Ethics In Everyday Practice

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***Welcome*:**

My name is Jim Heisel. I have been a practicing social worker since 1981. I specialize with adolescents, substance abusers and couples/families. I have worked in inpatient and outpatient settings. I have been an adjunct instructor at the University of Cincinnati and Xavier University. I have had in independent practice since 1984. Since 1984 I have sponsored and performed professional workshops on a variety of topics within my areas of expertise. I have performed over 450 presentations and have performed in 17 different states to behavioral health and substance abuse treatment facilities, professional associations, and state and national conventions.

In all of my workshops I strive to be informative about current practice trends and to offer practical advice to enhance the participant's skill level and comfort with the material presented.

***Introduction*:**

I believe the purpose of educating professionals about ethics is to protect the public, protect the practitioner and protect the provider of services. To properly learn how to do this the participant in this workshop will be encouraged to pay attention to 3 important areas of knowledge:

1. **Ethical Principles and Standards**
2. **Practitioner Experiences, Beliefs and Skills**
3. **Client Expectations**

It is the professionals' responsibility to be aware of and adhere to the relevant *Code of Ethics* of the profession licensing them. All of the professions which provide behavioral health services – social workers, counselors, psychologists, marriage and family therapists, substance abuse counselors, rehabilitation counselors – require their licensees to be aware of, know and adhere to the ethical principles and standards set forth by the professions. If you doubt this is true I would urge you to consult the relevant *Code of Ethics* published by the National Association of Social Workers, the American Counseling Association, the American Psychological Association, or the American Association for Marriage and Family Therapy. You can reach each of their websites by typing in the relevant name in your web browser.

Practitioner experiences, beliefs and skills are the unseen material the professional person brings to the provision of services. Research indicates that many professionals have had experiences which influence their choice of profession, which influence their use of skills and comfort level with particular clients, and which motivate them to provide services.

Client expectations cannot be known ahead of time. Client expectations are a significant factor when a practitioner decides how to alter their behavior in order to be of assistance to people seeking help. It is for this reason that most practitioners go slow or display a limited range of behavior when they initially meet with clients. It is the reason I would recommend we not offer help until it is asked for. I believe that the single biggest reason for failure in service provision is the failure to "start where the client is at". We learn about client expectations through interaction with clients and we cannot know ahead of time what an individual thinks, feels or believes.

A Cautionary Note:

There is little about ethics which is "written in stone". You will not find in this presentation, nor in the texts cited at the end of this presentation, nor in the Codes of Ethics themselves exact descriptions for right and wrong behavior for every practice situation. Rather, you will find guidelines for ethical practice. In order to properly use the guidelines presented here you will have to filter everything presented through 3 filters: Setting, Role and Personality.

Setting refers to where you work. Where you work influences what clients expect of you and what is consider proper professional behavior. Working in a hospital is different from working in a homeless shelter. Working in a hospice is different from working in a high school.

Role refers to what you do. I believe that clients have attitudes about what it means to be a "case manager" vs. a "social worker" vs. a "therapist" vs. a "psychologist", etc. What we do changes how clients will allow us to act and how they allow us to conduct ourselves.

Personality refers to your unique experiences and beliefs. I believe clients watch us as closely as we watch them. They can pick up on our demeanor and style. I believe professionals exhibit as wide a range of behavior as clients do. The important factor for clients is whether we are being genuine. When we are being genuine I believe clients will accept behavior from us they might not accept from another professional who they do not perceive as genuine.

Important Beliefs and Assumptions:

Of the various professions which license providers of behavioral health services, we should note that each is heavily influenced by the "medical model". The medical model is method for understanding disease states and providing services. It is a model of understanding which has some built in assumptions. For example the medical model, which was created by physicians attempting to understand biological and chemical processes in our bodies, assumes that a particular disease has an etiology and normal course. Thus a practitioner of services could predict the course of a disease. This works very well with what are called the "magic bullet" diseases. These are diseases which have one cause and one cure. During the 20th century physicians were very successful using the medical model to develop cures for a variety of magic bullet diseases: mumps, measles, diptheria, small pox, plague, polio, etc. I believe it was for this reason that the status of physicians grew exponentially during the previous century.

Physicians also have the benefit of numbers. These numbers help citizens to determine whether they are healthy or not. Every time anyone visits a medical office of any kind they check 4 numbers. These 4 numbers are widely known by the public and widely accepted as indicative of normal health. We all know what these numbers are: 98.6, 120 over 80, 60-70 beats per minute, 22 breaths per minute. Behavioral health practitioners have few, if any, numbers. In the addictions field we have the number .01 or .008, but few people know what this number is or what it represents. (It the measure of alcohol content in the blood stream and the legal definition to determine driving under the influence [DUI].) In fact we struggle to describe for clients what constitutes mental health. We have an entire book of definitions of mental illness, but no real definition of mental health. I believe the public has no widely accepted beliefs about what is mental health that they can easily point to or use to determine who is acting ill and who is acting normal.

In the mid-20th century behavioral health providers accepted the medical model as useful for understanding mental health and behavioral problems. I believe we did this in part to gain some of the status of physicians and in part to gain access to third party payments. But it comes with some consequences which influence our understanding of ethics:

1. **The client is assumed to be sick. The provider is assumed to be well. This is a simple, but significant distinction. A host of ethical concerns flow from this distinction. Our understanding of personal boundaries, client responsibility**

and provider conduct are tied to this important assumption. In addition, the way we write case notes and gather information is influenced by this assumption.

2. **The client is assumed to be one person. Practitioners who practice family therapy usually feel they are treating the family system in addition to an identified patient. We should remember that one of our ethical principles is centered on the dignity of the individual. This can have a significant impact if clients become confused about who they believe the patient is.**

3. **Professionals are expected to think of the client/patient first. This can cause problems over financial arrangements and advertising. Some providers are providing a service within a business framework. I'm sure you can easily imagine how this could cause misunderstanding.**

The medical model is not the only model for understanding human behavior. Some people believe you can understand human behavior by understanding personal experiences. It is undeniable that we all have experiences which influence how we act and which stay with us throughout our lifetime. Traumatic experiences would be an example. Other people believe you can understand human behavior by understanding family relations. Again, it is undeniable that we all have family experiences which influence us. Some people believe you can understand human behavior by understanding large group experiences. We all know that we carry in us certain beliefs or traditions which serve to include us in some groups and to exclude us from others. Everyone seems to have an identification with one or more large groups. There are character traits which "Americans" share, just as other groups share other traits. These traits are often displayed or honored during moments of ritual when a historical experience is remembered or an especially important trait is reinforced. Some people focus on stress as a determinant of human behavior. They focus on stressful life events or life stages. Lastly, some people believe you can understand human behavior by understanding choices people make. In many religious or spiritual systems people are encouraged to adopt certain values or beliefs which influence the choices they make about how to treat others. One doesn't have to travel far in today's world to encounter many people who focus on choices, consequences of choices and responsibility for one's actions.

The importance of these assumptions cannot be overestimated. All of the ways of viewing human behavior mentioned above influence how providers function. Yet we must keep in mind that our ethical principals and standards flow directly from choices our various professions have made about what to value most.

Ethical Principles and Standards:

Ethical principles are the lofty beliefs a profession hopes to inspire its practitioners to adhere to. Ethical standards are the rules and guidelines a profession publishes

to guide practice and decision making, and by which the public can hold professionals accountable.

In all the Codes there are disclaimers which note that the Codes are not specific rules which prescribe behavior in all situations. As the *NASW Code of Ethics* says on page 2 "The Code offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the Code must take into account the context in which it is being considered and the possibility of conflicts among the Code's values, principles and standards."

The APA says on page 2 of its Ethics Code "The Ethics Code is intended to provide guidance for Psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action …."

All of the ethics codes adhere to a set of ethical principles and/or values:

Social Work	Counseling	Psychology	Marriage & Family
Service	Client Welfare	Beneficence & Nonmaleficence	Responsibility to Clients
Social Justice	Confidentiality	Fidelity & Responsibility	Confidentiality
Dignity & Worth of the Person	Professional Responsibility	Integrity	Competence/Integrity
Importance of Relationships	Relationship With Professionals	Justice	Responsibility to Students/Supervisees
Integrity	Evaluation/ Assessment	People's Rights and Dignity	Responsibility to Research Participants
Competence	Teaching/Training		Responsibility to the Profession
	Research & Publication		Financial Arrangements
	Resolving Ethical Disputes		Advertising

Ethical standards are more specific. They outline behavioral standards which professionals are expected to adhere to and can be the basis for disciplinary action if a professional violates them. It should be noted, as stated on page 2 of the APA code "Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct."

To go over all the ethical standards here is not necessary. (I would urge all participants in this workshop to obtain for themselves a copy of the relevant Code of Ethics which governs their professional conduct and familiarize themselves with it.) Rather, it is enough for us to identify certain types of behavior which all practitioners must take account of in their dealings with clients. (Later in the workshop I will return to some specific "hot button" issues in ethics.) My way of describing these common areas of concern is:

1. **Personal Boundaries**
2. **Relational Boundaries**
3. **Institutional Boundaries**
4. **Societal Boundaries**

Personal boundaries **are behaviors which have to do with our own beliefs, attitudes and history. They would include things such as:**

What kinds of client situations am I most comfortable with?
What kinds of client situations am I most uncomfortable with?
How much or how little touching am I comfortable with?
Am I starting where the client is at?
Do I have predetermined beliefs I feel I cannot change?
Is there conflict between my personal ethics and those of my client, the organization I work for, or the board which issues my license or certificate?
Do I have a standard speech I deliver to all clients which clarifies for the client boundaries on the services offered, time constraints on sessions or length of services, personal conduct, fees, etc.

Relational boundaries **are behaviors which happen between a worker and a client. They would include:**

Where you meet, when you meet, what time you meet, how long you meet.
Who is responsible for client change?
What services are offered to the client?
Sexual conduct
Confidentiality
Dual Relationships
Payment of fees; bartering; gift giving
Intervention strategies
Termination

Institutional Boundaries **are boundaries imposed by an organization on the workers or the worker/client relationship. They would include:**

Limits on services offered or limits on worker availability
Predetermined outcomes
Supervision

Record keeping
Worker education or training
Informed consent
Liability insurance
Duty to warn
Worker disability

Societal Boundaries **are boundaries imposed by licensing boards, governing bodies, funding sources or legislatures. They include:**

Behaviors which must be reported to authorities
Ethical rules for licensed or certified providers
Rules for reporting ethical violations
Educational requirements to become licensed or certified and requirements for maintaining a license or certification
Mandates for promoting outcomes
Disclosure statements

Practitioner Experiences, Beliefs and Skills:

The experiences, beliefs and skills of the practitioner of services must be considered when planning for protecting the public, protecting the worker and protecting the provider from potential ethical problems. The practitioner brings to the provision of services their own unique set of perspectives, abilities and blind spots. The client cannot know ahead of time what these are. Indeed, it is likely the client will not know what some of these are no matter how long they are engaged with the practitioner.

Practitioner Experiences and Beliefs:

It is common, though anecdotal, knowledge that some experience often motivates an individual practitioner to choose a service provision occupation. It is fair to say that most of us do not choose these professions for the high salary or high status because we rarely enjoy a high salary or high status with the public. What motivates practitioners can be a variety of things. For example a sensitizing experience, exposure to a person or situation which stimulates us, or religious or spiritual experiences can leave us with a desire to do something meaningful which does not carry with it large financial or status rewards.

When clients meet us they have no idea what these experiences or beliefs might be. I'm sure you have the same experience that I have had of clients asking "Are you married?", "Do you have children?", "Are you a Christian?", and other questions which represent client's attempts to gain some common ground with us just as we attempt to gain common ground with them. If you work in chemical dependency treatment it is not unusual for a client to ask if you are recovering. There is nothing unusual about people who don't know each other checking each other out with simple, direct questions about experiences or beliefs.

There are some experiences which clients are unlikely to ask about, but which can have a profound impact on the service provision process. For example, there is a 1992 survey by Pope and Feldman-Summers which asked male and female therapists if they had been sexually or physically abused during childhood, adolescence or adulthood. They asked respondents if they have been abused by a relative, a teacher, a physician, a therapist or a non-relative, and they asked if had been harassed, raped, sexually involved or experienced non-sexual physical abuse with this person. A total of 32.85% of male therapists and 69.93% of female therapists indicated they experienced some form of abuse during childhood, adolescence or adulthood. In another survey of therapists as therapy patients 61.5% of respondents indicated they experienced what they felt was clinical depression, 29% reported suicidal feelings and 3.5% reported attempting suicide. These findings cannot be used to make direct correlations to service provision, but they do alert us to the likelihood of sensitivity for some topics on the part of practitioners.

Some practitioners' experiences and beliefs are more oriented to a group than to individual issues. I have known practitioners working in the adoption field who were themselves adopted or had an adopted brother or sister. I have known practitioners who have told me they feel a special affinity for a group they identify with, usually an ethnic or religious group. Being sensitive to a particular group does not disqualify a practitioner from practicing with another group, but, on occasion, it can place limits on what a practitioner is comfortable with. We all know individual practitioners who have strong beliefs about war, abortion, mixed race adoptions, homosexuality, and a host of other issues. In theory, the mature practitioner should be able to emotionally and intellectually set aside their own beliefs in the service of someone else, but in practice this isn't always the case.

Practitioner Skills:

Just as clients cannot know ahead of time what practitioners have experienced or believe, they also cannot know what practitioners are good at. It is again a common, though anecdotal, belief that we treat best clients who are just like us. We all know that, as individuals, practitioners display a wide range of behavior. This includes insightful, touchy-feely, spiritual practitioners and intellectual, problem solving, goal-oriented practitioners. I believe that we are at our best when we are oriented to the client's needs and being genuine with our own behavior. I do not believe there is one correct way to perform as a practitioner.

Nevertheless, there is outcome research to support certain practitioner behaviors. Lambert and Ogles in their chapter "The Efficacy and Effectiveness of Psychotherapy" in *The Handbook of Psychotherapy and Behavior Change,* 5th Ed., 2004, Wiley and Sons, argue that there are common factors in service provision which are effective regardless of theoretical orientation. They state "It should come as no surprise that helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful

directions for their lives, can be greatly facilitated in a therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness and human wisdom. These relationship factors are probably crucial even in the more technical therapies that generally ignore relationship factors and emphasize the importance of technique in their theory of change." In simple terms this tells me that forming good relationships which emphasize trust, acceptance and understanding is a primary factor in helping others. I believe that clients can read our behavior just as we can read theirs. When we are being true to ourselves we come across as genuine even if we are quite different from other practitioners a client may have worked with.

We also engage in some behaviors as practitioners that are intense for ourselves and for our clients. We routinely talk with people about topics they do not generally share with others. These risky and intensely emotional encounters create feelings in clients and in ourselves which require that we exercise maximum discipline in our relationships. For example a national survey of 4800 psychologists, psychiatrists and social workers (Borys & Pope, 1989) found that 38.9% of respondents "discussed details of current personal stresses to a client". Another national survey of 1000 psychologists (Pope, Tabachnick & Keith-Spiegel, 1987) found that 56.5% of respondents said they have experienced "crying in the presence of a client" and 89.7% engaged in "telling a client you are angry at him or her". A third national survey of 600 psychologists (Pope & Tabachnick, 1993) found that 31.2% of respondents reported "feeling hatred toward a client", 87.3% of respondents reported "a client tells you that he or she is sexually attracted to you", 48.4% reported "a client seems to become sexually aroused in your presence" and 3.2% reported "a client seems to have an orgasm in your presence".

Needless to say we are engaged in some highly emotional relationships and we must manage them well. If we are at a vulnerable point in our own lives we are at risk for mistakes. Clients cannot know prior to meeting us where we are with our own lives, what experiences have shaped our outlook and what skills we emphasize as part of our service provision.

Client Expectations:

As stated previously, we cannot know what clients expect from us prior to meeting them. We cannot know what they may have heard from others, what they may have seen in the media, or what they may have experienced in prior encounters with practitioners. We cannot accurately anticipate what stereotype they may have of practitioners. We cannot know what they think they are supposed to receive or what they think the process of receiving services is supposed to be.

We have known for over 100 years that it is a good idea to start where the client is at, be positive, be non-judgmental and build on client strengths. This is easy when clients are just like us or have easily understood circumstances. This is far more difficult when the client believes things very different from ourselves, is suspicious

of us, has misunderstandings about what we offer or how we are supposed to act and/or doesn't see themselves as the client.

Figuring out what clients want, what motivates them and what they see as needing to change requires some important steps on our part. We have to be careful not to jump to conclusions. We may think we know what clients want. We may have educated guesses based upon our work with previous clients or our work in similar situations we have been involved in. We may have assumptions about certain types of clients, such as assuming clients on probation want to get off probation or clients suspended from school want to return to school. Even if we are right it is a good idea to let the client tell us, instead of assuming too much.

This leads directly to my recommendations for avoiding ethical problems.

Preventing Ethical Problems: Personal & Relational Boundaries

1. Establish Good Relationships:

The single best thing we can do to avoid ethical problems is to create good relationships with clients. This involves remembering a number of steps:

a. **Start where the client is at: I mean it literally. Acknowledge the clients' point of view. It is not necessary for you to agree with the client, just pay some attention to their beliefs.**
b. **Do not offer help until it is asked for: This will help you avoid what I call "the responsibility trap", a situation in which the client thinks you are more responsible for the outcome of services than they are. You can help the client ask for help in any way you wish.**
c. **Be respectful: While working in school systems I learned to call each person I met Mister or Miss. A very simple thing which can yield large benefits.**
d. **Make sure you establish boundaries with the client: Be clear about what you, or your agency, offers and does not offer. Make sure you get your consent forms, releases, statement of understanding, treatment plan, etc. signed. Do not offer what you cannot deliver.**
e. **If work in a setting with a predetermined goal, or you have beliefs which you feel you cannot violate, then let the client know what the predetermined goal is or what your beliefs are.**

2. Assess Yourself:

Make sure you monitor your own reactions to clients and client situations. We all know there are clients and situations we handle well and others we don't handle well at all. It is our responsibility to know and manage

ourselves. If you can't handle something seek supervisory help to work on it. If a client has a specific request such as "Are you a Christian?", explore what they mean and let them know if you are or are not. Do not be offended if a client thinks you're not the person for them.

It is not necessary that you tell any particular client about your reaction to them. There are situations, such as traumatic events, where it could be clinically significant to share your reactions with a client. If you do so, keep it simple and direct – such as saying "I'm so sorry" to a person who has been assaulted. Telling a client too much about yourself can leave them confused about who is getting the most assistance from the meeting you are having.

3. Be Careful Self-Disclosing:

Many seasoned workers use self-disclosure to bond with, and reassure, clients about their sensitivity to clients, or their familiarity with the client's situation, or their history of experiences with circumstances similar to the clients'. Used in this manner, self-disclosure can be helpful and effective. However, you must take account of the setting in which you work and your role in that setting. Too much self-disclosure can be counter-productive. For example, if you had an extensive history of smoking marijuana from which you are now recovering it would not be a good idea to reveal the extent of your use to a group of high risk adolescents who might interpret your history as confirmation that nothing bad is likely to happen to them. In many public service settings with high risk clients it is probably better to keep your history to yourself.

4. Avoid Touching:

Touching is a personal boundary most professionals want to avoid. I don't mean a handshake, which is just a common courtesy and is known to be such almost universally. I do mean frontal hugging and touching any place which would be generally known as a private area. Private is not always sexual. Private areas might include a person's face, feet or knee. Again, setting must be taken into account as well as the client's age group and likely client expectations. For example, if you work in a setting for small children or in a hospice you might engage in significant touching. It may not be seen as inappropriate because of the events which take place there. If you work in a high school with young people who are experimenting with their sexuality, or if you work in a shelter for abused people, you might be overly careful so as to avoid client misunderstandings about your intentions.

5. Be Extremely Careful To Avoid Sexual Encounters:

Professionals are always responsible when sexual encounters occur with clients. Most of us know to avoid oral, anal and vaginal intercourse. What

we cannot know is what a particular client considers sexual and what they think of our intentions. Even minor slips of the tongue regarding situations which have nothing to do with a client can be interpreted as an overture or a directive toward a client. Joking with co-workers, hanging up pictures, having an open magazine or telling an off color joke can be interpreted negatively. Due to the intense emotional nature of much of our work clients are at risk to imagine that this experience is as intense for us as it is for them. Additionally, professionals are in a powerful position with clients and are expected to use that position to be helpful, not harmful. I would urge you not to take a client to lunch or offer them private gifts out of fear they would mistakenly think you're being suggestive.

6. Develop a "Standard Speech":

A lot of misunderstanding can be resolved in the first visit with a client by use of a standard speech. A standard speech gives the client some useful information about yourself, how you work and what the client can expect during your work together. It also clarifies who is responsible for the outcome of services. A standard speech generally occurs during a first visit with a client and occurs toward the end of that visit. If I could script a visit for you it would begin with hearing the client's story, re-stating to story to make sure you have it right, asking any clarifying questions, moving toward goal definition and beginning to consider how to proceed. Just before you consider how to proceed you want to deliver a standard speech. A standard speech might go like this:

"Let me tell you a little about how you sound, what I'm like and what you can expect here. My impression of your situation is ……. I like how you did ….., and I'm concerned about ….. Now let me tell you a little about myself. People who provide the services which I provide run the gamut of behavior. Some of us are deep insight, touchy feely, spiritual people and some of us are goal oriented, problem solving people. I'm more like ….. When you come here you can expect that I'll focus on our purpose each time we meet. I want to make sure we stay on task and you're satisfied with how things are proceeding. At the same time, please remember that I have no ability to make anyone change their behavior. What you (or each of you) do, or do not do, is your responsibility. I'll assist in every way I can, but remember that I am not a miracle worker. Generally speaking, there is a shift in behavior or attitude within 3 to 4 visits when things go well. If we are having the same conversation on the 4th visit as we are having today, then something is wrong. Either I'm not getting it or you're not as motivated to change as you might feel you are. Additionally, never hesitate to ask if you have questions about me or what I'm doing. I have nothing to hide."

A standard speech which is appropriate to this particular client and delivered well leaves the client with a sense of how you act, what your

demeanor is like, who you feel is responsible for change and how quickly to expect some small step in the right direction. It also allows the client to ask questions of you, your experiences with situations similar to theirs' and whether you are a good "fit" for them. It can be used to prevent problems before they occur.

7. Know Your Methods:

Learn to describe your service provision methods and be able to describe them to others. Teach your clients to predict what you are likely to ask them when you meet. For example, if you work in a school setting teach students how you operate by asking the same questions each time you get together: How many days have you been at school since we last met? How are your grades? Have you had any excitement since we last met? Have you been to principal's office since we last met? Have you had any detentions? What has gone well since our last meeting?

Ask clients how they feel things are going at the end of each session. Ask clients to rate their progress on a 1 to 10 scale, 1 being very poorly and 10 being great. Teach clients how to determine when it is time to end services, or, if there is an expectation that services will not end, when it is time to go into a maintenance mode. I teach my clients that if they are anticipating a visit and cannot think of what to talk about then it may be time to think of ending or slowing down.

Learn to expect client questions and answer them as best you can. I believe we should be able to describe for clients why we are doing what we are doing at any given time during our services. This is true even if we are "going fishing", searching for somewhere to begin without any idea what we will come up with.

8. Learn How To Fail With Grace:

Because many of our clients have multiple, difficult problems and because we often do not have clear measures of success, it can be very difficult to simply engineer progress. So much is out of our hands. I believe we do not actually solve problems. Rather, I believe we encourage hope, support trying and guide attempts to change things for clients. Nevertheless, many clients think we actually fix things. You can imagine the disappointment clients feel when they discover we help them help themselves instead of "curing" their troubles.

Because we don't actually control change we have to be able to accept and manage small changes, intermittent progress and lack of progress. Failing well means to maintain patience in the absence of change, knowing when to take a break because things are not improving and helping clients realize the

limits of our services. A significant source of client unhappiness with services occurs when they believe we are supposed to provide one thing, and we actually provide another.

9. A Special Category: Dual Relationships

Dual relationships are the number one reason providers get reported to licensing boards or sued for damages. Dual relationships is a broad term which covers a variety of behaviors. These relationships can be broken down into a few categories:

***Financial Arrangements*: providers who engage in bartering or special fee arrangements can be putting themselves into compromising positions. The potential problem with these arrangements stems from the unequal relationship between clients and providers. It is assumed that the provider is in a position to exploit the client, rather than the client exploiting the provider. As a rule I would encourage providers to avoid bartering. If you do barter make sure the arrangement is agreed upon ahead of time and it is written down.**

***Business Arrangements*: providers who use clients to create business opportunities for themselves are putting themselves at risk. We live in a society in which salespeople for some products or services routinely use friends or family as contacts for business development. People who provide the services we do are not allowed to do this. Again, it stems from the unequal relationship between a provider and a client.**

***Community Contacts*: some providers, especially in rural areas, have contact with their clients at the grocery, in church, at school, etc. We have to be particularly careful about how we handle those situations. We don't want to do anything which would be a breach of confidentiality. Some clients are not concerned about other people knowing about their relationships, but we should not be lulled into thinking everyone feels that way.**

***Co-Workers Who Used To Be Clients*: in some facilities it is common to hire ex-clients as workers. This is especially true of facilities serving people with serious mental illnesses and facilities serving chemically dependent clients. I have been asked numerous times during workshops about what to do when an ex-client wants to read their chart, or wants to discuss some experience from their treatment. I find the best way to handle this is to have an agency create a policy about these types of encounters. This helps to avoid the impression that it is a personal decision on a provider's part.**

Preventing Ethical Problems: Institutional & Societal Boundaries

1. Prove Your Competence:

a. **Keep a comprehensive list of all your educational and training experiences during your career. This list serves as proof that you have been trained in various areas of practice or skill. Such a list is easy to keep when you are new to the field. If you been in the field for many years it can be much harder to re-create. Nevertheless, if you don't have one of these start one today.**

b. **Keep your resume updated. In addition to a list of educational and training experiences you can also prove your competence by experience in providing services. Even if you have no formal training with a particular group of clients, you may still be competent based on a history of experiences.**

2. Keep Notes Which Reflect Facts, Not Opinions:

Learn how to keep case notes which describe client symptoms or behavior, focus on service goals and objectives, quote clients about problems, progress or lack thereof, and which are devoid of your opinion. Learn how to write in simple, clear sentences which employ simple, clear language. Avoid language which might have multiple interpretations.

3. Utilize Supervision:

I believe we all need 3 kinds of supervision.

a. **Formal supervision is supervision provided by someone who is chosen for you and is focused on making sure you are following the rules of an organization. The supervisor is likely to be in a position to hire and fire. Supervisory meetings may focus on your performance with paperwork and dates/times. Few of us like it, but we all need it.**

b. **Clinical Supervision is supervision provided (hopefully) by someone you respect. If you are stuck in a clinical situation you would like to know this person's opinion. The focus is likely to be on how you provide service and the various dynamics of yourself and your client.**

c. **Bitch Buddies are people with whom you have a mutual respect, who can comfortably confront you without worrying about your feelings, who also tell you about themselves, and who do not necessarily take you seriously.**

4. Know The Services Being Offered:

A common ethical concern for workers is the limits placed on them vs. those they feel are appropriate. For example, if you work in a homeless shelter and you are not allowed to ride clients in your automobile, but you want to take a client to a doctor appointment, what do you do? Or, if you are a caseworker in the community and you regularly ride clients in your car and one of them shows you a weapon they carry for protection, what do you do? There are many situations which occur on a daily basis which have the potential to become problems. Some providers feel they are performing a ministry as well as being a licensed provider. Where are the boundaries between your personal beliefs and your agency's expectations of you? Hopefully your employer will post rules in common areas where clients might congregate. This helps to prevent conflicts, but it doesn't resolve potential problems.

5. Be Aware Of Rules Regarding Your Colleagues:

As a licensed provider you have an obligation to protect the public which includes reporting ethical violations you are aware of involving other professionals. Most commonly this takes the form of hearing about a colleague who is having a sexual relationship with a client, or who is having a dual relationship with a client. Ethical standards require us to contact a colleague to inform them of what is being reported about them. It is also a good idea to be aware of how the licensing board for your profession in your state handles an investigation when they determine a violation may have taken place.

6. Know About Behaviors Which Must Be Reported:

Most professionals know that we are required to report physical and sexual abuse, threats of suicide or homicide, and felonies. It is best if we inform clients about this in the first visit. It can be done as part of a standard speech. However, in my training experiences I encounter few professionals who know exactly what a felony is. Everyone knows that murder is a felony, but not everyone knows how much marijuana you can posses before it is considered a felony. In the absence of good information clients may be unwilling to share some important information which they would like to get feedback on.

7. Let's Not Forget The Obvious:

Just to be safe, let us remember we need to get informed consent, we need our treatment plans and other forms signed, we must hang up our disclosure statements, we must keep records in locked files in a locked room, we need malpractice insurance, etc.

Ethical Decision Making: A Model

When faced with ethical decisions for which there are not clear guidelines (which is most situations) we need some model for helping us to decide what to do. I would suggest there are 4 factors we need to consider in order to make good decisions. They are:

1. **The Client**
2. **Ourselves**
3. **The Agency**
4. **The Law**

1. The Client:

Here are some questions we might ask ourselves about our client:

Who is the client?
What is the client a customer for?
What does the client feel is the problem?
What does the client believe caused the problem?
Does the client see the same obstacle to change as I do?
Where is the client in the process of change?
What does the client expect from me?
How does the client think the process of assistance is supposed to unfold?
Does the client have a hidden agenda?
Has the client sought help for this same problem before?

2. Ourselves:

Here are some questions to ask ourselves about our selves:

Are we starting where the client is at?
Are we in harmony with our client?
Are we having any significant counter-transference reaction to the client?
Is this problem within our area of expertise?
Are we stuck with a behavior, a relationship or an attitude/belief?
Have we done anything to compromise our flexibility?
Is it possible there is an alternative intervention I am unaware of?
Is there anything going on in my life which might be affecting my decision making?
Do I need guidance/support for this situation?

3. The Agency:

What are the agencies rules regarding the situation I am in?
Have I followed agency policy?
Have I satisfied the paperwork requirements of the agency?
Have I communicated with my supervisor what is going on?
Are there any duty-to-warn issues?
Are there any reportable issues in this circumstance?

4. The Law:

What is the relevant case law of the situation I am in?
What am I legally required to do, if anything?
Have I done anything I should be concerned about?
What are the potential consequences, if any, of my actions?
Do I need to consult an attorney?
Do I have malpractice insurance and does it cover this circumstance?

A Hypothetical Situation:

(The following hypothetical situation is fiction. It is unrelated to any situation or circumstance known to the author.)

You have a client who brings her teenage son to you for counseling help. You have met the client and her son for many visits over a 2 year period. The client has told you she goes to see another counselor by herself for issues unrelated to the situation with her son. She never tells you what those issues are.

You suspect the client has a history of abuse. On one occasion she experienced intense anxiety and had to leave your office, for reasons you have no idea about. She later tells you your tie reminded her of a past experience. This is strictly a hunch on your part.

During one visit with her son the client asks to see you be herself. After escorting the boy out of the office you return to find the client gripping the armrests on her chair. With a voice shaking with emotion she tells you the following story:

The counselor the client has seen for some years became her "friend". They went to lunch together. They went on a camping trip together and shared a tent. She insists the relationship was not sexual. The counselor was going through a divorce and she says he told her often during the counseling sessions about his divorce proceedings. She says she felt she was counseling him at times. She says she felt they were close. When the divorce was finally over he abruptly ended their counseling relationship, telling her they had gotten too close.

You are alarmed by what you're hearing. You are having fantasies of having to report this behavior and having conflict with the other counselor. You start to worry that this will become a legal mess for you and you will need to get your own lawyer to defend yourself. You wish you had never had this conversation. You interrupt the client to tell her this is very serious. When you tell her this will have to be reported she becomes alarmed and says that's not what she wants.

The client tells you she feels abandoned by the counselor and just wants to have closure. She tells you she contacted him to have a final appointment. She refused to meet him at his office and he refused to meet her at her business office. She asks if she can use your office. She says she will not cooperate with any investigation and will not consent for you to report this to the licensing board. You try to convince her this could happen to others. You say you feel an obligation to protect the public. She says she won't participate.

She says she just wants to use your office. What do you do?

If you contact the board, will they do anything without a statement from her?
Are you obligated to contact the other counselor?
Will you let her use your office? If you do, are you compromising yourself in any

way?
If you don’t contact the board, are you liable for any consequences?
Is there some clinical issue you should address with her?
Should you bide your time, hoping she will change her mind about reporting?

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ETHICS IN EVERYDAY PRACTICE

Post Test Questionnaire

1. The purpose of ethics education is to:

  a. protect ourselves against lawsuits.
  b. protect the public, protect the practitioner and protect the provider of services.
  c. protect funding sources.
  d. raise standards in the field.

2. Ethical guidelines have to be "filtered" through these 3 filters:
  a. setting, role and personality.
  b. practitioner history, client problem and agency guidelines.
  c. unconscious motives, personality and job responsibilities.
  d. legal rules, your supervisor and you job title.

3. Using the Medical Model the client is assumed to be:
  a. defiant.
  b. confused.
  c. odd.
  d. sick.

4. Ethical principles are strict rules about practitioner behavior.
  a. True
  b. False

5. Ethical standards are rules the public can use to hold professionals accountable.
  a. True
  b. False

6. Personal boundaries are:
  a. client problem areas.
  b. practitioner behaviors related to our own beliefs, attitudes and history.
  c. the space between people.
  d. culturally defined comfort zones around a person.

7. An example of a relational boundary is:
  - **a. a dual relationship.**
  - **b. starting where the client is at.**
  - **c. a predetermined outcome.**
  - **d. a supervisory relationship.**

8. Research indicates that roughly one third of male therapists and two thirds of female therapists have experienced some form of sexual or physical abuse during childhood, adolescence or adulthood.
  - **a. True**
  - **b. False**

9. The "common relationship factors" which appear to facilitate client change regardless of theoretical orientation are:
  - **a. probing, confrontation and selective silence.**
  - **b. bonding with feelings, promoting catharsis and identifying motivation.**
  - **c. positive regard, exploring the unconscious and expressing support.**
  - **d. trust, acceptance, warmth, understanding, kindness and human wisdom.**

10. A national survey of 4800 psychologists, psychiatrists and social workers found that just under 80% have "discussed details of current personal stresses to a client".
  - **a. True**
  - **b. False**

11. Professionals can accurately gauge client expectations and motivation by knowing whether the client has sought help voluntary or not.
  - **a. True**
  - **b. False**

12. The responsibility trap occurs when:
  - **a. clients sit silently and wait for professionals to make decisions.**
  - **b. a supervisor directs the delivery of services without ever meeting the client.**
  - **c. the professional offers help before it is asked for.**
  - **d. the professional fails to get the necessary forms signed to provide services.**

13. Self disclosure can be helpful, but should be avoided when working with/in:
  - **a. high risk clients.**
  - **b. public service settings.**
  - **c. adolescent alcohol and drug clients.**
  - **d. All of the above.**

14. Too much touching can confuse clients about what your intentions are with them:

- **a. True**
- **b. False**

15. You can tell a client's attitude about sex from their dress and demeanor:

- **a. True**
- **b. False**

16. A standard speech can help prevent ethical problems by:

- **a. directing a client to reveal personal information about themselves.**
- **b. giving useful information about yourself, how you work, who is responsible for change and how quickly to expect some movement.**
- **c. making certain the client knows the limits of your commitment to them.**
- **d. letting the client know what your biases are.**

17. Learning to fail with grace helps us because we:

- **a. get tired fixing other people's problems.**
- **b. are overworked and underpaid.**
- **c. cannot control the change process.**
- **d. need to soothe our feelings of inadequacy.**

18. Dual relationships:

- **a. are the number one reason providers are reported to boards and/or sued.**
- **b. occur when one person can't decide who to date among 2 suitors.**
- **c. always begin with a hidden agenda.**
- **d. arise out a mutual desire to help one another.**

19. You can prove your competence by:

- **a. taking a test.**
- **b. sharing your innermost thoughts and feelings.**
- **c. keeping tract of your education/training and constantly updating your resume.**
- **d. staying out of court.**

20. Formal supervision is usually provided by someone of your own choosing.

- **a. True**
- **b. False**

21. If you know a colleague who is performing unethically you are obligated to inform them.

- **a. True**
- **b. False**

22. We have to remember to report:

a. **theft, threats and hearsay.**
b. **threats of suicide & homicide, memories of abuse and drug sales.**
c. **physical and sexual abuse, threats of suicide/homicide and felonies.**
d. **All of the above.**

23. When making ethical decision we need to consider these 4 factors:

a. **The client, ourselves, the agency and the law.**
b. **The client, the family, our own feelings and what our supervisor might say.**
c. **Who is paying us, who we work for, the client's family and the law.**

I, _______________________________________ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: ____

HOME STUDY EVALUATION FORM

In the interest of continued improvement, we greatly appreciate your evaluation of this workshop. Please be as specific as possible. Thank you for your assistance.

A: Home Study Workshop: Ethics in Everyday Practice

B: Date Evaluated: ____

C. What is your overall evaluation of this home study workshop?

1 2 3 4 5 6 7 8 9 10
poor average excellent

D. The material was interesting and informative. It held my interest.

1 2 3 4 5 6 7 8 9 10
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E. I feel like I learned something useful to my work.

1 2 3 4 5 6 7 8 9 10
strongly disagree neither agree nor disagree strongly agree

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G. Would you recommend this workshop to a colleague?

1 2 3 4 5 6 7 8 9 10
no Maybe yes

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