CLINICAL SUPERVISION*

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CASE

You are supervising an intern on a case where childhood sexual abuse experiences emerge as a key issue. This is an area where your own skills are limited. You ask that she get supervision from another supervisor who has expertise in that area of work.

Your own style is to help supervisees find their own solution. The supervisee is accustomed to that style. She talks to you about the input she is getting and indicates that she is having trouble dealing with the fact that the other supervisor is giving her "orders" and pretty specific directions, some of which seem intuitively wrong.

You suggest that she "give it some time and try to go with it" but after two weeks she comes to you even more troubled about the situation and uneasy about how the case is going. She asks you for help in resolving the situation.

You are the intern's "supervisor of record" for the internship and have worked together with her for more than four months and have a good deal of confidence in her judgment. While you are disappointed in what she is telling you, the reality is that it is somewhat consistent with things you know about the other supervisor.

> **(1) What do you do to further assess the situation?**
> **(2) What action options are there?**

BACKGROUND

Counseling, case management, assessment, & treatment -- the work done in chemical health programs -- are all taught largely through an apprenticeship model. Clinical supervision is how we expect people to learn these skills and improve in these skills. As such ***supervision is key*** to these fields of practice.

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* Nothing in this workshop 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 provides a great deal of organizational and clinical consulting and training to mental health programs, substance abuse and alcoholism programs, and other health care programs.

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Yet until recently the training of supervision has been lacking as have standards connected with supervision in psychotherapy and counseling fields such as psychology, social work, marriage and family therapy, etc. Until recently the field of addictions counseling has had virtually no traditions or literature concerning clinical supervision. The National Institute on Alcohol Abuse (NIAAA) even titled their major supervisory tool ***Psychotherapy Supervision Checklist & Questionnaire*** (Witte & Wilber, 1997). The use of the term "psychotherapy" in this context is surprising. Powell (1998) created the first text on clinical supervision in alcohol and drug abuse counseling in 1993.

TYPES OF *SUPERVISION:*

In its most common usage in agency and organizational settings, ***supervision*** means **administrative supervision -- that is, some sort of oversight of professional work.** One's supervisor in many human service and correctional settings is simply the person one reports to and who helps do your performance reviews and possibly decides on your salary. It is sometimes quite vague and unclear as to how ***clinical supervision*** or practice oversight is provided by administrative supervisors. **Technically speaking, they have the responsibility to ensure that there is adequate *clinical supervision*, even though they may not provide it directly.**

In many programs the job title *CLINICAL SUPERVISOR* includes a number of administrative duties and responsibilities – not just mentoring practice and helping staff with their clinical duties as the term *clinical supervision* is often used. It is easy for *clinical supervision* to be left behind given all the other duties that are often assigned to supervisors.

GROWING INTEREST IN CLINICAL SUPERVISION IN ADDICTIONS WORK

Historically was de-emphasized or not taken seriously. Belief was that you (a) used your own personal experience in life, and (b) in treatment, and (c) learned by doing. There was a limited concept of counselors as professionals and as people seeking a professional career. The field has evolved and now clinical supervision is coming into its own in order to:

(1) **Nurture the professional growth of counselors;**
(2) **Promote the development of skills;**
(3) **Increase accountability**

Clinical supervision has emerged as a disciplined tutorial process – not just looking over someone's shoulder and giving advice, or keeping an eye on counselors so they don't screw up too badly. It has at least four major components:

(1) **Administrative role and duties;**
(2) **Evaluation of staff and their skills, and of service quality;**
(3) **Direct oversight and supervision of clinical work;**
(4) **Support of counselors and other staff.**

ASSUMING THE ROLE

In any organization getting started as a supervisor requires several things:.

(1) **You need an orientation period;**
(2) **You need internal or external mentor;**
(3) **You need to build a cohesive team;**
(4) **You need to solicit feedback and take it seriously**

SOME INTRODUCTORY NOTES ON LEGAL LIABILITY -- WHAT'S IN A NAME?

The term supervisor means that someone is in charge of the work being done. In effect, that they are responsible for it. For the supervision of a trainee or the supervision of a junior staff member or the administrative supervision of all staff, this should not be a surprise. It is taken for granted that **we are responsible for the work done by our students and our staff. If they mess up while under our supervision, we will share in the responsibility.**

But, what about the situation in which there is a looser arrangement -- where there is no clear administrative oversight or responsibility: e.g. when someone voluntarily comes to you for ***supervision*** to help them in their work. The answer is, generally speaking, that **if you permit the term to be used a client, or another party, can presume that you are in fact a true supervisor and thus responsible for the work**.

For example, there is the case in which a practitioner who was not yet licensed was supervised by a licensed practitioner. (Schoener et. al, 1989, p. 479). He had sex with a client whose case was never mentioned in supervision and whom the supervisor had never heard of. When the suit was brought the practitioner left town. The suit focused on the supervisor and his insurance ended up picking up the cost and settling the case -- largely because he allowed the use of the term and the client had heard that he was ***the supervisor.***

In actuality many so-called supervision relationships are, in fact, **case consultation. Case consultation involves the voluntary sharing of material that the supervisee chooses to share. It is presumed that the consultee has the skill and judgment to practice independently and that he or she can reasonably determine what things to get help with.**

By contrast, **with true supervision, the supervisor can compel the sharing of any and all cases, demand the review of files, and focus the supervision any way he or she wants to. While the supervisee may be bringing up the things which most require input, it is not presumed that he/she is, and the supervisor can always overrule the judgment of the supervisee and insist that a course of action be followed.**

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. Although cynics note that people sue the employer or supervisor because "that's where the deep pocket is," many aggrieved consumers are more troubled by the fact that their trust in an organization or agency was violated than that an individual staff member erred. Sometimes they believe that the employer "knew what was going on" or "knew that the worker was a problem."

Generally speaking, one must be able to show three things to provide the linkage to liability under a theory of respondeat superiori:

(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 does not have to be paid for this to be the case;

(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 worker who engages in very hostile confrontation 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;

(3) The supervisor must have the power to control and/or direct the work of the supervisee, even if in this instance there was no supervisory input.

DIRECT LIABILITY: *NEGLIGENT* SUPERVISION

While negligence in supervision can be charged in a civil suit for a variety of reasons, I am going to focus on **negligent supervision as a type of malpractice.** Malpractice is a type of professional negligence requiring the showing of errors or omissions in the oversight of work. **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 -- in this case a supervisory relationship. To show this one must prove that there is or was a supervisory relationship;

(2) That you failed to meet the *standard of care* in performing this duty -- that your performance of your supervisory duties was not at the level that one would *reasonably expect from a reasonable and prudent supervisor in your field faced with the same, or similar, supervisory situations*; and

(3) That damages to the supervisee, or to their client, were a *direct result* of your failure. While the most common cases are those brought by clients of the supervisee, it is conceivable that a supervisee might charge that they were damaged due to failure to properly train them, supervise their work, or manage your relationship with them (e.g. sexual involvement with supervisees)

Often the question is **What the supervisor knew, or should have known** abut the situation. So, there are instances where inattention to what is happening puts the supervisor at risk. One does not have to know of the substandard work or practice to be liable for it. If one doesn't actually know about the case in question, the issue can be raised if it is argued that the supervisor **should have known** what was going on.

NEGLIGENT CASE CONSULTATION

I have never heard of a case of "negligent case consultation," although this neither means that there hasn't been one, or that there couldn't be one. The case consultant would, for example, not be expected to engage in the detailed inquiry and case review that a "supervisor" would be expected to do. Secondly, the case consultant has no real power to enforce their views on the "consultee." Ethically, of course, you need to be careful, thoughtful, and give your best advice. Certainly this role is important and can be key to both the client being served and the professional to whom you are consulting.

QUALIFICATIONS

There is so little formal training of supervision in either graduate school or post-graduate work that it is hard to know what would constitute training and experience in supervision. It is only in recent years that there has been any sort of research on supervision and even the few supervision journals are relatively new. Practitioners have been expected to learn supervision from their own experiences with a supervisor.

WHAT WERE YOUR BEST SUPERVISORY EXPERIENCES?

What made them "best"?

You have to factor in organizational or agency problems. If things are going badly organizationally it is difficult for the clinical supervision to be remembered positively.

It is important to remember that **a good supervisory relationship requires a good match between supervisor and supervisee. This is not just a matter of either party alone -- but rather the match of two who are compatible.**

A list of some of the commonly cited qualities:

- **Able to maintain equilibrium in the face of crises; adaptive & flexible**
- **Attentive & available**
- **Solid professional skills – a good model professionally**
- **Collaborative; open-minded; non-authoritarian**
- **Dependable; Trustworthy**
- **Able to be critical without being judgmental**
- **Solid knowledge of ethics and legal responsibilities**
- **Good personal boundaries**
- **Empathetic & understanding; encouraging; supportive & warm**
- **Self-aware; self-revealing**
- **Sense of humor**

● WHAT WERE YOUR POOREST SUPERVISORY EXPERIENCES?

What made these non-helpful experiences or hurtful experiences?

Ramos-Sanchez & Esnil et. al. (2002), studied negative supervisory events and created a set of categories for negative supervisory experiences:

- **Interpersonal relationship & style:** Differing attitudes, personality conflicts, & communication difficulties including the supervisor's being critical, judgmental, disrespectful & unsupportive

- **Supervision tasks & responsibilities:** Issues pertaining to the activities, roles, goals, expectations, and time spent in supervision, including viewing tapes, lack of supervision, & inadequate & outdated knowledge and skills of the supervisor.

- **Conceptualization & theoretical orientation:** Conflicts involving client conceptualization, diagnosis, treatment decisions, & interventions, such as disagreements related to opposing theoretical orientations.

- **Ethics, legal & multicultural issues:** Ethical and legal considerations pertaining to the professional practice of psychology, including multicultural competence, clinical issues, case management, and professional development.

COMMON SUPERVISORY ERRORS

(1) Confusing supervision with case management – focusing on the client instead of supervisee;

(2) Falling back on counseling skills – trying to counsel the supervisee;

(3) Laid–back, laissez faire attitude – letting it slide by;

(4) Being judgmental, demanding, and authoritarian – giving orders;

(5) Supervisory burnout – feeling fraudulent and then feeling overwhelmed;

(6) Trying to fix an impaired staff member using just supervision.

HOW GOOD ARE YOU AT THE CENTRAL TASKS OF SUPERVISION?

(1) Providing a non-judgmental, supportive atmosphere;
(2) Providing insights into the handling of clinical matters;
(3) Providing guidance around ethical/legal dilemmas;
(4) Providing support and also confronting problems of personal impairment in the supervisee;
(5) Providing support and confronting practice deficits in the supervisee;
(6) Rewarding hard work and successes;
(7) Assessing and learning from errors;
(8) Providing balanced and fair assessments or evaluations of the supervisee;
(9) Handling challenge and confrontation by the supervisee;
(10) Protecting the supervisee against unreasonable challenge by clients, or staff

You can set your own goals in any of these areas, deciding for example o improve your ability in a given area of tasks. .

WHAT TYPES OF SERVICES ARE YOU QUALIFIED TO SUPERVISE?

In which areas of work do you have sufficient experience and/or expertise to be able to supervise? Of the 12 core functions of an alcohol and substance abuse counselor, where is your experience and strength in terms of being able to teach others as to how to do them well?

1. Screening	**7. Crisis Intervention**
2. Assessment	**8. Client Education**
3. Orientation	**9. Referral**
4. Intake	**10. Report writing & record keeping**
5. Counseling	**11. Consultation with other professionals**
6. Treatment planning	**12. Case Management**

SUPERVISING DIFFERENT TYPES OF PROFESSIONALS

It is not uncommon for professionals to end up supervising some who are in a different field which has other traditions. Psychology, social work, and counseling have specific texts. There are three major issues when supervising persons who are not in your profession:

(1) **Are you clear on the standards and expectations of the supervisee's field, especially any differences between that field and yours?**

(2) **Do you know something of the traditions of supervision in the other field?** In some settings supervision is viewed negatively as "someone looking over your shoulder."

(3) **Are you clear on reporting duties and standards for the supervisee's field?**

DIFFICULTIES WITH A NEW SUPERVISEE?

PROBLEM SITUATIONS

(1) You and supervisee used to be counselors together, or were at the same level in this or another organization;
(2) We grew up together – you were in AA together or literally grew up together;
(3) You are younger and have less life experience or less professional experience.
(4) Or you are in the same self-help group meeting

ISSUES

(1) You need to make clear what your "new" roles are and that you are going to try to do your best to do yours well. That it is important to you that this be what it is supposed to be.
(2) You don't know it all and also expect to be evaluated yourself and also to be working at improving how you do this job and this role;
(3) You need to reconsider self-disclosure and the nature of your informal interactions – you can be on very friendly terms but do need to keep some distance for this to be "REAL"

ASSESSMENT OF THE SUPERVISEE: THE DESIGN OF A SUPERVISION PLAN

The development of a plan for orientation and supervision of a new staff member or trainee is heavily dependent on an assessment of their strengths, weaknesses, needs, and a comparison of this with the job duties and challenges. Whether there are training needs beyond orientation of a new staff member also needs to be determined at the outset. All of these decisions, of course, are revisited periodically. Sometimes training needs are not apparent until someone has worked in a position for a period of time.

Supervision, like other professional duties and tasks, requires an assessment and game plan. One has the duty to gather background on the supervisee -- from them, from their training program, from former supervisors at the same facility -- so as to do a preliminary assessment as to their strengths, weaknesses, and supervision needs. **All supervisees should be directly asked about:**

(1) Past supervision experiences -- good and bad;

(2) What they have found helpful in terms of supervision methods;

(3) Any past complaints or problems in maintaining professional boundaries or in performing in the professional role;

(4) Any current problems or concerns which might limit their effectiveness or ability to perform [note that inquiry related to their problems or mental health history must be focused in implications for practice];

(5) Any clients they are unqualified to work with or with whom they have significant problems in the past;

(6) What they hope to get out of this experience -- what their training program or employer expects;

(7) Anything they could tell you that might make this a more useful experience.

If the person has had past difficulties, you may need to obtain outside information or background data to be able to fully assess current difficulties. At times one must obtain a release to permit a review of their situation with a past supervisor, employer, or even their therapist. **It is your job to make every effort to know the needs and the strengths and weaknesses of your supervisee.**

Under any type of supervision, the plan of supervision needs to include and elucidation of the same elements:

(1) types of meetings (group or individual);

(2) frequency and length of meetings;

(3) whether records are to be reviewed by you (a. prior to meeting; b. at meeting; c. after the meeting, as needed; d. which cases);

(4) how cases to be discussed will be selected;

(5) whether you will expect a full accounting for their caseload;

(6) how and when they can contact you for an emergency;

(7) who your backups are in such cases;

(8) your disclosure of your own reporting duties and practices;

(9) ground rules as to things which you consider essential you be told about;

(10) any expectations as to attendance at other meetings, review of manuals, continuing education, or anything else which is an expectation;

(11) your record-keeping requirements and expectations;

(12) any requirements for taping (audio or video) and observation;

There are a great many possible methodologies in supervision, all of which have pluses and minuses in terms of accountability. Unfortunately, as regards overall effectiveness of each method, or combinations of methods, little is known. For example, one study examined "hindering phenomena in group supervision," (Enyedy et. al., 2003) but did not examine the benefits of group supervision, nor did it compare problems in group supervision with those in individual supervision. So the study examined some problems with group supervision but left open the question as to whether the same problems exist in one- on- one supervision

Structuring of Supervision

(1) It can be individual
(2) It can be group supervision (or two supervisees may share their time)
(3) It can be done as a team meeting with a team leader
(4) It can involve audiotapes
(5) It can involve use of videotapes
(6) It can involve direct observation through camera or one-way mirror
(7) It can be done with varying bases of information -- e.g. study of client's chart, testing materials, etc. -- done before or during the meeting.

A great many methods can be used as supervision tools. An overview of them can be found in any of the major texts (e.g. Campbell, 2000, pp. 69-88; Haynes, Corey & Moulton, 2003, pp. 81-107). A discussion of these is beyond the scope of this program, but it is important to remember the many tools and approaches which are possible.

FEEDBACK STYLES:

(1) Facilitative – getting the counselor to play out his/her ideas and/or having the team generate the ideas and suggestions;
(2) Conceptual – focusing on examining or understanding the situation or options, or of setting up a framework inside which the counselor, or the team will make "their calls"
(3) Confrontational – challenging the counselor either because of concern for the situation, or challenging directly the "game plan"
(4) Prescriptive – directing a course of action, either because you've been asked to or because of the urgency of the situation, or lack of knowledge on the counselors part
(5) Catalytic – throwing out some challenges for the team to play the roles above so as to evolve a plan of action

Supervision Methods

(1) Chart review
(2) Use of process notes -- keeping more detailed notes than needed clinically
(3) Use of diagrams -- common in family therapy
(4) Discussion of supervisee's cases
(5) Discussion of supervisor's cases or case examples
(6) Co-therapy with supervisee (especially common in group therapy
(7) Live observation: video monitor or through one-way mirror
(8) Live observation with supervisor or consulting team contact by phone

(9) Audiotaping sessions: playing segments vs. listening to entire tape
(10) Videotaping sessions: segments vs. entire tape
(11) Role play and role reversal
(12) Modeling and demonstration by the supervisor
(13) Homework -- assignment of additional research or education -- via literature search, video or audiotapes, internet or library research
(14) Assignment of additional training experiences -- attendance at workshops

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SOME FOOTNOTES

GROUP SUPERVISION

(1) validation and reality testing by other group members
(2) a diverse make-up of the group can enhance this far beyond individual supervision
(3) can create a working alliance between staff
(4) can create a sense of shared values and help strengthen the program
(5) can provide considerable support
(6) can broaden critical review and feedback
(7) But, can diminish the focus on a given counselors struggles

CASE PRESENTATION – format is important to maximize gain and use time wisely

ROLE PLAYING – counselor can play any number of roles

(1) play the resistant client or the client who has stumped them
(2) play themselves struggling with the situation
(3) try out different approaches or techniques
(4) you can use a fish-bowl technique, where-in various counselors can step in and try to do it their way

ROLE MODELING – have the supervisor demonstrate

VIDEOTAPE – when counselor reports client is resistant, this is often actually resistance from the counselor – either subtle or not so subtle (e.g. "….they're making me do this tape…")

(1) Be clear how and why and when the video will be used
(2) Have the counselor comment on the segment before showing it so as to have a context – otherwise time will be wasted with question-answer
(3) Pick "teaching moments" rather than segments to be "scored"
(4) Give feed back on the case gradually – there is a tendency to give too much and overwhelm counselor

CO-FACILITATION – family or group session

(1) With a new counselor the supervisor may take the lead
(2) But best done with the supervisor secondary
(3) Some authors emphasize sitting next to supervisee to "underline the connection" but I have no clear guidelines

(4) Some authors emphasize that the supervisor should take notes – again, I do not have a recommendation on this

(5) Most agree that the supervisor, with the exception of (1) above, should say little during the session

(6) If asked a question, supervisor can't "duck it" completely, but would do well to give a quick "off the top of my head" response and turn back to the supervisee and say "well, what's your take on that?"

THE IMPACT OF ANXIETY

(1) SUPERVISOR'S ANXIETY –

- **a. Can lead to being overly supportive, de-emphasizing any (i) critical feedback, or (ii) demands, or (iii) negative appraisals. Clinical problems may even be minimized or overlooked.**
- **b. Can lead to being overly distant and formal, trying to emphasize different status, and creating an atmosphere were mistakes will not be admitted and where counselors will not feel support.**
- **c. Commonly there is anxiety about the evaluation role – evaluating supervisee performance.**

(2) SUPERVISEE'S ANXIETY –

- **a. Performance anxiety – fear of screwing up;**
- **b. Appraisal anxiety – fear of being judged;**
- **c. Fear of harming clients – "spun glass theory of the mind"**
- **d. Fear of failure – of treatment not working**

DANGER SIGNALS

Signs of potential problems in the work of a supervisee are always grounds for additional scrutiny of the work. Some of these danger signals cannot be observed by a supervisor unless he or she is actually on site and able to observe things, or obtain feedback from support staff. The relevance of any of these items depends a good deal on the nature of the supervisee and his or her strengths or weaknesses. The order of the signals listed below does not imply relative importance, and the list is not exhaustive:

(1) Supervisee taking on a case for which he/she does not have adequate training

(2) Supervisee fails to refer, or strongly resists referring client who needs a special service;

(3) Supervisee shows signs of significant depression or anxiety;

(4) Supervisee is, or becomes, extremely sensitive to criticism, or frankly paranoid;

(5) Supervisee has significant problems with anger control, or angers very easily;

(6) Supervisee seems preoccupied with sexual issues;

(7) Supervisee withholds information, or is unwilling to discuss a given case;

(8) Supervisee is having contacts outside the professional setting with a client or spouse of a client, or otherwise socializing with clients

(9) Supervisee is being contacted frequently by a given client, with messages left, letters, postcards, unexpected visits outside of appointment times, etc.

(10) Supervisee is continually arguing for extension of the treatment of a client well beyond the normal practice limits -- this can be length of treatment or frequency of contacts

(11) Family member of either client or therapist begins raising concerns about their relationship

(12) Insurance fraud or violation of agency rules on behalf of a client

(13) Overall breakdown including inability to keep up with record-keeping responsibilities, missing supervision meetings, missing staff meetings, etc.

(14) Intimate or inappropriate gifts by client, or by supervisee

(15) A relationship which appears radically different from the supervisee's normal style-- excessive joking, kidding, fraternizing with client in waiting room

(16) Excessive self-disclosure by the supervisee -- in terms of amount, timing, content, frequency -- claims that client and supervisee have "a lot in common" which are emphasized

(17) Dressing up for the client -- supervisee appears to "dress up" for the appointment in terms of clothing, makeup, etc.

PROBLEMATIC SUPERVISEES -- THOSE WHO HAVE VIOLATED OR WHO HAVE HIGH POTENTIAL TO VIOLATE BOUNDARIES

The failure to maintain professional boundaries or the violation of boundaries can take a great range of shapes and occur for a great variety of reasons. This can involve all types of over-involvement with clients including social contacts outside of the professional relationship, gifts, involving oneself in the client's life, confidentiality violations, excessive anger, physical contact, romantic game-playing, erotic talk, sexual contact, and numerous other things.

(1) **Poorly Trained for the Particular Role or Job:** The supervisee may have good training, but not for the role which has been undertaken.

(3) **Supervisees who lack awareness of transference/countertransference in general, or these factors in a given situation:** Some are not aware of their areas of vulnerability and lose their boundaries with certain clients. Some clients represent challenges to a wide range of workers.

(4) **Supervisees who have excessive need for client approval:** Workers who are insecure and who will do anything to gain client approval have great difficulty setting limits.

(5) **Supervisees who are naive and lacking in good social judgment:** Some workers appear to lack the "social intelligence" necessary to be a professional, or do not wish to be in the professional role and would like to function more like a friend. They subvert attempte to have them operate within accepted limits, challenging the supervisor as "up tight"

(6) **Practitioners with organic Impairment:** Post-accident or post-surgery.

(7) **Emotionally Needy & Dependent:** There are a number of problems associated with low self esteem and high dependency needs, which lead workers to be highly needy of client acceptance, and who seek to meet their needs through their clients.

(8) **Situationally Needy or Impaired -- the "Wounded Healer":** Due to depression, a life crisis, or other more transitory problems, a worker become situationally needy

(9) **The therapist or worker as a superhero:** Practitioners who are driven to be "perfect" or do everything for clients, regardless of risks. This is an easy role to slip into when trying to make up for what you believed was poor care in the past.

It should be obvious from the above list, but **supervision cannot necessarily significantly affect the underlying cause of the boundary violations. Hopefully a good assessment will have been done to rule out conditions which can't be easily changed, but this is not always the case.**

SUPERVISING THE PRACTITIONER UNDER DISCIPLINARY ORDER

The challenges of doing therapy on practitioners who have crossed boundaries have parallels in the supervision of the same people.

- **Supervisor as Cop:** To the degree that the supervisor is an extension of the licensure board or the disciplinary activities of an employer, the supervisor can drift into the role of a disciplinarian and watchdog.

- **Supervisor as Rescuer and Absolver:** Many disciplined professionals come for supervision in a traumatized state. Supervision may be seen as a place for confession and absolution. Seeing the supervisee as a victim, at least in part, is an easy step, as are rescue fantasies.

- **Supervisor as Authoritarian Parent:** Many professionals who violate boundaries have a long-standing resentment of authority and a rebellious streak which is easily triggered in some settings. In supervision they can bring about an authoritarian response from the supervisor. In the case of those with a history of self-destructive and masochistic relationships they may pity themselves sufficiently to bring on frustration in the supervisor eventually leading to some punitive interaction.

- **Supervisor as Corruptible:** Practitioners who have trouble managing boundaries in general will challenge the supervisory boundaries. To the degree that they can undermine these boundaries they may show that even the supervisor has problems with boundaries.

Transference and countertransference may occur in any supervisory relationship, but are especially likely in situations where the practitioner is forced into some sort of remedial supervision. These may parallel developments in the practitioner's therapeutic work with his/her client, or may be unique to the supervisory relationship. There may be a "parallel process" which can be discerned and used to explain the dynamics of what is happening, but this is not always the case. Believing that supervision can be accomplished by simply analyzing the dynamics of the supervisory relationship is naïve. There are many other factors one must take into account.

SUPERVISEE IMPAIRMENT & THE AMERICANS WITH DISABILITIES ACT:

This is not a topic for which there is a clear set of references. The law and I think general ethical standards require that where there is a disability, including a psychological one, the employer must make ***reasonable accommodations***. If someone can do the job with reasonable accommodations, then the accommodations should be made and the necessary adjustments in client load, supervision, etc. be made. By the same token, if the quality of client service cannot be maintained, or client safety might be compromised, then it is not necessary to keep someone on the job.

The Americans With Disabilities Act of 1990 includes a wide range of disabilities, but **excludes things such as current use of drugs (as opposed to a history of substance abuse) and sexual behavior disorders.** You may want to look at *Implications of the Americans with Disabilities Act for Psychology* (Bruyere & O'Keeffe, 1994).

When faced with a question of impairment in a supervisee, one has **a number of actions which can be taken to assess the situation:**

(1) a frank discussion with the supervisee concerning the apparent impairment and their view of how it is affecting their work;

(2) a review of selected work samples;

(3) requiring a release to have a discussion from their therapist, if they have one;

(4) a requirement that they be evaluated independently

(5) after # 3 or #4 above, setting up a game plan for ways of handling the impairment or disability:

- **a. some limitations on amount of work -- varying the workload;**
- **b. some change in caseload composition -- limiting work with certain types of cases;**
- **c. additional supervision;**
- **d. a change in the style or type of supervision;**
- **e. some sort of outpatient therapy;**
- **f. an inpatient therapy or evaluation;**
- **g. mandatory treatment for drug or alcohol abuse problems;**
- **h. post-treatment random urine screens for substance abuse;**

The key is that these interventions be aimed at trying to keep the person working without compromising client safety or quality of work.

THE NARROW LINE BETWEEN CONCERN & MIXING ROLES

With any supervision, but especially with clinical supervision, there is a need for the supervisor to be mindful of the personal adjustment and functioning of the supervisee. Problems in this area may require intervention for administrative or other purposes. A caring supervisor opens the door for the supervisee who is having problems and needs help. But, it is important to avoid shifting from supervision to doing some sort of supportive therapy with a supervisee. Having some understanding as to how their personal adjustment is affecting their work, or that it may dictate some change in duties, is important. But it must not be allowed to drift into provision of direct help or any undermining of administrative or supervisory duties.

CULTURAL ISSUES IN SUPERVISION

The topic of cultural issues in supervision is itself a full day program. Beyond the problems of racism and other types of bias, there are many practical issues in related to culture and supervision. To name a few:

(1) The supervisor's knowledge about the culture of the supervisee's clients -- especially as regards implications for diagnosis or treatment;
(2) Cultural differences regarding the manner in which feedback is given, relative to the culture of the supervisee;
(3) Special problems for ethnic workers in the community -- e.g. child abuse reporting & other mandates which may contradict cultural values;
(4) Understanding interpreters and how to utilize them.

SOME AREAS OF SUPERVISORY CHALLENGE

DEALING WITH TRANSFERENCE & COUNTERTRANSFERENCE

When there is undue anxiety about a case, or things are bogged down, the first duty is to rule out typical reasons for concern such as dangerousness, fear of suicidal thinking, etc. Then one might want to explore other dynamics between the staff member and client, or the possibility of some sort of a triangle in the treatment process. That is, a staff member reacting to the interaction between a staff member and client.

(1) Any particular feelings about this client – anything different about how you feel about them than the "average client"?
(2) Are there some particularly troubling things about the client – how he/she interacts with you?
(3) Does the client see you as similar to someone in their life – someone who is significant in their history, or in their current life?
(4) Does the client remind you of anyone in your past – or current life? Looks? Style? The way they interact?
(5) Any fantasies or strong feelings – positive or negative about them?

THE HIGH RISK SITUATION: THE SUICIDAL CLIENT

Studies of stressors on clinicians usually rate suicidal clients as among the top three stressors on practicing counselors. See the attachment **A High Risk Situation: The Suicidal Client.**

REPORTING DUTIES & EXCEPTIONS TO CONFIDENTIALITY

Child abuse & neglect, vulnerable adults, duty to report professional misconduct, and other reporting duties are the most frequent challenges that supervisees bring to supervisors. It is critical for supervisors to have readily available reference materials and to have updated knowledge in this area. Supervisees should be required to have copies of relevant statutes and to "do their homework," thus using the supervisor to double-check their decisions.

As regards the reporting of professional impairment or misconduct, as required by Minnesota

Statutes, there is a serious challenge. Based on CFR 42 and the Federal Law, no staff member in a substance abuse program is authorized to breach the client's privacy to make a report to a State Board. The only exception granted relates to Child Abuse reporting. Ironically, the licensure statute for alcohol and substance abuse counselors require that they follow these standards even if they don't apply. It is hard to see how a counselor could make a report to a board without violating both state and federal law.

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." See the attachment ***Personal Relationships With Former Clients or Patients.***

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.

THE HIGH RISK SITUATION: CLIENTS WHO ARE DANGEROUS TO OTHERS

See the attachment ***Dealing With Dangerous Clients and the Threat of Violence.*** Perhaps the greatest challenge in the area of client dangerousness is the encouraging of supervisees to come forward and discuss situations where they themselves are at risk. Many situations are not true "duty to warn or protect" cases but require a response including one which may breach privacy. Guidance and even direct requests may be necessary regarding the documentation, and the supervisor at times may want to do some documentation of his or her own.

SUPPORT IN CASES OF STALKING OR ASSAULT BY CLIENT

See the attachment ***Dealing With Dangerous Clients and the Threat of Violence.*** If your supervisee is working in a drug abuse evaluation or treatment unit, there is an authorization [section 2.12(c)(5) of the federal rules] to **contact a law enforcement agency when a client has committed or threatened a crime on program premises or against program personnel**. However, disclosure is limited to: (1) suspect's name & address; (2) last known whereabouts; (3) the fact that he/she is a client of the program. **Bear in mind that this would apply to harassment and stalking.** Otherwise, in general, remember these key rules:

(1) Stalking and harassment are generally <u>not</u> confidential -- only how you know the identity of the client;

(2) Obtain consultation & document it; document all incidents;

(3) With consultative help, attempt to get the behavior to stop via:

> **(a) Direct request by the supervisee;**
> **(b) Administrative demand by supervisor or agency director;**
> **(c) Cease & Desist Letter from an attorney or prosecutor;**
> **(d) Police intervention.**

SUPPORT IN CASES OF HARASSMENT OF THE SUPERVISEE

The supervisor may be the only person who is aware of the pressure the supervisee is feeling. It is often important that this be shared with other staff. While sexual harassment is the focus of most rules and laws, general harassment or conduct which "puts down" another staff member undermines the credibility of the organization. If it is witnessed by a client or patient, it may also undermine care.

DISPUTES BETWEEN STAFF

Supervisors may be called upon to mediate disagreements between staff. Understanding organizational dynamics is very important. There are times when an outside consultant can make a difference and when it would be good to bring in someone who can play this role rather than to try to settle the disagreement. There is a narrow line between disputes that can be settled as issues between people and significant issues in functioning on the job. There are times when individual workers need to be evaluated in terms of their ability to function in a given role.

WHEN HELPING HURTS

The sources of tension and stress in the workplace are often multiple. One has to differentiate between problems people bring into the workplace versus those created by work stress. High levels of job demands and little control over one's work can lead to work stress. Many times, however, "burnout" is caused by a combination of workplace stress and problems that people bring into the workplace. William White's (1997) **The Incestuous Workplace** provides a good overview of some of these dynamics.

RESOURCES

As the list of references illustrates, there are a growing number of texts which discuss supervision methods, boundaries, and ethical/legal dilemmas in counseling & psychotherapy. There are some which also propose evaluative structures for training programs, including internships and supervision. (e.g. Robiner, 1998A & 1998b; Robiner, Fhurman, & Bobbitt, 1990). Discussions of handling impairment in students are also finding their way into the literature (e.g. Forrest et. al., 1999; Schoener, 1999).

There are a few videotapes which can be helpful. Some tapes such as **Subtle Boundary Dilemmas** (Hazelden, 1995) and **Crossing the Line: When Professional Boundaries Are Violated** (National Council of State Boards of Nursing, 1998)**,** which are aimed at counselors or nurses but which illustrate situations in which supervisors become involved in cases of boundary crossings by supervisees.

There are four videotapes focused on supervision. Two come from the Social Work Program at the University of St. Thomas and the College of St. Catherine in St. Paul, Minnesota: **Boundary Dilemmas in Supervision** (Peterson, 1992) and **Challenges in Cross Cultural Supervision (**Kaiser, 2000). They illustrate a number of supervisory issues. Another tape from the field of social work, **Clinical Supervision Guide,** was developed for the Virginia Board of Social Work Examiners and is now distributed along with a

written guidebook by the National Association of State Social Work Boards (Munson, 1995a & 1995b). The American Psychiatric Association has produced a videotape entitled **Issues in Psychotherapy Supervision** but it cannot be purchased. It can be borrowed from a District Branch of the APA assuming that branch has a copy. The field of counseling has also produced a tape on supervision issues: **Learning to Think Like a Supervisor** (Borders et. al., 1999) which is distributed by the Association for Counselor Education and Supervision of the American Counseling Association.

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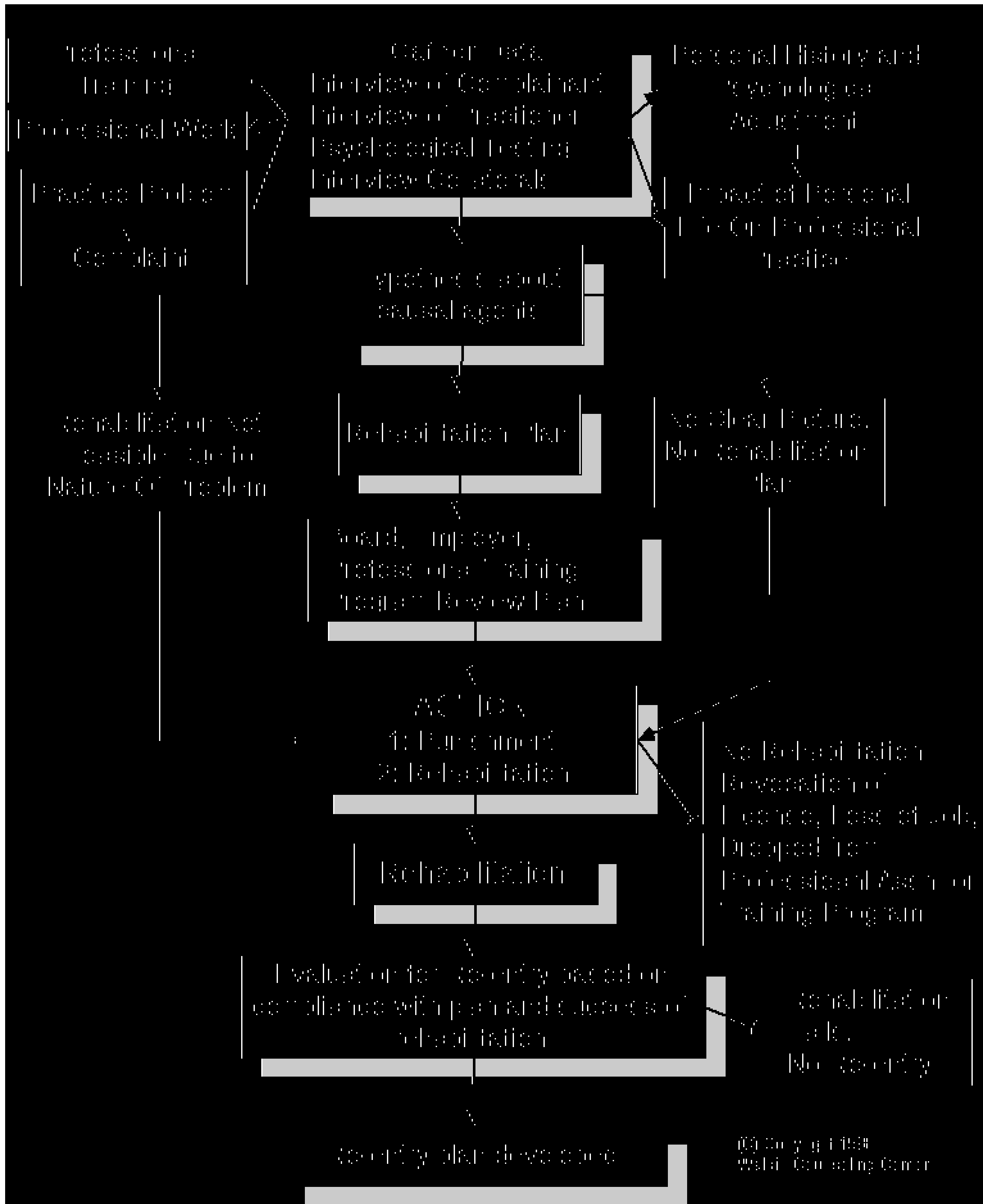
OVERVIEW OF ASSESSMENT OF IMPAIRED PROFESSIONAL



A HIGH RISK SITUATION: THE SUICIDAL CLIENT

Gary R. Schoener

Background:

In the year 2002, 31,655 people in the United States died by suicide – that is 11 out of every 100,000 Americans. Suicide was the 11th leading cause of death in the U.S.—more than died from either homicide or AIDS. 90% of suicides occur in association with mental health problems (including substance abuse and alcoholism). **50% who die by suicide are struggling with major depression, and the suicide rate of people with major depression is eight times that of the general population.**

- **Three times as many women attempt suicide as men –**
- **But men are four times as likely to die by suicide than women**
- **Death by suicide has typically been more common among Caucasians than any other group, but in 2006 the rates for African Americans caught up, largely due to a climb in rates for young African American males**
- **Suicide is the 3rd leading cause of death for Americans between the ages of 15 – 24**
- **Suicide is the 2nd leading cause of death for Americans between the ages of 25 – 34**
- **Elderly people who die of suicide are often divorced or widowed and suffering from physical illness**

Evolving State of Knowledge:

Although much has been written about suicide during the past forty years and there has been considerable research world-wide, this does not mean that the field of suicidology or suicide prevention is a static field. The reality is that new perspectives and models continue to evolve. For example, the ***New England Journal of Medicine*** recently published an excellent article by David Bent & J. John Mann entitled "Familial Pathways to Suicidal Behavior – Understanding and Preventing Suicide among Adolescents." (v. 355, pp. 2719-2721 – Dec. 28, 2006) which is available at **http://content.nejm.org/cgi/content/full/355/26/2729**

Practice Challenges:

Studies of stressors on clinicians usually rate suicidal clients as among the top three stressors on practicing clinicians. There are ethical issues, boundary issues, and legal risks in such cases. As in so many challenging issues of practice, these elements all interface and are not always easily separated.

As with all ethical dilemmas, the initial challenge is to determine: **How urgent is the situation?** Decisions, for example, about breaching confidentiality in order to try to protect the client and prevent a suicide are based on the degree to which the matter is urgent. You may be dealing with your own clients' potential for suicide, and that will vary with your role. The **Suicide Prevention Resource Center** website (**http://www.sprc.org**) allows for the printing out of customized guides to suicide which are designed for a variety of roles and professions. Some areas for consideration are as follows:

1) **Competence to Assess Risk:**

   (a) **There is a ethical duty to have periodic training or updating on this;**

(b) **You should have available texts or manuals relative to judgment of suicide risk so that you can have a quick refresher**
(c) **Assessing risk in children/adolescents vs. adults**

2) **Access to appropriate consultation in a timely fashion:**

(a) **There is an ethical duty and practice challenge to have this in place before trouble happens;**
(b) **You should always have a back-up consultant or two in case your primary consultant is not available.**

3) **Competence to provide appropriate management for the chronically suicidal client (the ethical duty is to have appropriate training and any tools available): Many professionals are not equipped to do this and need to be prepared to refer their client to someone with this specialty. Dialectic Behavior Therapy (DBT) is rapidly becoming the treatment of choice for those who are chronically suicidal.**

4) **Deciding when to breach confidentiality in order to prevent an imminent suicide (Legally not permitted or authorized by CFR 42 covering substance abuse work, but from an ethical perspective the duty to preserve life would seem to dictate action if the threat is imminent. Whereas the "duty to warn" or protect others from clients has often been the subject of laws and rules, strangely suicide has often not been the focus although it is far more common.) This can involve any of the following:**

(a) **Contacting the client at home or work to follow-up on concerns**
(b) **Contacting, without a release, other service providers to alert them to the risk or to obtain additional information**
(c) **Contacting a family member or third party to alert them to the risk and ask for their assistance in intervention.**
(d) **Having the police intervene and/or pursuing an emergency hold to involuntarily hospitalize the client.**

5) **Review of the situation in the event of an attempt or completion. If the client dies, a full review with an effort to understand why and how the suicide happened is worthwhile. It is sometimes called a *Psychological Autopsy.*** This is helpful clinically in terms of sorting out what can be learned, but it is also helpful to the clinician trying to process what happened.

6) **Assistance to other clients, students, and affected parties. A suicide can have considerable impact on other clients, other staff, families, etc.** This may be done in an individual session, or a group meeting

7) **Self care for the practitioner after a suicide attempt or completion: this is mostly a supervisory duty – that is to insure that the practitioner has had any assistance needed to be able to deal with the impact on him or herself.** There is a website which is a project of the Clinician Survivor Task Force of the American Association of Suicidology which has a bibliography and annotated references, personal accounts, and clinician contacts. A web address which can access this unique resource is: **http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm**

8) **Reconsideration of practice parameters after a death of a client: the professional, and any supervisor, needs to consider whether any adjustment in practice is dictated by the impact of**

the suicide or suicide attempt.

9) **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.

General Factors Predicting Suicide Risk in European-Descended 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 important person in one's life increases the risk, both acutely and on a longer term basis**
(9) **Serious health problems and pain can increase the risk, especially when chronic**
(10) **Loss of a job and unemployment increase the risk**
(11) **Risk is higher for those coming out of a depression or recently released from hospital care for depression**

Common Errors in the Handling of Suicidal Clients:

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, 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.

Another common error is over-reliance on a client promise to not kill themselves. While useful in some clinical settings, there is no clear evidence that they actually work. There is nothing wrong with asking for such a contract, but the clinical and forensic opinion on this is that they are no better than the quality of the relationship with the client. There is a case in Illinois where a counselor and agency were faulted by a regulator for not having a "no suicide" contract with a client who made a serious attempt. However, the use of such contracts is not necessary to meet the standard of care.

A special problem is the handling of members 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 read verses from the Qu'ran (Koran) and to pray.

In all cultures a personally humiliating event can be a precipitant for a suicide. 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 man who falls in love and cannot afford a dowry is at risk.

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. Furthermore, with a Somali, for example, feelings of hopelessness are not as serious as feelings of worthlessness. Religion is a protective factor, but cannot always be utilized by the health care practitioner. With Moslem clients a referral to a Sheik for an Islamic intervention may be very important. In the case of Hmong or other southeast Asians the family or clan may be essential if intervention is to be effective.

Bear in mind that many old assumptions are changing. For example, the death rate from suicide for Hispanic women was previously quite low. In recent years, however, in Texas, the data shows that an increasing number of Hispanic women have begun using a lethal means – handguns – and their death rate has increased substantially.

A number of professionals who testify in wrongful death cases and who have opined on risk management now consider it essential to question clients carefully about the presence of guns in the home. They note that some gun-owners will not consider a gun as a "weapon" or at least will not consider a hunting rifle a "weapon" so that it is important to specifically inquire about **guns of any type.** Well-known forensic psychiatrist Thomas Gutheil indicated in a workshop in 2006 that even if the suicide was not via firearm, if the clinician had not screened for the presence of guns in the home, he generally will not take the defense side in a wrongful death case. **Screening for the presence of guns as part of a clinical intake or risk assessment is now considered the standard of care by a number of experts.**

Guns & Suicide in the United States

The New England Journal of Medicine has recently (Sept. 4, 2008) published an article by Matthew Miller and David Hemenway entitled "Guns and Suicide in the United States" (v. 359, pp. 989 – 991) which compares suicide rates in states with the highest rates of gun ownership (Wyoming, South Dakota, Alaska, West Virginia, Montana, Arkansas, Mississippi, Idaho, North Dakota, Alabama, Kentucky, Wisconsin, Louisiana, Tennessee, & Utah) with the states of lowest rates of gun ownership (Hawaii, Massachusetts, Rhode Island, New Jersey, Connecticut, & New York). For men the states with highest gun ownership have 3.7 times as many suicide deaths as the states with low rates of ownership. For women, the ratio is 7.9 times as many suicide deaths.

This article suggests learning about strategies to limit access to lethal means of suicide such as guns and directs professionals to the website of the **Harvard Injury Control Research Center** at www.hsph.harvard.edu/means-matter The article also provides some recent research citations and ends with the admonition: **Effective suicide prevention should focus not only on a patient's psychological condition but also on the availability of lethal means – which can make the difference between life and**

death.

The College Campus

There has always been a challenge concerning the suicidal student on a college or university campus. Such persons are typically of the age of majority and thus have full rights to their privacy, and yet they are often still supported by their parents and seen as sons and daughters who are not yet independent.

The challenge is whether to contact parents in the event of a significant emotional problem and/or suicidal thinking or potential. Parents often expect this even though according to both law and codes of ethics since the student is an adult legally the threshold is quite high for a situation to require the breaching of confidentiality.

This situation has become controversial enough to rate a front page story in the **Wall Street Journal.** Published in the Saturday/Sunday Weekend Edition for March 24-25, 2007 (Vol. CCXLIX, No. 69, pages A 1, A 6 & 7), the story was entitled "After a Suicide, Privacy on Trial" by Elizabeth Bernstein. It examined the outcome of a jury trial in a wrongful death case brought in 2003 by the parents of Chuck Mahoney who took his own life in a fraternity house at Allegheny College in Meadville, Pennsylvania.

Among the claims in the case were that Allegheny College officials should have, among other things, breached their son's confidentiality to get them involved in the situation. Since 1974 the FIRPA (Family Educational Rights and Privacy Act), which protects the privacy of educational records, has allowed school officials to contact parents in the event of an emergency situation (health or safety related). Furthermore, the release used at the college made it clear that in the event of an immediate threat to the client or someone else that confidentiality can be broken.

The College did have a waiver that students can sign to allow communication with parents, but Chuck had not signed it nor had his parents pushed him to sign. Present in the case were the usual dynamics of the privacy of a young man vs. the desire of parents to be helpful. In this case there were a number of consultations among school officials and mental health professionals and the professionals were concerned that breaking the confidentiality could lead to a very negative response.

The jury voted 11-1 for the defendants. According to the story:

> **In interviews, many jurors said that as an adult, Mr. Mahoney was responsible for his own actions. They believed his parents should have recognized how sick their son was after he was hospitalized, and that they had a responsibility to make sure he signed the waiver form that would have freed the school to more easily share information. "If I am flipping the bill for college, you are signing the waiver," says Tom Yoder, 43, a tool-and-die maker. The lone dissenting juror, Barbara Collins Zurovchak, felt the suicide warnings required action. "I believe that safety must trump privacy," the retired high school teacher says.** (Bernstein, 2007, p. A 7)

In 2002 MIT settled with the parents of Elizabeth Shin who set herself on fire in a dorm room in 2000. On the other side are cases in which colleges try to pressure students to take leaves of absence when they become troubled. Currently the dispute over this practice rages, with several successful suits against universities under the Americans With Disabilities Act (ADA). Some schools are requiring that troubled students get counseling and pressuring them to do so. Many who do kill themselves are not in any sort of counseling or therapy.
In 2007 the terrible mass killings at Virginia Tech University led to considerable national discussion and to

an investigation as to how college officials handled the situation. In general the conclusions were that while campus police should have alerted the campus community to the situation earlier, it is possible that nothing would have prevented the killings.

Although there have been newspaper editorials trying to second-guess the situation and noting that various privacy laws and rules prevented some communication from service providers to the college, there is no convincing evidence that such communication would have made a difference. The reality is that a very troubled young man – who had been referred for and received help of various types – ran amok and killed a number of people. As tragic as this was, I have seen no convincing argument that somehow we should change our laws, rules, or ethical concepts as to the balancing of privacy with duties to warn or intervene.

The Virginia Tech events are a stark reminder of the challenges which colleges and universities have in dealing with young adults who are having breakdowns. Furthermore, issues of access to care and some challenges in providing community mental health services seem as critical as does the balancing of privacy rights with safety.

WEBSITES & INTERNET:

The internet has a huge body of resources for learning more about suicide and suicide prevention, including:

- **Suicide Prevention Resource Center:** **http://www.sprc.org** – Among the many resources on this site are a set of customized manuals for various types of people from teens to clinical social workers. You can download and print out a primer for a number of types of professionals.
- **American Association of Suicidology**: **http://www.suicidology.org**
- **American Foundation for Suicide Prevention:** **http://www.afsp.org**
- **National Center for Injury Prevention and Control:** **http://www.cdc.gov/ncipc/** -- part of the Centers for Disease Control and Prevention
- **National Suicide Prevention Lifeline**: **http://www.suicidepreventionlifeline.org/** Toll – free phone for information to providers at (800) 273-TALK (8255)
- **Suicide Prevention Action Network USA**: **http://www.spanusa.org** Dedicated to leveraging grassroots support among suicide survivors (family members who have lost a loved one)

VIDEOS & TRAINING FILMS:

The Suicidal Patient: Assessment and Care. Developed by the American Foundation for Suicide Prevention & Kingsley Communications in 1999, this is available from the American Foundation for Suicide Prevention at **http://www.afsp.org/survivor/doctor.htm**

BOOKS, MANUALS, & ARTICLES:

- American Academy of Child & Adolescent Psychiatry (2001). Practice parameter for the assessment and treatment of children and adolescent with suicidal behavior. **J. of the Amer. Acad. of Child & Adol. Psychiatry**, 40 (7 Suppl), 24S – 51S (members of the Academy can obtain the full text from the Academy website: **http://www.aacap.org**

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There is a growing concern, reflected in professional literature & public media, about suicides in young people who are on anti-depressant medications. While not fully understood, in some the suicide risk may increase while on anti-depressants. The exact risk-related parameters are not clear. This is an evolving issue.

DANGEROUS CLIENTS & THE THREAT OF VIOLENCE

Gary R. Schoener

A Wisconsin Case

In their regular 4 PM appointment, an experienced psychologist was listening to his client escalate into angrier and angrier talk. He was becoming violent. The man had a history of violence, but had been on medications for years. Once his family took on the duty of monitoring his medication compliance, there had been no more trouble with angry outbursts and assaults.. But something had changed. The psychologist began thinking about the Wisconsin "duty to warn" standards.

This was a major mistake. The man suddenly arose, taking the psychologist by surprise, and began to strangle him. After a terrible fight, both were knocked out. The psychologist awoke first, called 911, and the police came. Finding that the client was dead, they held the traumatized psychologist at gunpoint and transferred him under guard to a hospital to get care for his 37 stab wounds (from a letter opener which was on the desk. The prosecutor then spent months whether to charge the psychologist with murder.

In the meantime, horribly traumatized, the psychologist's life was threatened by the man's sons who vowed to kill him. Things shifted when the autopsy revealed no trace of medications in the blood stream. Apparently the medication monitoring had either stopped or been ineffective. The psychologist has severe PTSD and is disabled in terms of any work with clients.. He moved to another state. His advice is:

Remember that in such a situation knowing the legal standards for "duty to warn" is far less important than protecting yourself. You are the closest potential victim. Worry about yourself – not "third parties."

Following this advice, let us start with the issue as to your own safety. First rule is to not worry about legal standards for third-party warnings or other secondary issues. **Focus on your vulnerability and your safety first**.

(1) Have a policy in your office about signaling emergencies, and that staff are authorized to call into your office during a session or to interrupt with a knock on the door if they hear anything which is worrisome in terms of safety;
(2) Remember that you can break the client's angry "set" any number of ways. For example, you can suddenly say something like, "Oh, my goodness, I forgot to tell my receptionist that…." and pick up the phone and call someone.
(3) You can exit the office under a similar pretext or with "I'm terribly sorry, but I have to run to the bathroom …… I'll be right back ….. please excuse me but nature calls…."
(4) Try to not have potential weapons in sight – scissors, letter openers, etc. should be in drawers;
(5) The best seating arrangement is one where you can go to the door without tripping over the client. It is also good for them to be able to exit easily and neither should be "trapped"

WHEN YOU OR YOUR STAFF ARE THE TARGET OF STALKING OR ASSAULT BY A 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). We don't have data on alcohol and substance abuse treatment programs, but there is no reason to believe that they are any different.

When counseling professionals seek police assistance, 100% report it is helpful. When they talk with colleagues, only 60% do. What do we do wrong when a colleague tells us about stalking or harassment by a client?

There are some excellent resources on the internet, and I would highly recommend Mullen, Pathe, & Purcell (2000) -- **Stalkers and Their Victims.** An updated edition of this book is due out in November (2008). Also useful is **Stalking: Perspectives on Victims and Perpetrators** (Davis, Frieze, & Maiuro, 2002).

For drug abuse evaluation or treatment programs, there is an authorization [section 2.12(c)(5) of the federal rules] to **contact a law enforcement agency when a client has committed or threatened a crime on program premises or against program personnel**. However, disclosure is limited to: (1) suspect's name & address; (2) last known whereabouts; (3) the fact that he/she is a client of the program. **Bear in mind that this would apply to harassment and stalking which are crimes in most jurisdictions.**

Otherwise, in general, remember these key rules:

(1) Stalking and harassment are generally <u>not</u> confidential -- only how you know the identity of the client & the fact that they are a client are confidential;

(2) Obtain consultation & document it;

(3) Document all incidents, but typically have this in an administrative file – the client file, typically, should only contain a note that stalking or harassment have occurred;

(4) With consultative help, attempt to get the behavior to stop via:

> **(a) Direct request by the supervisee;**
> **(b) Administrative demand by supervisor or agency director;**
> **(c) Cease & Desist Letter from an attorney or prosecutor;**
> **(d) Police intervention.**

(5) Follow directions of law enforcement and other experts

RESPONSIBILITIES TO PROTECT PERSONS OTHER THAN YOUR CLIENT

Long before the ***Tarasoff case*** it was known that professionals had some duties to protect others which supersede their duties of confidentiality owed to their client. Many such situations involved either an accident resulting from impaired driving, or a direct assault by a person following discharge from a hospital.

Certainly most of us would acknowledge a ***moral duty to preserve life***, and few would argue that the client's privacy is more important than the life of another person. From a classical ethical analysis, this might relate to whether the principle of ***justice (welfare of persons other than your client)*** is more important than the principle of ***autonomy (your client's right) in a given situation***. However, there are complications here:

(1) First of all, it is well-acknowledged that health care professionals cannot reliably predict violence. In fact, the standards for action typically apply when you believe that you have received a serious threat of harm. Typical "duty to warn" statutes do not have standards for assessing risk – just that the professional has come to a conclusion the situation is dangerous.

(2) Secondly, the focus of all the attention is not that one undertakes a professional intervention – it is that one contacts either an intended victim or law enforcement or both – a lay solution. This is not a professional technique or method.

AN APPROACH TO THIS CHALLENGING PROBLEM.

Focus should be on (1) perceived dangerousness of your client, (2) the urgency of the situation, and (3) your intervention options. The true "duty to warn" situation as defined in statutes and/or case law is actually quite rare.

HOW URGENT IS THE SITUATION?

If it is imminent that harm will occur, you must act. If a serious threat is not immediate, then you should have time to obtain consultation and to plan your actions.

DO YOU HAVE TIME TO OBTAIN CONSULTATION?

If you do, obtain it and document it. If you do not, then do what you need to do and document it.

INTERVENE USING PROFESSIONAL SKILLS & TOOLS

Try to defuse the anger through ventilation, try to dissuade client from violent solutions, ask for permission to discuss the situation with significant others, attempt to get client to give up weapons or to put away weapons and ammunition. If in a family session, help family seek solutions.

WITH A MINOR THE PARENT, GUARDIAN, OR SCHOOL MAY BE KEY

Remember that the duty to warn or protect standards and case law are predominately focused on an adult client. When the client is a minor, their privacy rights are attenuated and the parent or guardian holds authority to intervene. If the parents are the intended victim, this is even more critical. Other times a school or other institution may have some potential control over the situation, and could also be the potential target.

CONTACT THE POLICE FOR AN EMERGENCY HOLD

An emergency hold can be placed by a police officer who has reason to believe that the client is mentally ill, developmentally disabled, or chemically dependent AND a danger to self or others. The hold is for up to 72 hours and the requirements are similar to those for involuntary commitment. Don't try to detain the person yourself.

IF DANGER IS VERY HIGH AND THERE ARE NO OTHER OPTIONS CONTACT THE POLICE AND/OR INTENDED VICTIM

Whichever has the best chance of preventing the harm.

THE *TARASOFF* CASE – HOW IT ALL STARTED

In the fall of 1967 Prosenjit Poddar came from India to attend the U. of Calif. at Berkeley. The following fall he met and fell in love with Tatiana (aka Tanya) Tarasoff whom he met at folk dancing classes. He sought an intimate relationship with her but she said "no." Her rebuff helped trigger a severe emotional crisis -- he was depressed, weepy, and withdrawn. His friends were concerned

Poddar's emotional adjustment reportedly improved during the summer of 1969 when Tanya went to Brazil, and friends convinced him to seek counseling. He sought treatment at Cowell Memorial Hospital, an affiliate of the U. of Calif. at Berkeley, and after seeing a psychiatrist for intake began therapy with a psychologist, Dr. Lawrence Moore.

During a therapy session on Aug. 18, 1969 he told Dr. Moore that he intended to kill Tanya when she returned from Brazil. Two days later Dr. Moore consulted with Drs. Gold and Yandell, psychiatrists, and they agreed that Poddar should be involuntarily committed. (This occurred only two months after the passage of the commitment law and both law enforcement and mental health professionals were inexperienced in its use.)

Dr. Moore asked the campus police to pick up Poddar, and followed up with a letter indicating that he was undergoing an acute and severe paranoid schizophrenic reaction and that he was a danger to others. The campus police detained Poddar but did not commit him, judging that he appeared rational and given the fact that he promised to avoid Tanya. The director of the psychiatry department asked the police to return Dr. Moore's letter, ordered that the case notes be destroyed, and ordered that no more attempts be made to commit Poddar.

Tanya returned home, unawares of any potential danger from Poddar. Poddar, meanwhile, had convinced Tanya's brother to share an apartment with him -- only a block from Tanya's residence. On Oct. 17, 1969, Poddar went to her house to speak with her, but she refused. He became insistent and she screamed, at which point he shot her with a pellet gun. She attempted to flee but he caught her and repeatedly stabbed her with a kitchen knife, killing her. He then returned to the house and called the police.

In his trial, Poddar used an insanity defense but was convicted of second degree murder. However, the verdict was reversed on appeal based on an error by the judge in his jury instructions. Poddar was released and returned to India. Forensic psychiatrist Alan Stone (1976) reported that Poddar claimed in a letter to be happily married after his return to India.

The Tarasoff family sued, arguing that the professionals had failed in two duties: (1) duty to commit and (2) duty to warn Tanya. The California Supreme Court issued an opinion in 1974, but reviewed its own decision and issued a second one in 1976 which superseded the first. This is often called *Tarasoff* II and it is the definitive ruling. The defendants were exonerated on the commitment issue, but found to have failed in a duty to warn her of the danger.

VandeCreek & Knapp (2001) note that **such a duty was not new in tort law, citing earlier cases against psychiatric hospitals.** A number of these dealt with things such as failing to warn patients being discharged that the medications they were prescribed would not mix well with alcohol. The patient in such cases then went out, drank, and had a car accident. **However, *Tarasoff* extended this duty to outpatient care**. Brooks (2005) discusses its application in substance abuse programs.

STATUATORY GUIDANCE

Nearly half of the states have enacted statutes which define the responsibilities of professionals for potential dangerous acts by their clients towards third parties. Chapter 380 of Minnesota Statutes went into effect on August 1, 1986. This statute created **a duty to warn of or take reasonable precautions to provide protection from violent behavior threatened by a psychotherapy client.** The original law covered <u>psychologists, school psychologists, nurses, chemical dependency counselors, and social workers who are licensed or who performed psychotherapy within a program licensed or established in connection with a state statute</u>.

However, although this statute referred to a number of professions, it was actually part of the Psychology licensure law. In 1996, as part of a "housecleaning bill" from the Board of Psychology, a change was made limiting the application of this section to licensed psychologists. This left some ambiguity as to the nature of

the duty for other professionals.

In 2001, as a result of an effort by the Minnesota Chapter of NASW, the Minnesota legislature passed and the governor signed a bill into law Minnesota Statutes 2000, Section 148B.281 to include social work licensees and their clients in section 148.975. So, as of 1 August 2001, both social workers and psychologists have the same protection, although other mental health professionals do not.

Psychologists **and social workers (as of 2001)** are also protected against **any cause of action** arising out of their good faith efforts to discharge this duty. The law specifically protects them from liability for "disclosing confidences to third parties", and other liabilities such as if your warning an intended victim resulted in that person doing harm to your client. Other counseling professionals would have a good defense in such cases, but not the statutory protection.

So, for psychologists and social workers licensed in Minnesota, or other Minnesota - licensed professionals seeking some guidance, the basics of the current Minnesota Statute are presented in the box below.

The threat must be:

(1) a serious specific threat of harm.
(2) against a specific, clearly identified victim

When in the professional's opinion both of the above conditions are present, the duty is to make reasonable efforts to communicate the threat to:

(1) the potential victim, or
(2) if unable to make contact with the potential victim, to the law enforcement agency closest to the potential victim or the threatening client.

DANGEROUSNESS AND CIVIL COMMITMENT

The issue of dangerousness can be examined from the perspective of civil commitment standards. One option for addressing dangerousness is civil commitment. In fact, the *Tarasoff case,* as noted earlier, grew out of a failure to properly execute an emergency civil commitment. The original suit filed by the Tarasoff family alleged a failure to commit, but the court ruled that there was no such course of action. Although it is not required, civil commitment is a commonly used tool when a client is deemed to be dangerous and have a likelihood of violence. "Danger to self or others" is the universal requirement for an involuntary detention or commitment.

SUBSTANCE ABUSE EVALUATION & TREATMENT PROGRAMS

Although the focus of attention has been on social workers, psychologists, and psychiatrists, **alcoholism and substance abuse counselors are often in a position to learn of potential violence. Should they receive a threat of violence that they believe to be credible, they are thought by many to have the same duty as psychotherapists who work with mental health clients.** Twenty three percent of reported *Tarasoff* cases, examined in one study, involved clients with a history of alcohol or drug abuse (Egley & Ben-Ari, 1993).

The substance abuse counselor is generally working for ***a program*** which comes under the requirements of

42 Code of Federal Regulations (CFR) based on the Drug Abuse Prevention, Treatment and Rehabilitation Act (42 U.S.C. 290). While limited to "federally assisted" drug abuse treatment programs, it includes any program which receives ***any*** funds from a unit of government (local, state, federal), through direct funding or payments from Medicaid, Medicare, Social Security, or state treatment funds. ***This also includes any non-profit which is tax exempt*** (the feds argue this is "assistance"). This law and rules ***do not authorize*** breaking confidentiality based on a state law or professional mandate to warn of intended violence. Thus far only one ruling has addressed this potential conflict between state law and federal law (**Hasenie v. United States, 541 F. Supp. 999, D.Md.1982)** and that concluded that the federal rules take precedence.

It has been suggested by some that the federal rules might be circumvented to some degree if the counselor **does not reveal that the person is a client of a drug abuse treatment or assessment program. I do not see how this is lawful.** However, as a practical matter there are a few other options:

> **(1) If the client is a minor who is applying for admission to the program, and you ask them for a release to share the information with their parent or guardian, if you do not believe that he/she is using good judgment in denying permission, you can contact the parents with your concerns about the violence potential.**
>
> **(2) If the client commits a violent act on premises or threatens to do so to staff of the program, it is permissible to contact law enforcement under the existing rules. (Note that this does NOT permit contact with the potential victim -- only law enforcement.)**
>
> **(3) If the client is in a criminal-justice connected program with a standing release to talk to a probation officer or some other correctional official, one can talk to the authorized parties.**

WHAT ABOUT CLIENTS WHO ARE MINORS?

The issue of clients who are minors is different from the typical case which is discussed as a "duty to warn" situation. First the privacy rights of minors are less than those of adults, so that the professional is obligated to release information to the parent or guardian. Even in a state like Minnesota where a minor who has special rights due to having born a child, been married, or who is living away from home and managing their own finances, ***there is a presumed authorization to contact parents or guardian*** ***if the failure to do so might harm the child***.

This does not mean that there are not important issues to examine in such cases. **The treatment contract with the minor – especially with an adolescent – needs to be considered in terms of not only any promises of privacy but the nature of the relationship. As with the *Tarasoff* case, undermining the treatment relationship can bring about harm in the long run because it removes the professional's best tools and the ability to help.**

THREATS MADE DURING SESSIONS WITH THE INTENDED VICTIM IS PRESENT?

Unfortunately, the codes of ethics and available law do not specify that the threat needs to be *latent -- that is, not known to the intended victim*. So, if the threat occurs during a session when the intended victim is present, I would recommend the following:

> **(1) Draw the intended victim's attention to the threat in case they missed it.**
> **(2) Indicate that you hear it as a serious threat and hope that the intended victim takes it seriously, and takes whatever precautions seem in order.**
> **(3) Document clearly in your notes that you carried on this discussion.**

The duty when the threat is not latent is unclear, but in circumstances when the intended victim does not seem to be taking it seriously, one can easily argue that there is a duty to try to impress upon them the risk that you perceive. Then one can engage in the discussion of “safety plans.”

A FINAL WARNING

There is a tendency for professionals to focus on legal standards for taking action. However, standards set out in case law, statute, and codes of ethics rarely address the complex situations we find ourselves in from time to time. **First and foremost is to consider what might be the best clinical response to the situation. If it is an urgent situation the specifics of legal standards are not the main issue.**

Situations of "creeping dangerousness" are far more common than true "duty to warn" situations in which a failure to act quickly could have fatal results. **Most of the time we need to be focused on what is occurring and how we intend to intervene clinically. Obtaining consultation and identifying and considering options are usually the best route for the appropriate handling of a volatile situation.** The central task in such situations is to prevent or diffuse harm while not losing the working relationship with the client (Binder & McNiel, 1996; Knapp & VandeCreek, 2003)

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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</u>

therapy was terminated before sex began, the offending practitioner tended to receive the same penalty as for 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 148.A** 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 IN VARIOUS PROFESSIONS

[As described in the Code of Ethics for that profession.]

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."

COMPLIMENTARY & ALTERNATIVE HEALTH CARE PRACTICES

Since 2000 the State of Minnesota has created regulatory authority over unlicensed *complimentary & alternative health care practitioners.* These include, but are not limited to, acupressure; anthroposophy; aroma therapy; ayurveda; cranial sacral therapy; culturally traditional healing practices; detoxification therapy; folk practices; healing practices utilizing food, food supplements, nutrients, and the physical forces of heat, cold, water, touch and light; Gerson therapy and colostrums therapy; healing touch; herbology or herbalism; homeopathy; non-diagnostic iridology; body work, massage, and massage therapy; meditation; mind-body healing practices; naturopathy; noninvasive instrumentalities; and traditional Oriental practices, such as Qi Gong energy healing.

Such practitioners are forbidden to have sex with clients during treatment, **or for two years following the termination of treatment.** These fields, otherwise, do not have clear standards in their codes of ethics in terms of post-termination relationships with clients. A massage therapist, LaRae Fjellman, challenged this when the state board took action against her when she married a former client. The state backed off after the Minn. Civil Liberties Union entered the case. On 15 November 2007 it was announced that she and the Associated Bodywork and Massage Professionals (ABMP) have sued to have that requirement dropped. The 2008 legislature has changed the law so that there is no longer such a standard.

MARRIAGE & FAMILY THERAPISTS:

Since 1 Aug 1988 the American Assn. for Marriage & Family Therapy has **forbidden sex for 2 years after termination or the last session. This applies to either spouse or any family member who is seen in even a single session of marital or family therapy.** Needless to say, ending up romantically involved with the spouse or former spouse of a client who came to you for help with a troubled relationship is likely to generate serious distress and upset. If the spouse has attended a single session or spoken to the therapist on

the phone there is a clear-cut duty to the spouse in most jurisdictions. The same is true of family therapy where a therapist ends up involved with a member of the family after therapy ends.

In the revised Code which went into effect on 1 July 2001, there is an additional standard for post-termination situations: ***Should therapists engage in sexual intimacy with former clients following two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client or to the client's immediate family.*** It would appear that retrospective upset caused to a former spouse of the former client might therefore be sufficient for an ethical complaint.

MEDICINE -- NON-PSYCHIATRIC PHYSICIANS:

Both the American Medical Association (AMA) standard and the general standard of care in U.S. for a non-psychiatric physician-patient relationship require **a discussion with patient about implications (e.g. that they can't be a patient again -- they can't have both a doctor and a lover), and termination of the professional relationship with referral to another physician**.

Although not explicitly stated, **cancellation of all medication prescriptions and having them rewritten by the new physician is advisable** since physicians are generally prohibited from writing prescriptions for persons who are not their patients. There are a number of cases where charges have been brought of sex with a client due to the fact that a physician has written several prescriptions for the former client after care was terminated.

If non-psychiatric physicians are engaged in psychotherapy or counseling related to emotional issues, the psychiatric standards (below) are recommended by the American Medical Assn. So the family practitioner, pediatrician, or even the surgeon who engages in counseling and diagnosis of depression, for example, would do well to keep this in mind.

MEDICINE -- PSYCHIATRISTS:

After having various standards for a number of years, the American Psychiatric Assn., in 1993, went from a "nearly never OK" standard to **an absolutely "never OK" standard** (although an article after the debate spoke of the burden being on the psychiatrist to show that the case was an exception, implying that there might be some sort of a loophole). The American Medical Assn. has indicated that where there was psychotherapy in the doctor-patient relationship, this more stringent standard should be used. **So, if a psychiatrist or any physician who is doing psychotherapy has evaluated or treated someone, it is never possible to have sex with that client, no matter how much time has elapsed.**

NURSING:

American Nursing Assn. (ANA) ethics code **does not deal with post-termination involvement with clients.** Where there is not a psychotherapeutic relationship, the situation is less clear and it would appear that it might not be unethical for a nurse to have a sexual relationship with a former client for whom they provided non-mental health services. As regards **psychiatric or mental health nursing**, **where there is a psychotherapeutic relationship, the nurse can expect to be held to a standard similar to that of other mental health professionals.**

In a document published in January 1994, entitled ***STATEMENT on Psychiatric-Mental Health Clinical Nursing Practice and STANDARDS of Psychiatric-Mental Health Clinical Nursing Practice*** (ANA Council on Psychiatric & Mental Health Nursing, American Psychiatric Nurses Assn., Assn. of Child &

Adolescent Psychiatric Nurses, Society for Education & Research in Psychiatric-Mental Health Nursing) **forbids intimate or sexual relationships with current clients, and indicates that the nurse "avoids sexual relationships" with former clients and "recognizes that to engage in such a relationship is unusual and an exception to accepted practice."**

PASTORAL COUNSELORS:

The American Association for Pastoral Counseling **prohibits sex for two years following termination of the counseling relationship**. For clergy in counseling roles any extra-marital sex is generally forbidden, even after termination of the counseling relationship, by denominational rules, canons, or expectations. This may be under a denominational sexual abuse or misconduct policy or because it is considered adultery or behavior unbecoming a pastor.

PROFESSIONAL COUNSELORS:

For a number of years the American Counseling Association (ACA) had standards similar to psychology. However, with the 2005 Revision of the ACA Code of Ethics the rules for at least professional counselors who are members of the ACA have a stricter set of limitations than professions other than psychiatry. The section of the ACA Code which is relevant reads as follows:

A.5.b. Former Clients. Sexual or romantic counselor-client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether thee is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship.

PSYCHOLOGY:

The American Psychological Association (APA) started with an unclear standard in the 1970's and early 1980's. A standard was developed in June 1987 that terminating a professional relationship in order to have sex was unethical although even this was not incorporated into the Code at that time. In its revised Code of Ethics in 1992, the APA created **an absolute prohibition for two years following termination of therapy. Even in relationships which begin after 2 years the psychologist has the burden of showing there has been no exploitation, in light of "relevant factors, including the seven listed below:**

> **(1) the amount of time that has passed since therapy terminated,**
> **(2) the nature and duration and intensity of the therapy,**
> **(3) the circumstances of the termination,**
> **(4) the patient's or client's personal history,**
> **(5) the patient's or client's current mental status,**
> **(6) the likelihood of adverse impact on the patient or client and others, and**
> **(7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the client.**

None of the seven points listed above page is elaborated upon or the subject of any explanatory notes in either the 1992 revision or the 2002 revision so no real guidance is offered as to what the expectations are or what the framers of the code thought were the relevant standards in each of these seven areas. The seven

points listed above do not constitute clear-cut "yardsticks" nor do they provide any specific guidance. For example, to say that the amount of time is relevant does not explain how much longer than 2 years would be acceptable. The same is true for vague factors such as “the circumstances of the termination,” or for that matter any of the items on the list.

The December 2002 revision of the code, which became effective 1 June 2003, made virtually no changes, except the addition of the term "intensity" under point (2) above. This does not appear to be a substantive change, and again it is not defined so its interpretation is unclear.

In the APA code a few standards are provided for terminating. For example, the provision that unless precluded by the client's conduct or other factors the psychologist discusses the patient's or client's views and needs, provides appropriate pre-termination counseling, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately.

The 2002 revision of the APA Code allows for compliance with requirements of health plans which may not permit, or not provide coverage for termination sessions. (Although the code does not explicitly deal with the issue of payment, the issue is normally payment-related -- not an outright prohibition on a termination session.) The 2002 revision is also expanded to include not only behavior of the client/patient which might justify termination, but the conduct of others associated with the client/patient. This would be a reference to harassment of the psychologist.

SOCIAL WORK:

For years there was no clear & explicit ban on sex with former clients. The National Federation of Societies for Clinical Social Work have for some years banned initiation of relationships with former clients "...whose feelings toward them may still be derived from or influenced by the former professional relationship." **The new NASW code now prohibits sex with former clients in section 1.09, but states that if a social worker claims an exception, the full burden is on them to demonstrate "...that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally." The code also bans sexual contact with clients' relatives or close personal friends where there is a potential to harm the client. It is not clear whether this extends to former clients' relatives/friends.**

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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