation to provide services in an ethical manner that serves to increase the well-being and integrity of the client. Each professional association provide practitioners with aspirational ethical principles, guidelines for practice, and standards for ethical conduct to which they are abide by in their practice. It is the responsibility of the professionals to understand and apply these often vague and nondirective standards to the best of their ability using the basic principles of beneficence, nonmaleficence, autonomy, justice, fidelity/integrity, and competency

as guidelines for ethical and effective practice. that are informed and supported by the ethical principles of is the first step in the ethical provision of mental health services.

Because ethical issues commonly arise within clinical practice, some general guidelines are:

- Familiarize yourself thoroughly with established standards
- Be sensitive to ethical problems as they arise, including the complexity of these issues
- Remember that ethical decision-making is an evolutionary process that requires you to be continually open and self-critical
- Engage regularly with colleagues and supervisors about ethical risks, red flags, and related issues.

There are many resources available to A practitioners when they encounter an ethical dilemma as discussed in this course. Ethical decision-making frameworks and case studies such as the one presented in this course are invaluable for helping practitioners identify, assess, evaluate, and explore ethical dilemmas to adhere to the ethical principles of practice as much as possible.

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