Ethical and Legal Issues Update

Colleen M. Peterson, Ph.D.

Why Ethics CEUs?

- Nevada was one of the last in the nation to require ethics CEUs
- Board's job is to protect the public
- Nevada has relatively few ethics complaints
- CEUs help keep clinicians current and prevent complacency/casualness in practice

Responsibility to Be Aware of, Monitor, and Correct/Improve Self

- Ethical Code codified in the NAC 641A for MFTs
  - AAMFT Code of Ethics

    Principle III – Professional Competence and Integrity

    3.1 MFTs pursue knowledge of new developments and maintain competence in MFT through education, training or supervised experience

    3.3 MFTs seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

Responsibility to Be Aware of, Monitor, and Correct/Improve Self (cont.)

- Ethical Code codified in the NAC 641A for CPCs
  - NBCC Code of Ethics

    A.7 – Certified counselors recognize their limitations and provide services or use techniques for which they are qualified by training and/or supervision. Certified counselors recognize the need for and seek continuing education to assure competent services.

    A.13 – Certified counselors are accountable at all times for their behavior. They must be aware that all actions and behaviors of the counselor reflect on professional integrity and, when inappropriate, can damage the public trust in the counseling profession. To protect public confidence in the counseling profession, certified counselors avoid behavior that is clearly in violation of accepted moral and legal standards

Responsibility to Be Aware of, Monitor, and Correct/Improve Self (cont.)

- ACA Code of Ethics
  - Section C – Professional Responsibility Introduction

  “ ... Counselors engage in self-care activities that to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.”
  - C.2.f

    “ Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity.”

Overview

- Review important elements of maintaining ethical practice (Ethical Decision Making Models)
- Update on some ethical practices (suicidal clients, children, practice will)
- Self-care
- Small group discussion with some vignettes

Ethical Decision Making

- What is ethical decision making?
- Why is it so important?

Kitchener Model of Ethical Decision Making – Four Processes

- Interpreting a Situation as Requiring an Ethical Decision
- Formulating an Ethical Course of Action
- Integrating Personal and Professional Values
- Implementing an Action Plan

Keith-Spiegel and Koocher Model – 7 Steps

- Describe the Parameters
- Define the Potential Issues
- Consult Legal and Ethical Guidelines
- Evaluate the Rights, Responsibilities, and Welfare for All
- Generate Alternate Decisions
- Enumerate Consequences of Each Decision
- Estimate Probability for Outcomes of Each Decision
- Make the Decision

Beauchamp and Childress Model

- Identify competing ethical principles
  - Autonomy: Promote self-determination
  - Nonmaleficence: Do no harm
  - Beneficence: Promote good
  - Fidelity: Act with integrity
  - Justice: Promote Fairness

(Adapted from Beauchamp, T., & Childress, J. [1994] *Principles of biomedical ethics, 4th ed.* Oxford: Oxford University Press – original adaptation by Daniel C. Claiborne, Ph.D.)

Beauchamp and Childress Ethical Decision-Making Model (cont.)

- Implement Strategy
  - Secure additional information
  - Identify special circumstances
  - Rank ethical principles involved
  - Consult with colleagues/supervisor

Beauchamp and Childress Ethical Decision-Making Model (cont.)

- Prepare for Action
  - Identify desired outcomes
  - Brainstorm actions
  - Identify competing non-ethical values or requirements
  - Test designated action
    - Universality: Could this step always be recommended?
    - Publicity: What if this action becomes public?
    - Justice: Is this action fair for all involved?

Current Research/Thought on Suicidal Behavior

- Psychological Theories
- Risk Assessment and Treatment Planning
- Treatment

Shneidman, 1996

- Developed the first major psychological theory of suicide
- Father of suicide prevention in the U.S.
- Posited that suicidal behavior had a purpose, and that it is an attempt to escape from unendurable psychological pain – “psychache”

Ten Commonalities of Suicide (Shneidman, 1996)

- Common purpose of suicide is to seek a solution
- Common goal of suicide is cessation of consciousness
- Common stimulus for suicide is unbearable psychological pain
- Common stressor in suicide is frustrated psychological needs
- Common emotion in suicide is hopelessness-helplessness
- Common cognitive state in suicide is ambivalence
- Common perceptual state in suicide is constriction
- Common action in suicide is escape
- Common interpersonal act in suicide is communication of intention
- Common pattern of suicide is consistency of lifelong styles

What produces suicidal behavior? (Joiner, 2005)

- Human beings do not easily come to an act of final, lethal, self-destruction
- For most, the fear of death is stronger than any other motivation
- Individuals are not born with the capacity for lethal self-injury and pain
- People who die by suicide have to work their way up to it – lose their natural fear of death
- Fear is reduced through a form of practice involving repeated desensitizing exposure (suicide attempts)

What produces suicidal behavior? (Joiner, 2005) – (cont.)

- Both suicidal desire and suicidal capacity must be present before a suicide occurs
- He argues that there are those who want to die by suicide but can't, as well as those who can but who don't want to
- Unique contribution is the recognition that people must acquire the capacity to enact lethal self-injury
- Emphasizes the role of perceived burdensomeness and failed belongingness as suicide risk factors

Treatment Planning with Suicidal Persons (McKeon, 2009)

- Identify the pain (psychache)
- Assess risk and protective factors
- Estimate risk level from risk and protective factor information
- Distinguish between acute and chronic risk levels
- Resolve contradictory risk factors
- Determine whether risk and protective factors can be modified
- Target interventions to lower risk or increase protective factors

Risk Factors for Suicide (McKeon, 2009)

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, borderline personality disorder
- Alcohol and other substance use disorders
- Hopelessness
- Impulsiveness and/or aggression
- Trauma and abuse
- Previous suicide attempt (efforts to prevent discovery and regret upon survival convey additional risk)

Risk Factors for Suicide (McKeon, 2009) (cont.)

- Relational or job loss
- Access to lethal means
- Social isolation
- Perceived burdensomeness
- Difficulty in asking for help
- Barriers to accessing health care, particularly behavioral health care

Protective Factors – the Oft Neglected Part of Suicide Risk Assessment

- Often the mirror image of risk factors
  - Social connection
  - Reaching out in a suicidal crisis
  - Cultural and religious beliefs

Suicidal Risk (McKeon, 2009)

- Is not static
- Can fluctuate greatly over time
- Maintaining awareness of time dimension is critical
  - Misperception that suicide risk can be eliminated during hospitalization (it can be reduced, but rarely eliminated)
  - Period following discharge from the hospital has been shown to be a high risk time for suicide)

Guidelines for Documenting Suicide Risk (McKeon, 2009)

- Lethality of recent attempt
- Past suicide attempt history
- Degree of suicidal intent
- Availability of means, including firearms
- Presence of a plan, and degree of planning
- Regret versus relief in response to survival
- Presence of continuing suicidal ideation including frequency and intensity

Guidelines for Documenting Suicide Risk (cont.)

- Availability of social/family support
- Family history of suicide Presence of active psychotic symptoms
- Presence of major depression and/or hopelessness or anhedonia
- Perturbation, anxiety or agitation
- Alcohol/drug involvement
- Impulsivity

Safety vs. No-Suicide Contracts (McKeon, 2009)

- Despite the lack of evidence to support their efficacy as a prevention technique, the use of No-Suicide Contracts is widespread
- No-Suicide Contracts provide a straight forward technique for making a complex, clinical judgment, a judgment often fraught with anxiety and uncertainty (if the client signs then out-patient; if not, then involuntary hospitalization)
- Although the No-Suicide Contract may reduce a clinician's anxiety, it may have too much influence in clinical decision making
- No Suicide Contracts may inadvertently encourage concealment by clients

Safety vs. No-Suicide Contracts (McKeon, 2009) (cont.)

- Refusal to sign a contract does not mean a client is in imminent danger, not does agreement mean that risk is lessened
- In Minnesota, no-suicide contracts were in place for almost every suicide that occurred in an in-patient, acute care facility (2002)
- Other studies have also found that a significant number of those who attempted suicide or died by suicide had no suicide contracts in place at the time of the suicidal act (APA, 2003)
- Real value in safety plan

Components of Safety Planning (McKeon, 2009)

- Provision of emergency phone numbers to call when feeling suicidal
- Removal of potentially lethal means, such as firearms
- Involvement of family, significant others, or friends for support
- Promote alternate coping techniques

Family Involvement Checklist

- Educate regarding suicide
- Discuss patient-specific warning signs
- Restrict lethal means
- Assure accessibility after hours
- Address perceived burdensomeness
- Enhance connectedness/reduce isolation

Treatment for Suicidal Behavior

- Initial, collaborative treatment planning session
- When a client does not engage in early treatment, and drops out, it is important for the therapist to reach out and re-connect
- Provide phone availability outside of scheduled sessions
- Restriction of lethal means

Dialectical Behavioral Therapy (DBT)

- Evidence-based therapy for reducing risk of suicidal behavior
- DBT skills training
  - Mindfulness
  - Interpersonal Effectiveness
  - Emotional Regulation
  - Distress Tolerance

Professional Will

A Professional Will is a plan for what happens if you die suddenly or are incapacitated without warning

Executor of Professional Will

- Designated executor to assume primary responsibility to carry out tasks in will
- Second and third designee, each ready to step in if necessary (primary out of town or unavailable)

Elements of Professional Will

- Know where important information is located (e.g.. appointment book, records)
- Introduce to people they will need to work with (secretary, accountant, attorney, office landlord, etc.)
- Office information (address, keys, security codes)
- Avenues of communication with clients (answering machine, e-mail, and passwords)
- Client records and contact information

Elements of Professional Will (cont.)

- Client notification (calling clients, notice in newspaper, changing messages, sending letters)
- Colleague notification (list of who to notify – group practice, co-facilitators of groups, supervisees, etc.)
- Liability coverage (contact information, policy number, etc.)
- Billing records and procedures
- Legal review of will
- Copies to possible executors and attorney

AAMFT Code of Ethics Principle I – Responsibility to Clients Multiple Relationships

Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately

AAMFT Subprinciple 1.3

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

AAMFT Subprinciple 1.4

- Sexual intimacy with clients in prohibited.

NBCC Code of Ethics

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

NBCC Code of Ethics

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

NBCC Code of Ethics

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

ACA Code of Ethics

- A.5.a – Current Clients

Sexual or romantic counselor-client interactions or relationships with current clients, their romantic partners, or their family members are prohibited

ACA Code of Ethics

- 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 interaction or relationship can be viewed as exploitive in some way and/or whether there 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.

ACA Code of Ethics

- A.5.c – Nonprofessional Interactions or Relationships (Other than Sexual or Romantic)

Counselor-client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client.

ACA Code of Ethics

- A.5.d – Potentially Beneficial Interactions

When a counselor-client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (where feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community.

Multiple Relationship Terms

- Multiple Relationship
- Boundary
  - Boundary Crossing
  - Boundary Violation

Multiple Relationship (MR)

- A situation in which the therapist functions in roles associated with a professional relationship with the client and also assumes another definitive and intended role that is not inconsequential or a chance encounter.
- The MR may be concurrent or consecutive
- It involves a professional role and another non-professional role.

Professional Boundary

- A frame or limit that demarcates what in included or excluded from the therapeutic relationship.
- Specifies what is allowed and what connotes a safe connection in order to meet client needs.
- Boundaries regulate where the therapist ends and the client starts

Boundary Crossing

- A non-pejorative term that indicates a departure from an accepted clinical practice that may or may not be harmful to the client.
- Not all boundary crossings are harmful, and therefore not violations.

Boundary Violation

- A departure from clinical practice that places the client or therapeutic process at risk.

Power

- Related to the construct of boundaries
- The ability to influence another person or events
- Potential to be both helpful and harmful to those involved
- Unequal power, or a power differential, is what can be problematic

8 Types of Non-sexual MRs (Anderson & Kitchener, 1996)

- Personal or Friendship Relationship
- Social Interactions and Events
  - Circumstantial
  - Intentional
- Business or Financial Relationship
- Collegial or Professional Relationship
- Supervisory or Evaluative Relationship
- Religious Affiliation Relationship
- Collegial or Professional plus Social Relationship
- Workplace Relationship

Prevalence of MRs (Stanley, 2001)

- Largest category of Ethics violations with AAMFT members had to do with MRs (40%)
- 65% of MR ethical violations with AAMFT members involved sexual or romantic attraction and behavior

Foundational Principles for Boundary Regulation in Therapy (Smith & Fitzpatrick, 1995)

- Abstinence – therapists refrain from self-seeking and personal gratification in the therapeutic process
- Neutrality – therapists focus on the client's agenda and refrain from unsolicited personal opinions in therapy
- Independence & Autonomy – clinicians strive to foster the client's independence and autonomy

Psychodynamic Theory – Rational for the Avoidance of MRs

- Transference and Counter-transference
- Often-unconscious role the therapist has in the client's fantasy life
- Part of therapy is to work through issues from the past, most often with powerful authority figures or caregivers
- Sometimes this process leads to client having tender or erotic feelings toward the therapist, not due to the therapist per se but rather because of the context of therapy
- Transference does not end with termination of therapy, therefore they can never have a relationship of equality

Role Theory and MRs – What Makes Them so Problematic? (Kitchener, 1988)

- As the incompatibility of expectations increases between roles, so will the potential for misunderstanding and harm
- As the obligations of different roles diverge, the potential for divided loyalties and loss of objectivity increases
- As the power and prestige between the professional's and the consumer's roles increase, so does the potential for exploitation and an inability on the part of the consumers to remain objective about their own best interests

Effects of MRs

- In a study of clients who had sexual relationship with their therapists, 90% reported that they experienced adverse effects (Houhoutsos et al., 1983)
- Therapist-Patient Sex Syndrome (Pope, 1988) – symptoms similar to those of sexual abuse, child abuse, PTSD, Battered Spouse Syndrome, and Rape Response Syndrome

Therapist-Patient Sex Syndrome Characteristics (Pope, 1988)

- Ambivalence
- Feelings of guilt
- Sense of emptiness and isolation
- Sexual confusion
- Impaired ability to trust
- Identity, boundary, and role confusion
- Emotional lability
- Suppressed rage
- Increased suicidal risk
- Cognitive dysfunction

Call to Embrace the Complexities of MRs

- Some argue that MRs provide therapists and clients the opportunity to enlarge their capacity for more complex human interaction
- Post-modern approaches which emphasize the importance of the therapeutic relationship being collaborative and egalitarian and which minimize or deny therapist power
- Based on belief that it would be safer to humanize and democratize the relationship than to fortify therapists with professional expertise and higher authority
- By being human and engaging with clients in a variety of ways, the therapist's power advantage is lessened
- By having more information about the therapist, a client has more power

Controversies on Boundary Issues (Lazarus, 1998, 2001)

- The general proscription against MRs has led to unfair and inconsistent decisions by state licensing boards, brought sanctions against therapists who have done no harm, and sometimes impeded optimal work with a client
- Some well-intentioned ethical standards can be transformed into artificial boundaries that result in destructive prohibitions and undermine clinical effectiveness.
- Some MRs can enhance treatment outcomes
- Focus on potential advantages, rather costs/risks

Unavoidable MRs

- Rural communities
- Small communities
- Minority groups
- Religious leaders/religious settings

Ethical Model for Avoiding Exploitative MRs (Gottlieb, 1993)

Low Little or no personal relationship or Persons consider each other peers	**POWER** **Mid-Range** Clear power differential present but relationship is circumscribed	**High** Clear power differential with profound personal influence possible
Brief Single or few contacts over short period of time	**DURATION** **Intermediate** Regular contact over a limited period of time	**Long** Continuous or episodic contact over a long period of time
Specific Relationship is limited by time externally imposed or by prior agreement of parties who are unlikely to see each other again	**TERMINATION** **Uncertain** Professional function is completed but further contact is not ruled out	**Indefinite** No agreement regarding when or if termination is to take place

Boundary Factors in MRs (Gutheil & Gabbard, 1993)

- Time – if clinicians are considering unusual adaptations to the beginning or ending of sessions, they should exercise caution because this indicates a susceptibility to crossing a boundary.
- Place & Space – if clinicians are considering doing home visits, meeting over lunch, or giving a client a ride home, they should exercise caution as well.
- If there is a clear therapeutic directive, it is important that the therapist document the rationale and professional literature supporting their approach.

Slippery Slope Phenomenon (Gabbard, 1994)

- One of the strongest arguments for carefully monitoring boundaries
- Based on premise that certain actions will lead to a progressive deterioration in ethical behavior
- If therapists don't adhere to rigid standards, then they may foster relationships that harm clients.
- To avoid going down a slippery slope, therapists are advised to have a therapeutic rationale for every boundary crossing and question behaviors in relation to their theoretical approach

Bartering

- Before bartering is entered into, both parties should talk about the arrangement, gain a clear understanding of the exchange, and come to an agreement
- Also important to discuss the problems that might develop and examine alternatives
- Clear dollar for dollar exchange in value

Giving or Receiving Gifts

- AAMFT Code of Ethics, Subprinciple 3.10

Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

Giving or Receiving Gifts (cont.)

- ACA Ethics Code (A.10.e)

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and the counselor's motivation for wanting or declining the gift.

Working with Children (Leslie, 2008)

- Parental Consent
- Be aware of custody status of parents
  - Legal custody
  - Physical custody
  - Joint or sole legal custody
  - Joint or sole physical custody
- Joint custody means that both parents share in the right and responsibility to make decisions related to the health, education, and welfare of a child
  - This does not mean that both have to sign an authorization related to the child's treatment, but that either can sign the authorization form

Working with Children (cont)

- Best practice if there is a custody situation, is to inform both parents of treatment
- Unless parental rights have been severed, parent has a right to know what is going on in treatment
- Issue is when one parent does not want child in treatment – what happens then?
  - Legal battle
  - Parental alienation syndrome
  - What is in the best interest of the child?

Stress in the Mental Health Profession

- Therapy can be a stressful profession
- Commitment to self-exploration and facilitating clients' self-exploration can be very difficult
- Therapists can be deeply affected by clients' pain
- Client's painful memories can activate therapists' own pain

Radeke and Mahoney (2000)

"Persons considering a career in psychotherapy should be informed that it will be likely to result in changes in their personal lives. Their development may be accelerated, their emotional life may be amplified, and they are likely to feel both stressed and satisfied by their work."

Stress Caused by Being Overly Responsible

- Clients' lack of progress
  - Not helping clients be responsible for their own therapy – barrier to client empowerment
  - Explore this with clients
- Experience clients' stress as their own
  - Signs – irritability, emotional exhaustion, feelings of isolation, substance abuse, reduced personal effectiveness, indecisiveness, compulsive work patterns, drastic changes in behavior, and feedback from friends or partners.

Stress

An event or series of events that leads to strain, which often results in physical and psychological problems.

Assessing for Stress

- To what degree do I recognize my problems?
- What steps am I willing to take to deal with my problems?
- What strategies am I practicing to manage my stress? (Meditation, time management, relaxation training)
- How am I doing at taking care of my personal needs in daily life?

Assessing for Stress (cont.)

- Do I recognize the warning signs/symptoms that I am in trouble?
- Do I listen to feedback from others (family, friends, colleagues) that stress is impacting me?
- Am I willing to ask for help to manage my own stress?

Stressful Client Behavior (Deutsch, 1984 and Farber, 1983)

- Suicidal statements (most stressful)
- Anger/hostility/aggression toward therapist
- Apathy/depression/lack of motivation
- Agitated anxiety
- Premature termination

Other Sources of Stress (Deutsch, 1984)

- Being unable to help distressed clients feel better
- Seeing more than the usual number of clients
- Not liking clients
- Having self-doubts about the value of therapy
- Having professional conflicts with colleagues
- Feeling isolated from other professionals

Other Sources of Stress (cont.)

- Over identifying with clients and failing to balance empathy with appropriate professional behavior
- Being unable to leave client concerns behind when not at work
- Feeling sexual attraction to a client
- Not receiving expressions of gratitude from clients

Burnout

State of physical, emotional, intellectual, and spiritual exhaustion characterized by feelings of helplessness and hopelessness.

“Index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will – an erosion of the human soul” (Maslach and Leiter, 1997).

Therapist Decay (Corey, Corey & Callanan, 2007)

- Absence of boundaries with clients
- Excessive preoccupation with money and being successful
- Accepting clients beyond one's level of competence
- Absence of camaraderie with friends and colleagues

Therapist Decay (cont.)

- Living in isolated ways, both personally and professionally
- Failure to recognize how they are being affected by clients' issues
- Unwilling to avail themselves of personal therapy when experiencing personal distress

Impairment

- Presence of an illness or severe psychological depletion that is likely to prevent a professional from being able to deliver effective services and results in consistently functioning below acceptable practice standards.
- Impaired therapists are unable to effectively cope with stressful events and are unable to adequately carry out their professional duties, which raises ethical and legal issues.

Impairment (cont.)

- Therapists focus on the problems of others, yet often fail to attend to their own needs and pay little attention to the effect of their profession on them
- They sometimes avoid the effects of their work on their families
- Being a therapist has both advantages and liabilities for one's family life (need to minimize liabilities and maximize advantages)
- Let go of professional role while at home

Personal Characteristics Associated with Impaired Functioning (Benningfield, 1994)

- Lack of empathy
- Loneliness
- Poor social skills
- Social isolation
- Discounting the possibility of harm to others
- Preoccupation with personal needs
- Justification of behavior
- Denial of professional responsibility to clients/students

Self-Assessment (Benningfield, 1994)

- Is my personal life satisfying and rewarding?
- To what degree am I taking care of myself, both physically and emotionally?
- Would I be willing for other therapists I respect to know about my professional conduct and decisions?
- Can I acknowledge and disclose my mistakes?
- Am I generally consistent in my practice?
- Do I think about or fantasize about a relationship that goes beyond being a professional with some clients or students?

Codes of Ethics on Professional Impairment

- AAMFT (3.3)

Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

- ACA (C.2.g)

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment and, if necessary, they limit, suspend, or terminate their professional responsibilities, until such time as it is determined that they may safely resume their work.

Self-Care

- Sustaining the personal self is a serious ethical obligation
- “Maintaining oneself personally is necessary to function effectively in a professional role” (Skovholt, 2001).
- Self-care involves searching for positive life experiences that lead to zest, peace, excitement, and happiness (Skovholt, 2001)
- The demands of professional work cannot be met if practitioners are not engaged in self-care.
- Is an ethical mandate, not a luxury

Feminist Therapy Code of Ethics (IV.E)

A feminist therapist engages in self-care activities in an ongoing manner outside the work setting. She recognizes her own needs and vulnerabilities as well as the unique stresses inherent in this work. She demonstrates an ability to establish boundaries with the client that are healthy for both of them. She also is willing to self-nurture in appropriate and self-empowering ways.

Factors of Therapist Wellness

- Self-awareness and monitoring
- Support from peers, spouses, friends, mentors and colleagues
- Values
- Balanced life that allows time for family and friends, not just work

Art of Caring for Self

- Helping professionals are experts at one-way caring, but there are dangers associated with that (Skovholt, 2001)
- Those who spend most of their professional time in caring for others need to acquire the art of caring for self

Self Care by Nurturing

- Emotional self
- Humorous self
- Financial self
- Loving self
- Nutritious self
- Physical self
- Playful self
- Priority-setting self
- Recreational self
- Relaxation-stress reduction self
- Solitary self
- Spiritual/religious self

Discussion

- Questions
- Vignettes

Vignette #1

Adult female with history of severe abuse in her background. You have been treating her for several months, working to empower her. She was physically assaulted, resulting in a trauma to the head and was treated at a local hospital ER. Client lists you are as emergency contact and the hospital calls and informs you of client's hospitalization. After client's release from hospital, you see her in session. At the end of the session, client becomes disoriented and exhibits memory loss.

What do you do as the therapist? Do you call emergency medical treatment? What do you tell paramedics if the client has memory loss and can't respond to their questions? What is your obligation to the client?

Vignette #2

Treating a 16 yo female client who has been having behavioral problems at home and at school. During course of treatment, client discloses that she has been sneaking out of the house at night and engaging in risky behavior with a false ID and older men (clubbing and having unprotected sex).

What is your ethical obligation? Do you inform the parents? What about the client's confidentiality with you? How do you move forward with treatment?