Title of Course: Ethics & Boundaries in Psychotherapy
CE Credit: 3 Hours
Learning Level: Intermediate
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Abstract:
This course gives psychotherapists the tools they need to resolve the common and not-so-common ethical and boundary issues and dilemmas that they may expect to encounter in their everyday professional practice. Among the topics discussed are definitions of boundaries; resolving conflicts between ethics and the law; boundary crossings vs. boundary violations; multiple relationships; sexual misconduct; codes of ethics of the APA, NASW, NBCC, and AAMFT; privacy and confidentiality in the age of HIPAA and the Patriot Act; ethics issues with dangerous clients; boundary issues in clinical supervision; ethics and cultural competency; technology and ethical boundaries; fees and financial relationships; termination of psychotherapy; and a 17-step model for ethical decision making.
* This course satisfies the ethics requirement for biennial relicensure for Florida mental health professionals.

Learner Objectives:
1. List four domains in which ethical boundary guidelines may be found
2. Distinguish between boundary crossings and boundary violations
3. List ways therapists can safeguard clients’ privacy under HIPAA regulations
4. Identify the ethical dilemma for psychotherapists posed by the Patriot Act
5. List three areas of clinical supervision where there may be ethical dilemmas
6. Identify ways therapists can manage their own cultural bias in psychotherapy
Introduction

*Before I built a wall I'd ask to know
What I was walling in or walling out,
And to whom I was like to give offence...*

*He only says, “Good fences make good neighbors.”*

Mending Wall - by Robert Frost

About Boundaries

In one sense, every discussion about ethics is a discussion about boundaries. In a larger sense, moreover, the psychotherapeutic process itself is all about boundaries – boundaries that join therapist and client, and boundaries that separate them; boundaries that define what is to be part of therapy and what is not; boundaries that the client may have compromised and must reinstate. It is this latter point that makes the issue of boundaries in psychotherapy one of the fundamental agendas for any therapeutic process: the fact that many clients find themselves in adverse situations they themselves have created by failing to establish effective boundaries. The ethics component is the therapist’s roadmap for providing assurance that therapeutic boundaries will be established and maintained throughout the client’s therapy experience.

Clear boundaries are necessary in order for both therapist and client to understand the nature and purpose of their relationship with each other. According to Ofer Zur, in his book *Boundaries in Psychotherapy* (2007, p. 3), boundaries in therapy “distinguish psychotherapy from social, familial, sexual, business, and many other types of relationships.” Confusion about the therapist-client relationship can only interfere with the goals and process of psychotherapy. A client who comes to view the therapist as friend, lover, or business associate – anything other than his or her source of professional help – is likely to have difficulty making use of the therapeutic alliance. In consideration of the implicit power imbalance that exists between therapist and client, the burden of responsibility for maintaining boundaries always falls upon the therapist.

Nagy (2011, p. 135) emphasizes the therapist’s primacy in maintaining boundaries in the therapeutic relationship. “Psychologists have many patients and have learned through experience about boundaries between their personal and professional life. Patients often may have only one therapist and usually are quite naive about professional boundaries, trusting and relying on the experience of the therapist.”

The concept of boundaries is not limited to professional relationships. Nations, tribes, families, and individuals all have boundaries. Robert Frost wrote "good fences make good neighbors." Cultures have widely differing understanding of boundaries, and when people from one culture move to a new environment their sense of boundaries may evolve, more closely mirroring the beliefs of the place where they now live.

Boundaries are the limits that allow for safe connections between individuals. A boundary is that defining space which clarifies "you" and "me." Our understandings of what are acceptable boundaries grow out of our family of origin. A healthy boundary allows an individual to relate with genuineness to others. Persons with healthy boundaries know how to provide for their own personal privacy and safety (and by extension, that of their young children). Appropriate intimacy and the achievement of trust is possible in relationships because there is no fear of losing "self" in establishing connections with others.
Zur (2011) offers the following definitions, with a further refinement distinguishing two different types of boundaries: “Boundaries in therapy define the therapeutic-fiduciary relationships or what has been referred to as the ‘therapeutic frame.’ They distinguish psychotherapy from social, familial, sexual, business and many other types of relationships. Some boundaries are drawn around the therapeutic relationships and include concerns with time and place of sessions, fees and confidentiality or privacy. Boundaries of another sort are drawn between therapists and clients rather than around them and include therapists’ self-disclosure, physical contact (i.e., touch), giving and receiving gifts, contact outside of the normal therapy session and proximity of therapist and client during sessions.”

Discerning and maintaining appropriate therapeutic boundaries is no easy matter. Pope and Vasquez (2011, pp. 238-240) ask “what makes this area so hard for us?” They suggest that there may be five potential causes at work:

1. Major boundary dilemmas often catch us off guard, sweeping us into unfamiliar territory where we are expected to make quick decisions of great importance.
2. Opportunities to cross boundaries can tap into our basic needs, convincing us to mistake our own self-interest for the needs of the client.
3. The need for clarity about boundaries can be misunderstood as the need for inflexible boundaries reflexively applied. Inflexibility can never be an acceptable substitute for thinking through boundary issues on an individual basis.
4. Boundary decisions can evoke anxiety and even fear, in consideration of the possibility of lawsuits and ethics complaints.
5. Most of us have received relatively little guidance in making real-world boundary decisions in our classrooms and treatment guides.

Furthermore, persons who have unclear boundaries establish the "locus of control" outside themselves. They may allow others to define who they are, what they think, where they go. Intimacy for such individuals can easily lead to abuse if those with whom they relate prove untrustworthy. People with rigid boundaries, on the other hand, may be generally distant, unconnected, and lonely. These individuals have found "safety" through rejecting connections with others. Frequently these responses are a result of past abuse or emotional trauma. Intimacy and trust seem beyond reach. In either case, there is the potential for damage if clear and healthy boundaries are not maintained by the therapist.

Nearly every component of professional ethical behavior has something to do with boundaries. Privacy and confidentiality (including management of HIPAA considerations), multiple relationships, conflicts of interest, self-awareness, therapy with families and couples, personal, cultural and religious values, duty to warn, duty to protect, professional accountability, supervision and peer consultation, fees and fee setting are all permeated with boundary issues. Such issues transcend the domains of therapist orientation, professional ethics, and law. Thus virtually every professional organization and regulatory board that sets forth standards for the practice of psychotherapy has a published set of legal and/or ethical guidelines describing the boundaries of professional practice.

**Video:** Ofer Zur, PhD – *Boundaries in Psychotherapy and Counseling: Introduction to Boundaries* (YouTube 9:57).

In this introductory segment, Dr. Zur gives an overview of therapeutic boundaries and the many complexities contained therein.

Sources of Ethical Guidelines

Boundary guidelines may be found in a number of domains that attempt to inform or regulate ethical behavior in psychotherapy. These domains include historical tradition, training orientation, professional organizations, regulatory entities, and standards of care.

A classic historical example of early tradition in medical ethics is the Hippocratic Oath. Authored between the 3rd and 2nd Century BC, the Oath of Hippocrates was part of a great body of medical writings collected by the Library of Alexandria in Egypt, the great library of the ancient world. In the Hippocratic Oath, the promise is made that "In purity and holiness I will guard my life and my art" and that the physician will treat the sick and "will keep them from harm and injustice."

Training Orientation

Professional training in one or more theoretical orientations may dictate how the therapist views and maintains boundaries. To what extent does the therapist form bonds and alliances with the client? How does the therapist view issues of closeness and distance between therapist and client? In what specific ways might the therapist demonstrate best practice with regard to issues like fees, gifts, touch, self-disclosure, bartering, and contact outside of sessions? Such orientations will have a significant effect on how the therapist structures and maintains boundaries in psychotherapy.

Some therapists may choose to maintain rather rigid boundaries, considering therapeutic distance to be a mainstay of professional comportment, as well as the foundation of the therapeutic alliance. Others, who espouse humanistic, cognitive-behavioral, Rational-Emotive, existential, or Ericksonian approaches, may be inclined to engage in what might be described as “beneficial boundary crossings.” Examples of these might be the following:

- Hugging a grieving parent who has just lost a child
- Engaging in self-disclosure as a way of modeling
- Offering games, snacks or drinks to child clients
- Accompanying a phobic client outside the office as part of exposure therapy
- Bartering for goods with a client who would be otherwise unable to pay for treatment

Within this mindset of professional training or orientation, what might be seen as appropriate and beneficial in one approach might be viewed as objectionable in another.

Professional Organizations

Most national organizations that govern and represent members of specific professions have published standards and guidelines for ethical behavior in psychotherapy. While there are many areas of overlap in the ethical codes of the various professions, there are also a number of points that are specific to each profession. Each has its own unique history and set of values and traditions that may set up arenas in which there are special ethical issues to be considered. For example, psychologists perform certain professional activities – like psychological testing and forensic evaluations – that are not part of the repertoire of practitioners in other mental health specialties. Marriage and family therapists, who may place a special emphasis on relationship therapy, need to consider the ethical considerations of treating dyads and other social systems. Similarly, professional counselors and social workers have their own values, histories, and practice specialties.
Regulatory Entities

Every state that certifies or licenses individuals practicing in various professions also has laws and rules that govern the practice and behavior of those professionals. Certain behaviors that are considered unethical may be subject to civil and even criminal proceedings. The state or province in which one practices is, therefore, an important consideration in the definition and regulation of professional behavior. This also brings up complicated questions in the evolving practices of technology-assisted distance counseling, in which the therapist and the client may reside in different states. There are also issues that arise when the codified ethics of professional organizations and the laws of state and federal entities require professional actions that appear to be mutually exclusive.

Standard of Care

Standard of care refers to the level of proficiency against which any other psychotherapist’s work will be measured or compared. In other words, what any other trained therapist would do with reasonable experience or the minimum below which a therapist must not fall. According to Zur (2007, p. 7), the standard of care is “one of the most important concepts in mental health. It has been described as the qualities and conditions that prevail, or should prevail, in a particular mental health service, and that a reasonable and prudent practitioner follows.” Zur adds that the standard of care is largely derived from laws or statutes, licensing boards’ regulations, case law, ethical codes of professional associations, consensus of professionals, and common practices within the community. He notes further that the field of psychotherapy has wrested since its inception with the relationships between boundary crossing and the standard of care as manifested in such issues as touch, self-disclosure, gifts, and dual relationships.

Conflicts between Ethics and Law

Psychotherapists of all stripes – psychologists, social workers, professional counselors, marriage and family therapists and others – will inevitably encounter blurred boundaries and apparent or real conflicts among 1) the theoretical orientation of their professional training, 2) published ethical guidelines, and 3) the legal obligations imposed by a variety of regulatory entities. Where training, ethics, and law seem to violate each other’s boundaries, there are usually provisions in the code of ethics for resolving these differences.

A contemporary example of such a boundary violation is the “Patriot Act” and the practice of psychotherapy – an ethical boundary dilemma that will be addressed in greater detail later in this course. Two sections found in this legislation passed in October 2001 and reauthorized in 2005 can be used to require the release of medical and psychological records without notification of the client whose records are being demanded. This is in direct conflict with professional boundaries and the privacy and confidentiality guidelines of most professional codes of ethics. For example, the American Psychological Association’s (APA’s) Ethical Principles of Psychologists and Code of Conduct (APA, 2002) contains a number of guidelines for psychologists to use in protecting confidentiality and informing clients when a demand has been made for their records. As is the case with a number of other codes of ethics, the APA Code has a standard that obliges psychologists to disclose the limits of confidentiality in their verbal and written office policy statements. This is an important practice to be observed by all psychotherapists, since most clients (and probably most therapists) might be surprised to learn that terrorism has had an impact even on the boundaries of privacy in their therapeutic sessions.
A more recent example was addressed by APA in 2010, in response to potential psychologist involvement in what were known as “enhanced interrogation techniques” during the last Bush administration. APA amended two ethical standards in APA’s “Ethical Principles of Psychologists and Code of Conduct” (2002): standards 1.02 and 1.03, which address situations where psychologists’ ethical responsibilities conflict with law, regulations, other governing legal authority, or organizational demands. Previously, it appeared that if psychologists could not resolve such conflicts, they could adhere to the law or demands of an organization without further consideration. That language has now been deleted and this new sentence added: “Under no circumstances may this standard be used to justify or defend violating human rights.” Following are the two ethical standards and the changes adopted. Language that is underscored was newly adopted.

1.02, Conflicts between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03, Conflicts between Ethics and Organizational Demands
If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.


Purpose of This Course

While there may be occasional allusions in this course to areas where ethics and law overlap or conflict, this course is by no means intended to be a dissertation on the legal considerations of practicing psychotherapy in any of the states or provinces. Nor is it offered as a compilation of rules to be observed in the maintenance of ethical boundaries in the practice of psychotherapy. While there is no lack of legal requirements and ethical standards, ethical practice ultimately boils down to the kinds of informed and responsible boundary decisions therapists make in their everyday professional activities.

A colleague of mine once described ethics as “what you do when no one is watching.” While this seems to say it all, there are – in reality – plenty of people and organizations watching. It seems likely that a professional’s personal code of ethics evolves from an inner sense of right and wrong, a healthy set of personal and professional boundaries, an informed awareness of relevant published standards, years of supervised experience, and ongoing consultation and lifelong continuing education. It will become clear throughout this course that ethical practice is more process than content, with individual professionals left to make individual decisions when ethical challenges present themselves. This is exceptionally well stated by Pope and Vasquez, (2011, p. 18):

We cannot avoid an ethical struggle by focusing only on the law and claiming “It violates no law [or the law requires it] so it must be ethical.” We cannot shrug off ethical responsibility by explaining that we were just following what our supervisor told us to do. We cannot hide behind ethics codes as refuge from an active, creative search for the most ethical response.

Awareness of the ethics codes is crucial to competence in the area of ethics, but the formal standards are not a substitute for an active, deliberative, and creative approach to fulfilling our ethical responsibilities.
They prompt, guide, and inform our ethical consideration; they do not preclude or serve as a substitute for it. There is no way that the codes and principles can be effectively followed or applied in a rote, thoughtless manner. Each new client, whatever his or her similarities to previous clients, is a unique individual. Each situation also is unique and is likely to change significantly over time. The explicit codes and principles may designate many possible approaches as clearly unethical. They may identify with greater or lesser degrees of clarity the types of ethical concerns that are likely to be especially significant, but they cannot tell us how these concerns will manifest themselves in a particular clinical situation. They may set forth essential tasks that we must fulfill, but they cannot tell us how we can accomplish these tasks with a unique client facing unique problems . . . . There is no legitimate way to avoid these struggles.

This course will attempt to give psychotherapists the tools needed to resolve the common ethical and boundary issues and dilemmas that they may expect to encounter in their everyday professional practice. Its overall purpose is to provide the opportunity to step back and examine one’s own principles and practices within the context of boundary issues that are included in the ethical codes of four of the major professional associations of psychotherapists in the United States – the American Psychological Association (APA), the National Association of Social Workers (NASW), the National Board for Certified Counselors (NBCC), and the American Association for Marriage and Family Therapy (AAMFT).

**Common and Not-So-Common Ethical Considerations**

In the everyday practice of psychotherapy, professional therapists may regularly expect to encounter a number of ethical dilemmas, some of them commonplace and routine, others more exotic and challenging. Psychotherapists probably make numerous ethical decisions every day, frequently without any awareness they are doing so. With years of experience, such decisions may become reflexive responses, requiring little – if any – deliberation.

Examples of these “garden variety” ethical issues may be questions like these:

- You want to present your client with the opportunity to give informed consent for the treatment you are about to deliver. How do you assure that you include all of the relevant issues, and that the client understands and is competent to give such consent?

- A grateful client brings you a gift. Do you accept it and thank her, do you explain that you do not accept gifts from clients, or do you choose some other ethical course of action?

- You encounter a client in a social situation. In consideration of his right to privacy and confidentiality, do you approach him in a friendly manner or do you wait for him to take (or not take) the initiative?

- You receive an invitation on your professional LinkedIn page from a current client who has “googled” you and wishes to communicate via this medium. Does a digital connection constitute an inappropriate multiple relationship?

- You find that the new minister in your church is the husband in a couple you have been treating in marital therapy. Do you find another church, discontinue therapy with the couple, or consider some other course of action?

- A client tells you in a therapy session that another therapist in town has become socially involved with your client’s friend, whom that therapist was recently treating. Do you report this activity to the state licensing board, confront the other therapist, or choose some other course of action?
Of course, even the most mundane situations can quickly become highly complex ethical dilemmas that demand considerable thought and possibly even consultation with a peer or supervisor. For example, the issue of gift-giving can represent an emotionally charged transference transaction, requiring the therapist to respond with great sensitivity. In negotiating such a complex interchange, the therapist may have to walk a thin line between maintaining appropriate professional boundaries and acknowledging important transference issues.

Issues that come up infrequently, are highly complex or unusual, those the therapist has rarely or never encountered before, and those that pose ethical dilemmas may require some thought, research, consultation, or all three of these. The “Patriot Act” scenario introduced above may fall into this category. It is an example of a novel situation that throws complex contradictions into a boundary issue that may have been more straightforward before the introduction of this piece of legislation. Not only is it novel, but it is also likely to arouse conflicting values in the therapist. How does one simultaneously 1) observe the letter and spirit of the law, 2) protect the client’s right to privacy and confidentiality, 3) fulfill the ethical obligation of informing the client when demands have been made for private records, 4) conform to the ethical standards set forth by his or her profession’s code of ethics, and 5) satisfy personal values and boundaries?

Other issues that may pose more complex boundary challenges are situations in which there either is no clear ethical solution or in which there are multiple paths available to the therapist, all of which contain some ethical complications. Here is one example:

You have been seeing a married couple for relationship therapy for several months. They decide to divorce, and both request to continue to see you individually. You have a good therapeutic relationship with both of them, and both are in significant distress. Can you see them both without encountering boundary issues that might compromise the individual best interests of each; do you choose one or the other; or do you decline to treat either one of them?

In this scenario, if the available courses of action include seeing both, neither, or only one of the partners, all of these seem to involve some possible hazards and ethical questions. If you provide individual sessions to both partners, can you offer the kind of unequivocal support each deserves when there are adversarial issues to be resolved? Can you offer genuine impartiality when you are aware of the details of both partners’ agendas? On the other hand, if you choose to continue treating one or the other, or decline to treat either, aren’t there potential issues of abandonment?

In my first experience with this sort of dilemma, I chose a course of action I subsequently concluded was probably not in the best interests of my clients. I was treating a couple in marital therapy, seeing them in regular weekly conjoint sessions for more than a year. At some point they commenced divorce proceedings, accompanied by a number of contentious issues, including child visitation and child support. At the same time, both partners expressed the wish to continue therapy with me individually.

I anticipated that there would be complications with this course of action, and I discussed them with both partners. First, I suggested that one or both of them might feel unsure whether they had my undivided loyalty. Second, I wondered how it would feel to them knowing that I was aware of and responding to the other’s approach to the contended issues. Third, I thought one or both of them might be inclined – intentionally or not – to use therapy sessions as a way of manipulating my responses to the other.

Having been advised all of these possibilities, both partners persisted in their requests to continue therapy individually with me. In view of my long-standing relationship with both of them, I agreed to do so, but with one condition. I told them that if I began to perceive that any of the aforementioned dynamics began to detract from the full benefits of individual therapy for either one of them, I would initiate a process of referring both of them to other therapists.
Within a few weeks it became clear to me that both partners were unsure of my true loyalties, felt compromised at knowing that I was also responding to the other’s needs concerning the contended issues, and were inadvertently using therapy sessions to manipulate my responses to the other. It occurred to me that these dynamics emanated from the structure of the situation itself, regardless of my capacity to maintain separateness. In other words, no matter how well I was able to manage to keep things straight, we were unavoidably compromised by the situation itself.

After consultation with a number of my colleagues, I told both individuals that I had come to believe that – though no fault of theirs – my attempting to treat both was not working. I told them I felt that I was not providing them with what they both deserved – a therapist of their own. I began and completed the process of referring both to other therapists.

In the course of discussing this case with other therapists, I discovered that of my peers who had experience with circumstances similar to mine, some had chosen to treat both partners, some had chosen to treat one or the other, and some had declined to see either one. For my part, I have altered my procedures in couples therapy based upon this experience. As part of my informed consent process, I now advise couples who are beginning therapy that if the focus of therapy moves toward separation and divorce, I will refer them each to separate therapists so that they can both have what they deserve – a therapist of their own. I am aware that this approach is not without its own ethical dilemmas.

Why Study Ethics?

Why study ethical theory? We already have multiple layers of codes of ethics, laws, and guidelines available to us from a variety of professional and regulatory sources. Furthermore, after engaging in professional practice over a number of years, don’t we pretty much know what to do and not do in most situations?

There are five fundamental reasons for psychotherapists to study ethical theories, principles, and guidelines on a regular basis.

1. Therapy is important work. It can never be taken lightly. The consequences of therapeutic decisions have a major impact – sometimes more than we ever know – on the lives of those with whom we work. There is no room for questionable ethical practice.

2. Ethical practice is not simple. One of the most difficult challenges in developing professional ethics is acknowledging the occasionally overwhelming complexity of clinical decision-making. Any situation a therapist encounters may have layer upon layer of complexity; moreover, the ethical standards, laws, and research relevant to that situation may form a complex tangle. Certain clinical situations may introduce added layers of complexity when they call into play conflicting ethical and/or legal guidelines.

3. Therapists – like all human beings – are subject to certain prejudices, biases, and blind spots. We are all steeped in culture-bound traditions that may or may not be at the forefront of our awareness. Most importantly, we do not know what we do not know. In other words, if there are blocks of information about the client or about ourselves or about the situation that are not in our sphere of awareness, then we may act inappropriately as a consequence. No one is exempt. The antidote to such human proclivities is ongoing introspection, in the form of clinical supervision, consultation, lifetime learning, and ethical self-awareness.

4. The practice and process of psychotherapy is a dynamic – not a static – process. The world and the therapists in it change with time and technology. When communications media like cell phones, the Internet, and email become tools that are used even peripherally by therapists and their clients, new challenges to privacy and boundaries have to be acknowledged and managed.
5. To the extent that psychotherapists effectively regulate themselves, they will be able to maintain professional autonomy and avoid undue intrusions by outside parties. It is impossible to overstate the importance of this consideration.

According to Bernard and Goodyear (2008), there is an essential difference in the tasks and responsibilities of the professions as contrasted with other occupations. Professionals make an ethical covenant with society to exercise self-restraint, to give and not take from the patient/client, and to monitor self-interests. Although we hear of daily violations of these covenants, our society nevertheless continues to uphold these implicit standards, especially in a court of law when a client has somehow been abused by a professional. The professional is considered the person of power in the relationship.

Professionals 1) have substantially more autonomy than those in other occupations; 2) need to make judgments under conditions of uncertainty; and 3) rely on a knowledge base that is sufficiently unique and specialized that the average person would have difficulty grasping it and its implications (p. 1). In light of these considerations, there is an unspoken recognition that lay people may lack the requisite knowledge to regulate the professions. Society, therefore, maintains an implicit contract with the professions: they are permitted to self-regulate in return for the assurance that they will place the welfare of their clients (i.e., society) above their own interests (p. 2). Thus, the conscientious maintenance of ethical boundaries is the cornerstone of this contract.

Ethical Principles and Boundary Issues

The codes of ethics developed by various professional organizations have evolved over many years from early ethical theories and concepts. As the specific ethical challenges to each profession became clear, parts of the codes were tailored to the professional goals and practices of that profession. As we have already seen, this evolutionary process continues through the present day.

A number of intriguing boundary issues may be seen in the clinical applications of the ethical principle of autonomy. This principle has ordinarily been seen as the concept whereby clients’ freedom of choice is respected and encouraged (Zur, 2007, p. 69). Most codes of ethics address this principle in some form. For example, Section 1.8 of the AAMFT Code of Ethics states “Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions.”

The NASW Code of Ethics for Social Workers contains the most direct expression of the conundrum imbedded in the principle of autonomy. Section 1.02 Self-Determination states “Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.” The very next sentence goes on the say “Social workers may limit clients’ right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.”

The widespread practice of paternalism as it was expressed in the earliest years of social work has, of course, undergone radical evolutionary mutations. The most prominently displayed principles in most codes of ethics feature the autonomy rights of each client. Nonetheless, the basic premise still seems to lie dormant in provisions describing circumstances under which therapists may and must override the expressed wishes of their clients. While there are material differences between 19th century paternalism and the threat of imminent risk, the two are related in that they both require the therapist to weigh the ethical principle of autonomy against the possibility that the client is not presently capable of determining his or her own best interests.
In the contemporary marriage and family therapy literature there is some controversy over the role of the therapist in setting the agenda for couples therapy. On one side of the argument are those practitioners who would support the autonomy principle in setting therapeutic goals, placing the responsibility on the clients. Within this framework, the therapist would be seen as a facilitator, assisting the partners to come to some agreement about what they wish to have happen as a consequence of the therapy. They would be the ones to decide whether they wish to resolve their differences and stay together or agree to disagree and work toward dissolving the relationship. This essential agenda-setting decision belongs to the couple. The therapist’s task is to help the partners anticipate the positive and negative consequences of their proposed actions so that they can make a decision they can live with. This process is, of course, much more complicated when the two partners have differing goals.

This approach seems to be at peace with the provision in the AAMFT Code of Ethics referenced above, in which it is stated:

Article 1.8: Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise the clients that they have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

On the other side of the argument, there is the suggestion that marriage and family therapists have a responsibility to promote the value of keeping relationships together. From this perspective, the breakup of families is seen as a societal problem, and the role of the therapist is seen as doing everything possible to help the partners stay together. In the extreme of this approach, the therapist might even refuse to work with couples who decide that they wish to work toward dissolution.

The essential difference between these two approaches is in the perception of who is to set the agenda for therapy. This is a very basic ethics and boundary issue, with important consequences for how the therapy is to be conducted. Obviously, this issue also becomes an area for discussion in the first session as part of informed consent. Before clients consent to treatment, they need to understand their rights and responsibilities in the area of setting the goals for therapy. If the therapist has an agenda of striving to preserve relationships or of leaving that decision to the partners, this needs to be clear from the onset.

Which is it to be? Is there to be an assumption that the client has the ultimate right of self-determination or the assumption that the therapist knows best? This is a quintessential boundary issue, in that the condition of imminent risk, the practice of paternalism, or the introduction of the therapist’s own values may induce the therapist to consider an intentional boundary crossing. It is this type of clinical situation that requires that all of the proscribed safety nets be put into place and activated. These are times for consultation, supervision, careful reading of ethics codes and consideration of standards of practice.

**Boundary Violations**

Boundary violation is more a process than a single event. Few professionals would make a conscious decision to take advantage of a client. Yet when professionals deny or remain unaware of their personal significance, power, or authority they may begin the process of boundary violation by misusing that power. Any time a professional exploits a relationship to meet personal needs rather than the needs of the client, the boundaries have slipped and not only the client, but also the professional, is in peril.
Zur (2007, pp. 4-5) makes the distinction between boundary violations and boundary crossings. A “boundary violation” occurs when a therapist crosses the line of decency and integrity or misuses his or her power to exploit or harm a client. Boundary violations usually involve exploitative business or sexual relationships. And, as stated earlier, boundary violations are always unethical and are likely to be illegal. Boundary crossings are very different from boundary violations; they are more elusive and much harder to define. Most broadly, boundary crossing refers to any deviation from the strictest professional role...or from traditional, hands-off, ‘only-in-the-office,’ ‘no self-disclosure’ forms of therapy or departure from risk management procedures."

According to Zur (2005), psychotherapists often endorse many forms of helpful boundary crossings, such as:

- Walking with an agoraphobic client to an open space outside the office as part of an exposure or in vivo intervention.
- Self-disclosure as a way of modeling, offering an alternative perspective, exemplifying cognitive flexibility and creating authentic connections to increase therapeutic alliance or level the playing field.
- Joining with an anorexic at lunchtime.
- Holding or hugging a grieving mother who just lost a child.
- Taking a short “walk-and-talk” session with a restless adolescent.
- Providing snacks, drinks, play cards and small gifts for very young clients.
- Joining Native American clients in a sacred ritual, a Latin client in a wedding, a Catholic client in a confirmation or a Jewish client for a bar mitzvah.
- Bartering with the poor or with art-rich but cash-poor artists.
- Home-visiting an ailing or bedridden client to provide face-to-face therapy.

According to Zur, “intentional boundary crossings should be implemented with two things in mind: the welfare of the client and therapeutic effectiveness. Like any intervention they should be part of a well-constructed and clearly articulated treatment plan which takes into consideration the client’s problem, personality, situation, history, culture, etc. and the therapeutic setting and context. Boundary crossings with certain clients, such as those with Borderline Personality Disorders or those who are acutely paranoid, are not usually recommended.”

In summary, Zur concludes: “whether to cross or not to cross or to dual or not to dual should be determined by the client’s best interest. Boundary crossings should be implemented according to the client’s unique situation, condition, problems, personality, culture, history and the setting in which therapy takes place. The rationale of boundary crossing, like any therapeutic intervention, should be articulated (in writing) in the treatment plan. Consultations with experts are advised in complex cases. Similarly, unavoidable dual relationships require consideration of the client’s welfare as paramount. The unduly restrictive, analytic and risk-management emphasis on clearly defined, rigid and inflexible boundaries often interferes with sound clinical judgment, which ought to be flexible and personally tailored to the client’s needs rather than to the therapist’s dogmas or fears.”

The Zur Institute http://www.zurinstitute.com/dualrelationships.html provides an extraordinary offering of educational materials regarding multiple aspects of boundaries and multiple relationships.

**Triangulation**

A classic boundary issue involving therapeutic boundary crossing that is likely to arise sooner or later when the unit of therapy is a couple or a family is the process in which a dyadic system enlists a third system member for the purpose of establishing or maintaining balance, or homeostasis. Known in the family systems therapy literature as “triangulation,” this dynamic is perceived to come about when a two-person system is rendered unstable in the face of conflict. Murray Bowen (1978) was one of the first theorists to identify and describe triangulation in the early family therapy literature.
An example is a family that presents for therapy, identifying the disordered behavior of one of the children as “the problem” for which they are seeking help. Upon more detailed inquiry, the therapist determines that the parents are engaged in a highly conflictual process, which they are neither acknowledging nor directly addressing. They are unknowingly enlisting the complicity of one of their children in de-intensifying the marital distress by diverting the focus of conflict to child behavior. The child that is selected is frequently one who is “different” from his or her siblings, or vulnerable in some way. The schematic representation of this triangulated system would look like Triangulation scenario A.

Rather than addressing their own difficulties with each other, the husband and wife are aligned against the child. The problem with this process is twofold. First, the true conflict is between the husband and wife, but they are not working to resolve it. Therefore, the “real” problem is not being addressed. Second, the resulting dynamic is destructive for the child’s developmental process in that there is a behavior problem and alienation from both parents. Since this is not the child’s problem, the child can do little or nothing to correct it. The boundary challenge for the therapist in this scenario is to remove the child from the focal point of conflict without being recruited to replace him (Triangulation scenario B).

The experienced therapist will recognize this development if the therapist encounters hostility when she chooses to align with the child in an effort to re-balance family dynamics. It can also be seen when the parents respond to inquiries about their marital relationship with hostility toward the therapist. Since the partners are in denial of the problem between them and have successfully avoided dealing with it by implicating a child, they may join together in trying to convince the therapist she is on the wrong track. As the therapist works to remove first the child - and then herself - from the triangulated position, the parents must confront the true source of their distress. This may involve a number of intentional strategic boundary crossings by the therapist, aligning herself temporarily with one family member and then another.

Dual or Multiple Relationships

Dual relationships (Zur, 2011) refer to situations where two or more connections exist between a therapist and a client. Examples of dual relationships are when a client is also a student, friend, employee or business associate of the therapist. Zur defines many types of dual relationships, including social, professional, business, communal, institutional, forensic, supervisory, sexual, and digital, online, or internet dual relationships. While all dual relationships involve boundary crossing, exploitive dual relationships are boundary violations.

For many psychologists practicing in rural and small communities, dual relationships are everyday occurrences. The person who bags groceries in the supermarket, pumps gas, works in a dentist’s office or chaperones children on school field trips may often also be the therapist’s client.
Unavoidable dual relationships are also the norm within numerous small populations in larger metropolitan areas, such as gay/lesbian, handicapped, various minorities, religious congregations and other such distinct small societies. In fact, duality, mutual dependence and prior knowledge of each other are prerequisites for the development of trust and respect in these communities.

Zur (2005) goes further in expressing the idea that “rigid avoidance of all boundary crossings and dual relationships raise two major concerns: First, I am concerned that rigid implementation of such boundaries decreases therapeutic effectiveness. Second, as exploitation as a rule happens in isolation, I am concerned that the isolation imposed by rigid boundaries increases the likelihood of exploitation of, and harm to, clients. Rigid boundaries in fact increase the therapist’s power and, therefore, increase the chance of a client being exploited.”

There is considerable variability in the psychotherapy fields, as well as within any given field (e.g. psychology), as to what is acceptable in some boundaries areas. For example, Borys, in a classic 1988 study, found extraordinary variability of attitude in a national survey of psychologists, psychiatrists, and social workers. Asked about whether they engaged in the following actions, participants responded as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Never</th>
<th>Few</th>
<th>Some</th>
<th>Many</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept a gift under $10:</td>
<td>19.5%</td>
<td>53%</td>
<td>10.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept invitation to client's special event:</td>
<td>50%</td>
<td>22%</td>
<td>3.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Become friends after termination:</td>
<td>65%</td>
<td>23%</td>
<td>3.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treat an employee:</td>
<td>57%</td>
<td>12.8%</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclose own stresses to client:</td>
<td>59%</td>
<td>26.8%</td>
<td>9.7%</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Invite to open house:</td>
<td>50%</td>
<td>5.7%</td>
<td>6.7%</td>
<td>2.7%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Epstein & Simon (1992) developed an "Exploitation Index" for clinicians to use to evaluate their own boundary maintenance. Some areas which require self-awareness and watchfulness by one’s supervisors or consultants are:

- Obvious therapist distress or upset
- Therapeutic drift -- shifting style and approach to a given client
- Lack of goals and reflection on progress in therapy
- Therapy which exceeds normal length for a client of that type in the particular therapist's practice
- Exceeding areas of competence, reluctance or unwillingness to refer for other types of therapy, assessment, etc.
- Unwise techniques such as hugs or excessive touch
- Becoming enmeshed in client's life -- treating close friends or family members
- Unique vulnerabilities like attraction to or over-identification with client
Multiple relationships are addressed in most professional codes of ethics. For example, the AAMFT Code of Ethics addresses the issue in Article 1.3:

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

The NASW Code of Ethics describes multiple relationships (“dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively”) and addresses them in Article 1.06 (c):

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.

Several other dimensions are added by the APA Code of Ethics Article 3.05 Multiple Relationships, which expands the concept to include relationships with individuals who are associated or related to clients:

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

In summary, it seems clear that multiple relationships are of interest in the ethics codes of most major professional organizations. Are they innately hazardous for client and therapist? Not necessarily. Are they cause for ethical alertness and introspection? Yes.

Video: Ofer Zur, PhD – *Dual or Multiple Relationships in Psychotherapy* (YouTube 11:08)

In this segment of the Boundaries in Psychotherapy Series, Dr. Zur presents on dual and multiple relationships in psychotherapy. Simply put, a dual or multiple relationship in therapy is when the clinician and client/s have a relationship outside the therapeutic one.

http://www.youtube.com/watch?feature=player_detailpage &v=Zc0XpuA_5cQ
Sexual Misconduct

Sexual misconduct within the context of psychotherapy represents one of the most egregious forms of boundary violation. It consists of “explicitly adding a sexual component to the professional relationship, regardless of who might have initiated it” (Nagy, 2011, p. 38). It has a high risk of harming the client and is always prohibited within professional relationships.

The devastating effects to psychotherapy clients, who are, by definition, in a vulnerable position, have been widely documented. According to Pope and Vasquez (2011, p. 211), the consequences for clients who have been sexually involved with a therapist tend to cluster into 10 very general categories:

1. Ambivalence
2. Guilt
3. Emptiness and isolation
4. Sexual confusion
5. Impaired ability to trust
6. Confused roles and boundaries
7. Emotional lability
8. Suppressed rage
9. Increased suicide risk
10. Cognitive dysfunction, frequently in the areas of concentration and memory and often involving flashbacks, intrusive thoughts, unbidden images, and nightmares

In an earlier classic national survey of psychologists, Pope and Vetter (1991) studied the characteristics of patients who had engaged in sexual intimacies with a therapist. The following are selected statistics from that study:

- 32% of the patients had experienced incest or other child sex abuse
- 20% of the patients were seen pro bono or for a reduced fee
- 14% of the patients attempted suicide
- 1% (7 patients) committed suicide
- 11% of the patients required hospitalization considered to be at least partially a result of the intimacies
- 12% of the patients filed formal complaints, such as licensing board complaints or malpractice suits

These statistics bring to light the extensive damage that is done to patients by psychotherapists who engage in this form of boundary violation. Among the most notable are the observations that nearly one-third of the patients in this survey were among the most vulnerable of client groups: those who were victims of child sex abuse; a large number (134 patients) attempted suicide; only 12% eventually filed formal complaints.

In view of the documented damage sustained by clients, it is not surprising that nearly all professional organizations and at least half the states have legal prohibitions against sexual relationships in psychotherapy.

It is important that each therapist become familiar with the state statutes that cover violations of this well-known prohibition against patient-therapist sexual relationships.
Many states proclaim a blanket prohibition against sexual activity between therapist and patient in any of the three situations:

1. While in therapy
2. Within two years of a normal termination
3. By means of “therapeutic deception.” - Therapeutic deception means the use of coercion to coax a client into inappropriate sexual behavior (i.e., I can only help you if you let me massage you).

**Professional Codes of Ethics Examples**

**The AAMFT Code of Ethics**

Since August 1, 1988 the American Association for Marriage & Family Therapy has forbidden sex for two years after termination. This applies to either spouse or any family member who is seen in even a single session of marital or family therapy.

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

1.4 Sexual intimacy with clients is prohibited.

1.5 Sexual intimacy with former clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. In an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients after the two years following termination or last professional contact. Should therapists engage in sexual intimacy with former clients following two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client or to the client’s immediate family.

**The APA 2002 Code of Ethics**

APA created an absolute prohibition for two years following termination of therapy. Even in relationships which begin after 2 years the psychologist has the burden of showing there has been no exploitation, in light of "relevant factors."

10.05 Sexual Intimacies with Current Therapy Clients/Patients.

Psychologists do not engage in sexual intimacies with current therapy clients/patients

10.07 Therapy with Former Sexual Partners.

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.
10.08 Sexual Intimacies with Former Therapy Clients/Patients.

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

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

The NASW Code of Ethics prohibits sex with former clients in section 1.09, but states that if a social worker claims an exception, the full burden is on them to demonstrate "...that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally." The codes also bans sexual contact with clients' relatives or close personal friends where there is a potential to harm the client, but it is not clear whether this extends to former clients' relatives and friends.

These themes are also expanded to include physical contact and sexual harassment.

1.09 Sexual Relationships

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

(b) 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.

(c) 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.

(d) 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.

1.10 Physical Contact - 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.

1.11 Sexual Harassment - Social workers should not sexually harass clients. Sexual harassment includes advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

**NBCC Code of Ethics Section A: General**

Para. 8. Certified counselors are aware of the intimacy in the counseling relationship and maintain respect for the client. Counselors must not engage in activities that seek to meet their personal or professional needs at the expense of the client.

Para. 9. Certified counselors must insure that they do not engage in personal, social, organizational, financial, or political activities which might lead to a misuse of their influence.

Para. 10. Sexual intimacy with clients is unethical. Certified counselors will not be sexually, physically, or romantically intimate with clients, and they will not engage in sexual, physical, or romantic intimacy with clients within a minimum of two years after terminating the counseling relationship.

Para. 11. Certified counselors do not condone or engage in sexual harassment, which is defined as unwelcome comments, gestures, or physical contact of a sexual nature.

**Privacy and Confidentiality**

**Privacy** is suggested by the 4th Amendment of the Bill of Rights (December 15, 1791) of the Constitution of the United States. Basically, it gives people the “right to secure their houses, papers, and effects, against unreasonable searches and seizures…” (The United States Constitution). This is the most basic of the three terms (Cato Institute, 1776/2002). It is this historic and essential right that is at some risk of erosion under the problematic tenets of recent legislation like the “Patriot Act.”

**Confidentiality** is an ethical term which denotes a contract between the client and the therapist in which the therapist promises to keep all utterances confidential communications, except those required disclosures by law. It is a principle given the most attention in almost all ethics codes and standard of care documents. According to Bernard and Goodyear (2008), this is so because confidentiality represents the essence of psychotherapy – a place where secrets and hidden fears can be disclosed. In more recent, increasingly litigious times, confidentiality has become less of a sacred trust and more of a “step-sibling to safety and judicial judgment.” Nonetheless, its role in the practice of psychotherapy has become no less central, only more complicated. Now the boundaries between the traditional therapeutic contract and considerations of legal liability must be mediated.

**Privileged communication** is a statutory term that refers to protecting clients from having their confidences publicly revealed during legal proceedings without their permission (Gladding et al, 2001, p. 20). Where such laws apply – and there are a large number of states where they are not legally supported – therapists are prevented from testifying in court about clients without their consent. Even where they do apply, and even when clients have not waived their rights, privileged communication can be subject to a number of exceptions (p.21):

- When the therapist is acting in a court-appointed capacity – for example, to conduct a psychological examination
- When the therapist makes an assessment of a foreseeable risk of suicide
• When the client initiates a lawsuit against the therapist, such as for malpractice

• In any civil action when the client introduces mental condition as a claim or defense

• When a client is under the age of 16 and a therapist believes that the child is the victim of a crime – for example, incest, child molestation, rape, or child abuse

• When the therapist determines that the client is in need of hospitalization for a mental or psychological disorder

• When criminal action is involved

• When information is made an issue in a court action

• When clients reveal their intention to commit a crime or when they can be assessed as “dangerous to society” or dangerous to themselves

The Florida Statutes Chapter 491 delineates the exceptions as follows:

491.0147 Confidentiality and privileged communications.--Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:

(1) When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

(2) When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(3) When, in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.

Specific to the practice of marriage and family therapy is the problem of determining who “owns” the privilege in the case of a family or a married couple. Most legal definitions specifically emphasize that ownership of the privilege – and therefore of the right to waive it – resides with the client. Who is the client when the therapist is treating more than one individual as the unit of therapy?

This dilemma is particularly acute when there is an adversarial event like a divorce or a custody proceeding. Such cases require therapists to be sufficiently informed in the ethical guidelines promulgated by their profession as well as in the laws of the jurisdiction in which they practice. Furthermore, this is one of the areas where the result may be a conflict between one’s ethical guidelines and the law of the land. The therapist may act in such a way as to protect the confidentiality of the client (or clients) and the court may act in such a way as to serve the letter of the law.
Confidentiality, Boundaries, and HIPAA

HIPAA (Health Insurance Portability and Accountability Act) was partially intended to protect the privacy of individuals in the arena of health care. Unfortunately for nearly all parties, it has not worked out that way. “HIPAA privacy rules suggested that the bar would be raised for clinical privacy, but, in fact, the standards were significantly lowered” (Freeny, 2007, p. 13). “The gravitation to an electronic medical record promises much greater speed and efficiency in using client medical information in critical situations. However, it is a direction that also contains great confidentiality compromises for the client as the world has gone global in distributing confidential information. Unfortunately, mental health clinicians are largely ignorant of the full ramifications of these new initiatives.”

Alonso-Zaldivar (2008) noted that in 2008, “despite 34,000 complaints of violations in the last five years, the federal act has resulted in only a few prosecutions, and no civil fines have been levied.” Pope and Vasquez (2011, p. 43) add “As we house confidential patient information in distant servers, send it over many networks, and carry it around in our laptops and personal digital assistants, it becomes ever more vulnerable to theft and other forms of loss.”

As clinicians, we are responsible for not only protecting our clients’ personal health information, but also for explaining the therapy process (informed consent) and for forming a professional opinion about whether the patient understands and consents. For a patient to be adequately informed, the consent must be given or withheld in the light of adequate knowledge about who will or may receive the results, which in turn may be affected by HIPAA and other legislation. Pope and Vasquez (2011, p. 287) include an entire section on focusing on legal responsibilities to the exclusion of ethical responsibilities. They note that there has been notable growth in HIPAA compliance training that is led by attorneys and not by mental health professionals. They quote the work of Mary Ellen Fisher:

> Legally based training creates several ethical problems for psychologists. First, it fosters the impression that attorneys—not clinicians—have become the only “real” experts about this aspect of practice. Second, it creates a legal language about confidentiality that threatens to usurp psychologists’ own clinical or ethical language about it: Laws take center stage, when what is needed is a language for placing them into ethical context. Third, it exacerbates the figure-ground confusion (by substituting legal rules for ethical rules) and often takes a risk-management perspective that raises anxiety: It encourages psychologists to focus on obeying laws in order to avoid risks to themselves, when what they need is a clearer focus on their ethical obligations and the potential risks to clients. Finally, the legal emphasis obscures an important fact about risk management: Understanding and following the relevant ethical principles is an essential ingredient in avoiding a malpractice suit.... (Fisher, 2008, p. 6)

Fisher specifies “psychologists,” but her caveats are clearly relevant to all mental health professionals.

What becomes of the boundaries of privacy in an era of electronic medical records (EMR)? In her article “Electronic medical records: Confidentiality issues in the time of HIPAA,” Margaret Richards (2009) notes

> For a psychologist in a major academic or medical institution, the EMR provides unique ethical conflicts of which the psychologist may be unaware. By documenting within the EMR, the psychologist is potentially informing all members of that patient’s medical team that this patient is involved in psychological care. While most informed consents the limits of confidentiality, patients may not always realize the information that is being shared and with whom. At a minimum, the psychologist using an EMR is providing information regarding the patient’s participation in therapy, dates of appointments, types of services offered, and diagnoses, even if the content of the session is not revealed. Typically, this is the same information that is being provided to insurance companies as a natural part of the billing process since the advent of HIPAA ... Yet, this may not be information that a client wants his primary care physician to have.
Amidst all of the complexities of HIPAA legislation, two considerations will be briefly noted here: “routine” notes vs. “psychotherapy” notes and informed consent. In short, routine notes are expected to be surrendered to outside parties and psychotherapy notes are expected to remain in the private records of the psychotherapist. Zuckerman (2009, p. 74) offers practical suggestions for sequestering sensitive therapy information that will provide more privacy protection in most cases from routine notes, which contains the nuts and bolts of a regular health care record.

**Routine notes:** If you mainly record the formalities of the therapy such as your interventions and the client’s responses you may feel comfortable in disclosing this to an insurer and so you have no need for records beyond the routine progress note.

**Psychotherapy notes:** If there is material which you believe you must record and yet you don't want it shared with:

- The client because it is your working hypotheses and was of value only at one time. Remember, clients have no access to psychotherapy notes unless you give it
- Insurance companies or others who are not required to protect its confidentiality as carefully as your profession requires you to
- Anyone else, because it is too sensitive and potentially damaging to the client or to others
- Other treaters, because they are not and will not be doing the kind of work you are with the client
- But you may want to share the information with professional students for training, or find value and meaning in these notes as you review them....

...the information should be kept in separate psychotherapy notes.

**Informed consent:** The process whereby we help protect our clients’ privacy from the very start of therapy, known as “informed consent,” is dealt with extensively elsewhere in this course. What changes with HIPAA is that the concepts of consents and authorizations have become confounded. Such highly specific HIPAA guidance is beyond the scope of this course. The reader is referred to Kenneth Pope’s webpage Informed Consent in Psychotherapy & Counseling for further discussion and sample forms for informed consent: [http://kspope.com/consent/index.php#forms](http://kspope.com/consent/index.php#forms) (retrieved December 2, 2011).

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**Confidentiality and the Patriot Act**

The case of the Patriot Act is a textbook example of multiple interlocking boundary issues. It involves the boundaries between the agencies of the federal government and private citizens as well as boundaries of trust in the areas of essential privacy and confidentiality between therapist and client. It will also serve here as vehicle for illustrating one way of attempting to resolve conflicts between ethics and laws.

The “Patriot Act,” known legally as “Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act,” was passed by the congress with little debate on October 21, 2001, only six weeks after the September 11 attacks on the World Trade Center and the Pentagon. Of particular concern to professional psychotherapists are two sections of Title II of the Act: “Enhanced Surveillance Procedures” (Mansdorfer, 2004).

One of the problematic areas is Section 215 “Access to Records and Other Items under the Foreign Intelligence Surveillance Act,” which allows access to “certain business records” in international terrorism investigations.
Legal experts have agreed that this might include all records, including medical and psychological records. At first blush this may seem like other situations in which a therapist is presented with a subpoena demanding a release of records. In such cases, procedure would dictate that the therapist initially:

1. claim privilege,
2. inform the client that a demand for their records has been placed.

But under the Patriot Act, that cannot be done.

Section 215 states “No person shall disclose to any other person (other than those persons necessary to produce the tangible things under this section) that the Federal Bureau of Investigation has sought or obtained tangible things under this section.” The other problematic section, 213, amplifies this prohibition by defining the circumstances under which notification of the issuance of a warrant may be delayed.

Here, according to Mansdorfer (2004), is the ethical dilemma. “Psychotherapy is based on trust. The Patriot Act creates a situation where government agents can come to your office, demand your records about a patient, and forbid you under penalty of law from telling the patient he or she is under investigation, and that you have broken confidentiality. These sections of the Patriot Act seem to put psychologists [and other therapists] in conflict with our own Ethics Code. Specifically, General Principle A: Beneficence and Nonmaleficence, Principle B: Fidelity and Responsibility, and C: Integrity. Also individual standards 1.02: Conflict between Ethics and Law, Regulations, or Other Governing Legal Authority; and Standard 3.04: Avoiding Harm.”

Principle A: Beneficence and Nonmaleficence
Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility
Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity
Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.
1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

3.04 Avoiding Harm
Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

How can we as therapists find an ethical solution to this ethical dilemma? Mansdorfer suggests that one possible answer may be found in Ethical Standard 10.01 of the APA Ethics Code:

10.01 Informed Consent to Therapy
(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

Based upon the admonition to inform clients “as early as is feasible in the therapeutic relationship” about limits of confidentiality, etc., legal experts have suggested we might change our office policy and/or informed consent statements to include something like the following statement:

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.

We may also hope that our professional organizations study the matter and provide more definitive guidelines.

Ethics Codes that Apply to Dangerous Clients

One of the complex boundary issues that confront therapists in the area of privacy and confidentiality is the question of what to do about clients who appear to pose a danger to themselves and others.

The APA Ethics Code Section 4 (Privacy and Confidentiality) provides guidance on this subject. The code allows psychologists to disclose confidential information when permitted by law, to obtain a needed professional consultation, or to protect one’s self, the client, or others from harm.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.
(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)
The NASW Code of Ethics provides for similar exceptions in service to the safety of the client or others:

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

NBCC Code of Ethics:

Section B: Counseling Relationship
4. When a client's condition indicates that there is a clear and imminent danger to the client or others, the certified counselor must take reasonable action to inform potential victims and/or inform responsible authorities. Consultation with other professionals must be used when possible. The assumption of responsibility for the client's behavior must be taken only after careful deliberation, and the client must be involved in the resumption of responsibility as quickly as possible.

Tarasoff

One of the landmark rulings in this area of duty to warn is the Tarasoff Ruling. In 1976, the California Supreme Court Justices made some important rulings that may have changed forever the responsibilities for all mental health professionals in all states.

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976), was a case in which the Supreme Court of California held that mental health professionals have a duty to warn individuals who are being threatened with bodily 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 discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Each state has its own laws regarding duty to warn and when to breach confidentiality in order to protect the public welfare. Therapists are required to know these laws in order to practice ethically.

An example is Chapter 491 of the Florida Statutes, which details the laws and rules governing the practice of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling in the State of Florida. Chapter 491 includes the following section:

491.0147 Confidentiality and privileged communications. – Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:
(1) When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

(2) When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(3) When, in the clinical judgment of the person licensed or certified under this chapter, there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.

Boundary Issues in Clinical Supervision

If ethical guidelines for the helping professions are perceived as fairly recent developments, the development of guidelines for the professional practice of clinical supervision could be said to be in its infancy. According to Bernard and Goodyear (2008) the first code of ethics that specifically addressed clinical supervision was passed in 1993 (Supervision Interest Network, 1993). Because of its close relationship to the practice of counseling and psychotherapy, it may not come as a surprise that many of the same ethical boundary issues that arise in these settings also arise in the practice of clinical supervision.

Informed Consent

Informed consent covers not only the relationship between a therapist and his or her client, but also the relationship between a supervisors and trainee. Trainees should be made aware of the fact that supervision is an evaluative process and upon what criteria they will be judged. Furthermore, the roles and responsibilities of both the supervisor and the trainee should be clearly delineated. More specifics should be presented in a clinical supervision disclosure statement.

It should also be noted that trainees who are receiving clinical supervision should inform their clients of this fact. This provides clients with the opportunity to choose a more "experienced" therapist should they feel that they need one.

Confidentiality in Clinical Supervision

In the helping professions confidentiality is one of the key ethical principles. Helpers are relied upon to provide a safe environment where clients are free to disclose their problems. This principle becomes more complicated to implement in the supervision process. The boundaries between what is and is not valid material for supervision are more difficult to discern. Trainees must learn that all client information must be kept confidential except that used for supervision purposes. Cases should be presented with first names only. Tapes and videotapes must also be treated carefully. Once again, clients must be made aware of the fact that they are being seen by a counselor in training and furthermore, that content from his or her sessions will be shared with supervisors (class instructors, etc.) in an educational context. Trainees must also apply the principle of confidentiality to their own supervision.
Supervisors must also treat their interactions with their trainees as confidential to the extent possible due to the complexity of the relationship. Trainees should be made aware of the fact that information might be shared with persons who have some stake in their evaluation. Furthermore, trainees should be made aware of the limits of confidentiality at the beginning of the supervisory relationship so that he or she can make an informed decision about what might be appropriate to share in supervision.

**Dual Relationships in Clinical Supervision**

Dual relationships in supervision are often tricky because of the fact that the clinical supervisor often has more than one professional relationship with the supervisee. For example, your clinical supervisor might be your teaching assistant or instructor in another class. In an agency, your agency supervisor might provide clinical and professional supervision. A dual relationship in clinical supervision might be described as unethical when the relationship impairs the supervisor’s judgment and the trainee faces the possibility of exploitation as a result of the relationship.

**Ethics and Cultural Competency**

The area of cultural competency in psychotherapy embodies a very broad spectrum of variables that need to be taken into consideration in planning and implementing a therapeutic process. The NASW Code of Ethics (Paragraph 1.05 Cultural Competence and Social Diversity) states it this way:

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

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

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion and mental or physical disability.

In paragraph 2.01, Boundaries of Competence, the APA Code of Ethics describes the ethical functioning of psychologists in the realm of cultural competence.

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
Nagy (2011, pp. 61-62) interprets these precepts as follows:

There are occasions when psychologists might have to initiate safeguards to help ensure the autonomy and safety of individuals or communities. This is reflected in cultural, individual, and role differences as well as a lengthy list of human attributes that describes the vulnerabilities in today’s society in which one’s personal rights and legal protections may be threatened. The list, as it appears in the principle, consists of the following 12 categories:

- age (chronological age or developmental stage; e.g., child, adolescent, adult, or elderly);
- sex (male or female);
- gender identity (how the person views him- or her self – male or female – regardless of genotype);
- race (e.g., physical traits, skin or hair color);
- ethnicity (shared cultural traits; e.g., Asian, Latino, etc.);
- culture (shared beliefs, customs, arts, practices, and social behavior; e.g., Native American or Cajun);
- national origin (Mexico, China, India, etc.);
- religion (Roman Catholic, Jewish, Buddhist, Muslim, etc.);
- sexual orientation (e.g., heterosexual, lesbian, gay, bisexual);
- disability (medically diagnosed condition; e.g., blindness, deafness, chronic pain, degenerative illness, etc.);
- language (e.g., native language or sophistication in comprehension and use –education level); and
- socioeconomic status (income level, social class, etc.).

Nagy (pp. 81-82) goes on to note that bias in psychotherapists can be insidious and particularly problematic, depending on the therapist’s awareness – or lack of awareness – of the particular bias. “It is important for a therapist....to be aware of his or her own bias or outright bigotry and how it may impact others....telltale signs of bias should herald a warning to remedy the situation by consulting a knowledgeable colleague, obtaining additional education or training, ...reading and studying, engaging in personal psychotherapy, or ultimately withdrawing from the setting altogether (treatment, research, or teaching) if the bias cannot be resolved.”

Technology and Ethical Boundaries

With the development of automated testing and scoring systems and the increasing acceptance of technological communication tools like email, cell phones, electronic storage and transfer of records, texting, and social networking, new ethical boundary issues must be considered. Regarding the question of ethical pitfalls to be considered when using computerized test administration and scoring, or the employment of organizations that provide such services, Barnett (2005b) writes:

*Many psychologists are finding that computers and the Internet greatly increase the efficiency of their practices. Computerized administration, scoring and interpretation services can greatly enhance the services we provide and make our professional lives much easier.*

*In addition to great convenience and cost savings ...the use of technology in psychological assessment brings with it a number of ethics concerns...*

*First, we should make sure that using the technology in question is appropriate for each client. While computers are a fact of life for many people it is best not to assume computer literacy and comfort for all clients. Some may be intimidated by completing a test on a computer, resulting in increased anxiety that could impact the results of the assessment. Others, due to financial limitations or other lack of opportunity may just be unfamiliar with use of a computer.*
The next concern involves confidentiality. It may be very convenient to sit clients at computer terminals and have them complete psychological tests while we are engaged in other activities. But, the location of the computer is important. If it is placed in a waiting room or if several are located together in a room, clients’ privacy and confidentiality will likely be jeopardized.

Barnett concludes that while the use of technology to aid psychological assessments may be a great convenience, it should never supersede clinical judgment. There are too many relevant factors to consider when interpreting test results that a computer program can not integrate into a valid interpretation.

The APA Code of Ethics offers a blanket admonition on practices involving the use of technology with this statement in the introductory paragraphs: “This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions.”

The NASW Code of Ethics addresses the issues surrounding ethics and technology briefly in several paragraphs:

1.03 Informed Consent

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

1.07 Privacy and Confidentiality

(l) 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.

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

(n) Social workers should transfer or dispose of clients’ records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

The NBCC Ethics Code addresses the issue in greater detail as follows:

Section B: Counseling Relationship

5. Records of the counseling relationship, including interview notes, test data, correspondence, audio or visual tape recordings, electronic data storage, and other documents are to be considered professional information for use in counseling. Records should contain accurate factual data. The physical records are property of the certified counselors or their employers. The information contained in the records belongs to the client and therefore may not be released to others without the consent of the client or when the counselor has exhausted challenges to a court order. The certified counselors are responsible to insure that their employees handle confidential information appropriately. Confidentiality must be maintained during the storage and disposition of records. Records should be maintained for a period of at least five (5) years after the last counselor/client contact, including cases in which the client is deceased. All records must be released to the client upon request.
6. Certified counselors must ensure that data maintained in electronic storage are secure. By using the best computer security methods available, the data must be limited to information that is appropriate and necessary for the services being provided and accessible only to appropriate staff members involved in the provision of services. Certified counselors must also ensure that the electronically stored data are destroyed when the information is no longer of value in providing services or required as part of clients’ records.

12. Counselors using electronic means in which counselor and client are not in immediate proximity must present clients with local sources of care before establishing a continued short or long-term relationship. Counselors who communicate with clients via Internet are governed by NBCC® standards for Web Counseling.

13. Counselors must document permission to practice counseling by electronic means in all governmental jurisdictions where such counseling takes place.

14. When electronic data and systems are used as a component of counseling services, certified counselors must ensure that the computer application, and any information it contains, is appropriate for the respective needs of clients and is non-discriminatory. Certified counselors must ensure that they themselves have acquired a facilitation level of knowledge with any system they use including hands-on application, and understanding of the uses of all aspects of the computer-based system. In selecting and/or maintaining computer-based systems that contain career information, counselors must ensure that the system provides current, accurate, and locally relevant information. Certified counselors must also ensure that clients are intellectually, emotionally, and physically compatible with computer applications and understand their purpose and operation. Client use of a computer application must be evaluated to correct possible problems and assess subsequent needs.

15. Certified counselors who develop self-help/stand-alone computer software for use by the general public, must first ensure that it is designed to function in a stand-alone manner that is appropriate and safe for all clients for which it is intended. A manual is required.

The manual must provide the user with intended outcomes, suggestions for using the software, descriptions of inappropriately used applications, and descriptions of when and how other forms of counseling services might be beneficial. Finally, the manual must include the qualifications of the developer, the development process, validation date, and operating procedures.

In a unique offering, the National Board for Certified Counselors has published its *NBCC Standards for Web Counseling* which can be viewed at the NBCC website: www.nbcc.org. Included are a detailed set of standards for the ethical practice of internet counseling. This document contains perspectives not easily found elsewhere and is worth reading.

**Fees and Financial Arrangements**

One of the more tangible elements of the boundaries between therapist and client is the issue of professional fees. Nowhere is the power imbalance in the relationship more clearly demonstrated than in the fact that the client pays a fee for the services provided by the therapist. Additionally, this is an issue that transcends the domains of ethics, business, and law.

Finances can be seen as a nuisance for some clinicians who would much rather be doing clinical work than discussing how much they are going to charge per session hour. Often the collection of fees takes a back seat to clinical considerations. On the other hand, most clinicians rely upon practice income to pay current living expenses, so regular collection of fees is an important component of practice.
Most of the professional codes of ethics have something to say about the setting and collection of fees. The NASW Code includes these sections:

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the service performed. Consideration should be given to the client's ability to pay.

(b) 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.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.


Marriage and family therapists make financial arrangements with clients, third-party payers, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payer. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

7.3 Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Marriage and family therapists represent facts truthfully to clients, third-party payers, and supervisees regarding services rendered.

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

7.6 Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client’s treatment solely because payment has not been received for past services, except as otherwise provided by law.
The APA Code of Ethics provides even greater detail for psychologists in Standard 6.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

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

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium.

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

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible.

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment.

6.05 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)
6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself.

Barnett (2005a) adds a number of practical considerations on the subject of ethics and legalities in fee setting appeared in The National Psychologist. These considerations will also be of interest to therapists other than psychologists.

It will benefit psychologists to have a clear policy on missed appointment and late cancellation charges. This policy should be reviewed in the informed consent process and clients utilizing insurance will need to be reminded that insurance companies do not reimburse for these charges. The policy used should be clear and fair. For example, does the psychologist charge for the appointment time if the client cancels with more than 24 hours notice? If less than 24 hours notice is given will the client be charged if the psychologist can fill the time with another appointment? What if the client experiences a true emergency and how is this defined? All these issues should be discussed up front and reviewed periodically to avoid misunderstandings.

Missed Appointment and Cancellation Policy

If you are unable to keep a scheduled appointment, please give 24 hours advance notice to ensure that you will not be charged for the appointment.

If less than 24 hours notice is given and we are unable to fill your time slot, you will be expected to pay for the appointment.

Thank you.

Termination of Therapy

One of the areas that is a routine part of day-to-day practice for most psychotherapists is the issue of termination of therapy. But it is also a process that merits a thoughtful approach in that there are a number of potential ethical and boundary complications that can accompany the termination of therapy. If not properly carried out, the attempt to end therapy can constitute abandonment of the client, resulting in a complaint to the licensing board, or even civil action for damages.

Terminations are an important part of the therapeutic process, and therapists have an ethical responsibility to terminate appropriately. According to Melba Vasquez (2005) a national study indicated that one third of all clients do not return to psychotherapy after one or two sessions, and only 10 percent remain for more than 20 sessions.
Some clients simply stop coming, despite the therapist’s recommendation of a “pretermination counseling process.” Multiple factors influence how long a client remains in psychotherapy. What are those factors and what can we do to facilitate successful separations? At the beginning of psychotherapy, and throughout the treatment, we have responsibilities to provide informed consent about psychotherapy. That is, we should educate clients about the process of psychotherapy, including the factors involved in deciding when to stop.

The therapist’s ethical responsibilities include the responsibility to terminate when the client no longer needs the service, isn’t benefiting or is being harmed by the service (APA 2002 Ethical Principles of Psychologists and Code of Conduct Standard 10.10a). Therapists are also responsible for making reasonable efforts to provide pretermination counseling and suggest alternative service providers as appropriate (APA Standards 10.10c, 10.09 and 3.12). A new APA Ethics Code standard indicates that a therapist has the right to terminate psychotherapy when threatened (10.10b). It is generally not appropriate to terminate when a client is in crisis.

According to Richard Leslie (2004) clients have the right to terminate treatment at any time for any reason, but this is not the case for therapists. Treatment is commonly terminated by the therapist under one or more of the following conditions:

1. when the course of therapy has come to a natural end due to improvement of the client
2. when the client is no longer able to pay for treatment according to the original agreement
3. when the therapist has determined that the client’s problem is beyond the therapist’s scope of competence
4. when the therapist determines that the client is not benefiting from the treatment
5. when the therapist is unable or unwilling, for appropriate reasons, to continue to provide care
6. when the treating therapist leaves his or her employment, either voluntarily or involuntarily

One of the tools that can preclude some of the potential pitfalls of termination is the disclosure or informed consent statement that is part of the process of beginning therapy. Typically included in these documents are issues like the therapist’s treatment philosophy and policies, information about what is expected of the client, and a discussion about termination of therapy. The latter may include the therapist’s request that a client who wishes to terminate the relationship discuss it with the therapist in advance so that there can be some closure, resolution of any misunderstandings, and possible referrals.

According to Leslie, therapists who get into trouble are those who terminate treatment with little or no prior discussion with the client, possibly by writing a letter or making a telephone call. Ethical practice generally demands more. Any termination that is initiated by the therapist should be the result of a process in which the client is given adequate time to meet face-to-face with the therapist to discuss the reasons for termination and the details of a transition to other care. Leslie suggests that, although sessions held for the purpose of discussing termination issues are a part of the therapy process, the therapist might want to consider waiving some part or even all of the fee in an effort to lessen the burden on the client.

Therapist-initiated terminations are most difficult with patients who are in significant emotional distress, including those who may be suicidal. The client may be reluctant to end treatment even though the therapist believes it to be in the patient’s best interest. In many such situations, it is advisable to obtain clinical consultations and to warn others of the suicidal threats.

Also accompanying the process of therapy treatment is the potential issue of dual relationships. Generally, such relationships are to be avoided both during the term of therapy and following termination. While there are some state laws and even professional codes of ethics that do not expressly prohibit even a sexual relationship and former client following a two-year period of time after termination, such relationships should be approached with every caution. The burden may ultimately be placed upon the therapist to demonstrate that the termination process was not contaminated by plans for a future personal relationship.
A final recommendation offered by Leslie is the use of termination letters and/or follow-up calls as part of a well documented termination. Especially in cases that have some volatility around the termination, it is useful to send a letter confirming the termination, the reasons for it, and who initiated it. This process bears some caution in attending to privacy and confidentiality issues by ascertaining in advance that the therapist has the client’s permission to send letters to a particular address.

**A Model for Ethical Decision Making**

Pope and Vasquez offer a 17-step model for thinking through how to respond to ethical dilemmas. The steps are meant to help identify key aspects of a situation, consider benefits and drawbacks of the options, and discover better approaches. They note that not every step fits every situation and that some of them may need to be adapted.

Steps in Ethical Decision Making (Pope and Vasquez, 2011, pp. 116-121):

**STEP 1: STATE THE QUESTION, DILEMMA, OR CONCERN AS CLEARLY AS POSSIBLE**
Does the statement do the situation justice? Does it make clear what the problem is and why it is a problem? Does it miss anything important to thinking through possible courses of action? Does any part of it get lost in the mists of vagueness, ambiguity, or professional jargon? Are some of the words misleading or not quite right? Is there anything questionable about the statement’s scope, perspective, or assumptions? Are there other valid ways to define the problem? Tight schedules, urgent situations, and an eagerness to “solve the problem” can rush us past this step, but coming up with the best approach depends on clearly understanding the ethical challenge.

**STEP 2: ANTICIPATE WHO WILL BE AFFECTED BY THE DECISION**
No one lives in a vacuum. How often do our ethical decisions affect only a single person and no one else? A client shows up for a session drunk. Whether the client drives home drunk and kills a pedestrian can depend on how we define our responsibility. A colleague begins to show signs of Alzheimer’s. Our choices can affect the safety and well-being of the colleague and his or her patients. A therapy client tells us about embezzling pension funds. Confidentiality laws may direct us to tell no one else, and the client may refuse to discuss the issue. How we respond can affect whether hundreds of families retain the pensions they earned or are thrown into poverty. An insurance claims manager refuses to authorize additional sessions for a client we believe is at risk for killing his wife and children and then committing suicide. Our supervisor may agree with the manager that no more sessions are needed. Whether the family lives or dies can depend on what we do.

**STEP 3: FIGURE OUT WHO, IF ANYONE, IS THE CLIENT**
Is there any ambiguity, confusion, or conflict about who the client is (if it is a situation that involves a psychotherapist-client relationship)? If one person is the client and someone else is paying our fee, is there any divided loyalty, any conflict that would influence our judgment?

**STEP 4: ASSESS WHETHER OUR AREAS OF COMPETENCE—AND OF MISSING KNOWLEDGE, SKILLS, EXPERIENCE, OR EXPERTISE— ARE A GOOD FIT FOR THIS SITUATION**
Are we well prepared to handle this situation? What steps, if any, could we take to make ourselves more effective? In the light of all relevant factors, is there anyone else who is available that we believe could step in and do a better job?
STEP 5: REVIEW RELEVANT FORMAL ETHICAL STANDARDS
Do the ethical standards speak directly or indirectly to this situation? Are the ethical standards ambiguous when applied to this situation? Does this situation involve conflicts within the ethical standards or between the ethical standards and other (e.g., legal) requirements or values? In what ways, if at all, do the ethical standards seem helpful, irrelevant, confusing, or misdirected when applied to this situation? Would it be helpful to talk with an ethicist or a member of a national, state, or provincial ethics committee?

STEP 6: REVIEW RELEVANT LEGAL STANDARDS
Do legislation and case law speak to this situation? Are the legal standards clear? Does a legal standard conflict with other standards, requirements, or values? Do the relevant laws seem to support—or at least allow—the most ethical response to the situation, or do they seem to work against or even block the most ethical response? Would it be helpful to consult an attorney and obtain legal guidance?

STEP 7: REVIEW THE RELEVANT RESEARCH AND THEORY
Is there new research or theory that helps us think through the situation? An occupational hazard of a field with such diverse approaches—cognitive, psychodynamic, pharmacological, behavioral, feminist, psychobiosocial, family, multicultural, and existential, to name but a few—is that we often lose touch with the research and theory emerging outside our own theoretical orientation.

STEP 8: CONSIDER WHETHER PERSONAL FEELINGS, BIASES, OR SELF-INTEREST MIGHT AFFECT OUR ETHICAL JUDGMENT
Does the situation make us angry, sad, or afraid? Do we want to please someone? Do we desperately want to avoid conflict? Do we fear that doing what seems most ethical will get us into trouble, make someone mad at us, be second-guessed by colleagues, or be hard to square with the law or the ethics code? Will doing what seems right cost us time, money, friends, referrals, prestige, a promotion, our job, or our license?

STEP 9: CONSIDER WHETHER SOCIAL, CULTURAL, RELIGIOUS, OR SIMILAR FACTORS AFFECT THE SITUATION AND THE SEARCH FOR THE BEST RESPONSE
The same act can take on sharply different meanings in different societies, cultures, or religions. What seems ethical in one context can violate fundamental values in another society, culture, or spiritual tradition. What contexts—or conflicts between contexts—may have escaped our notice? Does our own social identity in relation to the client’s social identity enter into the process? Could any potential issues of stereotyping or bias be relevant?

STEP 10: CONSIDER CONSULTATION
Is there anyone who could provide useful consultation for this specific situation? Is there an acknowledged expert in the relevant areas? Is there someone who has faced a similar situation and handled it well—or who might tell us what does not work and what pitfalls to avoid? Is there a colleague whose perspective might be helpful? Is there someone whose judgment we trust? When drawing a blank in the face of these questions, sometimes it is useful when a question takes this form: If what we decide to do were to end in disaster, is there some particular person we wish we had consulted?

STEP 11: DEVELOP ALTERNATIVE COURSES OF ACTION
What possible ways of responding to this situation can you imagine? What alternative approaches can you create? At first we may come up with possibilities that seem “not bad” or “good enough.” The challenge is not to quit too soon but to keep searching for our best possible response.
STEP 12: THINK THROUGH THE ALTERNATIVE COURSES OF ACTION
What impact is each action likely to have—and what impact could each have under the best possible and worst possible outcome that you can imagine—for each person who will be affected by your decision? What are the immediate and longer-term consequences and implications for each individual, including yourself, and for any relevant organization, discipline, or society? What are the risks and benefits? Almost any significant action has unintended consequences—what could they be for each possible course of action?

STEP 13: TRY TO ADOPT THE PERSPECTIVE OF EACH PERSON WHO WILL BE AFFECTED
Putting ourselves in the shoes of those who will be affected by our decisions can change our understanding. What would each person consider the most ethical response? This approach can compensate for the distortion that often comes from seeing things only from our own perspective... Although we often explain our own behavior in specific situations as due to external factors, we tend to attribute the behavior of others to their dispositions.

STEP 14: DECIDE WHAT TO DO, REVIEW OR RECONSIDER IT, AND TAKE ACTION
Once we have decided on a course of action, we can—if time permits—rethink it. Sometimes simply making a decision to choose one option and exclude all others makes us suddenly aware of flaws in that option that had gone unnoticed up to that point. Rethinking gives us one last chance to make sure we have come up with the best possible response to a challenging situation.

STEP 15: DOCUMENT THE PROCESS AND ASSESS THE RESULTS
Keeping track of the process through documentation can help us remain clear about what went into our decision: the elements of the problem; the options and potential consequences; the guidance provided by others; the perspective of the client, including the relevant rights, responsibilities, risks, and possible unintended consequences. Careful record keeping involves not only tracking what led up to our decision but also what happened afterward. What happened when we acted? Did we accomplish what we’d hoped and intended? Were their unforeseen consequences? Knowing what we know now, would we have taken the same path or tried a different response?

STEP 16: ASSUME PERSONAL RESPONSIBILITY FOR THE CONSEQUENCES
If our response to the situation seems in hindsight to have been wrong or has caused unnecessary trouble, pain, loss, or problems, do we need to address the consequences of what we have done or failed to do?

STEP 17: CONSIDER IMPLICATIONS FOR PREPARATION, PLANNING, AND PREVENTION
Did this situation and the effects of our response to it suggest any useful possibilities in the areas of preparation, planning, and prevention? Are there practical steps that would head off future problems or enable us to address them more effectively? Would changes in policies, procedures, or practices help?

Summary and Conclusions

If it appears at this point that there is great breadth and depth to the topic of ethics and boundaries in the practice of psychotherapy, then this course had found its mark. Much of the healing that happens in therapy and much of what goes awry can be attributed to the quality of the ethical boundary decisions made by therapists in the course of everyday practice. Challenges and dilemmas abound, but so do the many sources of thoughtful guidance that are available for the asking. The essential point of all of this is that ethics is a dynamic, living process that is fed by careful, attentive thought and is starved by mindless adherence to rigid sets of arbitrary rules. Good fences make good neighbors, and good boundaries make good therapists.
References


