ETHICS and BOUNDARIES in the SUPERVISORY ROLE*

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Review the vignette below.* We will discuss:**
The ethical and professional dilemma --What the options are for action;

Janet went in to see Dr. Smith for a consultation. She was depressed and drinking too much and asked for a referral to a female counselor, indicating that she preferred to work with a woman. She also asked if Dr. Smith could refer her to a woman who was experienced in dealing with professional boundary issues but did not explain why.

Dr. Smith referred Janet to Nancy Jones, LADC, and asked Janet if she would phone him within a week or so of seeing Dr. Jones so he could get feedback about how things were going. Beyond his normal practice of obtaining feedback from referrals, he was concerned about Janet's depression and wanted to be sure that she was seeing someone.

Janet's first meeting with Ms. Jones went well. Janet was very much reassured by Ms. Jones' promise of privacy since this was a small college town and most students worried about privacy in therapy relationships. However, at the very end of the Interview Ms. Jones indicated that she wanted a release so that she could speak with Dr. Max White, a therapist Janet had seen during her first three years of graduate school.

Janet refused. Ms. Jones indicated that she felt this was quite important when someone has had therapy or counseling in the past. Janet said that she was not comfortable with it right then but would reconsider and did not rule out giving permission.

[Continued on the next page….]

* Nothing in this presentation should be construed to be (1) legal advice; (2) professional advice for the handling of a given situation. These are the views of a clinical psychologist and executive director who does a great deal of organizational and clinical consulting and training. Consultation from other professionals and experts is the best way to handle complex situations. **This handout can be reproduced, without further permission, to share with colleagues as long as proper credit is given.**

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*** Vignette adapted from a vignette on pages 122-123 of Thomas Nagy's book **Ethics in Plain English** which provides a great many vignettes tied to various sections of the 2002 Revision of the Ethics Code of the American Psychological Association.

Nancy Jones was uneasy about departing from her standard practice but decided given the concerns about privacy that had been expressed that she might need to cut Janet some slack. Several weeks went by and Dr. Smith, not having heard from Janet, phoned Ms. Jones. Ms. Jones, without acknowledging that Janet was a client asked if he had a release. He did not but said <u>since he was the source of the referral</u> and just checking to see if she made it and if it was working out that so he didn't need a release.

Dr. Smith He also noted they were part of the same health system. He also expressed surprise that Janet did not want the background and history he could provide noting she didn't need a release to listen to what he had to say. Dr. Smith was an important source of referrals and they had worked collaboratively with Nancy and the center many times. But he was angry and suggested Nancy check with her supervisor.

YOU ARE HER SUPERVISOR – DO YOUR SUPERVISION.

INTRODUCTION

One of the key roles of the Supervisor is dealing with ethical and legal issues.

- **He/she is responsible for ensuring that supervisees are sufficiently knowledgeable about ethical standards and professional boundaries.**
- **He/she is often responsible for ensuring that there is an adequate program of training, either inside the agency or outside, to keep counselors sufficiently informed about ethical and legal decision-making.**
- **He/she is responsible for answering questions and guiding the counselor in ethical decision-making.**
- **Last but not least, he/she is responsible for modeling good boundaries and professional ethics.**

Today I am going to reference these formal codes and rules at many points, but **my main hope is that you develop a clearer sense of the basic principles which underlay them and develop a sense of some means of analysis when faced with complex situations.**

Overall it is not usually what is ethical vs. unethical, but a matter of the <u>comparative ethicality of options.</u> How each option meets satisfies various ethical principles. In other words, which of various options for action are consistent with ethical principles .

It is critical to remember that **consultation with peers, or with supervisors, or with outside experts is the smartest way to approach complex problems. When you do consult, document it carefully.**

The concept of **boundaries** is a broader one with less clear rules, but we will try to discover some methods of analysis and some standards which you can use to help determine courses of action.

THE NATURE OF THE PROFESSIONAL RELATIONSHIP

Professional relationships are ***fiduciary contracts***. They are contractual relationships between the client and the professional as well as between the client and the program, in which the **professional & program are deemed to have more power and more responsibility**. So, while both client and professional have responsibilities, the professional's are deemed to be greater. **It is assumed that the professional has the skill and knowledge that an ordinary member of the profession, in this community, has and that this skill and knowledge will be used in a timely fashion to help the client.** Like all contractual relationships, this one is defined by **both *explicit*** & ***implicit warranties***:

> (l) **Explicit warranties** are **statements the professional makes** about treatment rules & other matters as well as printed materials, client handbooks, posted notices, and brochures.
>
> (2) **Implicit warranties** are **beliefs that a "reasonable person" might hold** about the counseling or the program where explicit warranties are lacking or unclear. To the degree that you do not describe something to a client or potential client, he/she may make reasonable assumptions.

Where does the supervisor or organizational (e.g. treatment center) administration come in here? Does the supervisor have ***a fiduciary duty to the client of the agency or the client of the staff member who is under supervision?*** Well, this is a legal question in large part and the answers vary with the circumstances. However, **if the client has had any interaction with the supervisor, a duty probably exists.** Furthermore, **under some circumstances if the client knows of the existence of a supervisor and relies on that as a warranty of quality or safety, there might be some exposure to liability.**

The supervisor, whether administrative or clinical, needs to be aware of representations made about the program or its services and be sure that these are accurate and clear to clients. Workers may not be as focused on this but it is essential that the services be accurately described. **There is arguably a duty on the part of the supervisor to ensure that the supervisee properly represents their relationship.**

DIRECT LIABILITY: MALPRACTICE

Malpractice is a type of <u>professional negligence</u>. It has three elements. **To prove malpractice, one must show:**

> **(1) That you as a professional had a duty to perform vis a vis someone with whom you had a professional relationship -- a client.**
>
> **(2) That you failed to meet the *standard of care* in performing this duty -- that your performance of your clinical duties, or your supervisory duties was not at the level that one would *reasonably expect from a reasonable and prudent professional of the same or similar type facing the same, or similar, situation.*** (Note: With psychotherapy or counseling there can be a standard of care across various professional fields.)
>
> **(3) That damages to the client were a *direct result* of your failure.**

It is possible to prove malpractice – that the standard of care was violated – but that there were no damages that resulted. Damages are very separate from the question as to whether mistakes were made and these are different issues altogether. Since the question is what a reasonable and prudent professional of the same or similar type would have done, what is the best way to avoid malpractice?

VICARIOUS LIABILITY

In general, supervisors, administrators, and agencies may all be held accountable for the work done for the client under the theory of *respondeat superior* ("let the master respond" to the failures of the subordinate). This theory of liability flows from the fact that employers and supervisors may benefit from the work done by their supervisees or employees.

(1) **The supervisee or staff member must be under the supervision of the supervisor and be providing some services which benefit the supervisor or agency.** The "outside" supervisor to whom a practitioner goes for assistance does not have to be paid for this to be the case, so even someone volunteering to provide needed supervision can be viewed as gaining something.;

(2) **The supervisee must have acted within the "scope of employment" -- the defined tasks that go with the job**. Even if the work is misguided or not what the supervisor would have wanted, it can be within the scope. For example, a counselor who engages in very hostile confrontation with a client that the supervisor would not approve of would nonetheless be within the scope of employment if it was done in a misguided effort to provide counseling. Sex with clients is rarely determined to be outside of the scope of employment, even though no employer wants staff to have sex with a client.;

(3) **The supervisor must have the power to control and/or direct the work of the supervisee,** even if in this instance of substandard care there was no supervisory input. In fact, the supervisor does not need to know of the existence of the client for there to be a duty. This is where the major difference between supervision and case consultation comes into play. A "supervisor" who is really a case consultant makes suggestions and can even attempt to pressure the “supervisee” to do what he/she thinks they should do. But he/she cannot order the “supervisee” to act in this fashion.

Warning # 1: If you share office space or allow someone to use space in your agency you need to make it clear, both verbally and in writing, what your relationship is. If it is not a clinic, you need to make that clear. Even then under some circumstances you may have some duties vis a vis their practice.

Warning #2: If you are “supervising” by virtue of signing off on the care, bear in mind that the use of the title *supervisor* is sufficient to create liability. You do have responsibility for the work when that term is used with your permission.

CASE CONSULTATION

I began with advice that **one needs to obtain consultation in difficult situations. What liabilities are there in being a consultant?** I have never heard of a charge of "negligent case consultation." Defining the duties of a case-consultant would be quite difficult and showing that someone failed in these duties even more difficult. The case consultant would not be expected to engage in the detailed inquiry and case review that a "supervisor" would do and the case consultant has no real power to enforce views on the "consultee."

APPROACHES TO PROFESSIONAL DECISION-MAKING

The ***Standard of Ethics for the Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)*** can be found on the MARRCH website. I am not going to review it here. The MARRCH website can provide an easy link to the licensure board Code of Conduct which will also not be reviewed here. With the exception of legal standards which are mentioned in both codes, the codes discuss a wide range of ethical principles. I am going to try to narrow down to five more basic principles.

The five principles below underlie a large number of ethical systems and codes in health care. I use them to weigh decisions. In order to assist a supervisee, it is important that the supervisor assist them in developing a clarity about major issues which underlie the mixture of ethics codes (e.g. MARRCH) and rules of conduct (e.g. Licensure Board, internal agency Codes) and wide range of legal principles.

(1) BENEFICENCE: likelihood that it will help, or do good for the client;

(2) NON-MALEFICENCE: likelihood that it will <u>not</u> harm the client;

(3) AUTONOMY: likelihood that it will foster the client's autonomy;

(4) FIDELITY: the degree to which it is true to what was promised;

(5) JUSTICE: balancing the needs or rights of one versus another -- for example the issue of a duty to warn third parties of danger from our clients, involves the competing principles of Justice vs. Autonomy

The issue in most complex situations is **not what is ethical -- it is the comparable *ethicality* of the various options for action. How might a given course of action fulfill each of the five ethical principles above?** In each situation the analysis of how each of these principles would be met may produce a different pattern of positive vs. negative outcomes. One needs to decide which of these principles are more important in a given situation? There is not an automatic rank-ordering, except that if life is at stake it is not difficult to determine what is most important.

A DECISION-MAKING APPROACH

Another way to examine this is via a decision-making chart or table. With complicated decisions I find it is necessary to actually write down the anticipated outcomes in order to be able to decide on a course of action. I make a chart of likely positive and likely negative outcomes for each option. There could in fact be far more alternatives. Getting consultation from colleagues normally produces additional ones.

	Likely Positive Outcomes	**Likely Negative Outcomes**
Option A		
Option B		

To illustrate this approach, let's take a case where you are providing services to a single mother with a child. Let us presume that you have decided that what is going on meets the statutory test for a mandatory report (e.g. without a release) of child abuse or neglect. Whether to report is not the issue -- legally or ethically. The question is: ***Will you tell the mother before you report?*** (Obviously, we could also make options such as tell the mother before you report, when you report, immediately after you report, etc. But we are going to stick with (1) tell before; (2) don't tell.

	possible Positive Outcomes	**possible Negative Outcomes**
Tell mother that you are going to report	**1. increase trust** **2. helps working relationship** **3. you can explain what's next** **4. clarifies your concerns**	**1. decreased trust** **2. gets in the way of working rel.** **3. parent punishes child** **4. parent kidnaps child**
Don't tell mother	**1. Since they are in counseling CP may not even contact them** **2. Avoid panic, overreaction** **3. Avoid distractions**	**1. Shock if CP contacts parent** **2. Greater feeling of betrayal** **3. May not be able to explain if the family drops out of care etc.**

QUESTION: **What are some other alternatives besides the two offered above?**

QUESTION: **Do you have a case you would like to try this out with?**

CASE: **You are treating a 18 yr. old college student who is having problems with emancipating from family and is also depressed. She has been doing better, but she misses an appointment and you get a phone message that sounds very depressed. She had a drinking problem but claims to be abstinent at present.**

You are worried she may be suicidal based on some recent events where she failed a course, and also had a close friend kill herself. You try to phone her but her roommate says she's left for her parent's home for the Spring break -- a six hour drive. You have talked with her parents when the therapy began so they know who you are. What do you do?

TEACHING ABOUT BOUNDARIES

In the case of ethics there are codes and texts, but the issue of professional boundaries is less clear. Remember that boundaries can refer to a wide range of behaviors, and the issue is not only how the counselor manages his or her own professional boundaries, but also how he/she responds to clients' challenges to their boundaries. Beyond consultation on cases and having rules in some areas of professional

boundaries, there are exercises one can do. Both of these are described in an attachment to this handout:

What's OK, Not OK, or Maybe OK?

Personal vs. Professional

IS THERE A "SLIPPERY SLOPE" AND HOW DANGEROUS IS IT?

Kroll (2001) and others have questioned the concept of the "slippery slope" -- namely that the crossing of particular boundaries really leads, inevitably, to significant problems in the treatment relationship or harm to the client. Assuming that there is not an organization rule which is being broken can one clearly define a slippery slope. For example, if there is not a rule against accepting gifts as there is for example in federal facilities, how does this play itself out? How does one decide as to whether to accept a gift?

NOTE: One must consider: (1) the context, (2) likely appearance to other clients, (3) likely appearance to others in the community, (4) overall situation regarding boundaries in this therapeutic relationship, (5) how the client might perceive it, (6) how it might be expected to change the boundaries in the therapeutic relationship..

THE "DUAL" OR "MULTIPLE" RELATIONSHIP CONCEPT

While firmly established in the psychology and social work ethics codes for many years, during the past decade the "dual" or "multiple relationship" concept has come under attack from a number of perspectives -- usually that it is vague or that it does not apply well in rural areas or within small groups such as cultural or ethnic minorities, gay/lesbian communities, small religious denominations or groups, etc.

(1) **Encounter** with a client or former client outside the office; or

(2) one can have some **overlap in your lives** on a more ongoing basis (e.g. being members of the PTA, go to the same church); or a

(3) **true multiple or dual relationship where a conflict of interest is likely or a high risk**.

Living or working in small towns, rural areas, or being part of small ethnic, cultural, religious, or other minority groups make the likelihood of all three very great.. The concept that you could somehow go through life with minimal interaction with clients seems to apply only to a very large city….certainly one larger than the Twin Cities. **The recovery community is its own "small town" and since many practitioners and other staff are or were clients, there is a greater challenge for counselors than in any other type of counseling work.**

YOUR OWN PRIVACY & CONFIDENTIALITY

Becoming a professional does not mean that you give up your privacy, nor does it guarantee your privacy. Clients and their family and friends may be interested in learning more about you. This may be curiosity, it may be transference, it may be to try to curry favor with you, or for some other reason. On the other hand, virtually every complaint about a practitioner includes, or even starts with, a list of what the client knows about the professional's personal life or family. **Historically, substance abuse and alcoholism treatment has involved self-disclosure by the practitioner (assuming he/she is in recovery) about the fact that they are in recovery or that they had a problem and had treatment.**

WHAT ARE SOME RULES FOR SELF-DISCLOSURE?

(1) Are you obligated to answer all of the client's questions? Can you undermine the relationship by not answering certain questions, or by answering them incompletely?
(2) What self - disclosure that is helpful or expected? What are you obligated to disclose?
(3) What self-disclosure is risky or ill-advised? What are examples of excessively risky self-disclosure?
(4) Too often, too much, too personal – too much related to unresolved or current problems.

SELF-DISCLOSURE THAT IS INADVERTENT: (1) public events; (2) political action; (3) pregnancy; (4) involvement in an accident; (5) Media interviews; (6) Letters to the Editor or Op/Ed pieces in the newspaper; (7) encountering the client in the community.

Thinking through whether to discuss this information further with the client – what would you consider in weighing the options?

When feelings are generated which change the relationship, whether intended or not, it is critical to: (1) get consultation and document it; (2) document the processing of the issue in the case notes; (3) be open to the fact that the relationship has been altered, and it is possible that your effectiveness is diminished sufficiently to bring about the need for a referral or transfer.

TERMINATION OF THE RELATIONSHIP WITH THE CLIENT

Most ethical codes focus on the need to consider options if the client is not progressing and also to identify the reasons you are transferring care or terminating the relationship. Exactly what is necessary remains in the gray area in chemical health and in mental health counseling.

On the other hand there is the case of the psychiatrist who was successfully sued by the estate of a long term client whom he ceased to see following his own retirement. The man eventually stopped taking his medications and killed himself. Given that he was retiring, you might ask how could this be client abandonment?

(1) Well, the records and testimony indicated that the client was very dependent and also would have great difficulty approaching a new provider. In fact, the psychiatrist knew this better than anyone. Yet instead of working out a transfer of care, he simply gave him some names.

(2) No request for records was ever sent so he had reason to believe that the client had not located a new service provider.
(3) Because the jury was convinced that it was a virtual certainty, known to the psychiatrist, that without help he would not find a new therapist, they viewed that it was not too much to ask
(4) Had the transfer occurred and at some later time not worked out, this would not have been the psychiatrist's responsibility.

‘TIL DEATH DO US PART

Duties of confidentiality continue following the death of the client. **As with child abuse reporting, a substance abuse counselor is to follow existing state laws.** Two cases may help illustrate the dilemmas when a client dies. These are greater when the client is famous or when there is public attention to some sort of crime. Consider:

(1) The martial counselor who worked with OJ Simpson and his wife revealed a history of marital strife after she was murdered? Does it make a difference how that information emerged? Voluntarily given to the news media, vs. to the prosecutor or police? Or gotten by subpoena. As her heir, does OJ Simpson have control over records access?

(2) Anne Sexton, a poet who often shared her personal pain in her poetry, suicides. A biographer, Diane Middlebrook, contacts her daughter, Linda Gray Sexton, who is her mother’s literary executor some years later, seeking access to the therapy records of her treatment by Martin Orne, Ph.D., MD (both a psychiatrist & clinical psychologist). He provides not only the notes, but audiotapes of the therapy. The tapes were made to assist her in remembering what went on in a given session, and unlike what is often done, they were retained and not taped over. It is unclear why the tapes still existed years after her death.

Dr. Orne also gave countless hours of interviews and writes the forward to the resulting biography Anne Sexton. When challenged he argues that beyond the release, Ms. Sexton would have wanted in death to do what she had done in life – share her pain and what she learned in her therapy. Among the revelations to Linda was that her mother had touched her sexually, not something she was wanting to learn. Ms. Gray Sexton went on to write her own book, Searching for Mercy Street.

WHAT DUTIES DO YOU HAVE AFTER THE DEATH OF A CLIENT?

(1) What about access to the client's records?
(2) Do you retain or destroy the records?
(3) What sort of interaction with the family is legitimate?
(4) Can you protect the client’s privacy when contacted by the Medical Examiner?

These issues are greatly simplified when one works for a institution like a treatment center.

POST-TERMINATION RELATIONSHIPS WITH CLIENTS

Although in the worst case situations supervisees hide it, a common arena in which supervisees seek guidance -- clinical and administrative -- is regarding forming social relationships following termination of the professional relationship. It is very common for them to underplay the strength of their feelings and to understate the degree that there is "chemistry" between them and the client or recipient of services.

Sometimes the question will be asked as a hypothetical with few details.

A major issue is deciding who is a client, and who is "out of bounds." This definition is broadening considerably in the psychotherapy professions. Unfortunately, most agency rules focus on sexual or romantic relationships rather than the full range of things which can put a worker and former client on "a slippery slope."

Many health care and human service workers have no concept of the degree to which the power may shift and they may be at risk for relationships which began within the service context. They also are not aware that it takes very little for someone to argue that a professional relationship is continuing. A prescription, taking out some stitches, some brief therapy, may be sufficient. Supervisors need to discuss all risks and to warn supervisees to be conservative in their actions so as to avoid misunderstanding and harm to former client, or risk to themselves and their careers.

See the attachment **Personal Relationships With Former Clients or Patients.** In small towns and rural areas, of course, contact with former clients is commonplace. This is also the case when one is treating a student or health care professional.

CASE: A client asks for advice on making a will, and asks you to recommend investment counselors and a lawyer to help with the will. You offer several options but the client chooses an attorney who does some legal work for you. The client says that he would like to leave money to a large non-profit on whose board of directors you sit. (based on a real case)

RECORD - KEEPING

There are full day workshops on record - keeping not to mention helpful books on the topic. Each field has slightly different standards for documentation and there may be institutional standards or practices which also carry considerable weight. One of the greatest mistakes made is to fail to orient new staff to exact record-keeping expectations. Showing actual examples of charting is a very good idea. I have several simple rules to guide record-keeping. Your record should contain anything which is necessary to:

(1) Document your work for the purpose of keeping track of what you are doing and/or keeping team members informed.

(2) Provide documentation to meet contractual obligations such as with third-party payment or internal administrative rules.

(3) To cover yourself when risky decisions are made, or when you may need to document why you took a certain action.

***Note for high risk situations or key decisions:**

(1) Use quotation marks and if need be review with the client so that you quote it exactly.

(2) If later you realize that your records are incomplete, add to them, but carefully and accurately date and explain why you are elaborating at that time.

A NOTE ON CONFIDENTIALITY

To be confidential, something must be: (1) private; (2) learned of in the context of providing the professional service; (3) necessary for delivery of the service. Many things you may observe or learn may not be confidential. Events which occur outside of the clinical setting are generally not confidential, and the same is true for some observations and for things which occur in a public context.

This does not mean that it is ethical or good practice to disclose, but just that it may be permissible to do so. So, if a substance abuse counselor observes a client out drinking in a bar and later is asked by a police officer if you saw the person drinking, you can respond as long as you don't identify the fact that the client is a client. You can make a chart note later about the incident which you witnessed. While your notes on the incident are confidential, your knowledge of it is not so that if you were asked in a courtroom what you observed, you would not need the client's permission to speak about that incident.

In substance abuse work – either evaluation or treatment – any professional staff member functioning within the program is subject to a different set of rules. Under CFR 42 there is a much higher level of privacy than for general health care or mental health records.

A piece of history – why the greater level of privacy for assessment and treatment of substance abuse than for health care in general or mental health? Why does a subpoena or even a search warrant open other records but not these?

However, note that **in substance abuse work, if a crime is committed on premises or against a staff member, you are specifically authorized to contact the police and report it. There is no such exception for health care or mental health.** So, despite the greater privacy of the chemical health records (either treatment or assessment), there is a greater exception where the client is coming bad acts aimed at the staff or which occur on premises.

WHAT ABOUT GROUP THERAPY and FAMILY THERAPY?

The central duty the professional has is to be sure that confidentiality and its limits are defined for all who are present. In a group which is open and gets new members periodically, every time a new member joins this must be repeated. The ground-rules must specify:

(1) **What commitment group members must make to each other -- e.g. to not share group material outside of group.** (If there is such a promise, technically a group member could file a breach of contract or some other action against another member who broke this rule. But the key issue is that there is a rule.)

(2) **What your duties are -- e.g. any reporting obligations which could limit privacy;**

(3) **Whether material from out side the group can be brought up in the group. The most common scenario is that a group member does something wrong and is leaving the group and the group wonders why? You can share this if it isin the ground rules of the group.**

What about family counseling or therapy? The same rules apply, and again, it is important to consider (3) above. The classic case is when a member of the family wants to talk privately and then drops a bombshell after you have promised to keep it private.

While it is less so in group therapy, one of the great challenges with marital or family counseling is dealing with the situation which arises when the relationship breaks up. Under what circumstances can you continue to see one member of the couple?

Remember that in some situations such as small towns or rural areas there may not be a bunch of resources and one may have to undertake an arrangement which is not idea. <u>It is important to be clear with the client that it is not ideal and offer alternatives such as traveling elsewhere to receive services.</u> Often overlooked is the importance of discussing this with the client(s) so that the cards are all on the table.

REPORTING DUTIES & EXCEPTIONS TO CONFIDENTIALITY

Remember that you can always ask permission to report. With client consent reporting can be done easily. ***Mandatory reporting, typically, carries with it some protection for the breach of confidentiality.*** It is critical to have readily available reference materials such as ***Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters*** (Family & Children's Div., Child Protective Services, DHS, 444 Lafayette Rd. N., St. Paul, MN 55155 651-296-2217) and to have updated knowledge in this area. Organizational libraries should have key reference works.

Beyond the statutory duties connected with child abuse reporting, **if non-reporting leads to harm to the child a civil suit is possible.** In a Missouri case a jury awarded $ 5 million in damages to a woman who was abused for an additional two years after two psychologists agreed to counsel the abusive father without reporting the case to child protection. (***Bradley v. Ray, 904 S.W.2nd 302 Missouri Ct. of Appeals 1995)***

Needless to say, a licensure complaint which includes a claim of a failure to make a mandatory report virtually always leads to discipline if it is founded. In custody disputes some parents will attempt to "set up" a professional by making a claim that while possibly bogus probably requires a report.

With child abuse reporting, there may be challenges as regards some ethnic situations. Where a parent is struggling with cultural rules vs. American standards is it in the best interest of the child to report a situation if it drives the family from trusting you and continuing to seek care?

Case: 17 yr. old girl who has been sexually involved and who tells you that if this is revealed to her family she will be killed in an "honor killing."

Reporting is a topic unto itself. However, I would like to highlight a few details of reporting duties for special attention:

- **Child Abuse & Neglect reporting must be done if abuse occurred <u>within the past 3 years.</u>**
- **<u>Threatened abuse is included, as is unlawful acts related to parental rights</u>.**
- **Drug and alcohol programs have a specific exemption from federal rules in order to report.**
- **There is a Duty to Report Pregnant Women Who Have Used Non-Prescription Controlled Substances (cocaine, heroin, phencylclidine, methamphetamine, amphetamine, or their derivatives) During Pregnancy. MS 626.5562**
- **As of Aug. 1, 2007, Tetrahydrocannabinol use is included meaning that marijuana smoking during pregnancy is child abuse (despite a complete lack of evidence of fetal harm)**

- **As of Aug. 1, 2007, consumption of alcoholic beverages is included if it is <u>"habitual or excessive."</u> Neither the law nor medical convention has established a definition of either term. There is technically no "safe" level of alcohol consumption for a pregnant woman but the medical community is in disagreement about drinking by pregnant women. All advise very limited use, but some do not forbid it. A practical question is whether if Ms. Jones physician simply advised her to have no more than a glass of wine at dinner, and that is all she does, is this a mandated child abuse report?**

- **Reporting of Maltreatment of Vulnerable Adults Act is mostly aimed at facility residents or others unable to protect themselves from abuse or neglect. Outpatients are generally excluded.**
- **Since 1995 a facility complaint can be made on behalf of all of the workers who know of the event.**
- **CFR 42 does now have an exception to allow for reporting of vulnerable adults, so even though the licensure law indicates that this is a duty, one can only do it lawfully if one has obtained informed consent to permit the disclosure. Many agencies do this in their initial client consent form.**

DUTIES TO REPORT OTHER PROFESSIONALS

There is a duty to **internally report complaints or concerns about professional conduct within a facility or clinic. Once a staff member knows of a problem, the organization is "on notice."** As regards professional codes of ethics, there has always been some ambiguity about reporting duties to professional ethics committees. In some professions, such as psychology, ethics committees no longer adjudicate cases so that there is nobody to report to.

Health Professionals who hold Minnesota Licenses have duties to report other Minnesota-licensed professionals for conduct which the reporter reasonably believes constitutes grounds for disciplinary action. This generally covers personal impairment, sub-standard practice, etc. There is generally an option to report to the Health Professionals Services Program. This supercedes confidentiality.

As regards Licensed Alcohol and Drug Counselors, or any other professional who learns of the offense in the context of a drug abuse assessment or treatment program, it would appear that CFR 42 – the federal rules – would take precedent and that reporting would not be allowed because of confidentiality.

PSYCHOLOGISTS are the major exception. ONLY PSYCHOLOGISTS must report other licensed psychologists, and the reporting is not mandated if the information was obtained in the context of providing professional services to the psychologist in question. Furthermore, only three things require reporting: (1) failure to report child abuse or neglect; (2) a vulnerable adults act violation; or (3) sex with a client.

Note: Sometimes a client declines to complain or authorize you to do so, but when re-contacted at a later date with additional information, decides to go ahead with a complaint. So remember that when you get additional information – e.g. that you hear of other complaints – you can always phone that client back and see if this new information changes their mind about taking action.

A HIGH RISK SITUATION: THE SUICIDAL CLIENT

Studies of stressors on clinicians usually rate suicidal clients as among the top three stressors on practicing clinicians. Some areas for consideration related to your own practice, your supervisory duties, or even provision of consultation to a therapist dealing with a suicidal client are as follows:

(1) Competence to Assess Risk, and access to appropriate consultation in a timely fashion (there is an ethical duty and practice challenge to have this in place beforehand);

(2) Competence to provide appropriate management for the chronically suicidal client (the ethical duty is to have appropriate training and any tools available);

(3) When to breach confidentiality in order to prevent an imminent suicide (this has always been an option, but unlike the "duty to warn or protect" there are generally no standards in rule or law for when one takes this step);

(4) Self care for the practitioner after a suicide attempt or completion;

(5) Reconsideration of practice parameters after a death of a client:

(a) ***Psychological autopsy***
(b) consideration of its impact on future practice

(6) Awareness of cultural differences: There are huge international differences in suicide rates between various countries. The quality of the data varies, but generally speaking northern European countries have the highest rates (e.g. Finland, Norway, Sweden) and southern hemisphere countries (e.g. Ecuador) have very low rates.

The same is true in the United States. Ethnic groups vary considerably as to suicide rates. Suicide methods vary also. Firearms are not typically used by women to kill themselves, but in Texas they are a leading method for both men and women.

A special problem is the handling of groups, especially refugees or immigrants, who come from cultures where mental illness is considered a sign of a family defect, sin, or some immoral conduct. Suicide is a serious sin in the Roman Catholic faith and in Islam, so people often will not discuss it. Raising this issue must be done with extreme caution when dealing with persons from Southeast Asia, Africa, and the Middle East.

An immigrant or refugee may have moved to a small town to avoid the shame of seeing compatriots who would realize the degree to which they had dropped in status. This may also, of course, take them away from traditional support and helpers, such as with Moslems a mosque or the services of a Sheik. [Islamic "therapy" involves meeting with one or more Sheiks to resign assigned verses from the Qu'ran (Koran) and to pray.]

In all cultures a personally humiliating event can be a precipitant for a suicide. A "loss of face" can be an experience which leads to panic and a sense that life is not worth living or "there is no way out." There are cultural differences in what is likely to be the most humiliating event. For a Moslem immigrant from Africa, a young girl having an illegitimate child is most at risk. Mental illness may be humiliating. A young man who falls in love and cannot afford a dowry is at risk in some Indian and Pakistani groups.

Suicide assessment, intervention & prevention are a full day topic, and clinicians in all health care fields should stay up to date. In the box below I provide some useful guideposts:

SOME GENERAL FACTORS PREDICTING RISK IN MAINSTREAM AMERICANS:

(1) **Statements that the person plans to kill themselves** (even if chronically made)
(2) **Existence of a plan: the more specific, more lethal, the higher the risk** (generally speaking, a vague plan is less dangerous than a specific one, and one that one has actually practiced such as putting a gun to ones head, or when one has checked to see if there are enough pills to do it, is more lethal)
(3) **Possession of the means to do it -- e.g. having a loaded gun with bullets**
(4) **Past attempts -- approximately 80% of those who kill themselves have attempted it before**
(5) **Clinical depression --** approx. 15% of those with serious clinical depression kill themselves; the suicide rate for those with clinical depression is about twenty times that for the general population
(6) **Feelings of Hopelessness are the most significant depressive thoughts associated with suicide**
(7) **Alcohol & drugs --** 1/3 to 1/4 of suicides are associated with alcohol as a contributing factor; alcohol and drug abuse in general are risk factors
(8) **Loss of a parent or other bereavement increases the risk**
(9) **Serious health problems and pain can increase the risk, as does unemployment**
(10) **Risk is higher for those coming out of a depression or recently released from a hospital**

The most common errors relate to a failure to obtain a good history, failure to follow-up on intuition or "soft signs" and statements with more inquiry, over-reliance on a "no-suicide" contract with the client, or a failure to deal with your own cynicism, anger, or frustration with a long-term & chronically suicidal client. Writing the threat off as "just manipulation" is always dangerous. There is a case in Illinois where a counselor and agency were faulted by a regulator for not having a "no suicide" contract, but the clinical and forensic opinion on this is that they are no better than the quality of the relationship with the client.

NOTE: (1) With a very depressed client, besides referring them for special help for the depression, remember that you can use interventions along the way to assist such as suggesting exercise, good diet, warm bath or glass of milk before bedtime to aid in sleep, calling a friend to talk, etc.

(2) With a highly anxious or panicky client, teaching proper breathing – that is, how to prevent hyper-ventilation, can be very helpful to a client whose panic endangers them.

(3) Remember also to caution about the impact of alcohol and other chemicals on prescribed mediations (e.g. anti-depressants) and also on mood in general.

When dealing with someone from another culture in which suicide is sinful, one has to assume that one is not necessarily going to get a clear answer to questions about suicidal thinking or intent. With a Somali, for example, feelings of hopelessness are not as serious as feelings of worthlessness.

THE HIGH RISK SITUATION: CLIENTS WHO ARE DANGEROUS TO OTHERS

Concerns about client dangerousness are often brought to colleagues supervisors. Many situations are not true "duty to warn or protect" cases but require a response including one which may breach privacy. The attachment **Dealing With Dangerous Clients and the Threat of Violence** examines a number of these issues.

Do you have any case examples of dangerous clients where the duty was unclear?
Or where things turned out badly?

WHEN YOU OR YOUR STAFF ARE THE TARGET OF STALKING OR ASSAULT BY CLIENT

A random sample of university counseling center in the U.S. found that 64% of the staff had experienced harassment from a current or former client. This included 5.6% who had been stalked, 8% where a family member had been stalked, and 10% who had supervised someone who had been stalked (Romans, Hays & White, 1996). Other studies have found high numbers of professionals who have been threatened or attacked, with physical assaults more likely in hospitals and clinics than in private practices.

An archival study of former hospital inpatients who engage in post-discharge stalking found that the duration was short-term, generally only a few weeks. Such patients were more likely to have a history of fear-inducing or assaultive behavior pre-admission, and were more likely to have personality disorders or a paranoid disorder with erotomanic features. They are more likely male. (Sandberg, McNeil Binder, 1998)

There are some excellent resources on the internet, and I would highly recommend Mullen, Pathe, & Purcell (2000) -- **Stalkers and Their Victims.** An updated version is due out in November (2008). Another useful book is **Stalking: Perspectives on Victims and Perpetrators** (Davis, Frieze, & Maiuro, 2002). Unfortunately, when mental health professionals become victims of stalking or harassment they do not tend to talk about it.

The research shows that while 100% of those who talk to the police felt it was helpful,
Only 60% felt it was helpful to talk with colleagues. Why is this the case?

CULTURAL ISSUES

Cultural realities may shape decision-making. For example, while normally a parent has access to information about their child, what would you do in a situation where the following was the case:

A 17 yr. old girl from a Middle Eastern family revealed that she had been having sex in exchange for money -- in effect engaged in prostitution -- for a brief period of time. She was introduced to this by an American friend. Neither girl was doing it now. She begs you to not

tell her family because she indicates that her male relatives would kill her. You check this out and find out that it is likely accurate -- that she will be murdered if you tell.

You are asked by a recently arrived immigrant Hispanic family to come to the family's home to meet the grandparents and have dinner. Is this something you could do once?

Or you are asked to attend a wedding or other key social event by a family which you have been counseling. They say they would like you to participate in the celebration. They note that the purpose of such a ceremony is to insure the support of family and community. How do you proceed?

(1) Generally speaking one needs to examine requests or invitations based on knowing about the culture and the expectations, and weighing the risks vs. the benefits.

(2) When saying "no" one should do this in a culturally sensitive fashion. Statements about "boundaries" almost never make any sense and are not clear to most clients, let alone those from another culture.

(3) Obtain consultation and discuss this with a supervisor or colleague so that what you are doing is known and understood and you have heard other thoughts about it.

Although cultural competence is an issue in all health care fields, the licensure act for substance abuse and alcoholism counselors in Minnesota requires regular continuing education training related to developing and maintaining cultural competence.

Ideally, a medical center or clinic would attempt, as a particular ethnic or cultural group increases in numbers, to have persons from that group among the staff. In some instances this may be cultural workers who do not have an academic degree but who have received "on site" training to be of assistance. In urban areas bi-cultural workers are playing such a role. When this is not the case, obtaining training, and having consultation available can be helpful. Sometimes training to work more effectively with one cultural group may help provide a framework to assist in helping another group. The more experienced you are in asking questions and inquiring about cultural differences, the better you will be able to do it for other groups.

INTERFACE WITH MENTAL HEALTH WORK

One of the great challenges in substance abuse and alcoholism treatment is the overlap with mental health care. DUAL DIAGNOSIS is the rule, not the exception, these days. **As a licensure requirement, but also in terms of <u>professional ethics,</u> it is important to be familiar with common mental health diagnoses and know something about treatment resources.**

Some notes on choice of drug versus mental health diagnoses. Work of Stephen Pittel & Bruce Smith.

Warning: Most mental health diagnoses are really symptom syndromes, not diseases, and as such there is disagreement as to diagnosis, great overlap between some diagnoses, and there are many unsettled issues in treatment. While diagnostic history is important, the client cannot be presumed to be an accurate reporter, and it is possible that mistakes have been made in the past.

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PERSONAL vs. PROFESSIONAL

This exercise requires a blackboard, flip chart, overhead projector, or computer projection system such as Powerpoint.

At the top of the page the presenter writes the word "Personal" on one side and "Professional" on the other side, and then draws a dotted line down the middle of the page.

PERSONAL vs.	PROFESSIONAL

(1) The presenter asks the audience to provide characteristics or descriptions of relationships based on which we might differentiate personal from professional relationships. Then, the responses are written down, with the characteristics put at opposite ends of the page. For example, one such difference is money -- the professional is paid, the friend or family member is not. So, "No payment is put on the "Personal side and "Fee" is put on the professional side as illustrated below:

No payment ***Fee paid, or service provider paid***

(2) As they are written down the presenter comments on them. For example, after noting the fact that fees are paid to a professional but not to a family member or friend in a personal relationship, the presenter notes that on the other hand, in terms of monetary dealings, one can lend to or borrow from a friend; one can buy or sell a house to a friend -- but these are not things one should do to a psychotherapy client.

(3) Once they are written down, the presenter notes several things. First of all, that there is no real line or boundary down the middle -- these are all continua so it is hard to know if someone has crossed over since there is normally not a specific point which could be defined as "the boundary";

(4) Secondly, the presenter notes that one can establish an expected "profile" for a given job. Depending on the type of work one does, one may have a different profile as regards these boundaries. For example,

our center delivers free service largely through the use of volunteers -- this is more a characteristic of a personal relationship. A pastor, some family therapists, a home care nurse, a public health nurse, some types of social workers, and others practice in the community and may be present in a client's home to deliver service. In some cases it does not take much further movement towards the "personal" side before the client and helper have difficulty distinguishing whether this is a personal or professional relationship;

(5) Thirdly, that you can compare yourself with your normal practices. If you are bending rules towards the personal side, you need to examine why you are doing this. If a colleague is doing so, you need to give him or her feedback. In both cases this observation should be a "wakeup" call. **We emphasize that the most common issue is not that a boundary was crossed, but a gradual drift from the professional side to the personal side.**

Some examples of items which come up during this exercise and which can be added by the presenter if they do not come up are:

(1) **Fees & payment**: professional relationships involve fees or some form of payment;

(2) **Time: Longevity of the Relationship:** Personal relationships can last forever -- professional ones are always time-limited. They end if you change jobs, move away, or if the client is transferred or referred, changes health plans, joins a new church, etc.

(3) **Time: The Time involved in an interaction.** Interactions in personal relationships can be any length of time -- you can even go on a trip or spend a weekend with a friend or family member. A professional relationship involves "sessions," hospital stays, a "fifty minute" hour, and other units of time which may even be legally defined.

(4) **Site or Location:** You can get together with family or friends anywhere you choose. A professional encounter is at a particular site -- office, church, clinic, etc. Even when services are delivered in the client's home, they occur at a set time during which time the home is the professional setting.

(5) **Goals:** The professional relationship has formal goals -- that is generally not true of personal relationships. You don't think of "goals" of a friendship for example.

(6) **Notes/Records:** The professional relationship requires record-keeping. Although some people keep diaries about their personal life and relationships, that is their choice. While there are some legal records in personal relationships such as marriage agreements, for the most part they are not required. They are with professional relationships.

(7) **Licenses and Regulation:** The professional needs to be licensed or approved by the state in many circumstances. Although Minnesota psychologist David Lykken has suggested that parents should be licensed, that isn't required. Likewise, friends do not need certification. However, there may be legal agreements between friends, such as when one buys a house, or gets married.

(8) **Self-disclosure:** In a personal relationship it is two-way (although admittedly this may vary from time to time -- one time you cry on your friend's shoulder and the next day they do so). In a professional relationship it is largely one-way with the client doing most of the disclosing, although again, professionals do engage in some self-disclosure.

(9) **Power Differential:** In a personal relationship one aims at equal power, although admittedly that may vary over time, or relationship to relationship. The professional is more powerful than the client or student or parishioner (although if the professional engages in misconduct, this power may shift if the client realizes that he/she can make a complaint).

(10) **Physical Contact:** In a personal relationship physical contact is based on what adults agree to and is generally limited only by a desire to avoid harm or pain. In a professional relationship physical contact is limited to treatment - related contact, which in some relationships means only a handshake.

(11) **Sexual involvement:** Exclusively limited to a personal relationship. But while the touching of the professional's sexual areas is always forbidden, in some physical procedures a professional may be expected to touch the private parts of the client (e.g. a physician performing a pelvic examination).

(12) **Privacy & Confidentiality:** In personal relationships these are guided by understandings between the parties, personal discretion, and other informal arrangements. Both parties in a personal relationship are typically bound by the same understanding and have the same duties. In a professional relationship it is the professional who has the duties. In professional relationships these are defined by codes of ethics, rules, and laws and the professional is obligated to maintain them, with certain well-defined exceptions.

WHAT'S OK, MAYBE OK, NEVER OK?

This exercise requires a blackboard, flip chart, overhead projector, or computer projection system such as Powerpoint.

(1) To begin the exercise the presenter creates three columns -- with "Always OK" on the left, "Maybe OK" in the middle, and "Never OK" on the right, as illustrated below:

ALWAYS OK	**MAYBE OK**	**EVER OK**

(2) The presenter then asks the audience to name something that is "Always OK" in a given type of professional relationship (e.g. for a counselor in this agency to do). Whatever is given, the presenter then asks the audience if everyone agrees. Most of the time they do not and instead of listing the behavior in the "Always OK" column it ends up in the middle in the "Maybe OK" column. For example:

AUDIENCE RESPONSE: "handshake"
PRESENTER: Does everyone agree?
MEMBER OF AUDIENCE: "No, I don't"
PRESENTER: Well, when would a handshake not be OK?
AUDIENCE RESPONSES (which can be augmented by the presenter if the audience does not come up with them):

(1) **if the client appears fearful and wary of touch;**
(2) **if there has just been an angry outburst by the client;**
(3) **if there are any questions about the cultural propriety of a handshake with this client;**
(4) **if you begin to offer it and the client backs off or refuses it**

PRESENTER: So, even with a handshake there are exceptions

(3) Then the presenter asks for something that is never OK. The most common response is "Having sex with a client" and that goes into the "Never OK" column if the audience agrees. We usually say, "Yes, that is one of the few which is never OK. But what about a Hug?

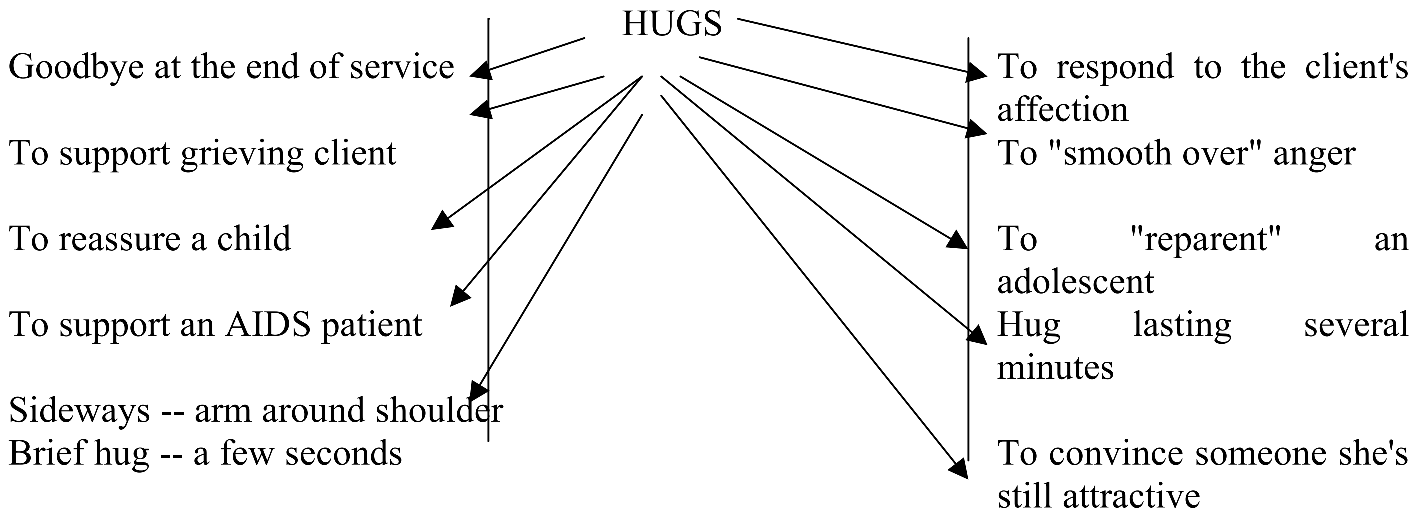
(4) When you introduce "A Hug," the presenter should stop and say, "Well, perhaps we had better define a hug." You then get the audience to define a hug by asking the following questions:

- **IS IT SIDEWAYS, OR FRONTAL?**
- **WHAT IS TOUCHING? Just the shoulders? Or the chest?**
- **WHERE ARE THE HANDS OF EACH PERSON?**
- **HOW LONG DOES IT LAST?**
- **DOES IT MAKE A DIFFERNCE WHO INITIATES IT?**

(5) At each item that is volunteered, you ask for a show of hands as to how many think it is "Always OK" and how many think it is "Never OK." **Most things will end up in the "Maybe OK" category in the middle, and you will be discussing what factors would make it "OK," versus "NOT OK."** The issues that may be raised which would affect the decision are many. Here are some examples:

- **Whether the client requests it**
- **Whether the professional feels comfortable doing it**
- **What has preceded it -- an angry outburst, an expression of grief**
- **The context -- client has had a death of a child, client is angry at you, you and client have had a disagreement**
- **Timing -- it is the first session, it is the last session & you are saying good-bye**
- **The age of the client -- child vs. adolescent vs. adult vs. older adult**
- **The gender of the client and that of the professional**
- **Whether there have been romantic feelings expressed or sensed**
- **The type of service & clientele -- for example, hugging at the end of support groups is relatively common in substance abuse treatment; any touch in a criminal justice setting is viewed as dangerous**

An example is given below of how a discussion about the propriety of hugging can lead to the articulation of a variety of principles:



The point of the exercise is to involve the audience in sorting through the many contextual factors which play a role in determining whether a particular action is "OK" or "NOT OK."

(6)An alternative way to do this exercise is to have the presenter supply all of the inputs rather than have the audience volunteer them. So, based on material provided beforehand by the supervisory staff, or just based on the presenter's general knowledge, the presenter can query the audience about specific issues. Any of the boundary issues in the book may be utilized -- hugs, accepting gifts, doing special favors, etc.

(7) Several of the videotapes discussed in the last portion of this monograph on videotape resources illustrate this sort of analysis. For example, in the tape ***Crossing the Line*** the concept of an intentional boundary crossing done to assist the client is introduced. A nurse is depicted giving a patient the same gift under two different circumstances, with two very different outcomes. The tape ***Subtle Boundary Dilemmas*** also illustrates the point that context is important in judging the propriety of an action via a number of vignettes on gift giving.

RELATIONSHIPS WITH FORMER CLIENTS

Gary R. Schoener

INTRODUCTION

One of the basic differences between a personal and professional relationship is that **the professional relationship is time-limited**. However, the pattern of contacts in a professional relationship varies dramatically. For example, you may see your dentist only once or twice a year for a brief visit and yet he or she may remain your dentist even though you are not having regular professional contacts and there may be long breaks between appointments.

Depending on the type of professional relationship, there is wide variability in what is professionally

appropriate in terms of having personal relationships with **former** clients or patients. As a general rule, the psychotherapy and counseling professions are very restrictive, whereas in general health care the restrictions are few. Both clients and professionals are often unclear what standards exist. There is surprisingly little in the way of literature on termination. **Termination in Therapy** (Joyce et. al, 2007) is a very recent contribution.

It is not uncommon for staff to approach supervisors or colleagues with questions about the propriety of "friendships" or other "contacts" or "involvements" with clients who have terminated their professional services. **Often they underplay what is actually going on, understating the intensity of the feelings, the dependency, or the amount of involvement.**

Many a colleague or supervisor has unwisely supported, or at least not challenged, such involvement, believing it to be harmless. Sometimes a simple reminder is given about avoiding sexual contact. Typically, **the person requesting the consultation is not asked for any details and so there is not a frank discussion of what is actually going on.**

The issue of continued professional service outside of the professional context is especially problematic in the psychotherapy and counseling professions. This is because supportive discussion and counseling by friends and family is quite similar to professional counseling. Thus, **if you are the person's former therapist or counselor, if you lapse into discussion of the former client's personal life this may experienced and defined as such. An angry former client can easily claim that this was a continuing professional relationship, carried on outside of regular office hours.** Furthermore, as a practical reality, many a practitioner has sought a romantic and/or sexual relationship with a former client, claiming that the past professional relationship was "terminated." So it is no surprise that ethics committees and licensure boards are open -minded when a complaint comes in alleging no "real" termination.

It should be noted that a great many post-termination sexual relationships have occurred in situations where either there was (1) no termination, or (2) a "quickie" termination.

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But an additional problem here is a possible ***slippery slope.*** Even when sex or romance is not intended, an eventual boundary violation is the culmination of a series of boundary crossings. It is *not the key event*, but simply a culmination of a series of events. A friendship or other social relationship can easily lead to any or all of the following:

(1) a sexual or romantic relationship;

(2) a financial or business relationship;

(3) continued professional service done outside of the professional context.

Although the literature, ethics codes, and licensure standards have focused on the danger to the former client, **professionals need to be aware of their own liability and vulnerability. If something goes wrong in the eventual relationship, the professional may be liable civilly and criminally, and stand to lose a great deal.** As much as there can be harm to the former client, the professional can suffer incredible losses as a result.

Many professionals overlook this since when the relationship begins they are the more powerful party and

feel quite confident in their knowledge of the client. This, of course, may be self-deception – many times professionals do not know the client as well as they think they do. Furthermore, the power differential in the relationship can shift once the relationship becomes personal (Luepker & Schoener, 1989). Once lines are crossed, the professional is at considerable risk if the former client becomes angry or frustrated, and especially if the relationship ends. **I'm going to focus on the sexual relationship because this is where the most clear-cut standards are articulated. But the risks go beyond sex.**

WHEN THE CLIENT IS A MINOR

Debate in the counseling professions about standards for post-termination involvement with clients has typically presumed that the client is an adult. **When the client was a minor, the professional needs to remember that the parents and rest of the family are typically clients too.** In fact, since parents must authorize the care, it is presumed that they are clients. So, an involvement with the parent of a former primary client who was a child or adolescent carries with it the same risks as involvements with primary clients who are adults.

Standards which refer to possible harm to third parties in this case might include harm to the former client brought about by a professional's relationship with the parent of that former client. The same may be true of other relations of the client.

Another issue is involvements with minors who reach the age of majority during or after treatment. While this has been largely examined with regard to teacher – student relationships, largely due to highly publicized cases around the country, it can be an issue for any type of health care worker, psychotherapist, counselor, case worker, etc.

It is normally presumed that a young adult, who was seen for professional services as a minor, is quite vulnerable. This can become an issue when one employs a former client, or his or her parents, or engages in business dealings such as investment plans. To the degree that the former client or their family believe that the situation is trustworthy or desirable because of their trust in you as a professional, there is potential liability. The issue here is not just legal liability. It is the potential for disappointment, frustration, anger, and even retroactively undoing the good work done during the professional relationship.

LICENSURE-RELATED STANDARDS

Laws under which professionals are certified or licensed in each state usually include codes of conduct which may define post-termination relationships. Most of the time such codes adopt the ethical standards of the major national professional association in that field (APA, AMA, NASW, AAMFTA, etc.) Some Boards have created more stringent rules than the ethics codes do. For example, the Florida Board of Psychology adopted a rule that for the purpose of judging therapist – client sex, the therapeutic relationship is "…deemed to exist in perpetuity." (This was struck down by an appellate court in March of 2000 as violating the Privacy Amendment in the Florida State Constitution.).

Closer to home, **as of January 1 of 2006 social workers licensed in Minnesota are bound by a stricter standard than that of the NASW Code of Ethics – namely that minimally two years must pass before sex with a former client is allowable, and furthermore that other criteria must also be met for such a relationship to be permissible.** This is very similar to the ethical standard for psychologists presented below.

Research on the actions of psychology licensure boards has found that <u>when the defense was used that the therapy was terminated before sex began, the offending practitioner tended to receive the same penalty as for</u>

sex which occurs during therapy. It is possible that these defenses were deemed to be bogus and that a true termination had not occurred. A substantial number of cases of which I am aware did not involve true terminations. (Bisbing, Jorgenson & Sutherland, 1995, 1997, 1999; Schoener, 1989).

For those licensed in Wisconsin, generally the standards of the profession itself are reflected in licensure board actions. The one major exception is professional counseling where the licensure rules do **not** incorporate the Code of Ethics of the American Counseling Associaton. Following the standard of your profession is the safest plan of action.

CRIMINAL STATUTES

Twenty four states have criminal statutes which cover psychotherapist-client sex. Approximately half of them allow for prosecution of post - termination situations under some circumstances. Most common are termination in order to have sex, exploitation of emotional dependency, or contact within a certain time period.

Minnesota's criminal statute allows for criminal prosecution for sex with a former psychotherapy client when the sex occurred as a result of emotional dependency or therapeutic deception*** (leading the client to believe that the sex is part of therapy or consistent with it). There is no time limit**. In the case of the emotional dependency, it must be sufficiently strong to render the client unable to resist the therapist's advances. But the definition of psychotherapy is looser than Wisconsin's and far more situations can be considered "psychotherapy." Note the definition of these standards in the footnote at the bottom of the next page. It is important to note that many professionals who may provide some counseling as part of their work with a client or patient could be considered "psychotherapists" under this sort of broad definition of "psychotherapy."

Iowa includes the one year period following termination, but requires that it be proven that emotional dependency brought about the sexual involvement. In other words, the **Iowa criminal statute concerning therapist-client sex presumes that the year following termination is essentially the same as when sex occurs during therapy.**

CIVIL LIABILITY

This is a matter of case law except in Minnesota and Illinois where there are statutes which govern this situation, at least as far as psychotherapy is concerned..* In Minnesota, **MS 148A.01** limits a cause of action to **sex which occurs within two years of termination, and which occurs as a result of therapeutic deception*** or emotional dependency** created in the therapy relationship.**

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* ***"Psychotherapy" means the professional treatment, assessment, or counseling of a mental or emotional illness, symptom, or condition.*** *If the sex occurs within two years of the last professional session and is accomplished by* ***therapeutic deception or as a result of the client's emotional dependency*** it can be a criminal offense or grounds for a lawsuit

** *"**Emotionally dependent**" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the psychotherapist are such that the psychotherapist knows or has reason to know that the patient or former patient is unable to withhold consent to sexual contact or sexual penetration by the psychotherapist.*

*** *"**Therapeutic deception**" means a representation by a psychotherapist that sexual contact or sexual penetration by the psychotherapist is consistent with or part of the patient's treatment.*

If such behavior is forbidden by the code of ethics in a profession it is easily shown to be malpractice. As such, in the psychotherapy professions, post- termination sexual contact with a former client (at least if it occurs within two years of termination) is generally malpractice.

Strictly speaking, **in most jurisdictions if one can show that the eventual relationship grew out of the past professional one, it can be seen as a "continuous course of action" and be argued that the professional relationship never really ended, or that it set the stage for the later relationship.**

ETHICAL STANDARDS FOR ALCOHOLISM & SUBSTANCE ABUSE COUNSELORS:

In this field there is no one generally accepted national code of ethics. The Code of the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) states (Principle 9(d): "The NAADAC member shall not under any circumstances engage in sexual behavior with current **or former clients.** In states which have a certification process or licensure, those laws and codes of conduct apply. Many such rules include all clients of the agency -- not just those for whom you are a primary counselor. There are some special challenges in this field in that professionals may themselves be in aftercare groups which may include as members their former clients. Termination may be unclear since programs expect clients to return for "aftercare."

The Licensure standard in Minnesota is essentially the civil standard in 148A.01 as described above. This means that former clients cannot be approached for sex within two years of termination if there is (1) a representation by the counselor that the sexual contact is consistent with or a part of the therapy ("therapeutic deception) or (2) if the nature of the client's condition or treatment is such that the counselor knows or has reason to believe that the client is unable to withhold consent to sexual contact (e.g. say "no") ("emotional dependency").

CONCLUSIONS REGARDING STANDARDS IN ETHICS CODES

While standards vary, even within professions which work side by side in the provision of psychotherapeutic care and mental health services, **the clear trend is towards the prohibition of romantic or sexual relationships with former clients. No counseling profession believes that simply stopping formal sessions in the office or stopping billing, or writing a "termination note" is sufficient to declare a professional relationship ended.**

By contrast, with general medicine, all that is expected is that the original doctor-patient relationship has been terminated. We would recommend that a serious discussion be held with the patient about the implications of such a decision, and that all prescriptions be transferred, but the AMA Code of Ethics does not have such requirements. If there has been anything psychotherapeutic which has taken place during he professional relationship, the psychiatric applies – sex with a former client is strictly forbidden no matter how much time has passed.

Only one text has focused on post-termination involvements other than sexual relationships with former clients -- **Boundaries and Boundary Violations in Psychoanalysis** by Gabbard & Lester (1995). There are texts that argue for the legitimacy of post-termination involvements with former clients, including intense friendships and even romantic relationships (Heyward, 1993: Ragsdale, 1996), although this point of view is rarely articulated in recent literature. In the 1970's it was sometimes argued that if a marriage resulted the situation would be considered quite differently.

Even surveys in the late 1980's found therapists rating a marriage to a former client quite differently from sex with a former client (see Schoener, 1989). For an elucidation of the legal issues with post-termination

sexual contact with clients, see Bisbing, Jorgenson, & Sutherland (1995) for a thorough examination.

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