Law & Ethics: Confidentiality, Privilege, and Dual Relationships

6 CE Hours

Approved by the California Association of Marriage and Family Therapists (CAMFT Provider #029056) to sponsor continuing education for LMFTs, LCSWs, LPCCs, and LEPs. CAMFT is approved by the California Board of Behavioral Sciences (BBS) as a CE Provider Agency. CEUCafe.com maintains responsibility for courses and their content.

Rhonda Thomson, LMFT, LPCC

General Outline: This course provides an overview of legal and ethical issues that apply to confidentiality, privilege and dual relationships in the practice of Marriage and Family Therapy and Licensed Clinical Social Work in California. Ethical considerations are drawn from the ethical guidelines of AAMFT and NASW. Case studies are discussed to illustrate sound clinical practice. This course meets the BBS requirement for MFT and LCSW licensure. (A total of 6 CE hours in Law & Ethics is required by the BBS to be completed during each renewal period.) This course offers 6 hours of CE credit.

Goals Statement: The goals of this course are to inform the participant of relevant aspects of California law that apply to confidentiality, privilege, and dual relationships; to provide information about the ethical standards that apply to confidentiality, privilege, and dual relationships; and to deepen practical understanding of the application of legal and ethical standards in various situations that professionals may encounter in clinical practice. Moreover, it is intended that participants will ultimately gain confidence in their own understanding and application of legal and ethical principles related to confidentiality, privilege, and dual relationships.

Course Objectives: The participant will:

- Define the terms confidentiality and privilege according to BBS usage
- Examine ethical standards relating to confidentiality and privilege in AAMFT and NASW codes
- Identify sound legal and ethical practices in regards to confidentiality and privilege
- Identify exceptions to confidentiality under California law
- Define the legal concept of privilege
- Examine the relationship between privilege and confidentiality
- Identify ways that confidentiality and privilege impact clinical practice, including record-keeping, treatment of minors, treatment of couples, reporting suspected abuse, and managing dangerous patients
- Evaluate legal and ethical issues of confidentiality and privilege in various case studies
- Define dual relationships according to BBS usage
- Examine the harms that dual relationships may cause in clinical practice
- Differentiate between harmful and non-harmful dual relationships
- Examine ethical standards relating to dual relationships in AAMFT and NASW codes
- Identify California legal standards pertaining to dual relationships
- Evaluate legal and ethical issues relating to dual relationships in various case studies
- Identify sound legal and ethical practices pertaining to dual relationships

IMPORTANT DISCLAIMER: The information in this course is meant to give the professional an overview of the subject of dual relationships, and the legal and ethical statutes that might be relevant in professional practice. This information is NOT meant to be an exhaustive examination of the subject, nor is it meant to take the place of professional legal counsel. The reader is advised to seek appropriate legal or professional consultation when necessary, and to verify all information based on their professional circumstances.

Confidentiality and Privilege: Related, Yet Distinct

Confidentiality is considered a cornerstone of psychotherapy. In order for therapy to succeed, a trusting relationship must be allowed to develop between the therapist and the client. Without an assurance of confidentiality, the benefit of psychotherapy would be compromised.

As therapists, confidentiality is one of the first things we discuss with our clients at the commencement of treatment. In order to provide treatment that is both ethical and lawful, a thorough understanding of both confidentiality and the related principle of privilege are essential. While these principles are linked, there are differences between them that should be understood.

Confidentiality is addressed in both legal statutes and ethical standards. It is the basic principle that ensures the privacy of the client in the therapeutic relationship. Only under limited circumstances will the therapist breach confidentiality, the most well-know of which are in the case of reporting child or elder abuse, or if the client is a danger to self or others.

Privilege is a legal term. It is related to confidentiality, but is a separate concept. Privilege has to do with the unique relationship that a psychotherapist has with a client under the law, which renders communication between the client and psychotherapist as "privileged". It enables the holder of the privilege, usually the client, to withhold the testimony of the psychotherapist in a court of law. It is important for mental health professionals to understand both confidentiality and privilege, and how they inform the practice of psychotherapy.

Confidentiality and California Law

Professional Statutes

California legal statutes clearly address the issue of confidentiality for mental health professionals in the Business and Professions Code section of law. Confidentiality is addressed in this section of the California Code because it is relevant to the practice of

each mental health profession, and is specifically related to what constitutes professional and unprofessional conduct. Failure to maintain confidentiality is not only unethical, but also unlawful.

In each section of the law referring to individual professions, California law states that the licensing board that governs each profession "may refuse to issue any registration or license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:
Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means." (California Business and Professions Code Sections 4992.3 - Clinical Social Workers; 4989.54 – Psychologists; 4999.90 – Professional Clinical Counselors; 4982.25 - Marriage & Family Therapists)

Release of Confidential Medical Information

Another section of California law that has relevance to the discussion of confidentiality has to do with confidential medical information. In the following section of the Civil Code, specific instruction is given pertaining to the release of such information.
56.**11**. Any person or entity that wishes to obtain medical information pursuant to subdivision (a) of Section 56.10, other than a person or entity authorized to receive medical information pursuant to subdivision (b) or (c) of Section 56.10, shall obtain a valid authorization for the release of this information. An authorization for the release of medical information by a provider of health care, health care service plan, pharmaceutical company, or contractor shall be valid if it:
(a) Is handwritten by the person who signs it or is in a typeface no smaller than 14-point type.
(b) Is clearly separate from any other language present on the same page and is executed by a signature which serves no other purpose than to execute the authorization.
(c) Is signed and dated by one of the following:

(1) The patient. A patient who is a minor may only sign an authorization for the release of medical information obtained by a provider of health care, health care service plan, pharmaceutical company, or contractor in the course of furnishing services to which the minor could lawfully have consented under Part 1 (commencing with Section 25) or Part 2.7 (commencing with Section 60).

(2) The legal representative of the patient, if the patient is a minor or an incompetent. However, authorization may not be given under this subdivision for the disclosure of medical information obtained by the provider of health care, health care service plan, pharmaceutical company, or contractor in the course of furnishing services to which a minor patient could lawfully have consented under Part 1 (commencing with Section 25) or Part 2.7 (commencing with Section 60).

(3) The spouse of the patient or the person financially responsible for the patient, where the medical information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.

(4) The beneficiary or personal representative of a deceased patient.

(d) States the specific uses and limitations on the types of medical information to be disclosed.

(e) States the name or functions of the provider of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information.

(f) States the name or functions of the persons or entities authorized to receive the medical information.

(g) States the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information.

(h) States a specific date after which the provider of health care, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

(i) Advises the person signing the authorization of the right to receive a copy of the authorization.

The main points to consider in this section of law are the specific guidelines it gives to therapists when creating a release of information form, and who may authorize a release of confidential information. The statute outlines two ways of executing a release. Either the person signing the release must write the release, or if it is a form, the typeface must be at least 14-point font, must be separate from any other language on the page, and the signature must serve only to execute the release. Additionally, the release must state the name of the person or party who may release the information, the name of the person or party who is authorized to receive the information, the specific uses and limits of the information, and the specific date after which the release ceases to be in effect. Following is a sample of how this information might be presented on a form:

Authorization to Release or Exchange Confidential Information

I, [Name of Patient]_____
hereby authorize [Name of Provider]_____
to □RELEASE ***or*** □ EXCHANGE confidential information regarding my treatment with [Name and Function of the person(s) or entities to which information is to be released or exchanged]_____
_____

This Authorization permits the □ RELEASE ***or*** □ EXCHANGE of the following information:
□Any and All Information Necessary
□Diagnosis □Treatment Plan □Prognosis □Progress to Date
□Clinical Test Results □Dates of Treatment □Patient Records
□Summary of Treatment □Other [Specify]_____
_____

I authorize the exchange of the information described above for the following purpose(s):_____
_____
_____

The recipient may use the information described above solely for the following purpose(s):_____
_____
_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: [“Expiration Date”]_____

By:_____ Date:_____
[Patient or Patient’s Representative*]

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:_____

Patient Dangerous to Self or Others

California Civil Code addresses the issue of a client who is a danger to self or others. In this case, breaking confidentiality is permitted because the law imposes on the therapist a duty to warn an intended victim of a client's serious threat of physical violence.

43.92. (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.
(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

A complete discussion of the issues involved in managing a dangerous patient is beyond the scope of this course. For the purposes of this discussion, it is important to remember that the law is clear that there is " no monetary liability on the part of, and no cause of action shall arise against," a therapist who takes action under this statute, even though discharging this duty will surely involve breaking confidentiality. Therapists should be careful to only provide as much information as necessary, and not share more than what is necessary to communicate the threat.

Minor Consent and Confidentiality under California Law

The issue of minor consent and confidentiality is complex. There are both federal and state statutes that apply, and it is necessary to determine the context of the situation to know which laws apply. Following is an overview of the California statutes that apply to minor consent and confidentiality.

Minors of any age may consent to the following:

- Medical care related to the prevention and treatment of pregnancy, including birth control, except sterilization (CA Family Code § 6925). The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (CA Health & Safety Code §§ 123110(a), 123115(a)(1); CA Civ. Code §§ 56.10, 56.11)

- Abortion (CA Family Code § 6925). The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (American Academy of Pediatrics v. Lungren, 16 CA 4th 307 (1997); CA Health & Safety Code §§ 123110(a), 123115(a)(1); CA Civ. Code §§ 56.10, 56.11).

- Sexual assault and rape services, including the diagnosis, treatment, and collection of medical evidence related to the assault or rape (CA Family Code § 6928). The health care provider must attempt to contact the minor's parent/guardian and note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (CA Family Code § 6928). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. The child abuse authorities investigating a child abuse report legally may disclose to parents that a report was made. (See CA Penal § 11167 and 11167.5.)

Minors 12 years of age and older may additionally consent to the following:

- Outpatient mental health services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services." (CA Health & Safety Code § 124260.) The

health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. (CA Family Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).) For services provided under Health and Safety Code § 124260, providers must consult with the minor before deciding whether to involve parents. (CA Health & Safety Code § 124260(a).) While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor's authorization. The provider can only share the minor's medical records with parents with a signed authorization from the minor. (CA Health & Safety Code §§ 123110(a), 123115(a)(1); CA Civil Code §§ 56.10, 56.11, 56.30; CA Welfare & Institutions Code § 5328.)

- Medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." (CA Family Code §6929(b)). This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (CA Family Code § 6929(f)). Provisions regarding confidentiality parallel the confidentiality rule described under mental health services, above. (CA Family Code §6929(c).)

While California law protects minors' confidentiality, state law also requires that a parent or guardian be involved in the minor's treatment unless the involvement would be inappropriate, based on the professional opinion of the treating therapist. The therapist must state in the client record whether and when the therapist attempted to contact the minor's parent or guardian, and whether the attempt was successful, or the reason why, in the therapist's opinion, contacting the minor's parent or guardian would be inappropriate. (CA Family Code § 6924(d)). While involving parents in treatment will require sharing certain otherwise confidential information, it doesn't mean parents have a right to access

all confidential records. The therapist should attempt to honor the minor's right to confidentiality to the extent possible while still involving parents in treatment.

When a therapist encounters an issue of minor consent and confidentiality, it is best to seek legal consultation and examine the specific statutes that apply to the particular circumstances. See the Resources for Further Study section at the end of this course for additional sources of information on this topic.

Privilege and California Law

Privilege is related to confidentiality, but it is solely a legal principle. It is found in the Evidence section of law, because it pertains to information that is brought into evidence in a legal proceeding. The following section of the California Code deals with the principle of privilege:

1014. Subject to Section 912 and except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:
(a) The holder of the privilege.
(b) A person who is authorized to claim the privilege by the holder of the privilege.
(c) The person who was the psychotherapist at the time of the confidential communication, but the person may not claim the privilege if there is no holder of the privilege in existence or if he or she is otherwise instructed by a person authorized to permit disclosure. The relationship of a psychotherapist and patient shall exist between a psychological corporation as defined in Article 9 (commencing with Section 2995) of Chapter 6.6 of Division 2 of the Business and Professions Code, a marriage and family therapy corporation as defined in Article 6 (commencing with Section 4987.5) of Chapter 13 of Division 2 of the Business and Professions Code, or a licensed clinical social workers corporation as defined in Article 5 (commencing with Section 4998) of Chapter 14 of Division 2 of the Business and Professions Code, and the patient to whom it renders professional services, as well as between those patients and psychotherapists employed

by those corporations to render services to those patients. The word "persons" as used in this subdivision includes partnerships, corporations, limited liability companies, associations and other groups and entities.

1015. The psychotherapist who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision (c) of Section 1014.

The Holder of Privilege

In most cases, the holder of privilege is the client, not the therapist. If a client has a guardian or conservator, then this person would hold the privilege. The personal representative of a deceased client could also hold the privilege. If the client is a minor child, the child holds the privilege, not the parents. If the child has an attorney, the attorney can waive or assert privilege on behalf of the child. The court can also appoint a guardian ad litem to act on behalf of the child in legal matters. The only way the parent could waive or assert privilege for the child would be if the parent were specifically appointed as guardian ad litem for the child by the court. The court will make the decision regarding the privilege of a minor child if there is no attorney or guardian ad litem for the child.

If a therapist receives a subpoena, the correct course of action is to assert the privilege on behalf of the client until instructed to do otherwise, either by the action of the client in waiving the privilege (in writing), or when instructed by the court that there is an exception to privilege. There are situations in which privilege does not apply. If a client makes his or her mental or emotional condition an issue in a legal proceeding against another party, then privilege does not apply. If a judge orders an examination of a client's mental or emotional condition, then communications pertaining to this specific purpose are not privileged. If a therapist determines that a client is in need of hospitalization for a mental illness, then communications in the course of this type of proceeding are not privileged. However, it is important to remember that whenever a therapist receives a

subpoena for records or testimony pertaining to a client, it is not up to the therapist to determine whether or not privilege applies. The only thing the therapist needs to do is assert the privilege until instructed otherwise by the client or the court. Therapists should always seek legal advice whenever they interact with the court on issues of confidentiality and privilege.

Ethical Standards of Confidentiality

Professional organizations develop ethical standards to guide and inform the practice of their professions. These guidelines are generally aligned with the legal statutes that apply to professionals, and also take into account specific applications that may be distinct within each profession. The American Association For Marriage & Family Therapy (AAMFT), the National Association of Social Workers (NASW), the California Association of Marriage & Family Therapists (CAMFT), the American Psychological Association (APA), and the American Counseling Association (ACA) are a few examples of these organizations. It is strongly recommended that practicing professionals join a professional organization associated with their profession in order to stay informed about important ethical, legal, and practice issues. Some organizations provide free, legal and ethical consultation to their members on issues that arise in their professional practice. Association websites also offer a great deal of information about legal and ethical best practices for your specific profession.

The issue of confidentiality touches multiple areas of the therapeutic relationship such as client interactions, record keeping, teaching, supervising, research, and consultation. It is important to remember that confidentiality informs nearly every aspect of professional practice, and it should be kept in the forefront of every practice decision. Confidentiality should be considered from the very beginning of therapy, and kept at the forefront of every practice decision.

Therapists should discuss confidentiality as early as possible in their professional contacts. The nature of confidentiality should be addressed, as well as limits of the clients' rights to confidentiality. One way to make sure that clients are informed about

confidentiality is to develop a policy of always discussing it with a client in the very first session. Confidentiality should be a part of any complete Informed Consent document, and it should be verbally reviewed with the client before commencement of treatment. Additionally, it should be brought up and discussed at any time that circumstances dictate a review is necessary.

Marriage and family therapists have unique concerns regarding confidentiality because the client in a therapeutic relationship may be more than one person. Therapists who are treating couples or families should also clearly explain at the beginning of treatment the ways that confidentiality and privilege impact their communications with the therapist. Both AAMFT and CAMFT address this issue in their Ethical Standards.

Social workers also regularly work with multiple people within a system. Clearly defining policies about confidentiality with all involved parties from the start helps establish clear boundaries and a sense of safety in the treatment process. NASW has clear guidelines for their professionals in maintaining ethical standards of confidentiality among individuals within a system.

Release or Exchange of Confidential Information

As part of their practice, therapists should develop written consent forms to release confidential information that comply with all applicable laws. Verbal authorization from a client to release or exchange confidential information is not sufficient, except in emergency situations, or when the disclosure is mandated or permitted by law. When the treatment unit is a family or couple, the therapist must obtain written permission from each individual within the treatment unit before disclosing information about treatment. If necessary, a limited record can be released to an individual member of the treatment unit as long as the confidentiality of other individuals in the treatment unit is fully protected. If actual copies of records that include the names of others are provided to the client, any other names present in the record should be completely marked out with permanent marker. Alternatively, a summary of treatment can be given that does not include names of other individuals, and also avoids any discussion of other individuals who could be

identified by context even without using names. This may require significant redaction of the record to preserve confidentiality.

Therapists should also protect the confidentiality of clients during legal proceedings to the extent permitted by law. A court of law may order the disclosure of confidential or privileged information without a client's consent. In this case, the therapist should seek to limit the order to disclose only such information as is directly relevant to the proceedings, or to maintain the records under seal, or to order that they not be made available for public inspection in order to protect the privacy of the client.

Using Confidential Information in Consulting, Teaching, and Research

Therapists should only use clinical materials in consulting, teaching, writing, research, or public presentations if a written release is obtained, or if appropriate steps have been taken to protect the client's confidentiality. If using actual clinical materials, protecting the client's identity is paramount. When a therapist is developing case examples of this nature, a helpful exercise is to imagine the client reading it. If the client could recognize the example as their own, the therapist has violated confidentiality. Focusing on process rather than content is key. Think about the therapeutic process at issue—rather than the content—and then build specific details around that process that are generic—not specific to a particular client.

Consultation is an important aspect of effective therapy. However, confidentiality can be easily compromised during consultation. Just as in therapy, it helps to focus on the process and not get stuck on the content. Identify the general themes and issues before seeking consultation. This will help maintain focus, and will allow better feedback from the consultation process.

Maintaining Confidential Records

Therapists must be careful to store, safeguard, and dispose of client records in such a way that confidentiality is maintained. While there are not specific standards on storing records, it is generally considered sound professional practice to keep client records in a

locked file cabinet when paper records are kept, and to use password protection for electronic records. When disposing of records, it is safest to shred or burn them, or use a professional document destruction company. Written policies regarding document storage, transportation, and destruction should be developed as a reference for the therapist, and then enforced. Additionally, therapists should consider under what circumstances it is acceptable to transport client records. The safest policy would be for records to remain at a single, secure location. Any exceptions should be limited to exceptional circumstances, and clearly designed to protect client records during transport. If records must be transported, therapists may consider using a portable locking file container, available at most office supply stores.

Electronic health records (EHRs) are an alternative to paper records, and offer some advantages to paper records. Electronic health record platforms are becoming more popular with therapists, and there are a number of EHRs that are designed specifically for mental health professionals. EHRs can increase the security of records because the data is stored in cloud-based servers that are HIPAA-compliant. EHRs can improve patient care by improving the accuracy and clarity of medical records, making the health information more readily available, and providing a more secure system of storage. Therapists who utilize any type of EHR, or who store protected health information in electronic format on a personal computer should always take security precautions such as using strong passwords for logins to cloud-based accounts as well as personal computers, updating passwords regularly, using 2-factor authentication where available, and having systems in place to remotely wipe the memory of any electronic device that is lost or stolen.

Therapists should also have policies and procedures in place for the storage, transfer, or disposal of records in the event of a therapist moving from the area of practice, closing the practice, or upon incapacitation or death. These policies must maintain confidentiality and safeguard the welfare of clients. Clients have a reasonable expectation to that protection. A therapist may wish to partner with a colleague, each offering to take responsibility for the records of the other in the event of death or incapacitation. A written policy should be established and a copy given to the designated colleague that

includes specific instructions for accessing client records, and perhaps a prewritten letter that would be sent to each client. This letter could include the name of the designated colleague and specific information regarding the client's records and how to access them if necessary, as well as offering the opportunity to process the loss with the designated colleague, or to obtain a referral from the colleague if additional therapeutic intervention is necessary.

Protecting Client Confidentiality in the Office and Beyond

Client confidentiality needs to be a consideration in all aspects of professional practice. It is important for therapists to consider how client confidentiality will be protected, and develop policies before they are needed. Arrangements should be made regarding how to contact the client. Ask specifically about what type of information can be left on voicemail or answering machines, and what type of communication is acceptable for email messages. Also inquire as to how to direct written correspondence. All of these details should be discussed at the beginning of treatment, and kept in the client's file for reference.

Also discuss with clients how you will act if you see them in public. It is standard practice to inform you client that you will not acknowledge them if you see them in public, unless they initiate contact with you. Even if a client greets you in public, it is important for the therapist to never divulge the nature of the relationship, even if the client does so. It is preferable for the therapist to model good boundaries and politely move on from a random encounter without needlessly prolonging the conversation.

Always be careful to keep the fact of the therapeutic relationship confidential from anyone who inquires. For instance, suppose you work with a woman you know to be married. If you receive a call from your client's husband wanting to share information about your client, you should not acknowledge whether you do or do not have a therapeutic relationship with his wife. While it may seem obvious that the husband is aware of your relationship with his wife, you cannot take it for granted. Speaking to him would be a breach of confidentiality unless your client gives you written permission to

share confidential information with her husband, and approves the purpose for that communication. However, listening to him without acknowledging the relationship does not break confidentiality.

Maintaining Confidentiality in the Practice of Social Work:

Social workers process a great deal of information with clients, and because social workers frequently advocate for their clients across multiple agencies and stake-holders, the potential for violations of privacy and confidentiality are significant. Social workers should be careful to only solicit information that is essential to providing services, and to only disclose information that is necessary. It is crucial that social workers recognize what types of information are confidential, and disclose only the information that is necessary and relevant to the issue at hand.

The exception to confidentiality is made in situations when a suspected child abuse report must be filed, or when a client is deemed to be a danger to self or others. Whenever possible, social workers should inform clients of disclosure of confidential information in cases of legally required reporting, ideally before the disclosure is made. When this type of disclosure would endanger the safety of the social worker, it need not be made, as safety should be the greater consideration.

Confidentiality in Group Therapy:

When therapists conduct group therapy, the participants should be informed of rights as well as limits to confidentiality. In addition, therapists should ask that group participants agree to respect the privacy and maintain the confidentiality of fellow group members. Therapists should also inform participants that they cannot guarantee that all group members will honor the commitment to privacy.

Confidentiality in a School Setting:

Mental health professionals who work in school settings may be subject to HIPAA, FERPA, and/or California confidentiality law. If the school based program “is funded, administered and operated by or on behalf of a public or private health, social services, or

other non-educational agency or individual" then the program is not subject to FERPA, and would be subject to HIPAA if it engages in any HIPAA covered transactions, such as electronic transmission of information. If the school-based program is funded, administered and operated by or on behalf of a school or educational institution, then FERPA applies. Regardless of program funding, if the professional is an employee of the school, or contractor of the educational institution, FERPA likely applies. HIPAA and FERPA never apply to the same information at the same time. However, California law can apply in both cases. When California law provides greater confidentiality protections, it supersedes HIPAA. If California law and FERPA are in conflict, legal advice should be obtained.

There are similarities between HIPAA and FERPA in terms of confidentiality. Both provide important privacy protections; both require a signed release to disclose protected information; both allow sharing of information in limited circumstances without a signed release.

There are also some important differences. Under FERPA, a parent must sign the release on behalf of the minor for release of information; under HIPAA, a parent signs the release on behalf of the minor except when the minor has consented to treatment as allowed under California law. Additionally, a parent's right to records differs. Under FERPA, a parent has a right to access all records pertaining to their minor child; under HIPAA, a parent's right to access a minor child's records is limited if the therapist determines that it is not in the best interest of the minor, or if the minor has consented, or could have consented to treatment, and the minor does not permit the parent to access the records. Under FERPA, a provider can share information with any school personnel who have a "legitimate educational interest" in the information. Under HIPAA, this information sharing would require a signed release.

This is not a complete list of differences between HIPAA and FERPA. Professionals who work in school settings and who are subject to either HIPAA or FERPA must stay

informed about the requirements unique to their situation. For further information, see Resources for Further Study at the end of this course.

Confidentiality When a Client Dies: It is a good idea to withhold any comment to members of the media prior to professional consultation, and discussion with the client.

Exceptions to Confidentiality

Most therapists are familiar with the major exceptions to confidentiality. These include the legal mandate to report suspected child abuse, suspected elder abuse, the ethical obligation to protect a client who is a danger to himself, and the duty to warn an intended victim if a client threatens physical harm, or if the therapist believes that the client is a danger to others. These exceptions to confidentiality should be clearly stated in a therapist's "Consent for Treatment" form, and verbally discussed with the client at the commencement of treatment. Therapists should stay abreast of changes in the law that affects their obligations regarding these issues.

The Dangerous Client

A client who presents a danger to others can be a complex situation to manage. In California, the law grants immunity to therapists who break confidentiality when a client communicates a threat to an identified victim, in the Civil Code section 43.92. Under the landmark Tarasoff decision, a therapist must also take reasonable precautions to protect an intended victim if the therapist *determines* that the client is dangerous, even if that determination is made in the absence of direct communication from the client. In any case, thorough documentation of any determination made, and the rationale behind that determination, is essential to avoiding liability. Therapists would also be wise to seek legal consultation from their professional association, a colleague, or another professional resource.

A Client With AIDS/HIV

A therapist has a duty to warn if the therapist becomes aware that a client poses a serious and imminent threat of physical violence against an intended victim. But what if the

therapist discovers that his or her client has AIDS or is HIV positive, and is engaging in unprotected sex? Can a therapist breach confidentiality in this case, and warn the unsuspecting partner? While laws and ethical standards may vary in different states and different professions, in the State of California there is no mandate or permission to break confidentiality in this situation. Although AIDS/HIV is a serious condition, having consensual sex with one or more partners does not meet the criteria of threatening imminent physical violence against an intended victim. A therapist who breaks confidentiality in this situation opens the door to charges of unprofessional conduct.

Confidentiality When Treating Minors

It sometimes comes as a surprise to therapists that the parent of a minor child does not hold privilege for the child; the child hold the privilege unless the child has an attorney or a guardian ad litem appointed by the court. If a child does not have an attorney or a guardian ad litem, the court makes the decision regarding the privilege of the child. Even if the parent consents for the treatment of the child—and is the child's legal guardian—the parent does not hold the privilege. The only way the parent holds the privilege for the child is if the court specifically appoints the parent to act as the guardian ad litem for the child in legal decisions.

What about parental access to the mental health records of the child? In the State of California, a minor child's confidentiality is protected under the law. If the therapist determines that sharing the child's mental health records with the parent(s) would negatively impact the child, or the therapeutic relationship, the therapist can deny access to the parent. However, the therapist needs to weight the obvious cost/benefit ratio in denying a parent access to the child's records. The parent requesting the records may also be the person who is authorized to consent for treatment, and the therapist's denial of access could result in the parent prematurely terminating the child's treatment. For the purposes of this discussion however, it is sufficient to note that the State of California extends the right of confidential treatment to minor children under the law, and a therapist who denies a parent access to a child's records if it is deemed detrimental to the child's treatment would be acting within the bounds of the law.

Confidentiality When Treating Couples and Families

Treating couples and families raises important issues with regard to confidentiality and privilege. From the beginning of treatment, the therapist needs to decide who is the client. Marriage & Family Therapists are professionals who regularly treat couples and families. Therapists trained in systemic modalities of treatment also typically consider the couple or family to be the "client" rather than the individual. When the couple or family is the client—as opposed to the individual—this needs to be clear to the participants. Generally, if individual issues arise with one or more participants in the treatment unit, they should be referred to another therapist for individual treatment. Sometimes an individual will start treatment as an individual client and then later want to engage in conjoint therapy with another family member. In this case, a clear discussion needs to take place to decide whether the current therapist will conduct the conjoint therapy, or whether a referral will be made to another therapist.

The advantages and disadvantages of transitioning from individual to conjoint therapy should be thoroughly discussed before a decision is made. The advantages are typically that the therapist and client have already established a good working relationship, and there will be less time needed to gather history and background. The disadvantages are that the client(s) joining the therapy will not have the benefit of the same therapeutic history, and may feel more distance from the therapist. The individual client transitioning to conjoint treatment may also feel the loss of the individual relationship with the therapist. If the therapist believes that the loss of individual therapy would be detrimental to the client, then referring to a new therapist for conjoint work is the best practice. The therapist needs to be aware that the client may not be in the best position to understand the significance of the change from individual to conjoint work, and therefore must be ready to advocate for the client's best interest.

As a general rule, the longer a therapist has worked individually with a client, and the deeper and more intense the work, the more likely that a referral to another therapist should be made for conjoint work. If a therapist has worked individually with a client for

a shorter period of time, transitioning to conjoint work is easier. In this case, a few individual sessions may be scheduled with the client who is joining the conjoint work in order for the therapist to establish a relationship before continuing with conjoint sessions.

Many therapists have a "No Secrets" policy when it comes to treating couples and families. A "No Secrets" policy is an important clinical tool for therapists who might have some individual sessions with members of the treatment unit as part of the treatment plan for the couple or family. Because the therapist makes clear from the outset of treatment that the "client" is the couple or family, a "No Secrets" policy allows the therapist to use information from individual sessions to advance the goals of the couple or family.

A "No Secrets" policy can be included in the therapist's Consent for Treatment document, or it can be presented and discussed as a separate policy document. The benefit to a separate policy is that it makes it clear to both the therapist and clients exactly who the client is, i.e. the couple is the "client" not the individual. The separate policy highlights the specific treatment of confidentiality in the case of conjoint therapy as distinct from individual therapy, and adds extra focus to the significance of the policy by separating it from the other disclosures in the Consent for Treatment. A separate policy is also useful when a transition is being made from individual therapy to conjoint therapy.

A "No Secrets" policy usually states that the therapist will not keep secrets between members of a family or couple, but will use his or her clinical judgment to determine whether and how information shared in individual sessions will be disclosed in joint sessions. An opportunity might also be extended to the individual to share any pertinent information personally, prior to the therapist making such a disclosure.

The therapist should also make it clear that any information shared in this way has the sole purpose of advancing the goals of the couple or family. Such a policy is not a mandate that the therapist *must* share everything that takes place in an individual session. Rather, it ensures that a therapist will not become triangulated into a system and confined

in his or her ability to advance the goals of treatment. Therapists must exercise their clinical judgment in determining what information should be shared as part of the couple or family treatment, and what information can be kept private. Individual members of the treatment unit should be informed that they could receive a referral for individual treatment if there are issues that they wish to work on privately, with complete confidentiality from the couple or family unit. This referral should be to another therapist whenever possible.

Regarding privilege in couple or family therapy, if the therapist receives a subpoena for records, privilege should be asserted unless every participant in the treatment unit waives privilege in writing. It is not enough for just one member to waive privilege. Additionally, if one participant requests records, the therapist would need to get written authorization from all parties before releasing records.

Summary

The issues of confidentiality and privilege are of paramount importance to the lawful and ethical practice of Marriage and Family Therapy and Clinical Social Work. Professionals in these fields can ensure the integrity of their practice by considering the ways that confidentiality and privilege affect the various aspects of their practice. Again, joining a professional organization is one of the best ways to keep abreast of changes in the law that affect your practice, and afford you the safety of legal and ethical consultation when you need it.

Case Studies

One of the best ways to understand what constitutes unethical and illegal behavior in regard to confidentiality and privilege is to examine case studies of possible clinical scenarios. All case studies that follow are based on fictional scenarios meant to illustrate the intended point. Any resemblance of the facts of these case studies to actual people or events is unintentional.

Case Study #1: A Custody Dispute

Evelyn is a Marriage & Family Therapist working in a clinic setting. She begins seeing a couple, Nora and her husband Leo, for marital therapy. One issue in the marriage is conflict over their 4-year-old son Seth, who has severe asthma. Nora believes that Leo does not take their son's health condition seriously enough, because he continues to smoke. Nora states that she does not allow Leo to smoke in their home, but Leo does smoke in front of their son when Nora is not around. Nora also states that she handles all of her son's medication because Leo doesn't want to learn how to do any of it. Evelyn spends one session focused on finding ways for Leo and Nora to work together in managing their son's asthma, but Leo disagrees with this focus, and states that Nora is making a big deal out of nothing. After several sessions, Leo decides that therapy isn't working and he moves out of the couple's home and files for divorce.

Evelyn continues to see Nora in individual therapy to work through the divorce issues. Custody of the couple's children (Seth, and a daughter, age 6) becomes a point of contention, as Nora believes that Leo is a danger to their children, especially Seth. Nora states that Leo continues to smoke in the children's presence, and does not give Seth's medication when necessary. At Nora's request, Evelyn meets with the children and discusses their time with their dad. Both children state that dad smokes around them, and that it sometimes triggers the Seth's asthma. They both say that sometimes dad forgets to give medications, but usually one of the children reminds him. A few weeks after this session, Evelyn receives a subpoena from Nora's attorney requesting records of the couple's session that dealt with managing the asthma, and records of the session with the children. Nora also offers a signed release to access these records. She tells Evelyn that she needs these records to use in her custody case against Leo.

Discussion

Therapists are often caught in the middle of custody disputes with their clients. One of the biggest mistakes therapists make is to improperly release confidential records when they receive a subpoena from a client's attorney. In this case, the therapist should not release records of the couple's sessions together, because *both* Nora and Leo must waive

their privilege, in writing. While Nora agrees to waive her privilege, it is highly unlikely that Leo will also waive privilege. Therefore, the therapist must claim the privilege until both parties waive it. In regards to the records of the minor children, the therapist must also claim privilege for the children's records unless the children have an attorney of their own, or a guardian ad litem. While Nora can consent for treatment of the minor children, she cannot waive the children's privilege unless the court has specifically appointed her as the guardian ad litem for the children. Another issue pertaining to confidentiality in this case is the question of whether or not the child with asthma is in danger of medical neglect while in the care of his father.

If the therapist believes that the child is in danger, then a Suspected Child Abuse Report must be submitted to the proper authorities, in which case confidentiality can be lawfully breached. Evelyn needs to clearly document in the case notes how this determination was made. This situation would not fall under Tarasoff or the duty to warn under California law, as Leo is no longer Evelyn's client. Further, even if Leo was still a client, the allegations of danger to the son in this case are not likely to meet the requirements of imminent, serious physical harm threatened to another. Evelyn should carefully document in her treatment notes the rationale for whatever decision she makes, as well as listing the professionals she may have consulted with. It is a good practice to consult with a colleague or seek out a legal consultation from your professional organization whenever a safety issue arises, especially with a client who is already involved in legal proceedings.

Case Study #2: Safeguarding Client Records

Gary is a Licensed Clinical Social Worker who works for a foster family agency. He frequently transports written client re- cords between the agency office and his client's homes. He also completes case notes while in the field, sometimes stopping at a favorite coffee shop to get caught up on paperwork. While Gary's agency has a written policy regarding records, Gary is not familiar with it. One day, he inadvertently leaves a folder with client information on a chair in a coffee shop. The information includes the name of a teacher at a local school, who is the mother of a child in foster care on Gary's caseload. Gary realizes that he has misplaced the folder when he gets back to the office. When he

returns to the coffee shop, the folder is no longer there, and the person at the counter states that no one has turned it in. Several weeks later, the foster family agency informs Gary that an attorney representing the mother of Gary's client has contacted them, alleging a breach of confidentiality. Gary later discovers that a person in the coffee shop who picked up the folder was a coworker of the mother. That person gave the folder to the mother.

Discussion

Gary compromised his client's privacy by failing to protect his client's records. The agency has a written policy that states that employees have an obligation to exercise care and prudence in the handling of confidential information, but no specific policies and procedures are delineated to de- fine what this means. The agency should develop specific policies regarding the handling of client records, and provide training on those policies and procedures. Agency social workers should be aware of the policies, and consequences for their violation. Additionally, Gary is personally liable even though his agency did not have a clear policy in place, because he is responsible for practicing within the legal and ethical boundaries of his profession. The law clearly states that breaching confidentiality is a violation, and ethical standards are similarly clear. Gary could have taken steps to protect client records by transporting records in a locked briefcase or other such container when necessary, and he could have chosen to complete paperwork at the office or other secure location. Therapists who keep client records on laptop computers should also consider confidentiality issues if they are working within view of others, and what the ramifications will be if their computer is lost or stolen.

Case Study #3: Client Referred by County

Manny is referred to Bill, a Licensed Clinical Social Worker, by the local Department of Social Services. Bill has a contract with the local County office to provide therapy to Manny for anger management as part of a family reunification plan. The County pays for the therapy, and expects to receive quarterly updates about Manny. At the beginning of therapy, Bill obtained a written release from Manny for the exchange of confidential information between Bill and the County social worker responsible for Manny's case,

and forwarded a copy of this release to the social worker. However, after three months, Manny has made little progress in therapy, and tells Bill that he doesn't want Bill to give any information about his treatment to his social worker, because Manny is concerned that it will jeopardize his family reunification plan.

Discussion

In this situation, Bill properly discusses the limits of confidentiality with Manny at the beginning of treatment, and obtains a release. However, Bill must maintain the confidentiality of the client when requested, even though the County Department of Social Services has referred Manny and is paying for treatment. Bill should require that Manny offer a written withdrawal of his consent for exchange of information, and forward this to the social worker. It would also be useful for Bill to discuss with Manny the possible results of his decision to withdraw his consent, as this will also impact his family reunification plan, and his ongoing treatment.

Case Study #4: A Parent's Right to Know

Rita is a 17-year-old girl who is referred to therapy with Yolanda, a Licensed Marriage & Family Therapist, by her parents. Rita's parents are concerned that their daughter has become withdrawn and secretive over the last several months. She spends hours online, usually on Tumblr and Twitter. Her parents are concerned about who she might be meeting online, and don't know what to do to protect her. They are also concerned that she seems depressed. During the course of therapy, Rita develops a trusting relationship with Yolanda, and discloses to her that she has a boyfriend that she met on Twitter who is 37 years old. Rita has never met this man, as he lives in another state. They do not have current plans to meet, but Rita says that they frequently exchange private messages, and have talked about getting married after she turns 18. Rita does not want her parents to know about this relationship. Rita's parents, however, want Yolanda to inform them of any information that impacts the well being of their child.

Discussion

There is not an issue of privilege in this case, as there is no subpoena for records in a

court proceeding. However, confidentiality is an issue. If Yolanda believes that disclosing this information to Rita's parents would be harmful to Rita or the therapeutic relationship, she can withhold this information. If, however, Yolanda believes that Rita is a victim of sexual exploitation, she must break confidentiality to report this to the proper authorities regardless of whether or not she discloses the information to Rita's parents.
For instance, if Rita disclosed that she had shared nude photos of herself with this man, a Child Abuse Report is required. Even without sharing photos, Yolanda may have enough information to suspect that her minor client is being exploited and should file a Suspected Child Abuse Report. Yolanda only needs to suspect abuse; it is not her job to investigate or prove it. If Yolanda doesn't suspect abuse, she should still document in her clinical record the reason that she does not think a Suspected Child Abuse Report is required.

Yolanda should discuss with the parents and the minor client all limits to confidentiality at the beginning of therapy, and should also clearly point out that California law respects the confidentiality of the psychotherapist-patient relationship, even when the client is a minor. If Yolanda was treating Rita in the context of family therapy, a "No Secrets" policy may have been discussed at the beginning of therapy, and used in this situation. The "client" is then the family, and the goals of therapy would be specific to the family rather than to one individual within the family. The advantage of family therapy in this case would have been to strengthen the parent/child relationship, and to circumvent the therapist being triangulated into the relationship between the parents and the child. The disadvantage however, is that Rita might have never disclosed the information in the first place, knowing that it would potentially be shared with her parents. While involving parents in their minor child's treatment is the preferred ideal, it isn't optimal in every case, and California law protects a minor's confidentiality when the therapist determines that it is in the best interest of the minor.

Case Study #5: Confidentiality at School

Silvia is a Licensed Professional Clinical Counselor working in a program contracted to provide mental health services at a public high school. Silvia began working with 16-year-old Leo after his math teacher, Carlos, referred Leo to Silvia. Carlos suspected that

something was going on with Leo, a smart boy who had previously excelled in math, due to his recent decline in performance in class. Carlos also noted that Leo had seemed tired and disengaged in class, often falling asleep, and that his eyes were sometimes red and glassy. Carlos was concerned that Leo may be abusing marijuana and that it was interfering with his learning. Leo met with Silvia, and acknowledged that he had been smoking weed with some new friends he had been hanging out with. Leo stated that he wanted to work with Silvia, but didn't want to tell his mother, whom he lived with along with his stepfather and two stepsiblings. Leo stated that he didn't get along with his stepfather or stepsiblings, and that his stepfather had threatened to kick Leo out of the house on other occasions. Silvia agreed that under the circumstances, Leo could consent to his own treatment, and documented in the record why she decided it was in Leo's best interest for her to not contact his parents and involve them in his care. Leo and Silvia set goals for therapy, and Leo was able to make some changes such as reconnecting with some old friends who didn't use drugs. However, he fell back into old habits after a few weeks and began to come to class high again. After a week in which he was late to class every day, and mostly slept through class, Carlos checked in with Silvia to let her know how Leo was doing, and to ask about anything that she could share with him about Leo that would help Carlos in class. Silvia shared that Leo was committed to doing well in school, but that he was struggling with some conflicts at home, and had recently fallen back into smoking weed. Carlos and Silvia discussed ways that they could support Leo in succeeding academically and personally.

Discussion

Did Silvia break confidentiality by discussing Leo's treatment with Carlos? The answer is, it depends. If Silvia's records are covered by FERPA, then she did not violate confidentiality because FERPA allows disclosure to a teacher with legitimate educational interest in the information. However, if Silvia were covered by HIPAA instead of FERPA, then this disclosure would be a violation of confidentiality unless Silvia had written consent to disclose treatment information. Additionally, if Silvia's records were covered by FERPA, then as educational records, Leo's parents would have access to them regardless of Leo's preferences, but this could conflict with California law, which

protects the privacy of minors. In this case, Silvia should seek legal consultation to see which guidelines apply.

There are many variations in this scenario that can impact the decision of the therapist. Consulting with a colleague and/or legal consultation, as well as thorough documentation is always an important aspect of sound clinical practice.

Understanding Dual Relationships

What is a dual relationship? According to the California Board of Behavioral Sciences (BBS), it is a relationship that occurs "when a therapist allows a separate connection to develop with a client outside the boundaries of therapy." [i] If a dual relationship exists between a client and therapist which causes harm to the client—either by exploiting the client or impairing the clinical judgment of the therapist—this constitutes grounds for disciplinary action against the therapist.

Harmful dual relationships develop when the therapist or social worker lacks clear, professional boundaries. This lack of boundaries can result in actions that ultimately harm the client by damaging the integrity of the therapeutic relationship. These harmful dual relationships can fall into such categories as:

1. Social or personal
2. Sexual or improper physical contact
3. Business or financial
4. Caretaking
5. Improper gift giving or receiving
6. Interference with personal autonomy or undue influence
7. Self-disclosure
8. Advocacy or enmeshment
9. Employment of patients or interns, whether monetarily or otherwise[ii]

Of course, not all dual relationships cause harm to the client. And in many small communities, they are impossible to avoid. A therapist and client might attend the same

church, shop at the same store, or both participate in the local PTA. In these examples, the burden rests on the therapist to maintain strong professional boundaries, receive appropriate clinical consultation when concerns arise, keep detailed records that demonstrate understanding of boundary issues and their management, and know when to refer a client to another therapist in the event that it becomes necessary.

Ethical Standards

Professional organizations develop ethical standards in order to define professional standards and values, and to honor the public trust. For MFTs, the ethical guidelines used in this course are taken from the American Association for Marriage & Family Therapy (AAMFT). For LCSWs, the ethical guidelines are taken from the National Association of Social Work (NASW). Other professional organizations, such as the California Association of Marriage & Family Therapists (CAMFT) and other state and regional organizations develop ethical standards for their members. It is a wise professional choice for therapists and social workers to become a member of a professional organization and become familiar with the ethical standards of their chosen organization. Professional organizations usually provide free consultation on legal and ethical issues to their members, which can avert problems before they arise.

AAMFT Ethical Standards:

AAMFT is a national organization focused on the profession of Marriage & Family Therapy. It represents MFTs in the United States, Canada, and around the world. The following ethical standards have relevance to the subject of dual relationships. They are listed under the specific category headings to which they pertain.

Responsibility to Clients

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. [iii]

1.4 Sexual intimacy with clients is prohibited. [iv]

1.5 Sexual intimacy with former clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. In an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients after the two years following termination or last professional contact. 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.[v]

1.7 Marriage and family therapists do not use their professional relationships with clients to further their own interests.[vi]

Professional Competence and Integrity

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

3.4 Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.[viii]

3.9 Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.[ix]

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.[x]

3.14 To avoid a conflict of interests, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations

for custody, residence, or visitation of the minor. The marriage and family therapist who treats the minor may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.[xi]

Responsibility to Students and Supervisees

4.1 Marriage and family therapists are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.[xii]

4.2 Marriage and family therapists do not provide therapy to current students or supervisees. [xiii]

4.3 Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. Should a supervisor engage in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.[xiv]

4.6 Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.[xv]

Financial Arrangements

7.5 Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it, (b) the relationship is not exploitative, (c) the professional relationship is not distorted, and (d) a clear written contract is established.[xvi]

NASW Ethical Standards:

NASW is a national organization that represents professional social workers throughout the world. The following ethical standards have relevance to the subject of dual relationships. They are listed under the specific category headings to which they pertain.

Social Workers' Ethical Responsibilities to Clients

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to

clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.[xvii]

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers--not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship--assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers--not their clients--who

assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.[xviii]

1.10 Physical Contact

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

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.[xx]

1.13 Payment for Services

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume

the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.[xxi]

1.16 Termination of Services

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.[xxii]

Social Workers' Ethical Responsibilities to Colleagues

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.[xxiii]

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.[xxiv]

Social Workers' Ethical Responsibilities in Practice Settings

3.01 Supervision and Consultation

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.[xxv]

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.[xxvi]

3.02 Education and Training

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.[xxvii]

Many of the ethical standards for MFTs and LCSWs are the same or similar, though at times with different emphasis based on the uniqueness of each profession. Additionally, note that the ethical standards for both AAMFT and NASW are concerned with professional conduct between colleagues, students, and supervisory relationships as well as clients.

Dual Relationships and California Law

California law does not specifically address the subject of dual relationships with clients. (The exception is sexual interaction between a therapist and client.) If a therapist were involved in an exploitative dual relationship with a client, it would be considered "unprofessional conduct."

Section 4982 of the California Business and Professional Code states that "[t]he board may refuse to issue any registration or license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct."[xxviii] The Code continues to enumerate more specific examples of unprofessional conduct, including the following:

> (d) Gross negligence or incompetence in the performance of marriage and family therapy.[xxix]
>
> (i) Intentionally or recklessly causing physical or emotional harm to any client.[xxx]

(r) Any conduct in the supervision of any registered intern or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.[xxxi]

The law provides latitude for addressing individual complaints under these statutes. This allows the BBS to bring disciplinary action against clinicians based on the specific nature of the offense.

Sexual interaction with a client is the only type of dual relationship that is specifically addressed by the law. Sexual interaction is also considered to be unprofessional conduct under the law, but the law makes specific note of it. The following Business & Professional Codes deal with sexual relations between a therapist and client:

726**.** The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3. [xxxii]

728. (a) Any psychotherapist or employer of a psychotherapist who becomes aware through a patient that the patient had alleged sexual intercourse or alleged sexual contact with a previous psychotherapist during the course of a prior treatment, shall provide to the patient a brochure promulgated by the department that delineates the rights of, and remedies for, patients who have been involved sexually with their psychotherapist. Further, the psychotherapist or employer shall discuss with the patient the brochure prepared by the department.

(b) Failure to comply with this section constitutes unprofessional conduct. [xxxiii]

729**.** (a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual

intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor. [xxxiv]

California civil code also addresses sex between a therapist and client. Section 49.93(b) states:

> (b) A cause of action against a psychotherapist for sexual contact exists for a patient or former patient for injury caused by sexual contact with the psychotherapist, if the sexual contact occurred under any of the following conditions:
> (1) During the period the patient was receiving psychotherapy from the psychotherapist.
> (2) Within two years following termination of therapy.
> (3) By means of therapeutic deception.[xxxv]

(Sexual deception is when a therapist tells a client that sexual contact is a part of treatment.) [xxxvi]

Common Dual Relationship Traps

Sexual Relationships with Clients:

Dual relationships cross into dangerous territory when they become exploitative of the client, or they impair the clinical judgment of the therapist. Perhaps the most well known example of a harmful dual relationship is when a therapist allows a sexual relationship to

develop with a client. When this happens, the client is exploited for the needs of the therapist, and the therapist's clinical judgment is obviously impaired. Sexual relationships with clients are especially damaging because of the intimacy and physical and emotional vulnerability inherent in sexual relationships. As such, legal and ethical codes specifically address therapist/client sexual relationships.

The ethical standards for both AAMFT and NASW are clear that sexual relationships with former clients should not take place due to the risk of harm to the client. However, both also make clear that if a sexual relationship does take place with a former client, it is up to the therapist to be able to demonstrate that no harm came to the former client out of the sexual relationship. AAMFT designates a two-year minimum after the end of therapy before a therapist can even consider a sexual relationship with a former client. NASW does not specify a minimum number of years prior to beginning a sexual relationship with a former client, but is nevertheless clear that the social worker bears the burden of proof that the relationship is not harmful to the client. Additionally, California civil code states that sex between a psychotherapist and client within two years of terminating therapy is grounds for action against the therapist.

In any case, avoiding sexual relationships with former clients is always the safest policy. If a therapist chooses to pursue a sexual relationship with a former client, the therapist should carefully consider the many issues involved. These issues include—but are not limited to—the nature of the therapeutic relationship with the former client, the length of therapy, the level of transference that developed in the therapeutic relationship, the former client's current level of functioning, and any future ramifications to the former client if the sexual relationship ends.

Unfortunately, sexual relationships with clients happen all too often, and cause harm to clients, their families, and to the professions involved. If a client discloses to a therapist any type of sexual involvement with another therapist, the therapist receiving this disclosure is required by law to give that client the brochure "Professional Therapy Never Includes Sex." The brochure is available on the BBS website, and can be printed and photocopied, or ordered from the BBS. The therapist must also remember that personally

reporting this information without written authorization from the client is a breach of confidentiality. Instead, the therapist who receives this disclosure should support and encourage the client in making the complaint.

Dual Forensic Roles With Clients:

Another type of dual relationship to be aware of and avoid, is the dual forensic role. This happens when a therapist is treating a client in a therapeutic role, but then is asked to play a role as the client's advocate in a legal proceeding. A typical scenario is one in which a therapist is asked by a client to write a letter or report to the court on behalf of the client, or to testify in court on behalf of the client in a way that advances the client's interest in a legal matter. Therapists are often confused because they believe that they have an ethical duty to advocate for their client. Therapists should be aware that their advocacy should be limited to the therapeutic treatment the client receives. The client's attorney is the proper legal advocate for the client, not the therapist.

A treating therapist may also be asked to provide a custody evaluation in a child custody dispute. AAMFT ethical guidelines clearly state that a therapist cannot serve as both the treating therapist and forensic evaluator for custody, residence or visitation to clients involved in these types of actions. NASW ethical guidelines require that social workers clarify their roles to clients when they are in a position of performing in "potentially conflicting roles"[xxxvii] such as custody, residence, or visitation disputes involving clients.

Dual Relationships and Clinical Supervision:

Relationships between supervisors and supervisees are similar in dynamics to therapist/client relationships. Because the supervisor is in a position of authority over the supervisee, and because transference and counter-transference exists within this relationship, the supervisee is vulnerable to exploitation and harm when a supervisor does not maintain professional boundaries.

Both AAMFT and NASW codes of ethics are very clear that dual relationships within the supervisor/supervisee relationship are to be avoided. Supervisors should not provide

therapy to supervisees, nor should they engage in any type of sexual behavior with supervisees. It is the supervisor's duty—not the supervisee's—to establish clear, professional boundaries, and to bear the burden of proof that any dual relationship entered into with a supervisee does not exploit the supervisee's dependency or trust, or cause harm in any way. Supervisors should also avoid entering into a supervisory relationship with someone with whom they have a personal friendship, as this can jeopardize the supervisor's objectivity.

Case Studies

One of the best ways to understand what constitutes unethical and illegal behavior in regards to dual relationships is to review the disciplinary actions taken by the BBS. These actions can be found on the BBS website, and in professional publications.

The following case studies are created for educational purposes. General information has been taken from an extensive review of disciplinary actions by the BBS, but this information has been organized into composite cases. Any resemblance of the facts of these case studies to actual BBS cases is unintentional.

Case Study #1

Summary:

Ned is an MFT in private practice. He begins a therapeutic relationship with a female client, Willa, for treatment of an Adjustment Disorder With Anxious Mood, following her recent divorce. Around the 3rd or 4th session, the client tells the therapist that she is attracted to him. The therapist admits that he is also attracted to her, but tells her that it would be unethical for them to pursue a relationship. Around the 6th session, the client again brings up her attraction to the therapist. The therapist tells Willa that the only way for them to pursue a relationship would be if they were to terminate therapy. Ned rationalizes that the therapeutic relationship has been short-lived enough that no harm will come from termination and pursuit of an intimate relationship. Therapy is terminated at this point, and a sexual relationship ensues. Six months later, Willa is feeling an increase in her anxiety, and is now having difficulty sleeping, which begins to impair her work performance. Furthermore, she is beginning to have doubts about

her relationship with Ned. Willa feels like Ned wants the relationship to move along faster than she wants. She decides to find another therapist, and with the new therapist's support, Willa ends the relationship with Ned and files a complaint with the BBS.

Discussion:

In this case, the treating therapist violated the ethical standard that recommends no sexual relationships with former clients. He further violates the ethical standard that would have required him to wait two years prior to entering a sexual relationship with a former client. The result was actions that opened him up to charges of unprofessional conduct, stemming from emotional harm to the client, and loss of objectivity of the therapist. The therapist could have avoided an unethical dual relationship by addressing the client's attraction within the therapeutic setting, normalizing the attraction, and perhaps exploring it in the context of the recent divorce, while also setting strong professional boundaries. The therapist should have also sought professional consultation for the attraction that he felt for the client, and if this counter-transference could not have been managed professionally, he could have referred the client to another treating therapist.

Case Study #2

Summary:

Hilary is an LCSW in private practice. She runs a personal growth group for women. In the course of one of her groups, she begins a friendship with Liza, one of her clients. They begin talking at the end of each group, and have many similar interests. Hilary also begins to make more personal disclosures within the group, acting almost like a group member. At the end of the therapy group, Hilary offers Liza a job as a live-in babysitter for her 2-year-old daughter, which Liza accepts. Hilary continues to provide individual therapy to Liza at home. Approximately 4

months after moving in with Hilary, Liza begins a relationship with a man, Ron. Hilary becomes controlling and patronizing about Liza's new relationship. Liza is angry that Hilary won't allow her to see Ron in the home she shares with Hilary. The conflict continues for another month until Hilary asks Liza to move out. Liza files a complaint with the BBS against Hilary.

Discussion:

In this case, the treating therapist lost objectivity when she pursued a friendship with a client, which put the client at risk of emotional harm. The therapist further violated professional boundaries by making undue personal disclosures in the group she facilitated, thus jeopardizing the emotional safety of the clients in the group. Hilary's actions of hiring Liza as a live-in babysitter, then acting in a controlling and patronizing way about Liza's new relationship was exploitative of the control she had over Liza as a therapist, and an example of gross negligence and recklessly or intentionally causing harm to a client. Hilary's actions show a lack of professional boundaries on many levels, and an inability to effectively manage counter-transference. Hilary could have avoided harmful dual relationships with a client by setting strong professional boundaries, keeping abreast of ethical standards, and seeking ongoing professional consultation.

Case Study #3

Summary:

Bruce is an MFT supervisor in a community mental health clinic. He is supervising Nancy, an MFT trainee. During the course of supervision, Bruce ascertains from case discussion that Nancy feels discomfort in handling sexual issues that have arisen in sessions with a client. Bruce points out this discomfort to Nancy and suggests that he can help her overcome her discomfort by providing her with a few therapy sessions to address the issue. Nancy goes along with her supervisor's suggestion, though she feels uncomfortable with it. During the course

of the therapy sessions, Bruce asks Nancy to share details of her sexual experiences, and makes numerous statements about sexuality that do not seem to have a therapeutic rationale, including graphic comments about sexual positions and female arousal that seem gratuitous. When Nancy resists sharing personal details about her sex life, Bruce makes humiliating comments of a sexual nature. Nancy becomes increasingly uncomfortable with the supervision process. She reports the situation to one of her professors who facilitates the termination of this supervisory relationship, and encourages Nancy to make a formal complaint.

Discussion:

In this case, the supervisor entered into an unethical dual relationship with a supervisee. Bruce exploited the power of his position with Nancy by conducting therapy sessions with a supervisee, in violation of ethical standards. Bruce further exploited the trust and dependency of Nancy for his own purposes by inappropriately sexualizing the interactions in a way that caused emotional harm to Nancy. Further, Bruce's inappropriate sexualizing of the supervisor/supervisee relationship constituted sexual harassment. Bruce could have avoided a harmful dual relationship by referring Nancy to a therapist instead of providing therapy himself. He should have also kept abreast of ethical standards in regards to supervisor/supervisee relationships, and pursued professional consultation to manage his counter-transference, and individual therapy to address his own issue of sexualizing relationships in which he held a position of power over another.

Case Study #4

Summary:

Doris is an MFT in private practice. She begins treating Fern for depression and anxiety. During the course of treatment, Doris begins to suspect that Fern was sexually molested by her father as a child. Doris suggests this idea to Fern, and also discloses her own sexual abuse as a child. Treatment continues for 5 years, during which Fern's symptoms marginally improve, but continue to impair her functioning. Doris's possible childhood

sexual abuse is a continuing theme. Fern does not have any clear memories of molestation, but she begins to have dreams of being molested by a shadowy figure, and begins to feel a great deal of anxiety around her father, which seems to be exacerbated by therapy. Doris reinforces the idea that Fern was molested, and frequently shares details of her own childhood abuse. Eventually, Fern becomes frustrated with the lack of progress in therapy with Doris and initiates termination. Doris cancels two termination sessions in successive weeks, without rescheduling. Fern begins therapy with another therapist, and finds that her symptoms improve. She begins to doubt that she was molested by her father.

Discussion:

In this case, the therapist lost professional objectivity and failed to manage her counter-transference with Fern, projecting her own abuse history onto her client. Whether or not Fern was molested by her father became extremely difficult to sort out due to Doris's mismanagement of countertransference. Doris's actions put her at risk for charges of unprofessional conduct, negligence, and causing harm to a client. Doris could have avoided this risk by setting clear, professional boundaries at the start of therapy, addressing counter-transference issues in professional consultation and personal therapy, updating treatment goals throughout the course of therapy, and addressing the lack of improvement in Fern's symptoms by revising the treatment plan or considering referral to another therapist. Doris should have also provided an appropriate termination process.

Case Study #5: Business and Therapy Don't Mix

Summary:
Steve, an LCSW in private practice enters a therapeutic relationship with Monte, a Social Work graduate student. Steve sees Monte in weekly therapy sessions for three years to work through family of origin issues. Over the course of treatment, Monte graduates from his degree program, and Steve also provides coaching to Monte for the BBS licensure exam. The relationship begins to feel collegial in addition to the therapist/client dynamic. Monte often uses therapy sessions to discuss cases that he is handling in his new job. Steve offers to rent office space to Monte, and to refer clients to him. Monte begins seeing some clients referred by Steve in the office where he also continues to have sessions with Steve.

Discussion:
In this case, Steve entered a harmful dual relationship with a client by blurring the boundary between client and colleague, and entering into a business relationship with a client. Steve's actions put him at risk for charges of unprofessional conduct. Steve could have avoided this risk by setting clear, professional boundaries at the start of therapy. Steve should not have provided coaching to Monte for the licensure exam, or rented his office to his client.
Steve's actions compromised the therapeutic relationship with Monte.

In all of the above cases, there is evidence of unprofessional conduct stemming from inappropriate dual relationships. In each case, there is evidence of emotional harm to the client or trainee, and a loss of therapeutic objectivity on the part of the therapist. These are only a few examples of dual relationships that result in harm to clients. The key to avoiding harmful dual relationships is to stay aware of the legal and ethical issues at stake, and to always maintain clear, professional boundaries. Seek regular, qualified case consultation before problems arise.

Extended Learning

Take Steps to Protect and Secure Information When Using a Mobile Device

Think about where you store and access your clients' protected health information. Do you text your clients with a mobile phone? Do you keep or access client records on a laptop or tablet? Do your mobile devices go with you outside the office? The most likely answer to at least one of these questions is yes. If so, take some time to go through the list below and think about where you can increase security in order to protect your clients' personal health information.

1. Install and enable encryption to protect health information stored or sent by mobile devices.
2. Use a password or other user authentication.
3. Install and activate wiping and/or remote disabling to erase the data on your mobile device if it is lost or stolen.
4. Disable and do not install or use filesharing applications.

5. Install and enable a firewall to block unauthorized access.
6. Install and enable security software to protect against malicious applications, viruses, spyware, and malware-based attacks.
7. Keep your security software up to date.
8. Research mobile applications (apps) before downloading.
9. Maintain physical control of your mobile device. Know where it is at all times to limit the risk of unauthorized use.
10. Use adequate security to send or receive health information over public Wi-Fi networks.
11. Delete all stored health information on your mobile device before discarding it.

https://www.healthit.gov/sites/default/files/fact-sheet-take-steps-to-protect-information.pdf

Personal Reflection

Use the checklist below to reflect on your own level of professional development in the areas of confidentiality, privilege, and dual relationships in your professional work. Use your answers as a guideline for areas to address to increase your mastery.

- My policies about confidentiality are clearly explained in the documents I share with clients.
- I am confident in talking with my clients about how I protect their confidentiality, and in explaining limits to confidentiality.
- If I were to receive a subpoena, I would know what to do.
- I am careful to avoid talking to clients or about clients in public areas.
- I am careful to avoid identifying information about clients when I seek consultation.
- I have a plan for client records in the event of my incapacitation or death.
- If I use mobile devices in my practice, they are secured with passwords and encryption, and I have procedures in place to protect confidential information in the event that a device is lost or stolen.

- If I use unencrypted texting or emailing in my practice, I obtain written permission from clients to use this communication. I inform my clients of the risks to their personal information using unencrypted channels, and offer secure, alternative ways to contact me if they choose.
- I know if I am a HIPAA covered entity, and I maintain compliance if I am.
- When seeking consent to exchange or release confidential information, I discuss with my clients the specific information to be released, and limit it to the least amount necessary to meet the needs of the client.
- I have a plan for how to respond to a client who expresses that they wish we could be friends.
- I use self-disclosure only when I have a clear rationale for the benefit it provides the client, and I take into account the client's own personal boundaries.
- I am confident discussing multiple roles that I have with supervisees and other colleagues.
- I respond confidently to other professionals who may try to push me into a role I consider ethically challenged.
- I seek consultation when I am unsure of an ethical boundary.

Resources for Further Study

- www.teenhealthlaw.org This website is a project of the National Center for Youth Law, and provides important information about laws in California that impact consent and confidentiality of minors.

References

i BBS News. (2005, Fall). [Electronic Version]. (14), 9.
ii Jensen, D. (2005, September/October). Unlawful and/or Unethical Dual Relationships: A Word to the Wise. The Therapist, 17 (5), 25-29.
iii AAMFT Ethical Standard 1.3
iv AAMFT Ethical Standard 1.4
v AAMFT Ethical Standard 1.5
vi AAMFT Ethical Standard 1.7

vii AAMFT Ethical Standard 3.3
viii AAMFT Ethical Standard 3.4
ix AAMFT Ethical Standard 3.9
x AAMFT Ethical Standard 3.10
xi AAMFT Ethical Standard 3.14
xii AAMFT Ethical Standard 4.1
xiii AAMFT Ethical Standard 4.2
xiv AAMFT Ethical Standard 4.3
xv AAMFT Ethical Standard 4.6
xvi AAMFT Ethical Standard 7.5
xvii NASW Ethical Standards 1.06
xviii NASW Ethical Standards 1.09
xix NASW Ethical Standards 1.10
xx NASW Ethical Standards 1.11
xxi NASW Ethical Standards 1.13(b) xxii NASW Ethical Standards 1.16(d) xxiii NASW Ethical Standards 2.07 xxiv NASW Ethical Standards 2.08
xxv NASW Ethical Standards 3.01(b) xxvi NASW Ethical Standards 3.01(c) xxvii NASW Ethical Standards 3.02(d) xxviii CA B&P Code Section 4982
xxix CA B&P Code Section 4982(d)
xxx CA B&P Code Section 4982(i)
xxxi CA B&P Code Section 4982(r)
xxxii CA B&P Code Section 726
xxxiii CA B&P Code Section 728 (a), (b) xxxiv CA B&P Code Section 729(a)
xxxv CA Civil Code Section 49.93(b)
xxxvi CA Civil Code Section 49.93(a)(5)
xxxvii NASW Ethical Standards 1.06(d)

AAMFT Ethical Standards
CAMFT Ethical Standards
NASW Ethical Standards
California Business & Professions Code 4982(m)
California Business & Professions Code 4992.3(m)
California Civil Code 43.92
California Civil Code 56.11
California Evidence Code 1014
California Evidence Code 1015

California Minor Consent and Confidentiality Laws. California Health and Human Services Agency. Retrieved from http://www.chhs.ca.gov/Child%20Welfare/CA%20Moinior%20Consent%20and%20Confidentiality%20Laws.pdf

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 Retreived from https://aspe.hhs.gov/report/health-insurance-portability-and-

accountability-act-1996

HIPAA for Professionals. U.S. Department of Health and Human Services. Retreived from https://www.hhs.gov/hipaa/for-professionals/index.html

Riemersma, M.J. (September/October 2007). Use of a "No Secrets" Policy in Couple and Family Therapy - An Interview with Richard S. Leslie, J.D. Attorney at Law Interviewer: Mary J. Riemersma, Former Executive Director. *The Therapist.* Retrieved from https://www.camft.org/COS/The_Therapist/Legal_Articles/Mary/No_Secrets_Policy_in_Couple_and_Family_Therapy.aspx

Tarasoff v. Regents of University of California