ETHICS AND BOUNDARY ISSUES

INSTRUCTOR

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OBJECTIVES

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

1. Explain the major ethical principles of mental health and human services professionals and common ethical dilemmas.
2. Describe confidentiality, the limits of confidentiality, and informed consent in clinical practice.
3. Explain competence and steps clinicians can take toward maintenance of competence.
4. Recognize the risks and challenges of dual and consecutive relationships with clients and other boundary issues.
5. Identify ethical issues related to emerging topics in mental health care, such as telehealth, artificial intelligence, and social media.
6. Describe ethical decision-making strategies.

INTRODUCTION

While each of the helping professions has its own distinct code of ethics that its members must follow, they all share common general principles and values to ensure their clients' best interest and safety. Although this aim is straightforward in theory, it is challenging in practice to navigate the complex circumstances and, at times, dilemmas that arise throughout the course of work in human services. Ethical standards are often written in a necessarily broad way to address the variety of unpredictable ways that human relationships and contexts may interact and manifest. Scholarship and discourse to translate ethical standards into decision-making guidelines and practical application are needed, in addition to peer and supervisory consultation. Clinicians must take into consideration the context, cultural values, and individual characteristics of each client and situation they encounter when ethical concerns arise.

This learning material, designed for social workers, psychologists, counselors, and marriage and family therapists, presents information about the ethical values, standards, and principles that guide client or patient care, as well as several guidelines for making ethical decisions when dilemmas inevitably arise. The learning material differentiates between violations and dilemmas and participants are offered an exploration of the intersection between ethical and legal requirements for practice. This learning material examines a wide variety of ethical challenges common to clinical practice and provides examples to apply these concepts to real world experience with clients. It also discusses current research on emerging concerns such as dual relationships, telehealth, and social media. Multiple case examples throughout this learning material provide opportunities to put these ethical considerations into practice, including the participant's own specific work and case concerns.

Clinicians are encouraged to reflect on the questions at the start of each section before reading the accompanying material. Application of professional values and ethical standards to specific clinical situations is the crux of practicing competently and ethically. A key part of learning and reflection is to develop sound ethical judgment. Some guidelines for this include the following:

- Familiarize oneself thoroughly with established professional standards.
- Recognize ethical problems as they arise and take into account the complexity of these issues.

- Remember that ethical decision-making is an evolutionary process that requires self-awareness and critique.

Mental health and human service professionals should keep these guidelines in mind and work through each scenario presented in the text in a way that connects their thinking to their own practice in the present, past and future.

ETHICS AND PROFESSIONAL CODES OF ETHICS

Conceptions of Ethics Over Time

The field of ethics is constantly changing in response to new concerns, trends in care, research, and events that affect the delivery of mental health services. Consider, for example, the COVID-19 pandemic, which created multiple novel situations for professionals that required new and quickly adapted approaches to ensure the provision of quality care. This included a dramatic increase in telehealth services so that clinicians could reach clients amidst the physical danger presented by in-person care. It also involved working with clients who were experiencing some of the same stressors in real time as their clinicians. As the danger of the illness became better understood, appropriate precautionary measures were taken and a return to in-person care became more ethically viable. Now, the field must consider the ethics of telehealth versus in-person care in the post pandemic environment. (The section Emerging Concepts in Ethics will cover some of the current scholarship relating to these concerns).

Because ethical guidelines continuously evolve over time, mental health and human services professionals must remain aware of current best practices. As the field advances, concepts like the duty to warn, facilitating involuntary treatment, and protecting children who are experiencing abuse will require ongoing examination. Due to the ever-changing nature of ethical thinking and guidance, it is important that providers consider this learning material as a springboard for career-long engagement with ethical concepts and principles as they apply to real client experiences and interactions.

Overview of Professional Codes of Ethics

Most professionals have a working definition of ethics, which may simply be: "Ethics are the rules of conduct for my profession." Professional codes of ethics often add a word like *enforceable* to further delineate the importance of professional ethics. The National Association of Social Workers (NASW, 2021, Purpose of the NASW Code of Ethics), for example, states,

> Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The NASW Code of Ethics sets forth these values, principles, and standards to guide social workers' conduct.

Similarly, the American Psychological Association (APA; 2017, Introduction and Applicability) states that

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

Social workers, psychologists, counselors, and marriage and family therapists each agree to adhere to their specific profession's code of ethics. A **code of ethics** is a guide of standards and principles created to help clinicians and providers conduct themselves professionally in all client and client system interactions. Each organization's code defines how a professional is to approach problems, the core values and principles of that profession, and the standards to which the provider is held. The ethical principles dictate professional standards of behavior; for example the principle of integrity informs the practice standards of confidentiality and informed consent. Ethics codes protect client trust and safety by delineating professional standards for mental and behavioral health professionals with the purpose of protecting the well-being and dignity of clients and client systems. The American Counseling Association (ACA, 2014) sets forth guidelines that can be generalized to all helping professions by stating that all codes of ethics provide guidance to clinicians and providers, and those professionals in turn must

- create and maintain relationships with client/client systems based on trust, while avoiding dual relationships;
- obtain informed consent for services and collaborate with client(s) whenever possible;
- be aware of how factors of diversity including culture, values, and beliefs affect the clinician-client relationship;
- ensure client confidentiality and privacy whenever possible including the use of technology/social media;
- be honest in all communications and explain services to the best of their ability; and
- adhere to their specific discipline's code of ethics.

Professional associations (e.g., NASW, APA, ACA, National Board for Certified Counselors [NBCC]) each provide their own ethical codes for their respective professions and require their members to adhere to them. Portions of these specific codes are provided throughout the learning material to illustrate guidance on particular concerns and values. Clinicians are expected to attain and maintain competency. **Competency** is commonly defined as a skill or ability and denotes an end point. The implication is that if one gathers enough knowledge, information, and experience, they can achieve competency. However, with respect to professional ethics, among other topics, it is helpful to take the perspective that one can never be fully competent in ethical matters because ethics, like the contexts in which they exist, are ever-changing. Thus, striving to be competent should not be the goal of learning about ethics; instead, one should focus on understanding how their code of ethics and its ethical standards apply to a variety of situations, along with having an ethical decision-making model/framework that can assist the clinician when ethical dilemmas arise.

Ethical and Legal Intersections

Many ethical issues faced by mental health and human services professionals involve legal issues. All providers are bound both by their professional ethical codes and by the laws of their respective states and practice jurisdictions. All clinicians are responsible for maintaining familiarity with current legal standards in the states in which they practice and/or are licensed. Ethical decisions in mental health and human services practice that involve legal issues do not always involve ethical dilemmas. In many cases, such decisions are compatible with both legal and ethical standards. However, other cases involve more difficult ethical dilemmas, particularly when clinicians' decisions are compatible with legal standards but not consistent with prevailing ethical standards or vice versa. The following case examples illustrate this type of dilemma. It is important for professionals to seek consultation with supervisors and colleagues when such conflicts arise.

Case Example: Ethical and Legal Intersections

Sarah is a social worker in a child welfare agency. She is working with Jessica, mother to a 7-year-old son, Daniel. Jessica has struggled with substance abuse, but is making progress in her treatment program and is committed to her recovery. Daniel has been temporarily placed with his grandparents while Jessica works on her rehabilitation. Sarah faces a dilemma between her ethical obligation to support Jessica's efforts to regain custody of her son and the legal requirement to ensure Daniel's immediate safety and well-being. The legal standard in their state dictates that children must be removed from a potentially unsafe environment until the parent demonstrates consistent and significant recovery from a substance use disorder. Sarah believes that Jessica has made considerable progress and could safely care for Daniel if given the chance. She also believes in client self-determination and the importance of human relationships, in concert with her values as a social worker, and that the relationship between child and parent is paramount.

Sarah decides to document Jessica's progress comprehensively and advocate for a thorough review of Jessica's case. She collaborates with Jessica's treatment providers and other professionals involved to gather evidence of Jessica's recovery and stability. At the same time, she is cautious about being sure that she is seeing Jessica's case realistically. She looks for objective evidence of Jessica's recovery rather than relying on what she knows are some of her biased emotions about the case. Sarah prepares a detailed report highlighting Jessica's achievements, the support systems in place, and the safety measures that have been implemented, and talks with her supervisor extensively about this to double-check her assessment.

At the same time, Sarah ensures that Daniel's current living situation with his grandparents remains stable and supportive. She keeps Daniel's best interests at the forefront while working to balance the goal of family reunification with the legal requirements for child safety. Sarah advocates for a gradual, supervised reintegration plan that aligns with both legal standards and ethical principles. This approach aims to respect the legal framework while acknowledging and supporting Jessica's progress and the potential benefits of reuniting her with Daniel in a controlled and monitored manner. She works hard to navigate the balance of care for Jessica's interests, Daniel's interests, and the interests of the family as a unit. In this way, Sarah navigates the complex intersection of ethical obligations and legal requirements, striving to

achieve a solution that upholds the safety and well-being of the child while supporting the parent's journey towards recovery and family reunification.

Personal Reflection

- What do you think about Sarah's approach to working with this family?
- Would you do anything differently?
- How do you approach balancing ethical and legal obligations as well as competing interests when working with clients within the context of their families?

Case Example: Ethical and Legal Intersections

Lenore is a licensed professional counselor (LPC) working in a for-profit agency that provides services for adults seeking outpatient mental health care. The agency accepts many different types of private insurance for their work with clients, and primarily sees clients who are using their insurance benefits for care. Lenore has been working with Melissa for about a month when Melissa shares that her wife, who earns a significant amount of their household's income, recently lost her job and will be actively seeking work. Melissa describes her concern about the situation from many angles, including the new financial pressure that this will put on the couple.

Around the same time, Lenore learns that Melissa's insurance benefits vary depending on whether the care being provided is in person or virtual. Melissa's plan requires she pay an $80 copay for in-person sessions, but she can pay $0 for virtual sessions. At their next session, Lenore shares this information with Melissa and inquires as to whether she would like to transition to virtual sessions to save money on the copay, given her financial situation. Melissa expresses appreciation to Lenore for thinking of this, but says that she greatly prefers in-person sessions and would like to continue working together in the office, even if it costs more. Lenore decides that she values the ethics of providing the best she can for her client's needs over the legal concern of committing insurance fraud, and states that she will bill for the in-person sessions as though they were virtual.

Personal Reflection

- What do you think about Lenore's decision?
- Would you make the same decision in her position, or a different one?
- How would you advise Lenore if you were her supervisor and she shared this concern and her decision with you?

It is important to note that, while clinicians may at times have good reasoning for why ethics are a higher priority than legal concerns, there can nonetheless be dramatic consequences for illegal behavior. In Lenore's example, for instance, both she and the agency she works for are at risk of legal consequences for breach of contract and insurance fraud if this behavior comes to light. It is unlikely that an argument from the point of ethics would be upheld in court and prevent recourse for this fraud, which also breaches the ethical principle of integrity. If clinicians are

concerned about an intersection between legal and ethical guidance, they should engage openly with the ethical decision-making models and document their reasoning. As needed, they should seek legal expertise as part of the consultation process when legal issues are at play. A good practice is to refrain from engaging in any behavior one would not wish to document openly.

ETHICAL PRINCIPLES AND COMMON VALUES

Helping professions share many common values and principles. While each ethical code may talk about these concepts in different ways, all agree that they are important guiding principles for all service providers. Therefore, clinicians should not only attend to the guidance provided, but also reflect on their specific profession and context to think about how to apply these principles to their everyday practice.

Nonmaleficence

Questions to Consider

- What does the principle of nonmaleficence (do no harm) mean to you?
- Are there situations in which a clinician might need to act against this principle, or in which clinicians might differ about what constitutes harm?

Nonmaleficence is the foundational ethical principle in which a person agrees to do no harm. Clinicians vow that they will not cause intentional or avoidable harm to clients and client systems alike, and thus refrain from engaging in any behavior or action that may place others at risk. Harm is broadly defined and can include physical, emotional, and psychological harm, as well as violations of human rights (Beauchamp & Childress, 2019); such definitions are culturally specific and value-laden. In general, clinicians from all disciplines would agree that yelling at a client, forcing a client to do something against their will, or hitting a client is unacceptable. There are times when clients are, in fact, harmed by clinicians when it prevents a greater harm. For example, clients who are experiencing suicidal ideation may be hospitalized involuntarily. This may be seen as an act of maleficence as it goes against a client's autonomy and right to choose, but it prevents a greater harm to the client.

Another common ethical dilemma pertaining to nonmaleficence is a client's decision to take psychotropic medication. Clients have the right to decide whether to take such medications and are made aware of the positive, potentially life-changing aspects of taking such medications, as is the case for many individuals with schizophrenia, schizoaffective disorder, anxiety, and severe depression. However, taking certain medications will cause side effects that can cause harm to a client. The potential side effects of such medications range from mild annoyances to potentially life-threatening situations. It is the clinician's job to discuss both the potential benefits and risks of taking medications with clients—except in cases where a lack of competency or capacity for autonomous decision-making has been legally established—and allow clients to decide their own best course of action. This can cause ethical dilemmas for many clinicians who may believe that the potential benefits of taking medication outweigh the risk for harm or disagree

with a client's decision about what is best. A clinician must assess their own beliefs and values pertaining to medication, provide the most up-to-date information on the risks and benefits of medications, and then allow clients to decide without coercion. The Ethical Decision-Making section offers guidance to clinicians in thinking about how to navigate conflicting ethical principles in the quest for nonmaleficence.

Autonomy

Questions to Consider

- What limitations are there to autonomy for clients?
- How do you think about navigating the complexities of client autonomy?

The principle of autonomy asserts that clients have the right to make decisions about their own lives, free of pressure or coercion from providers. Autonomy is a universal principle among helping professions, referred to by social workers as self-determination (NASW, 2021). Clinicians in all disciplines should strive to preserve clients' autonomy, which is achieved by

- providing support and honoring clients' rights to make decisions,
- increasing clients' capacities for positive changes through appropriate interventions,
- discussing with clients how a decision may be perceived by others,
- problem-solving various options with clients to achieve autonomy, and
- maintaining clients' privacy and confidentiality (APA, 2017).

One way many clinicians support autonomy is through adhering to specific care frameworks, such as person- or client-centered practices, that place clients in the role of decision-maker toward the most competent choices possible.

Providers may encounter clients who cannot be fully autonomous in their decision-making due to age, developmental/cognitive disabilities, or other impairments. In these cases, clinicians must engage in supporting autonomy to the extent that it is feasible. For example, when working with minor children, the clinician should support developmentally appropriate approaches to autonomy for the child. Complex ethical dilemmas can arise around ensuring that support for autonomy is in the client's best interest, and that clinicians do not uphold or revoke autonomy inappropriately. In these cases, clinicians should engage in thorough and well-recorded decision-making processes that consider the potential benefits and harms of all potential courses of action. Working with aging clients may also present dilemmas related to upholding autonomy for individuals who may struggle to make decisions in their own best interest. Upholding client well-being as well as client autonomy can be challenging in such cases, but clinicians must strike this balance. Consider the following case example of Mr. R as an example of this.

Case Example: Autonomy

Mr. R. currently resides in his home where he and his now deceased wife raised their three children. In the past few months, Mr. R has received home nursing services from a care professional for a broken hip, and daily assistance with activities of daily living. During this time, Mr. R's children begin to notice that Mr. R. is experiencing cognitive difficulties and loss of memory. Worried for his safety, his children seek the assistance of Mr. R's treatment team, who diagnose him as experiencing the early stages of dementia.

During a daily visit, the care professional finds Mr. R.in his pajamas, sitting outside in the cold in the middle of the afternoon, seemingly unaware of the inappropriateness of his attire for the weather. The care professional brings Mr. R. inside, asks if he is okay, and asks him to get dressed or at least wear a coat outside. The care professional checks to see if he is disoriented. Mr. R. becomes agitated and says he has every right to do whatever he wants, whenever he wants, and that he simply didn't feel like getting dressed that day. Though the care professional is concerned, she does not want to be disrespectful. Instead of continuing the confrontation, she documents the interaction and continues with her duties.

Later, the care professional consults with her supervisor to discuss the dilemma of caring for Mr. R. appropriately. They discuss his need for autonomy, the right to make his own decisions, and concerns that his dementia might be interfering with his ability to make safe choices for himself. Together, they decide to have a meeting with Mr. R., his family and other members of the treatment team to work together on a plan for how to manage these concerns going forward, as there are likely to be more of them due to the progression of his dementia. The care professional and her supervisor agree that bringing Mr. R. into this conversation while he is as lucid as possible will be important for upholding both his autonomy and his well-being.

Personal Reflection

- How would you want your team to proceed if you were Mr. R.? If you were Mr. R.'s family member?
- What other challenges around autonomy might arise for Mr. R.?
- When do you think it is acceptable to act outside of a client's autonomy, if ever? How do you determine the appropriateness of this action?

Beneficence

Questions to Consider

- What does the principle of beneficence mean to you in your work?
- How do you determine whether you are upholding this principle?

The principle of beneficence stipulates that clinicians work toward the betterment of client lives and contribute to their overall well-being. It is the duty of clinicians to work towards the overall health and well-being of clients throughout the professional relationship and to assist clients in overcoming challenges and obstacles in their efforts to achieve the clients' desired results and outcomes. Through their careful actions, clinicians seek to benefit their clients' health and well-being via respectful, thought-out interactions and interventions. Coupled with the other ethical principles of nonmaleficence and autonomy, beneficence strives for the best possible care for clients with the least possible harm. Thus, beneficence refers to a professional obligation to act for others' benefit and help them to further their interests, often by preventing or removing possible harm. While the relationship between clinician and client may have benefits for the clinician (e.g., financial and relational benefits), the primary beneficiary of the relationship must be the client.

Providers uphold beneficence in obvious ways by supporting clients in an appropriate setting and with whatever problems clients are coming in to address. Beneficence includes practices like referring a client to a more appropriate setting and/or clinician when their concerns are outside the scope of a provider's competence, or thoughtfully terminating treatment when it is no longer supporting the client's best interests. Beneficence is upheld when clinicians evaluate their ability to provide effective services during difficult times in their own lives, as well as when they seek further consultation and/or education in order to provide adequate care.

Case Example: Beneficence

Jordan is a social worker who recently began working with Timmy, an 8-year-old boy who is coming to therapy after witnessing his father have a seizure related to alcohol withdrawal. Timmy has been exhibiting symptoms of difficulty managing the traumatic experience, including generalized fearfulness, difficulty sleeping, poor school performance, and irritability. Based on her initial assessment, Jordan believes that trauma-focused cognitive behavioral therapy (TF-CBT), an evidence-based treatment, would be helpful to Timmy. She was trained on TF-CBT in graduate school, but hasn't practiced it in a while, so she takes a two-hour continuing education course to refresh her skills before her next meeting with Timmy. She is upholding the principle of beneficence by working to ensure that she can deliver optimal treatment in the best interest and well-being of her client.

Personal Reflection

- If Jordan did not have experience with TF-CBT, what would have been an appropriate course of action in line with the principle of beneficence?
- Have you ever had a situation in which you felt you or your workplace were unable to adequately meet your client's needs? How did you resolve the issue with respect to beneficence?

Justice

Questions to Consider

- Consider a recent time when ethical and legal standards came into some level of conflict in your practice.
- How did you think about resolving this dilemma and upholding the principle of justice?

Mental health and human service professionals are charged with acting in a fair and just manner. The principle of justice works to ensure that all clients have access to services, resources, and opportunities for growth despite challenges. Professions differ in how they specifically address this principle. For example, the NASW (2021) charges social workers to actively challenge social injustice and work for social change on behalf of vulnerable and oppressed populations. The APA's (2017) principle of justice affirms that all people should have access to services, resources, benefits, and opportunities. According to the ACA, justice does not necessarily ensure equal treatment, but rather in cases of difference, a specific rationale for one's course of action (Forester-Miller & Davis, 2016). Often, issues of justice arise around financial issues and access to services. Clinicians often serve as advocates for clients who have difficulty paying for services, finding payment alternatives, or other resources to ensure just and fair access to treatments.

Acting in accordance with the principle of justice can be challenging when in many places there are more clients in need than there are clinicians, or when providers work in means-tested settings where not all potential clients are eligible for care. Providers should be thoughtful about their processes for ensuring just care, such as working to provide appropriate referrals for clients who are not able to be seen, or adjusting financial requirements when clients experience changes in financial status. Some other examples of upholding the principle of justice include:

- Providing accessible settings for people with physical disabilities (e.g., ramps, elevators, wide hallways, and supported bathrooms).
- Ensuring access to bathrooms that feel safe and comfortable to clients of all genders.
- Providing services to clients in the language most comfortable and accessible to them.
- Developing cultural humility and competence in providing care to clients that views their cultural values as assets for their well-being.

CONFIDENTIALITY

Questions to Consider

- Think about a recent time when confidentiality was important to a case. Were there challenges to maintaining confidentiality?
- How do you determine whether and when to violate confidentiality?
- How do you communicate with clients about confidentiality?

Confidentiality is a complex legal, therapeutic, and ethical issue. Confidentiality is central to developing a trusting and productive counseling relationship and is a concrete manifestation of an essential boundary in the therapeutic relationship. Clinicians are familiar with the concept and it is a central principle of the therapeutic relationship and mental health services. Nonetheless, violating confidentiality is a leading cause of complaints (Pope et al., 2021). Confidentiality is also a leading concern in telehealth and social media; in fact, research suggests that the private health information of around one in 10 people in the United States has been breached (Pope et al., 2021). Confidentiality is central to developing a trusting relationship between clients and providers, as breaches of confidentiality have the potential to create wide ripple effects across lifespans and multiple clients.

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

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

- The ACA (2014, Introduction) Code of Ethics states:

> Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

- The American Mental Health Counselors Association (AMHCA; 2020, Section I.A.2) Code of Ethics indicates that clinical mental health counselors (CMHCs) "…have an obligation to safeguard information about individuals obtained in the course of practice, teaching, and research.…Confidentiality is a right granted to all clients of mental health counseling services."

- The APA (2017, Standard 4.01) Code of Ethics similarly states that psychologists

> have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

- The NASW (2021, Standard 1.07c) Code of Ethics states:

> Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling

> professional reasons. 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 others.

- The National Board for Certified Counselors (NBCC; 2023, Standard 19) Code of Ethics states:

> Counselors shall not share information that is obtained through the counseling process without specific written consent by the client or legal guardian except when necessary to prevent serious and foreseeable harm to the client or others, or when otherwise mandated by Federal or State law or regulation.

- Additionally, the NBCC Code of Ethics (2023, Standard 18) also looks at the content of information shared within therapy sessions and reminds counselors that they should solicit from the client "…only information that contributes to the identified counseling goals or facilitates the counseling process..."

The general expectation that mental health professionals keep information confidential does not apply when disclosure is necessary to prevent "serious, foreseeable, and imminent harm" (NASW, 2021, Standard 1.03i) to a client or other identifiable person. In these instances, professionals should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. This is open to some degree of discretion on the treatment professional's part. As a general guideline, the entirety of the client's chart and notes are rarely released for reasons of confidentiality. In cases such as duty to warn and protect, the clinician should only release the information necessary to provide the requisite protection. When facilitating transfer of care or outside treatment, the clinician should only release information necessary for the provision of effective care, while protecting information superfluous to the particular care being provided.

Case Example: Confidentiality

An outpatient therapist, Stacy, is working with her young adult client, Kyle, when it becomes clear he needs urgent support for suicidal ideation. Kyle agrees to talk with his parent, with whom he lives, when he gets home and that he will have his parent reach out to Stacy to discuss next steps. Kyle's parent calls Stacy and expresses concern about what Kyle has shared. Together, Stacy and Kyle's parent create a plan to bring Kyle to the local crisis response center to seek inpatient care. Stacy shares what Kyle has told her in terms of means for suicide he has hidden in his bedroom, so that his parent can confiscate these. Stacy does not share information about Kyle's recent recreational substance use. When Stacy talks with staff at the inpatient treatment center, she discloses the information about the suicidal ideation, the means, and the substance use, since this information is all important for Kyle's care.

Personal Reflection

- Would you have handled Kyle's case any differently than his therapist did?
- What issues might arise in managing confidentiality with Kyle moving forward?
- Have you ever had to share information to ensure the safety of a client experiencing suicidal ideation? How did you proceed?

DUTIES TO PROTECT AND WARN

Questions to Consider

- Have you had to engage in protection/warning in a way that violates confidentiality in your practice?
- How do you think about balancing these duties with the sanctity of confidentiality and self-determination in the clinical relationship?

In 1974, the Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with harm by a patient (Tarasoff v. Regents of the University of California, 1976). This ruling came in a case following a death that might have been prevented if a mental health professional had warned the victim based on information they gained during a session with a client. A professional may carry out this duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual. Clinicians are responsible for protecting the public and warning others when they become aware of a threat to someone's safety through their interaction with a client.

The duties to warn and protect challenge the mental health profession's commitment to confidentiality. A clinician should be aware of the laws and statutes in the jurisdictions where they practice, as well as their discipline's code of ethics to help guide them whenever the context of treatment is involuntary. When a client is at risk of harming themselves or others, involuntary hospitalization is unavoidable. Because the issues related to *harm to others* are different from those related to *harm to self*, it is best to consider them separately. Reamer (2018) suggests four considerations when determining whether involuntary treatment is necessary because of a client's potential for harm to others:

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

Clinicians should carefully weigh the options with the client (if possible) and use an ethical decision-making framework to help guide their decision. The ethical dilemma that arises with the duty to warn mandate is between a clinician's ethical responsibilities to the client and to public safety. A clinician must weigh the options carefully and provide documentation for their decisions (see Ethical Decision-Making). As part of the informed consent process, providers must inform clients that they have an ethical and legal obligation to break confidentiality when they suspect that the client is at risk of harm to others. By providing this information at the beginning of treatment and revisiting it throughout services, the potential for a lawsuit or miscommunication with clients about the professional's role can be minimized.

Case Example: Involuntary Treatment and Informed Consent

Shonda is a therapist in private practice. Her intake paperwork includes detailed information about the nature of informed consent, including the exceptions to the rule of confidentiality in her relationship with her clients. In addition to asking them to read and sign this paperwork, Shonda always gives the following script during her initial meeting with clients:

"I would like to highlight one important aspect of the intake paperwork, which is confidentiality. This is a really important part of our building a trusting relationship, and you should know that the things you and I discuss will not be shared with anyone else by me without your written permission. There are a couple of exceptions to this rule. If I am concerned that you are in danger of harming yourself, or that you are in danger of harming someone else, I have to act in a way that protects the person who is at risk. This might involve sharing some confidential information about the reasons that I am concerned and the nature of our relationship. I will always tell you if this is something that I have to do and we will discuss it together. Do you have any questions about that?" Shonda then engages with whatever questions clients have about the nature of this exception to the rule and about confidentiality in general. She is transparent and open about the limits of confidentiality, and this is both ethically required and an important building block for her clients in learning that she is trustworthy.

Personal Reflection

- Is there anything that you would change in Shonda's process or her scripted description of confidentiality?
- What is the process within your workplace/practice around managing a concern for duty to protect or warn?
- What supports would you rely on if you needed to work through a concern about the safety of a client or an identified other in the course of your workday?
- What do you think about balancing the concern for clients compared to concerns for public safety?

INFORMED CONSENT

Questions to Consider

- What is your current informed consent process like when bringing new clients in to therapy? Have there been times when informed consent was difficult in your work?
- What supports would benefit your informed consent processes?

Informed consent provides clients with information necessary to make educated decisions about treatment. The informed consent process provides an opportunity to begin the communication pattern that will guide and structure the therapeutic relationship. By being transparent and clear with clients about the nature of treatment and its nuances, clinicians build trust and develop a blueprint of what clients can expect in therapy. Clients learn implicitly that their clinician will respect their choices and consider them leaders in decision-making around the process of clinical intervention.

Providers must also ensure that they tailor the provision of information and solicitation of consent to their particular client's needs. Conversations and written materials related to consent must be provided in a language and at a comprehension level that is fully accessible to the client. Written materials addressing consent should also be discussed orally with the client as well, highlighting areas of particular importance such as limits to confidentiality and the duties to report and warn, self-determination, boundaries, and risks and benefits of treatment. Clinicians should help clients understand both their rights and their responsibilities in the therapeutic process and encourage clients to make an active decision about entering into the process of counseling.

All ethical codes relevant to mental health care require informed consent, and it is a legal requirement as well. It is important that clinicians think of informed consent not as a box to check off in their intake process, but rather as an important conversation and opportunity for rapport building with clients. Although the content of the informed consent process may vary from client to client, it generally includes the following factors (APA, 2017, Standard 10.01):

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

If the provider needs to be compliant with the Health Insurance Portability and Accountability Act (HIPAA) due to the transmission of information to third parties, the informed consent process must also include specific information about access to protected health information (PHI). In general, the informed consent process should be both *formal* (i.e., in writing) or *informal* (i.e., by discussion). Clinicians should be thoughtful about the transparency needed in their informed consent process given their boundaries and/or the limits of their competence. For

instance, clinicians who receive requests for letters or other documentation for medical care (e.g., for gender-affirming surgeries or bariatric procedures) should be clear about their evaluation process, their competence, and their limits around writing these types of letters. This also applies to clients seeking support and documentation related to school or workplace concerns (e.g., injuries, absences, family and medical leave requests, compliance with Americans with Disability Act requests), or those who are looking for possible court, legal, or custodial involvement by the clinician. Ethical practice demands that when obtaining informed consent to treatment, clinicians are transparent and clarify with clients the limits of confidentiality when faced with these concerns, as well as making appropriate referrals based on competence.

PROFESSIONAL AND CULTURAL COMPETENCE

Questions to Consider

- How do you think about your duty to maintain competence as a professional?
- What actions do you take to maintain professional competence as well as cultural competence?
- How do you determine where to focus your efforts in terms of growing and maintaining your competence?

Mental health providers cannot expect to be experts in treating all psychological disorders, working with all populations, or managing independently all the complex situations that arise with clients. Professional competence is at the heart of professional practice. It is so important that NASW considers it one of the core values of their profession. The concept of professional competence, however, is not unique to social work but is key in the ethical codes and training of all mental health professions:

- The AMHCA (2020, Section I.C.1 & Section I.C.1d) Code of Ethics instructs:

  > The maintenance of high standards of professional competence is a responsibility shared by all CMHCs in the best interests of the client, the public, and the profession…CMHCs represent accurately their competence, education, training and experience, including licenses and certifications.

- The APA (2017, Standard 2.01a) Code of Ethics links competence to "education, training, supervised experience, consultation, study, or professional experience." When addressing emerging areas of treatment "psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm" (Standard 2.01e). The code therefore outlines procedures that psychologists may take if there is an emergent situation that supersedes their normal scope of competence.

- The National Association of School Psychologists (NASP; 2020, Standard II.1.1) states:

> School Psychologists recognize the strengths and limitations of their graduate preparation and experience, engaging only in practices for which they are qualified. They enlist the assistance of other specialists in supervisory, consultative, or referral roles as appropriate in providing effective services.

- The NASW (2021, Standard 1.04) Code of Ethics provides a comprehensive description of the many facets of competence, and one that encompasses the lifespan of professional counselors. The code states that "Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience."

- Similarly, the NBCC (2023, Standard 1) states "Counselors shall perform only those professional services for which they are qualified by training, education, and supervised experience."

Given the importance of competence, providers should be clear about the scope and limits of their own abilities and have plans in place for ensuring that they are practicing within their scope. Most licensing boards mandate ongoing development of competence through continuing education requirements and clinicians should be thoughtful about seeking quality education that addresses gaps in their knowledge, skills, and experience. This is particularly important in areas that are relevant to their current practice. Developing robust supervision and consultation resources is an effective way to ensure assistance when presented with a client concern or experience that falls outside of a provider's scope of competence. In addition, clinicians should maintain a network of qualified and ethical providers with varying specialties to whom they can refer clients when such referrals become appropriate.

Competence implies that the treating clinician has the appropriate knowledge to identify therapeutic goals and interventions within the context of the patient's diagnosis and presenting issues. Furthermore, the clinician must have the technical expertise to apply these interventions. In addition to knowledge and skills, emotional competence is also an important factor. Clinicians need to be aware of personal problems that may interfere with or impair their ability to provide care. For example, NASP's (2020, Standard II.1.2) Code of Ethics states that "School psychologists refrain from any work-related activity in which their personal problems or conflicts may interfere with professional effectiveness." These problems could include issues such as a divorce or an illness (medical or psychological). Additionally, problems that a provider is experiencing or has experienced that are relevant within the client experience can be either helpful or create a barrier to the provision of competent care. Clinicians should be clear about where and how their personal concerns overlap with clients and how they will ensure appropriate care in these situations.

A clinician's identity and experience may also play an important role in the provision of culturally competent care. **Cultural competence** consists of a person's ability to accept differences, continually assess themselves regarding culture and the dynamics of difference, and the development of cultural knowledge and resources within service models to meet the needs of specific populations (Zhu et al., 2023). **Cultural humility** emphasizes recognizing that there are

many different ways of knowing, and that the clinician's culture is not preeminent in understanding the world over the client's culture. Rather, the client's cultural lens should be understood, respected, and used by the clinician to think about solutions and effective care (Zhu et al., 2023). Cultural competence is critical to maintaining an effective and nonharmful clinical relationship, particularly with clients who are part of historically marginalized groups and/or have cultural backgrounds distinct from that of the clinician. Clinicians must be aware that cultural competence and cultural humility are continual practices rather than an end goal at which one arrives. An ongoing education and training plan to address continual growth in cultural competence is an important part of career development for mental health professionals. Additionally, clinicians should be comfortable exploring cultural differences and their influence on the therapeutic relationship, as well as having a clear plan for filling in specific cultural knowledge gaps when they arise and are relevant to professional practice.

Culturally responsive treatment has been shown to improve outcomes and participation among marginalized groups, particularly with clients for whom there is a lack of informed evidence-based research (Banks et al., 2023). Culturally competent and culturally humble care has meaningful effects on the clinical relationship and creates effective space for client healing (Zhu et al., 2023). One study by Choe et al. (2023) on client contributions to outcomes, focused on a client's cultural humility as a factor in their well-being. They found that a client's openness to cultural differences as a buffer to diverse relational dynamics (e.g., power differences, tolerance for differing beliefs in others) is associated with greater improvement in the client's well-being over time, in addition to a decrease in their symptoms. They suggest that using therapy to increase client cultural humility also increases the client's well-being. Mental health and human service providers are not only ethically required to continually improve their cultural competence, but they also can be confident that culturally competent practice will improve their work with clients.

Case Example: Cultural Competence

Monique, a licensed marriage and family therapist (MFT), receives a phone call from a couple seeking family counseling due to challenges with their 14-year-old son. In a brief phone conversation, Monique learns that the couple emigrated from Laos 15 years ago, and that their son is the first generation of their family to be raised in the United States. The mother, who has initiated the phone contact at the request of the school guidance counselor, expresses disappointment in the son, who has been exhibiting behavioral concerns during school. Monique feels out of her depths due to a lack of knowledge about Laotian culture. Because of this, she refers the family to a colleague who has worked with other Laotian families who have immigrated to the United States.

Personal Reflection

- What other steps might Monique have taken if she wanted to work competently with this family?
- Is this how you would have handled this case? Why or why not?

Case Example: Professional Competence

Michael, a licensed MFT, has been working with John and Maria in couple counseling. He has seen the couple in counseling for 6 months and is supporting them in managing Maria's depression and its effects on the relationship. Michael receives a phone call from John, expressing concerns that his wife has started engaging in behavior symptomatic of an eating disorder, including purging. Michael is not familiar with treating eating disorders, but feels that since he has already been treating the couple and that many of their communication problems are improving, the eating disorder does not need to be the focus of treatment. Maria's symptoms continue to increase in frequency, although Michael is not aware of this. At work one day, Maria experiences severe vertigo. She consults with her primary care physician and learns that her blood panels are abnormal. Maria is referred for intensive outpatient treatment to address her eating disorder. Meanwhile, the couple would like to continue working with Michael on their communication problems and the effect of Maria's eating disorder on the relationship.

Personal Reflection

- Is Michael competent to continue providing clinical treatment to this couple, given the change in Michael's understanding of Maria's presentation?
- Are there steps that he could take to improve his competence if he would like to continue working with them?
- If Michael concludes he is not competent to continue, how should he talk to the couple about this?
- Have you ever encountered a situation with a client in which you felt you lacked adequate training or experience? How did you proceed?

DUAL AND CONSECUTIVE RELATIONSHIPS

Questions to Consider

- What kinds of potential dual relationships do you encounter most frequently in your line of work?
- Have you ever entered into a dual or consecutive relationship with a client? Why or why not?
- If so, how do you feel about the way that this happened? How do you think this affected the client in question?

Boundaries and ethical guidelines help determine the parameters for acceptable behavior within the professional relationship. Therapeutic and clinical relationships are often very intense and involve great emotional vulnerability on the part of clients, making clear boundaries even more important to safeguard the client from harm and potential exploitation. From a risk management perspective, boundaries are also important for the protection of the professional and their livelihood. Boundaries indicate the beginning and end of the professional relationship—what it is

and what it isn't. Just like in other relationships, healthy boundaries vary in their flexibility and rigidity and require significant consideration to determine the best interest of both clients and professionals.

To establish clear boundaries, the concepts of boundary crossings and boundary violations provide helpful frameworks. The difference here highlights the flexible nature of boundaries and recognizes that in the clinical relationship, some boundaries are more rigid than others. For instance, all ethical codes of conduct for mental health service providers explicitly forbid sexual contact with current clients. To engage in such contact constitutes a clear violation of a rigid boundary, with no room for consideration of the intricacies of the context in which the violation occurred. However, to accept a bouquet of flowers from a client at the ending of the clinical relationship is a boundary crossing, but one about which more information is needed to determine whether a violation has occurred. Contextual information, such as the worth of the bouquet, the particulars of the client's work with the client, and the setting may all be relevant to understanding the nature of harm and protection in this scenario. Paramount to the consideration of a boundary crossing is the question of the best interest of the client.

Non-Sexual Dual Relationships

Ethical codes and state laws address potential conflicts of interest in relationships with clients. There are several areas that could present potential conflicts of interest, but some of the most commonly occurring ones involve sexual relationships and nonsexual dual relationships. Sexual relationships are extremely harmful and therefore are discussed in detail in the next section. It is also important to review issues related to multiple/nonsexual dual relationships as well. The APA (2017, Standard 3.05a) Code of Ethics defines a **dual** or **multiple relationship** as: 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.

The APA Code of Ethics expects a psychologist to refrain from being involved in a relationship that "could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists."

Other professional codes of ethics offer guidance around dual relationships as well.

- The AMHCA (2020, Section I.A.3a) Code of Ethics indicates:

  > CMHCs make every effort to avoid dual/multiple relationships with clients that could impair professional judgment or increase the risk of harm. Examples of such relationships may include, but are not limited to: familial, social, financial, business, or close personal relationships with clients.

- The NASP (2020, Standard III.4.1) Code of Ethics states:

  > School psychologists refrain from any activity in which multiple relationships with a client or a client's family could reasonably be

> expected to interfere with professional effectiveness. School psychologists are cautious about business and other relationships with clients that could interfere with professional judgment and decision making or potentially result in exploitation of a client.

- The NASW (2021, Standard 1.06c) Code of Ethics guides social workers to

> …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.

- The NBCC (2023) Code of Ethics cautions against multiple relationships and provides guidelines on steps the NBCC should take if a dual relationship develops. It states:

> Counselors strive to avoid multiple relationships with clients, to the extent possible, except in cases when it is culturally appropriate or therapeutically relevant. In the event that a multiple relationship develops in an unforeseen manner, the counselor shall discuss the potential effects with the client, and shall take reasonable steps to resolve the situation, including termination and the provision of referrals. This discussion shall be documented in the client's record.

Examples of dual/multiple relationships include counseling a friend, family member, or someone previously known to the therapist, providing individual therapy to two members of the same household, providing simultaneous individual and group therapy, entering a business relationship with a client and possibly when entering a noncounseling relationship with a former client. A **current dual relationship** exists when a clinician and client have a relationship in addition to the clinical relationship while the clinical relationship is still active. C**onsecutive dual relationships** happen when a nonclinical relationship occurs after the clinical relationship has been terminated. It is important to understand that every form of dual relationship carries the potential of harm to the client. A dual relationship that leads to harm for the client may leave the clinician subject to malpractice claims; clinicians should be highly attentive to potential harm and avoid dual relationships whenever possible. In the extremely rare circumstances, where dual or multiple relationships are unavoidable, it is incumbent on the clinician to make reasonable efforts to avoid them, clarify boundaries, and mitigate any harm.

Overall, dual relationships present the possibility of jeopardizing professional judgment, client well-being and the process of therapy. One of the fundamental principles of therapy is that the clinician is there to meet the needs of the client; the reciprocity in the relationship is limited mostly to financial compensation for the clinician's services. While a relationship between client and therapist develops, that relationship is clinical and, thus, different from the mutual relationships in the client's and the therapist's personal lives. By being contained to a singular relationship clinical interactions are egalitarian, secured with a reliable and dependable set of boundaries, and unhindered by conflicts of interest—all of which allows for objective and sound professional judgement (Pope et al., 2021).

Some forms of dual relationships may be obviously problematic and avoidable, while others offer more room for nuanced understanding. Consider the following examples:

Case Example 1: Dual Relationships

Geri, a clinical social worker in private practice, receives a call from Mary, an old college friend. Mary has recently discovered that her daughter, Kim, has been engaging in self-harm, and Mary is very concerned. Kim has refused all treatment, but says she is willing to talk with Geri, whom she knows and trusts. Geri is not entirely comfortable with this, but feels that the potential benefits of treating Kim would outweigh any of the risks related to dual relationships. Geri sets up a consultation with Kim and will reassess her position following the meeting with Kim.

Personal Reflection

- Did Geri make the right decision? Why or why not?
- Have you ever been asked by a friend or family member to intervene in a difficult mental health situation with someone who was not your client? How did you manage the request?

Case Example 2: Dual Relationships

Hattie, a clinical social worker in private practice, has been working with Sara for about one year now, with a focus on relationship issues stemming from childhood trauma. Recently, Sara moved to a new apartment. When she shared her address with Hattie, Hattie recognized that Sara's new home is right around the corner from Hattie's house. Hattie shares with Sara that they are now living in the same (urban, highly population dense) neighborhood and may be at increased risk of seeing one another incidentally. Since the move one month ago, Hattie has seen Sara in passing on the street several times, including once when Hattie was leaving her house, so that Sara now knows where Hattie leaves. Hattie asks Sara several times whether she has any concerns about their new proximity, but Sara is adamant it doesn't mean anything to her. Hattie, however, notices herself worrying about it and approaches her supervisor to discuss the matter.

Personal Reflection

- What questions might you ask of Hattie if you were her supervisor?
- What do you think the risks are in this scenario in terms of potential harm to the client?
- How should Hattie proceed?
- Have you ever encountered a client outside of the office? How did you manage the incident? How did you address the possibility of another chance meeting in your ongoing work with your client?

Case Example 3: Dual Relationships

Jeremiah works with several therapy clients who are in the service industry (e.g., restaurant staff, baristas). Often, clients will offer to "hook him up" with perks like hard-to-get reservations, free food at their establishments, and special treatment if he asks them for it. Jeremiah loves going out to eat and would certainly enjoy taking advantage of these benefits.

Personal Reflection

- Should Jeremiah take his clients up on their offers?
- What potential risks and negative consequences for their therapeutic relationship might be possible for his clients if he does so?
- Have you ever been offered similar benefits in your practice? How did you handle the situation?

In considering whether to enter into a dual or multiple relationship with a client, clinicians can work through some helpful problem-solving exercises (Pope et al., 2021). The Ethical Decision-Making section offers further discussion of these guidelines.

- Consider what might be the best and worst possible outcomes of the relationship. Weighing whether there are any real benefits against the extent of the harmfulness can guide decision-making around the relationship. For Jeremiah in the provided example, the possible benefit of free food and restaurant perks is greatly outweighed by the potential harm of confusing the boundaries of his clinical relationship with clients, creating a sense of obligation for both himself and his clients, and implicit self-disclosure involved in spending time with clients in his personal life.

- Consult with supervisors or other knowledgeable professionals and reflect on available literature pertinent to the relationship concern. In Hattie's example, she discussed her concern in clinical supervision. She and her supervisor may have developed a list of the possible concerns that could arise in the course of having a client who is also a neighbor. Hattie might then make a plan to discuss these directly with Sara. She could also plan to collaborate with Sara on thinking about what signs might indicate that their proximity is becoming a problem in the future, so that they can continue communicating and taking action if needed.

- Pay attention to uneasy feelings, doubts, or thoughts about wanting to hide behaviors in professional relationships. These can be a clear indicator that a relationship needs further examination and open reflection. In Geri's example, she immediately sensed that it would not be appropriate for her to see her friend's child. Listening to this intuition, rather than overriding it, is an important part of being an ethical professional.

- Carefully document in the client's record any boundary crossing, including any steps taken in the ethical decision-making process and steps taken to mitigate harm to the client. If one finds oneself reluctant to document choices, it may be wise to reconsider them!

Sexual Relationships with Clients

While sexual relationships with current or former clients constitute a dual relationship, the extent and type of harm involved is sufficiently increased to merit separate discussion. The mental health and human services fields are united in the prohibition of sexual relationships with current clients under any circumstance, and in some states this conduct is also illegal. Harm may arise from the professional's exploitation of the patient to fulfill their own needs or desires, and from the professional's loss of the objectivity necessary for effective therapy. The therapeutic relationship is very intimate. Often clients may share stories and aspects of themselves with their therapist that they do not share with anyone else, or only with the closest people in their lives. Introducing sexual contact of any kind with current clients is an exploitation of that intimacy and deeply unethical.

There is evidence that sexual attraction in therapy is fairly common, with over four out of five psychologists (87%) and social workers (81%) reporting that they have experienced sexual attraction to a client at some point in their professional experience (Pope et al., 2021). It is therefore imperative that clinicians at all levels of experience have supportive professional counsel with whom they can discuss any issues of attraction that arise in the therapeutic relationship. This can occur simply because client and clinician happen to be two people who might be attracted to one another if they had met in some other way. More often, however, arising feelings of intimacy may relate to transference or countertransference issues that the therapist should resolve and prevent harm to the relationship. Discussions in supervision can help to resolve these feelings and channel them into something more helpful for the client. In this regard, supervisors and consultants may normalize attraction to clients that may arise during or after the course of treatment while simultaneously emphasizing the exploitative and unethical nature of any kind of sexual intimacy with current clients. In their booklet entitled *Therapy Never Includes Sexual Behavior* (2019), the California Department of Consumer Affairs offers potential warning signs of therapist sexual inappropriateness, which include:

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

Pope et al. (2021, p. 446) note:

> The consequences of sexual exploitation of clients by therapists tend to cluster into 10 very general categories including:
>
> 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.

Professional governing bodies do not agree on the appropriateness of sexual relationships with former clients. The APA (2017), for instance, in Standard 10.08a, states: "Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy…except in the most unusual circumstances." Similarly, the NASW (2017) Code of Ethics, however, in Standard 1.09c states:

> 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.

Providers should be familiar with their field's guidelines, as well as applying their ethical code's general precautions against dual relationships to the possibility of sexual relationships with former clients.

Clinicians should consider supervisory relationships to be an important avenue for the prevention of inappropriate relationships with clients. Rather than simply assuming that they would never engage in such egregious behavior, professionals should be honest about the challenging nature of the intimacy involved in clinical relationships. Experiencing erotic feelings (romantic or sexual attraction) toward clients within the confines of a clinical relationship is a fairly common occurrence (Stefana & Youngstrom, 2023). This is particularly true for clinicians who experience tender feelings toward the client, or hostility toward significant others in the client's life. Clinicians who are male, have a psychoanalytic orientation, or who have less than 20 years of experience may be particularly likely to experience these feelings (Stefana & Youngstrom, 2023). A safe, supportive supervisory relationship in which these feelings can be unpacked and understood can safeguard against escalation into inappropriate behavior. Rather than being

ashamed of attraction and hiding it from supervisors, clinicians should consider this part of the countertransference that is arising in the relationship.

BOUNDARY ISSUES

Multiple relationships are an area of boundary-related concerns in clinical practice, but there are other ethical boundary challenges that sometimes arise and are worthy of consideration. These include giving and receiving gifts, bartering, and physical contact with clients. Each of these is discussed in more detail in the following subsections.

Giving and Receiving Gifts

Giving a gift is a universal way to express gratitude and appreciation, and more important in some cultural contexts than in others. Many therapists receive gifts from clients (especially during holidays) or choose to provide a gift to a client at times like the termination of the relationship. Even within ethical codes there is some degree of variability regarding gift giving and receiving. Therapists' practices also vary with some declining all gifts and others accepting gifts of a more nominal nature. Gifts can be appropriate or inappropriate in terms of their

- type (e.g., cookies versus an item of clothing),
- monetary value (e.g., a small versus a large gift certificate),
- timing (e.g., a holiday versus after missing sessions),
- content,
- frequency,
- intent of the giver (e.g., thanks, manipulation, or something else),
- perception of the receiver about the reason for the gift, and
- their effect on the giver, receiver or anyone else that may be touched by the gift giving.

Client diagnoses and presenting concerns, as well as the length and stage of the therapeutic relationship, may also affect clinicians' thinking about how to manage giving and receiving gifts.

Most clinicians and ethicists agree that small, inexpensive, appropriate gifts, by either therapists or clients, are neither clinically contraindicated nor unethical. Care should be taken around policies that refuse gifts outright, especially if there are differences in culture around gifts between a client and the care provider. Clients for whom simple gifts are a basic cultural currency may feel deeply alienated by a provider refusing to accept one. Children, additionally, may be unable to comprehend the reasons for a gift refusal and feel bad about themselves or the clinician if a gift is refused.

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

- The ACA (2014, Section A.10.f) Code of Ethics takes a flexible stance on gifts. The code states:

> Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect

> and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

- The AMHCA (2020, Section I.E.2) Code of Ethics states:

> CMHCs are cognizant of cultural norms in relation to fee arrangements, bartering, and gifts. CMHCs clearly explain to clients, early in the counseling relationship, all financial arrangements related to counseling…CMHCs usually refrain from accepting goods or services from clients in return for counseling services, because such arrangements may create the potential for conflicts, exploitation, and distortion of the professional relationship.

- The NASW (2021, Standard 1.13b) Code of Ethics provides guidance the following guidance: "Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients."

- The NBCC (2023, Standard 21) Code of Ethics states:

> Counselors shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant. Counselors shall consider the value of the gift and the effect on the therapeutic relationship before accepting. Acceptance of a gift shall be documented in the client's record.

Therapists' gifts to clients have been given less attention than clients' gifts to therapists in ethical scholarship. It is common for clinicians to provide a client with a small token, such as a form of transitional object (e.g., a rock) or a therapy-related educational material (e.g., workbook), or small gifts of minimal value given to child/adolescent clients to help establish the therapy relationship. As in any clinical intervention, therapists are cautioned to be aware of their own motives when giving the gift and to be careful about the perceived meaning of the gift. Clinicians should be thoughtful about the timing in the therapeutic process and their own motivation for gift giving. It is important that clients not be burdened with a sense of obligation or excessive gratitude in response to a gift. Additionally, gifts should not blur therapeutic boundaries.

Case Examples: Boundaries

- *Marianne is a counselor working with Brenda, a client who has experienced domestic violence. After working together for over a year, Brenda is able to successfully leave her partner who inflicted the abuse. Marianne and Brenda often discuss the symbolism of a*

butterfly as transformation and change. While Marianne is attending a craft show one weekend she sees a small bowl in the shape of a butterfly. She considers purchasing the bowl as a gift for Brenda.

- *Tom has been working with his client Jalen for two years. Over the past year Jalen has done some important therapeutic work, including weathering a difficult breakup with his partner. At his birthday party, one of Jalen's friends distributed buttons that say "Jalen is 40!" Jalen gives one of these buttons to Tom, thanking him for the support that he has offered over the previous year.*
- *Sandy, a physician, has been working with her therapist for 3 years. They have been focusing on working through her childhood sexual trauma, which she has never previously discussed with anyone. At Christmas, Sandy gives her therapist a card thanking her for her support, along with a $20 gift card for a local donut shop.*
- *Tianna works with Lara, a client who has borderline personality disorder, while Lara attends 2 years of undergraduate school and 2 years of graduate school for painting. To commemorate her graduation, Lara gives Tianna a painting that she created during her graduate program, stating that it represents the work that they have done together in therapy.*

Personal Reflection

- What do you think about the appropriateness of the gift in each scenario?
- How would you advise a clinician to act if you were in a position to do so?
- What other information would be helpful to you in understanding these cases?
- Have you ever been offered a gift in your practice? Did you accept it? Why or why not?

Bartering in Psychotherapy Practice

Bartering is the exchange of goods or services, rather than money, for other goods or services. Different cultures have different norms around bartering; additionally, clinicians may sometimes encounter clients who may not be able to pay for services and offer instead to barter for them. While on the one hand, bartering may provide access to services for clients who might not otherwise be able to afford them, clinicians need to be very cautious around these types of agreements. The nature of the power differential between client and clinician makes coercion a real possibility, even if it is not intentional. Defining the appropriate exchange in terms of the value of objects or other services for psychotherapy services can be difficult. Bartering for some services, such as home repair work, may involve additional boundary crossings and implicit self-disclosures on the part of the clinician.

Case Example: Bartering

Virginia, a certified counselor, has been treating Anna, an administrative assistant. Within the course of an intensive treatment including childhood trauma issues, Anna loses her job and cannot afford to pay for treatment. Virginia tries to find a referral that will do pro bono work and

ultimately decides to establish a trade whereby Anna does some typing and filing without access to the confidential information of others in exchange for continued counseling.

Personal Reflection

- Did Virginia make the right decision? Why or why not?
- Have you ever been in a situation in which a client asked to barter for mental health services? How did you proceed?

In the case example, Anna and Virginia would be entering into a dual relationship that involves ongoing and consistent contact outside of the therapy space and outside of the roles of client and therapist. Virginia would also be entering into the position of being Anna's boss, adding tremendously to the power differential and creating a real conflict of interest. The therapeutic rapport is likely to be damaged by any work concerns that arise, and Anna is likely to gather self-disclosures about Virginia that are unintentional and not targeted to the benefit of her therapeutic process. This arrangement is very likely to do harm to Anna's therapy process and should not be pursued. Clinicians who are thinking about entering into bartering agreements should consult their profession's current code of ethics and work through an ethical decision-making process to decide how to move forward.

Physical Contact with Clients

As with the previous boundary-related concerns, physical touch and its meaning, expectations, and importance vary across cultures and subcultures. The NASW (2021, Standard 1.10) Code of Ethics provides some clear guidelines on the issue of nonsexual touch. The guidelines state:

> Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

Clinicians should be very thoughtful about whether, when, and how to engage in nonsexual physical touch with clients. Clients should be considered individually and in the context of their culture, presenting concerns, personality, relationships to gender and sexuality, trauma history, and individual expressed need. Given the power differential, clinicians should rarely, if ever, be the person to initiate physical touch with clients—even when asking for consent, clients may not feel that they are able to decline. Physical touch should be something that client and clinician can discuss and be recorded in the client's record.

Case Examples: Physical Contact

- *Kayla is a 28-year-old client with a history of long-term sexual abuse by an uncle. She has been in treatment with Catherine, a clinical social worker with 15 years of experience in treating abuse issues. Kayla trusts Catherine and wants to work on her fears of physical touch. Catherine consults with a colleague, and both agree that this would be beneficial to the client. Catherine develops a hierarchy of situations in which Kayla will tolerate physical touch, culminating with a hug from Catherine. Kayla is able to work through the issues and feels a great deal of relief.*
- *AJ, a 21-year-old college student, comes to therapy to discuss her concerns around body image and potential disordered eating. Her therapist, Tisha, a 60-year-old woman, conducts the initial session with empathy and good initial development of rapport. At the end of session, Tisha stands between AJ and the door and asks, "Are you okay with a hug?"*
- *Meena is a provider who comes from a family and community in which physical touch is very normative and part of both intimate and unfamiliar interactions with others. When clients are leaving her office, she habitually holds the door for them and offers a pat on the arm or elbow as a way of saying goodbye until next time. Some clients have converted this into a handshake, and with those clients Meena uses a handshake instead.*

Personal Reflection

- Do you think that the touch in these cases is concerning or acceptable?
- What additional information would help you to draw your conclusion?
- How would you advise the clinician in each case?
- How do you address physical contact in your own practice?

EMERGING CONCEPTS IN ETHICS

In the last decade, and particularly since the COVID-19 pandemic, there has been a significant rise in the use of technology and digital media in the everyday lives of Americans. Technology use and digital media also are now more integrated into the mental health field through cloud-based electronic health care records, telehealth platforms and delivery, texting, social media, email, consumer review sites/solicitation of testimonials, and even digital interfaces for entering buildings for in-person care. In order to maintain ethical practice, clinicians must be mindful about confidentiality and informed consent as well as the maintenance of professional boundaries. Engaging in online searches and monitoring of social media accounts by clients or by clinicians may constitute harmful boundary violations that can damage the therapeutic relationship (Pascoe, 2023).

Similarly, the rise of social media has transformed large swaths of American culture, mental health, and the field of ethics. While the development and spread of technology has outpaced ethical scholarship and research, both ethical philosophy and research are beginning to emerge. The National Association of Social Workers offers social workers valuable tips for social media etiquette and the development of a social media policy, which providers should share and

regularly discuss with their clients (Johnson, 2024). Since clinicians are engaged with social media, sometimes personally and professionally, clear thinking about their practice ethics on these matters is also necessary. Providers should be mindful about the possible effects of clients witnessing them on social media and the forces of comparison and negative outrage in social media, and the behavior those forces incentivize. Additionally, social media postings may involve direct and indirect forms of self-disclosure; clinicians must be aware of this and work to actively avoid any harm related to inappropriate self-disclosure or personal affiliations with biased groups. Furthermore, clinicians may consider offering guidance to their clients regarding social media, such as setting clear boundaries, taking breaks, and being intentional about the tenor and nature of content consumed (Popescu, 2023).

Challenges connected to the use of technology and social media are covered by a number of long-standing ethical guidelines. For example, NASW's (2021) Code of Ethics requires clinicians to obtain informed consent, avoid conflicts of interest and dual relationships with clients, respect clients' rights to privacy, and ensure that their private conduct does not affect their professional duties. Additionally, it is important for social workers and cognate professionals to develop practice policies for many things including social networking, email, texting, and consumer review sites/solicitation of testimonials. When applying these long-standing ethical obligations to technological considerations and practice policies, NASW (2021) Code of Ethics provides the following directives:

> … when using technology to communicate, verify the identity and location of clients (Standard 1.03f).
> … assess the clients' suitability and capacity [intellectual, emotional, and physical] for electronic and remote services. … and ability to understand the potential benefits, risks, and limitations of such services (Standard 1.03g).
> … obtain client consent before conducting an electronic search on the client. [Exceptions include] … when the search is for purposes of protecting the client or others from … imminent harm or for other compelling professional reasons (Standard 1.03i).
> … [avoid] engaging in personal relationships with clients [via electronic media] … to prevent boundary confusion, inappropriate dual relationships, or harm to clients (Standard 1.06h).

Many other professional groups have also updated their ethical codes to address online relationships with clients, the clinician's professional presence online, and the need for written policies. For example, the AMHCA (2020, Section I.B.6.j–k) Code of Ethics suggests that

> CMHCs may maintain professional profiles that are kept separate from personal profiles. CMHCs need to be aware of their impact on clients should personal information or opinions be disclosed in a public platform. When applicable, CMHCs educate clients on confidentiality, implications for client activity on these pages, and appropriate channels for contacting CMHCs. CMHCs only seek information about their clients through internet searches to determine their own or their client's safety, as necessary to conduct a forensic evaluation, or at the client's request.

The NBCC (2023) Code of Ethics advises in Standard 109 and 114 that services for and interactions with current and former clients align with an appropriate written policy about the use of social media and other related digital technology. This policy details protections for clients with respect to the disclosure of their confidential information. The written policy also explains the rules against multiple relationships including that client and counselor personal accounts are distinct from social media accounts used for professional purposes and that counselors do not have nonprofessional relationships with clients online which includes not connecting with or following the social media accounts of clients.

Mental health providers should be familiar with their field's ethical statements and consider the appropriateness of maintaining familiarity with others via social media, which may contribute to ethical decision-making (see Case Example 1: Ethical Challenges in Practice).

Also rising in use over the past several years is artificial intelligence (AI) and large language models (LLMs) like ChatGPT, which cause other concerns for the mental health field. Scholars of ethics and clinicians are grappling with the potential ethical implications of these technologies as they become fairly ubiquitous in everyday life (e.g., when searching the internet) as well as in practice (e.g., using AI to develop treatment plans, templates, memorandums, and chart notes). Issues of privacy, accuracy, and the integration of and/or amplification of existing bias in data and decision-making models present real ethical dilemmas for the field of mental health treatment (Terra et al., 2023). Large language models work by using all previously entered data to predict appropriate future data; thus, anything entered into an LLM becomes part of its working algorithm. If this information is biased or private, there may be present and future risks to clients. At the same time, AI shows some promise in being able to support assessment and diagnosis, potentially removing some of the bias and human error present in current modes of assessment. A study of one such decision support system showed 89% accuracy in identifying mental disorders with no human interaction, as well as with fewer questions than with a human assessor, potentially increasing the likelihood of assessment completion (Tutun et al., 2023). As this technology continues to develop and be implemented, clinicians will need to be thoughtful and well informed about potential ethical risks and how to mitigate them without disrupting potential benefits to clients.

As discussed previously, providing mental health services via telehealth expanded greatly in response to the global COVID-19 pandemic starting in 2020, and has continued through the present (Asbury, 2023). More research is needed, but some studies show that telehealth outcomes for particular types of therapy are not different from those achieved in person, and that telehealth may even improve adherence (Swartz et al., 2023; Shaw et al., 2024). When providing virtual therapy, it is important to maintain the same ethical standards as when providing in-person care. However, more attention may be required to emphasize security and data safety, establishment of clear boundaries and ongoing assessment of the appropriateness of the virtual care medium for specific clients (du Preez et al., 2024). Clinicians should be attentive to their own competence to practice therapy virtually and their legal ability given the client's location. Thoughtful systems should be developed to assess whether a client is appropriate for virtual versus in-person services, and how to manage changes in that assessment over the course of the therapeutic engagement.

Case Example: Technology

Kaitlyn is an LCSW licensed to practice in the states of New York and Pennsylvania. She has recently decided that she would like to transition her practice to being fully online to work with clients who are located in New York or Pennsylvania at the time of service as required by her licenses. Kaitlyn discusses this plan with her supervisor and they work together to think about how Kaitlyn can make this transition in an ethical way, chiefly ensuring that the clients that she works with fully consent to the plan and that they are appropriate for therapy work that will be online-only.

Kaitlyn and her supervisor develop a screening tool to consider each case for appropriateness. The tool takes into account factors like access and facility with technology as well as clinical concerns like suicidal ideation and substance use that could rule out therapy from a distance in some cases. Kaitlyn is confident that she will be able to maintain her existing knowledge about local resources for her clients as well as relationships with appropriate referral networks to use, as necessary. She creates a new informed consent form for both new and existing clients that outlines the changes to her practice and refers out clients who are not appropriate for online therapy or who prefer to be connected to another in person therapy provider.

Personal Reflection

- Is there anything else that Kaitlyn should consider in making the plan for this transition to fully online therapy?
- What considerations do you use to determine the appropriateness of clients for virtual versus in person therapy?
- What consultations would you seek if you were going to do something like what Kaitlyn is planning to do?

ETHICAL DECISION-MAKING

When a situation arises in which a clinician must decide upon one course of action among several choices, they are faced with a dilemma. An **ethical dilemma** is one in which there is a moral imperative to take more than one action, but the professional doesn't know which imperative takes precedence in the specific situation. If a decision does not have to be made, there is no dilemma. If there is a clear rationale for one choice, while the other choice does not uphold any ethical principles, there is no dilemma. It is an ethical dilemma only when a decision must be made and choosing either action compromises an ethical principle. After recognizing an ethical dilemma, one must outline the principles or standards which are at odds in the decision in order to sufficiently confront it.

Some decision-making models offer a hierarchy of principles, suggesting that some principles always supersede others. A clinician can consult the hierarchy for their decision once the principles have been identified. Other models offer processes for working through the potential courses of action on a case-by-case basis and choosing a path based on the outcome of this thinking. In considering which type of model to use, providers might consider their own risk tolerance as a metric for choosing a general decision-making method. While clinicians strive to do

no harm, often some level of risk is unavoidable. Thus, one's comfort level with taking risks is known as **risk tolerance**. Some questions a clinician must address include:

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

While ethical dilemmas often occur unexpectedly, knowing in advance one's own level of risk tolerance and one's approach to making ethical decisions can be helpful. Professionals who have a more difficult time tolerating ambiguity may prefer a hierarchy of principles, while those who prefer degrees of freedom and nuance may look to more complex decision-making models. To complicate matters further, as clinicians consult their codes of ethics they will note the requirement to uphold both individual and societal well-being, which can often be at odds. Additionally, decisions may uphold certain aspects of well-being while having a deleterious effect on other aspects of well-being (Ale et al., 2023). For example, safety measures can influence economic or social well-being at the individual and public health levels, and some decisions will lead to different benefits for different individuals. In these cases, principles to be upheld might include (Ale et al., 2023):

- Equal benefit for all
- Do no harm to anyone
- Maximize the benefit for a group or society
- Equivalence of costs and benefits

Consider, for instance, the size and content of caseload on a particular clinician's ability to provide quality care. A clinician may provide high quality care to a small number of people, but at the cost of the many people who would also benefit from that care. On the other hand, a clinician seeing an overly large number of clients will certainly, at some point, begin to provide lower quality care due to the human limitations of energy and focus. Many mental health agencies require all clinicians to maintain a similarly sized caseload; however, some clients will need more care than others. Determining appropriate caseload sizes that provide effective services to all clients quickly becomes an ethically murky process.

Hierarchies of Ethical Principles

Scholars in clinical ethics have considered using hierarchies of ethical principles to guide decision-making when one or more principles are at odds with one another. One such hierarchy suggests the following (Hepworth et al., 2002):

- The right to life, health, well-being, and the necessities of life takes precedence over rights to confidentiality and opportunities for additive "goods" such as wealth, education, and recreation. This concept comes into practice when individuals are at risk of harming

themselves or someone else. The violation of confidentiality to prioritize safety is considered appropriate in cases of mortal danger.

- An individual's basic right to well-being takes precedence over another person's right to privacy, freedom, or self-determination. This is an appropriate social principle—upholding freedom until the point where one's actions are causing harm to another's well-being. While this guideline may sound simple, clinicians may find themselves encountering challenging questions such as what constitutes harm, who defines it and how much harm is sufficient to restrict self-determination. To the extent that coercion (i.e., mechanical restraint, isolation, or involuntary commitment) is ever used in the case of concern for imminent harm, the intervention should be proportional to the potential harm (Faissner & Braun, 2024).

- A person's right to self-determination takes precedence over their right to basic well-being. Professionals should uphold the right to self-determination, even the right to choose to violate one's well-being. Individuals should be respected in terms of their right to, for instance, choose unhealthy behaviors like smoking cigarettes, using drugs or refraining from connecting with preventative health care. This guideline can be controversial, and clinicians may disagree vehemently about the particulars of these two principles and their importance relative to one another.

- A person's rights to well-being may override laws, policies, and arrangements of organizations. Policy makers should not enact policies that threaten the well-being of clients, and clients should not be expected to comply with such policies. To the extent that a legal requirement is harmful to a client, it is ethical for clinicians to understand a client's violation of that law.

Hierarchies of ethics can be helpful at times in guiding clinical decision-making, but at other times they may not be sufficient and more practice-based models may be required.

Case Example: Hierarchy of Ethical Principles

A multisite provider of mental health and substance use services has convened its board to discuss a new policy proposal. Noting the higher incidence of cigarette smoking among individuals with substance use or serious mental disorders, advocates suggest that the provider enact a nonsmoking policy at all campuses. They recognize that although historically the organization has used the guideline of self-determination over well-being, in the current situation, another guideline indicates that client well-being is more important than the law and organizational policies. If there are factors associated with client illness that cause them to be at greater risk of damaging their health with cigarette smoking, the organization is doing them a disservice by not working against this negative influence of their presenting health concerns. Meanwhile, self-determination advocates are adamant that clients have a right to choose, and that removing this right on the basis of their mental illness constitutes an insidious form of discrimination and abuse of power.

Personal Reflection

- How would you decide what policy upholds the best interests of clients in this case?
- How might your own lived experience influence your decision? (E.g., are you a former smoker, or a lung cancer survivor, or someone who has otherwise been impacted by cigarette use in your personal life?)
- How do you deal with this type of situation in your own practice?

It is important that professionals are aware of their own biases and work to mitigate them in this decision-making process. Consultation can be helpful to reveal personal biases, and in extreme cases one might consider giving the decision-making capacity to someone who is more neutral. In all cases, ethical dilemmas should be considered opportunities for careful consideration, consultation and documentation.

Ethical Decision-Making Process

One potential decision-making process that is helpful in healthcare settings offers a stepwise process of working through ethical dilemmas by highlighting certain ethical criteria (Ghonimat & Aburashideh, 2023):

1. **Identifying the Problem or Issue:** This includes identifying any and all ethical principles or standards, according to the relevant professional code of ethics, that are involved and at odds in the case in question.

2. **Gathering Relevant Information:** This may include review of the literature, further investigation into the case and consultation with colleagues and/or supervisors and allied professionals.

3. **Considering Different Options:** Identify the potentially appropriate and available courses of action that may be taken in this case.

4. **Evaluating the Ethical Implications of Each Option**: Thoughtfully work through the potential outcomes and their alignment with ethical principles and standards. Here again one may consider the literature and/or engage in consultation in order to gain from historical examples and insight.

5. **Making a Decision:** Given all of the previous steps, take the action that one has decided is the most ethical and appropriate in this case. Document the decision-making process and all of the thinking that went into the decision.

6. **Implementing and Evaluating the Decision:** Ethical dilemmas should always be revisited to assess the outcome based on the decision that was made. This is helpful for following up on the case and adding to the body of knowledge that can aid in working through future dilemmas.

The Transcultural Integrative Model

The Transcultural Integrative Model (TIM) for ethical decision-making takes into account the importance of cultural competence and addressing cultural bias in care provision (Garcia et al., 2008). This model offers four steps for decision-making in the case of a dilemma:

1. **Awareness and Fact-finding:** In addition to thinking about the case and the standards involved, professionals should be attuned to their own cultural identities and experiences and how these influence the way that they perceive the case and the dilemma. Clinicians should be aware of their biases, emotional reactions, and the client's position regarding cultural and social identities relevant to the dilemma. Consideration of the worldview of all stakeholders involved is part of the first step of thinking about the problem.

2. **Formulation of Potential Courses of Action and Determination of Best Possible Ethical Decision:** In this step providers should (a) reflect on all information gathered in step one; (b) study relevant laws and institutional regulations, particularly regarding cultural and discriminatory concerns; (c) ensure that all potential courses of action identified will take into account the worldviews of stakeholders in the situation; (d) use the cultural perspectives of the parties involved to reflect on the likely outcomes of the potential courses of action; (e) seek advice from cultural experts and resources, as necessary; and (f) select and agree upon the best course of action. Note that this model assumes more than one decision maker being involved and expects consensus about the decision to move forward.

3. **Identify Potential Barriers to Implementation:** This may include, for example, action that requires a level of competence for navigating systems that is beyond the current ability of the client. Any concerns about barriers should be addressed and plans made to support effective implementation of the course of action.

4. **Implement, Document and Evaluate the Plan of Action:** As in Ghonimat & Aburashideh's (2023) model, it is important to clearly document the intervention as well as the decision-making process, and to follow up to determine the results of the chosen course of action. This includes the provision of any additional support and care as needed.

ETHICS Model

Another popular model also supported by the ACA and other professional organizations is the ETHICS model (Congress, 2000). This is a grounded ethical decision-making model that draws from the latest relevant literature in ethics, ACA's suggestions for good ethical decision-making models, and updates in the ACA Code of Ethics (ACA, 2014). The steps of this model are (Ling & Hauck, 2016):

E - Evaluate the Dilemma: The clinician utilizes their code of ethics to help frame and understand the dilemma. Upon determining the dilemma, the remainder of the ETHICS model can be used to decide upon a course of action.

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

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

I – Information: When gathering information, a clinician should look beyond the facts of the case and the code of ethics of their discipline to other literature, laws, agency policies, and any other written information that pertains to the dilemma (Ling & Hauck, 2016). Clinicians may consult literature pertaining to evidence-based practice, best practices, and reputable journal articles relating to ethics. Once they gather information, the clinician can weigh the pros and cons of each action and potential outcomes. Remaining open to all possibilities is key to the success of this step (Ling & Hauck, 2016).

C - Calculate Risk: As described previously, all clinicians have some level of risk tolerance and know that work in their discipline places them at some level of risk. Recognizing the risk involved in each possible outcome is an important component in the decision-making process.

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

Ethical Decision-Making in Practice

The following example illustrates working through an ethical decision-making process regarding a practice concern.

Jenny, a 27-year-old woman, has been receiving counseling for the past 2 years. Her sessions have become less frequent, though she does not feel she is ready to terminate. In addition to being a counselor in private practice, the counselor is also a part-time employee and supervisor of direct staff in a nearby agency for children. During Jenny's most recent session with the counselor, Jenny tells him that she is experiencing increased anxiety due to taking on a new position in the same agency in which he works. Upon asking her questions, he realizes that although he will not be her direct supervisor, there will be occasions where they will work with each other on specific cases in the agency where he would function as her supervisor. Jenny is aware of his position at the agency and, despite feeling anxious about it, does not see it as a conflict of interest. In fact, she has asked to return to biweekly sessions to address her increased anxiety and is relieved to "have someone who understands what it's like at the agency." The counselor explains the ethical dilemma he encounters if they enter into a dual relationship.

The following steps outline Jenny working through this problem using Ghonimant & Aburashideh's (2023) ethical decision-making process.

Step 1: Identifying the Problem

The issue in this scenario is that the clinician and the client are now experiencing the potential for multiple relationships. In addition to seeing Jenny in private practice, the clinician is now a colleague and potential supervisor at the agency in which they are both employed. However, Jenny is experiencing increasing anxiety and is still appropriate for counseling services. Jenny does not want to end therapy and, in fact, wants to increase her sessions. The clinician wishes to avoid doing harm to his client by prematurely terminating therapy. An ethical dilemma therefore exists between nonmaleficence (do no harm) and a possible dual relationship. The potential dual relationship is the conflict that must be addressed.

Step 2: Gathering Relevant Information

First, the clinician should review relevant ethical guidelines by consulting their specific code of ethics. For example, the NASW (2021, Standard 1.06c) Code of Ethics guides social workers to

> … not engage in dual or multiple relationships with clients or former clients in which this is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.

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

Next, the clinician should know the applicable laws and regulations that apply. In this case, there are no laws that are applicable, though the code of ethics of different disciplines are very clear as to what is in violation.

Finally, the clinician needs to obtain consultation regarding this situation. Given that there is an established therapeutic relationship (i.e., providing Jenny with counseling services over the last 2 years), a clinician may have difficulty deciding if they should end their counselling relationship based on a possible dual relationship. The clinician should seek out his own

supervision and consultation to talk through issues such as the maintenance of confidentiality in the workplace as well as the clinical significance of Jenny's obtaining employment in a setting where her therapist is an established supervisor and not disclosing that information until now. In addition, the clinician might seek out culturally competent expertise regarding Jenny's ethnic, religious, or sexually-orientated background to further inform the decision-making process.

Step 3: Considering Different Options

In this critical step the clinician can brainstorm, identify, and list possible courses of actions while considering cultural, ethical, legal, and clinical ramifications of each possible solution/outcome. Some possible options include:

- They could do nothing.
- They could maintain the counseling relationship and Jenny could request that they not work together at the agency.
- The clinician could terminate the therapeutic relationship with Jenny and refer her to someone who has no affiliation with the agency.
- Jenny could inform her new supervisor of the counseling relationship and waive some portion of her confidentiality so that the dilemma of the dual relationship could be systematically considered and addressed within the place of employment.
- The counselor could quit his job at the agency.

Question to Consider

- What other course of actions can you can think of?

Step 4: Evaluating the Ethical Implications of Each Option

If the choice is to do nothing, there will be a dual relationship between the clinician and the client/staff. The clinician has knowledge of Jenny that others do not and maintaining confidentiality in the workplace could become an issue.

Asking Jenny to request they not work together at the agency is an option, but it cannot be guaranteed that they would not encounter each other or have to work together. A dual relationship remains. This suggestion also involves an imbalance of power (e.g., Does Jenny feel empowered to decline the clinician's request? How is the counselor's therapeutic value affected?). As a supervisor at her place of employment, there will be an even more obvious power difference and likely access to information about the counselor that infringes on boundaries established by their therapeutic relationship (i.e., unintended indirect self-disclosure).

Jenny is not in a position to quit her job, as it is her livelihood. There are numerous qualified counselors to which Jenny could be referred to upon terminating therapy with her current counselor. However, there may be therapeutic consequences which will need to be addressed, particularly depending on where she seeks treatment.

Questions to Consider

- With whom should the counselor consult about this case?
- What are the confidentiality considerations in consulting about this case?
- What is the counselor's professional obligation to the agency in this situation?
- How can the counselor address their own feelings about Jenny's actions?

Step 5: Making A Decision

Because Jenny is not in a position to quit her job and there are numerous qualified counselors for Jenny to continue her therapeutic work, they decide the best option would be to terminate therapy and refer Jenny to another clinician. They agree to share the dilemma with the new clinician and further discuss the potential of requesting a formal arrangement through the agency where their work would not overlap, should it become necessary. It is important to them both to uphold their obligations to the agency without interfering with the individual obligation to Jenny on the part of her current counselor. Both are aware that indirect self-disclosures are likely to occur in this scenario and that there may be ongoing work needed to mitigate the effects of any potential future interactions on Jenny which would be facilitated by her new counselor.

Step 6: Implementing and Evaluating the Decision

It is important to document the decision-making process and different courses of actions considered, as well as all communication when finishing the ethical decision-making process so that all parties are clear on the parameters set on the therapeutic relationship. Jenny's counselor should clearly document all the steps taken to consider this dilemma as well as those who were consulted in the process. Documentation should make clear Jenny's response to and participation in the decision, as well as planning for the future around any concerns that may arise, such as exposure to indirect self-disclosures. Jenny's new counselor would be responsible for evaluating the effects of the decision with Jenny. Clear advice on who should be consulted about this in the future (supervisor(s) within the practice and/or outside consultants and/or personnel within the agency) should be included as well.

Questions to Consider

- What do you think of the choices that were made in each step of the ethical decision making process for Jenny's case, and the conclusion?
- Are there suggestions you would make for additional steps or changes to the process in this case?
- How would you think about this case if you were in Jenny's position? Is it different from your thoughts from the counselor's position?

ETHICAL CHALLENGES IN PRACTICE

Mental health and human service providers may benefit from further guidance in problem-solving ethical challenges. The following vignette therefore provides an ethical dilemma and walks clinicians through questions and possible treatment options to help guide clinicians in their decision-making process. In addition, two Case Examples follow the initial vignette to offer mental health professionals the opportunity to further apply their own critical thinking to each scenario.

Jan has been in therapy for several months, dealing with issues of postpartum depression, stress, and difficulty with her husband. She is agitated and sad when she arrives at her appointment with her therapist of 6 months. Jan believes her husband is having an affair with his administrative assistant. Jan blames herself for not feeling like herself since having their third child four months ago and for not being able to communicate her wants and needs. She reports that they have not had sex since she got pregnant and she has no sexual desire.

Halfway through the session, Jan becomes angry and says she wants to kill her husband and his assistant. When asking additional questions, Jan breaks down in tears and states she would never kill them, but she does want to kill herself. She describes a plan to take several bottles of prescription drugs she's been saving up for the past two months upon leaving the session. The session continues and Jan states she doesn't want to kill herself, but she feels like she has no other option. Jan's biggest concern is abandoning her three children because her husband "doesn't care about them anyway."

The clinician is worried for Jan and her children's safety. The clinician has recently attended a suicide prevention training with a key point being that whenever a parent is experiencing any form of suicidality due in whole or in part to problems in the marriage or partnership, the children's safety should also be assessed, because although rare, filicide (killing one's children) is linked to this context (Holland et al., 2018). The clinician asks Jan if she would consider going to the local hospital for an additional evaluation. She declines, stating she doesn't want other people to know how she feels.

Discussion

What are the ethical issues raised in this vignette?

The first consideration is whether there is risk of harm to others or self. If yes, is it sufficient to warrant involuntary treatment while considering issues of autonomy (self-determination), nonmaleficence, and confidentiality.

Should the counselor let Jan leave?

Consider the following possible answers and select the one you think is most appropriate. More importantly, identify the ethical principles that inform your decision.(NOTE: Some answers may be more appropriate than others, and the best/correct answer may depend on your profession's code of ethics.)

- Yes. Although there is a potential for suicide, there is not enough evidence based on the counselor's assessment to warrant involuntary treatment.

- Maybe. Jan made a clear threat against herself, but the clinician feels confident in the assessment that the danger is not imminent. There is also a clear plan to mitigate any ongoing potential for harm by having Jan contract for safety (e.g., removing lethal methods of suicide from the home, increased support by trusted adults who are nearby and willing to assist), and checking-in regularly with the counselor.

- No. The fact that Jan was not willing to voluntarily submit to an evaluation at the hospital proves that she is at risk for self-harm.

- No. There is an identifiable risk of suicide, the threat is imminent, the means are available, the stressors unchanged (e.g., marital issues), and the clinician possesses knowledge of these risks. The client should be involuntarily committed for additional evaluation.

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

Questions to Consider

- Can you think of a time in which your client revealed suicidal ideation?
- Did you follow a similar process in determining how to proceed?
- What factors influenced your decision?

Case Example 1: Ethical Challenges in Practice

Joe is a licensed clinical social worker (LCSW) who has developed a strong following on social media, including Instagram and TikTok, in his professional capacity. He started by sharing some thoughts that he had about current events from the perspective of a therapist and talking about these things with his clients. Joe has since expanded his content considerably in the past several years. Early content included psychoeducation around topics like attachment theory or personality disorders, using current events to connect these concepts with real-life examples that may illustrate them.

Slowly, Joe begins referencing specific cases and conversations that he has had with real clients, stating that he always seeks informed consent from clients before doing so, and never provides identifying information about clients. For example, on one occasion he shares that he

works with a client who is struggling with his dating life. Joe uses some details about the conversation and its direction, and then makes a teaching point based on that content. Joe finds that this content garners a lot more engagement and viewership, and he begins including snippets of real dialogue from clients. Joe also starts writing and selling articles about his thoughts and experiences with clients on an online platform for freelance work where writers can self-publish work for free or for profit and even develops a podcast. On his podcast, he sometimes invites current and former clients to be guests and to talk with him about their work together and their mental health journeys.

Joe also engages in a significant amount of self-disclosure on his social media profiles, talking about his own dating life, social relationships, family background, and racial and ethnic identities. Recently, he does skits related to politics, caricaturing extremists of all political affiliations and doing mock couple's therapy with them. He is very active, posting most days and sometimes more than once a day, and frequently engages with a significant percentage of the comments he receives.

Two colleagues from Joe's graduate school internship are intensely divided about their opinions about Joe's behavior. Jared is also an LCSW who is active on social media. Although Jared doesn't agree with all of Joe's opinions, he thinks Joe's public efforts are valuable and within the bounds of ethical practice for social workers. He notes the social work value of equity, and that Joe is expanding access to mental health information and benefits from therapeutic interactions to people who might otherwise not be able to gain them. He also sees Joe's integration of mental health and therapeutic concepts into understanding current events as a clever way to contribute to citizen education and societal transformation. Jared points out that Joe receives informed consent from clients to share anything about their sessions, and that he never includes identifying information unless they are also appearing as themselves in the work, which he sees as a further form of consent. Jared notes that social media use is particularly relevant for younger clients and that this is an important way to decrease stigma associated with mental health concerns and with seeking therapy.

Wanda, a fellow LCSW, is deeply bothered by the way that Joe is engaging on social media and believes that it is unethical. Wanda points out that seeking informed consent from established clients to share their information in this way ignores the power differential between clinician and client, and that coercion may be present, even if it is not overt, on the basis of the power imbalance. Regarding client participation on videos and podcast, Wanda points out the unpredictable nature of interviewing. Clients may not be able to accurately predict what information they will share or what emotions they might experience. She argues that because of these reasons, self-determination cannot be assured in this case. Further, she notes that Joe's public work includes a significant amount of self-disclosure that is not targeted specifically to the best interests of any client and may damage clinical relationships with clients who listen to or watch his content. She disagrees with Jared's ideas about access, arguing that individuals who receive his content may falsely believe they are receiving mental health care and fail to seek support in real life. She sees Joe's work as a way for him to seek fame and wealth rather than an effort to uphold the social work ethical values of caring for those most in need.

Personal Reflection

- What are your thoughts about the behavior that Joe is engaged in? When you use ethical decision-making to consider the case, where do you land?

- How does your own relationship with social media, and social media therapists, inform the way that you think about this case?
- In your clinical work, do you encounter clients who are engaging with social media therapy content? How does this come up, and how do you talk with them about it?

Case Example 2: Ethical Challenges in Practice

Alex is an LPC who has been working with Mark, a 28-year-old man who has generalized anxiety disorder. Alex is experienced with clients who have anxiety and feels comfortable working with Mark on strategies for managing his symptoms and addressing barriers to functioning that arise because of anxiety. Mark has been making progress using techniques from CBT and recently had a consultation with a new psychiatrist who prescribed a medication for anxiety. Mark asks to discuss this with Alex, expressing his reservations given the possibility of side effects, and Mark's general reticence toward taking medication.

Mark shares his concerns about the medication, worrying about whether it might change his personality or otherwise cause more harm than good to him. He asks for Alex's opinion and advice about whether he should start the medication or not. Mark states that he would prefer to continue with therapy alone for now, but he is interested in Alex's opinion and trusts his expertise. Privately, Alex believes that a combination of medication and therapy is the most likely approach to benefit Mark and reduce his symptoms. Alex finds himself in a dilemma, as he believes that given his position in the relationship Mark may likely take his advice, even if it goes against Mark's stated wishes.

Alex quickly notes his considerations. Respecting Mark's autonomy means supporting him in making his own decisions, but his ill-advised thinking might lead to an unnecessary extension of unchecked symptoms of anxiety. Alex feels that he is obligated to provide the best possible care and accurate information, but that this is in conflict with respecting Mark's right to make his own choices. Alex also worries about how this interaction will impact the therapeutic relationship. Will pushing Mark on the medication issue cause resentment, particularly if Mark experiences negative side effects? Will avoiding the question and failing to advise Mark cause him to feel disrespected or insufficiently cared for?

Alex decides to engage in an open dialogue with Mark. He provides general information about his knowledge of the research related to the combined effect of medication and therapy on anxiety, as well as anecdotal notes around his own experience of seeing medication be helpful. He is also honest about what he knows to be the most common side effects that his clients have reported related to the medication in question. He reassures Mark that their therapy sessions will continue to offer coping strategies and support, regardless of whether Mark decides to take medication for anxiety now or in the future.

Personal Reflection

- What do you think about the way that Alex resolved this dilemma?
- Are there other possible ways that Alex might have approached this situation that you think would have been equally or more appropriate?

- Sometimes, as in this example, dilemmas arise in the session's context and decision-making must be relatively quick. How do you think about resolving these types of dilemmas in your work?

SUMMARY

Ethical practice is foundational to work in the mental health and human services fields and involves much more than a simple rote memorization of regulations. Clinicians need to begin with a clear understanding of the ethical principles and values of their profession, as well as the legal requirements of their locality relevant to the type of work they do with clients. Clinicians should uphold the principles of nonmaleficence, beneficence, autonomy, and justice. Additionally, they should be guided by the importance of adequate consent to treatment, confidentiality, managing client well-being, attending to boundary issues, and having deep familiarity with their profession's code of ethics. Furthermore, clinicians should heed newly emerging ethical practices appearing in some professional codes regarding rising technology (e.g., telehealth, artificial intelligence, social media, email communications, and electronic records) and its influence on service delivery.

With these concepts in mind, professionals are prepared to approach the practice of working with clients with an eye toward upholding principles and identifying ethical dilemmas. When ethical dilemmas arise, clear decision-making processes should be chosen, worked through, and documented to support the best course of action for resolution of the concern. Providers may choose steps from established decision-making processes that best suit the nature of their practice, the clients with whom they work, and the specific concern that is arising. Clinicians should routinely discuss ethical issues within supervision and have several appropriate professionals and resources to consult when working through such dilemmas. Ongoing maintenance of general and cultural competence and knowledge of emerging ethical concerns in the field should be a fundamental part of professional development.

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