



LAW & ETHICS:
Part One: Dual Relationships
Part Two: Confidentiality and Privilege
Guidelines for California Social Workers
and Marriage & Family Therapists

6 CEUs



PCE #3226

Course Objectives

After completing this course, the student will:

1. Become familiar with how the BBS defines dual relationships, and recognize the harm that dual relationships can cause within the practice of Marriage & Family Therapy and Licensed Clinical Social Work.
2. Become familiar with ethical standards regarding dual relationships confidentiality and privilege, using the codes of ethics from the American Association for Marriage and Family Therapy (AAMFT), and the National Association of Social Workers (NASW).
3. Become familiar with the California legal statutes that relate to Marriage & Family Therapists (MFTs) and Licensed Clinical Social Workers (LCSWs) in regards to dual relationships with clients.
4. Understand various forms that dual relationships might take in the practice of Marriage & Family Therapy and Licensed Clinical Social Work.
5. Utilize case studies to understand improper dual relationships in clinical practice.
6. Identify sound legal and ethical practices in regards to dual relationships, confidentiality and privilege.
7. Identify exceptions to the mandate of confidentiality permitted or required under California law.
8. Understand the legal concept of privilege and how it relates to confidentiality.
9. Identify important ways that confidentiality and privilege impact professional practice, including record keeping, treatment of minors, treatment of couples, reporting suspected abuse, and managing dangerous patients.

IMPORTANT DISCLAIMER: The information in this course is meant to give the professional an overview of the subject of dual relationships, confidentiality and privilege 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.

Part One: 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 otherwiseⁱⁱ



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 join 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}

Marriage and family therapists do not provide therapy to current students or supervisees.

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 super-

viser 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.

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(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.

Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client.

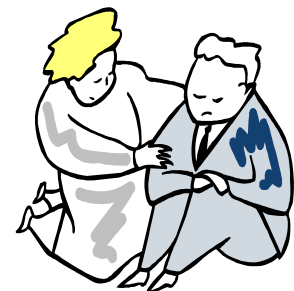
(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives 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}

AAMFT and NASW are concerned with professional conduct between colleagues, students, and supervisees, as well as clients.

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}

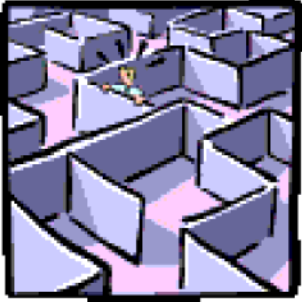
2.08 Sexual Harassment

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:

If a therapist were involved in an exploitative dual relationship with a client, it would be considered unprofessional conduct.

(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. ^{xxx}

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 California 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

Additional Information:

The California Board of Behavioral Sciences (BBS) publishes a helpful guide to the laws pertaining to California licensed MFT's and LCSW's.

LAWS AND REGULATIONS RELATING TO THE PRACTICE OF MARRIAGE AND FAMILY THERAPY, LICENSED CLINICAL SOCIAL WORK, AND LICENSED EDUCATIONAL PSYCHOLOGY is available by contacting the BBS at 1625 North Market Blvd., Suite S-200, Sacramento, CA 95834 Phone: (916) 574-7830 Fax: (916) 574-8625 WEBSITE ADDRESS: <http://www.bbs.ca.gov>.

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}

(Therapeutic 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.

...avoiding sexual relationships with former clients is always the safest policy.

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:

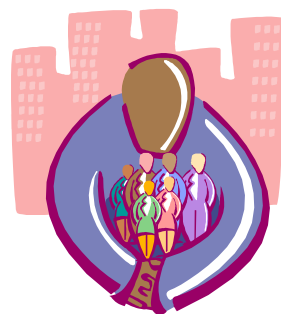


Another type of dual relationship to be aware of and avoid, is the dual forensic role. This happens when a therapist is treating a client in a therapeutic role, but then is asked to play a role as the client's advocate in a legal proceeding. A typical scenario is one in which a therapist is asked by 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.

One of the best ways to understand what constitutes unethical and illegal behavior in regards to dual relationships is to examine case examples. The following examples 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 persons or events is unintentional.

Case Studies

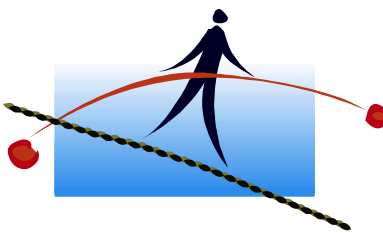
Case Study #1: Sexual Attraction

Summary:

Paul is an MFT in private practice. He begins a therapeutic relationship with a female client, Sally, 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 Sally that the only way for them to pursue a relationship would be if they were to terminate therapy. Paul 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, Sally 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 Paul. Sally feels like Paul wants the relationship to move along faster than she wants. She decides to find another therapist, and with the new therapist's encouragement Sally ends the relationship with Paul 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: Making Friends

Summary:

Hillary 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 Lisa, one of her clients. They begin talking at the end of each group, and have many similar interests. Hillary also begins to make more personal disclosures within the group, acting almost like a group member. At the end of the therapy group, Hillary offers Lisa a job as a live-in babysitter for her 2-year-old daughter, which Lisa accepts. Hillary continues to provide individual therapy to Lisa at home. Approximately 4 months after moving in with Hillary, Lisa begins a relationship with a man, Ryan. Hillary becomes controlling and patronizing about Lisa's new relationship. Lisa is angry that Hillary won't allow her to see Ryan in the home she shares with Hillary. The conflict continues for another month until Hillary asks Lisa to move out. Lisa files a complaint with the BBS against Hillary.

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.

Hillary 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. Hillary's actions of hiring Lisa as a live-in

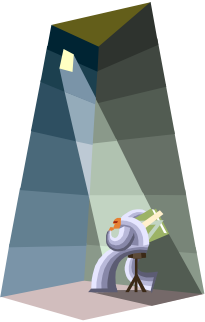
babysitter, then acting in a controlling and patronizing way about Lisa's new relationship was exploitative of the control she had over Lisa as a therapist, and an example of gross negligence and recklessly or intentionally causing harm to a client. Hillary's actions show a lack of professional boundaries on



many levels, and an inability to effectively manage counter-transference. Hillary 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: Supervision Never Includes Therapy

Summary:



Ben is an MFT supervisor in a community mental health clinic. He is supervising Nancy, an MFT trainee. During the course of supervision, Ben ascertains from case discussion that Nancy feels discomfort in handling sexual issues that have arisen in sessions with a client. Ben 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, Ben shares details of his own sex life, and asks Nancy to share details of her sexual experiences. He makes a number of sexual comments that do not have a therapeutic rationale. When Nancy resists sharing personal details about her sex life, Ben makes demeaning comments of a sexual nature. Nancy feels 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. Ben exploited the power of his position with Nancy by conducting therapy sessions with a supervisee, in violation of ethical standards. Ben 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, Ben's inappropriate sexualizing of the supervisor/supervisee relationship constituted sexual harassment. Ben 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: Countertransference

Summary:

Haley is an MFT in private practice. She begins treating Carol for depression and anxiety. During the course of treatment, Haley begins to suspect that Carol was sexually molested by her father as a child. Haley suggests this idea to Carol and also discloses her own sexual abuse as a child. Treatment continues for 5 years, during which Carol's symptoms marginally improve, but continue to impair her functioning. Carol's possible childhood sexual abuse is a continuing theme. Carol 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. Haley reinforces the idea that Carol was molested, and frequently shares details of her own childhood abuse. Eventually, Carol becomes frustrated with the lack of progress in therapy with Haley and initiates termination. Haley cancels two termination sessions in successive weeks, without rescheduling. Carol 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 Carol, projecting her own abuse history onto her client. Whether or not Carol was molested by her father became extremely difficult to sort out due to Haley's mismanagement of countertransference. Haley's actions put her at risk for charges of unprofessional conduct, negligence, and causing harm to a client. Haley 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 Carol's symptoms by revising the treatment plan or considering referral to another therapist. Haley should have also provided an appropriate termination process.

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

Summary:

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

Discussion:

In this case, Chris 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. Chris's actions put him at risk for charges of unprofessional conduct. Chris could have avoided this risk by setting clear, professional boundaries at the start of therapy. Chris should not have provided coaching to Michael for the licensure exam, or rented his office to his client. Chris's actions compromised the therapeutic relationship with Michael.



References

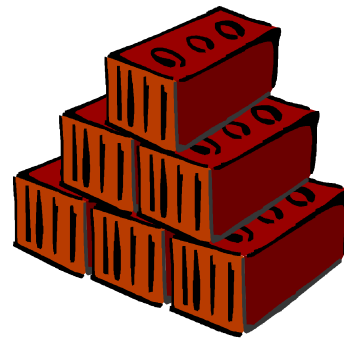
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- ⁱⁱⁱ AAMFT Ethical Standard 1.3
- ^{iv} AAMFT Ethical Standard 1.4
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- ^{viii} AAMFT Ethical Standard 3.4
- ^{ix} AAMFT Ethical Standard 3.9
- ^x AAMFT Ethical Standard 3.10
- ^{xi} AAMFT Ethical 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
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- ^{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)

Part Two: Confidentiality and Privilege

Confidentiality

The principle of confidentiality is a cornerstone of psychotherapy. As therapists, it 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-known 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 is important for mental health professionals to understand both confidentiality and privilege, and how they inform the practice of psychotherapy.

Confidentiality is a cornerstone of psychotherapy



Ethical Standards of Confidentiality

Professional organizations develop ethical principles to guide and inform the practice of their professions. For the purposes of this course, the ethical guidelines of the American Association For Marriage & Family Therapy (AAMFT) and the National Association of Social Workers (NASW) are used. Other professional organizations, such as the California Association of Marriage & Family Therapists (CAMFT), develop similar guidelines for their members. It is strongly recommended that practicing professionals join a professional organization in order to stay informed about important ethical and legal issues that affect their profession. Most organizations provide free, legal and ethical consultation to their members on issues that arise in their professional practice.

AAMFT Ethical Standards of Confidentiality:

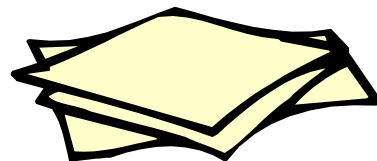
AAMFT offers clear guidelines to its members on the subject of confidentiality. These guidelines cover many aspects of confidentiality, including client interactions, record keeping, teaching, supervising, research, and consultation. It is important to remember that confidentiality informs nearly every aspect of professional practice, and it should be kept in the forefront of every practice decision.

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures. ⁱ

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.

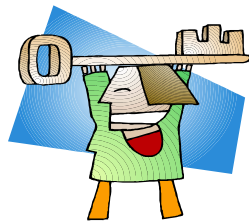
2.2 Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual. ⁱⁱ



As part of their practice, therapists should develop written consent forms to release confidential information that comply with all applicable laws. 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.

2.3 Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Subprinciple 2.2, or when appropriate steps have been taken to protect client identity and confidentiality. ⁱⁱⁱ

If using actual clinical materials, protecting the client's identity is paramount. When you are developing case examples of this nature, imagine your client reading it. If your client could recognize the example as his or her own, you have violated confidentiality. Focusing on process rather than content is the key. Think about the therapeutic process you are conveying—rather than the content—and then build specific details around that process that are generic—not specific to a particular client.



Focusing on process rather than content is the key.

2.4 Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards. ^{iv}

While there are not specific standards on storing records, it is generally considered a good idea to keep client records in a locked file cabinet, and if electronic records are kept, to use password protection. 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.

2.5 Subsequent to the therapist moving from the area, closing the practice, or upon the death of the therapist, a marriage and family therapist arranges for the storage, transfer, or disposal of client records in ways that maintain confidentiality and safeguard the welfare of clients. ^v

This is an important point for therapists in private practice, and one that is routinely overlooked. Having a written policy about the handling of client records, especially in the event of death or incapacitation of the therapist, is crucial to protecting client confidentiality, and a client has 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.



2.6 Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation. ^{vi}

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 keep you focused, and will help you get better feedback from the consultation process.

NASW Ethical Standards:

NASW also has clear standards of confidentiality for its members. These standards cover many aspects of social work, so it is imperative that social workers have a thorough understanding of confidentiality and how it informs their practice.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply. ^{vii}

Social workers process a great deal of information with clients. It is imperative that they be aware of the types of information that are confidential.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. ^{viii}

Because social workers are often in a position to speak for or advocate for their clients, this is allowed within ethical standards as long as a valid consent is available. Social workers need to make sure that the person who gives consent for a client is legally authorized to do so.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. ^{ix}

The exception to confidentiality is made when it is necessary to file a suspected child abuse report, or if the social worker deems the client to be a danger to self or others.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent. ^x

It is always best practice to discuss any disclosure of confidential information with clients, if at all possible. There are times when it is not possible, and may even endanger the safety of the social worker. In these cases, safety is paramount.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.^{xi}

(The above principle is similar to an AAMFT principle discussed in the previous section.)

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.^{xii}

Social workers often 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.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.^{xiii}

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.^{xiv}

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.^{xv}



The above principles give clear, specific guidance to social workers about confidentiality in clinical practice.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

xvi

Whenever a social worker receives a court order regarding a client, it is prudent to consult with their professional association, or other knowledgeable person, such as an attorney, regarding the situation.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media. ^{xvii}

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

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access. ^{xviii}

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible. ^{xix}



(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure. ^{xx}

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death. ^{xxi}

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information. ^{xxii}

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure. ^{xxiii}

(The above principles are similar to AAMFT principles discussed in the previous section.)

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards. ^{xxiv}

The records of a deceased client should continue to be protected. Social workers and therapists are advised to seek legal consultation if this situation arises.



1.08 Access to Records

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records. ^{xxv}

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 can be given that does not include names of other individuals.

Confidentiality and California Law

Professional Statutes

California legal statutes clearly address the issue of confidentiality. The most pertinent statutes pertaining to the practice of Marriage & Family Therapy and Clinical Social Work are found in the Business and Professions Code, and are virtually identical in wording. Confidentiality is addressed in this section of the California Code because it is relevant to the practice of the profession, and is specifically related to what constitutes professional and unprofessional conduct. It is clear from the following statutes that failure to maintain confidentiality is not only unethical, but also unlawful.

The following section pertains to Marriage & Family Therapists:

4982. The 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. Unprofessional conduct shall include, but not be limited to:

(m) 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. ^{xxvi}

The following section pertains to Clinical Social Workers:

4992.3. The board may refuse to issue a registration or a 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 includes, but is not limited to:

(m) 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. ^{xxvii}

From the statutes above, it is clear that failure to maintain client confidentiality is considered unprofessional conduct, and is grounds for suspension or revocation a therapist's license.

Release of Confidential Medical Information

Another section of California law that has pertinence to a 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.

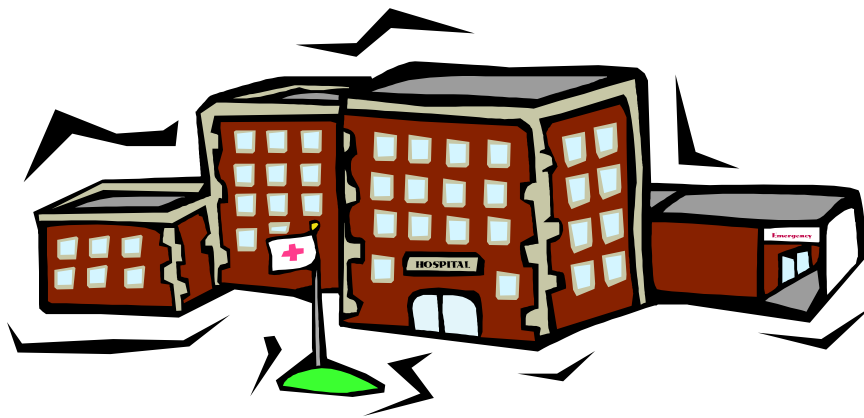
(e) States the name or functions of the provider of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information.

(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.^{xxviii}



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 CONFIDENTIAL INFORMATION

I (Name of Client) authorize (Name of Therapist) to release (Specific Type of Information) to (Name of Recipient) for the purpose of (Specific Purpose of Information). This release will be in effect from (Effective Date) to (Date of Expiration). I understand that I am authorized to receive a copy of this authorization.

Signature of Client

Date

Patient Dangerous to Self or Others

California Civil Code also 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.

The psychotherapist must make reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.



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.^{xxix}

(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.^{xxx}

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.

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. ^{xxxii}

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.^{xxxii}

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 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.

The therapist needs to assert the privilege until instructed otherwise by the client or the court.

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.

Special Issues In Clinical Practice

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. Client records should be secured, typically in a locked file cabinet. Electronic files should be password protected. 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 that you will not acknowledge a



client if you see them in public, unless they initiate contact. 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 acknowl-

edge 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.

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. A complete discussion of each of these exceptions is beyond the scope of this course. Therapists should stay abreast of changes in the law that affects their obligations regarding these issues.

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.

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^{xxxiii} discussed previously. Under the landmark Tarasoff decision,^{xxxiv} 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, or any other source of professional advice that they choose to use.



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.

Treatment of Minors

It sometimes comes as a surprise to therapists that the parent of a minor child does not hold privilege for the child. As discussed previously, the child holds 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 appointed 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 will need 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.

Treatment of Couples/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. If a therapist is treating a couple or family, generally it will be the couple or family who is the client. 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.



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.

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. It 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.

Having a “No Secrets” policy ensures that the therapist will not be triangulated into the family system.

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.



Conclusion

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 regards to confidentiality and privilege is to examine case studies of possible clinical scenarios. Any resemblance of the facts of these case studies to actual people or events is unintentional.

Case Study #1: A Custody Dispute

Evelyn is an MFT working in a clinic setting. She begins seeing a couple, Nora and her husband Leo, for marital therapy. One issue in the marriage is how to deal with their 4-year-old son's 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 working on a plan to get Leo more involved in managing their son's asthma, but



Leo is resistant, 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 (a son, and a daughter, age 6) becomes a point of contention, as Nora believes that Leo is a danger to their son. Nora states that Leo continues to smoke in the children's presence, and does not give their son'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 boy'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 courts 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, this necessitates a Suspected Child Abuse Report to the proper authorities, in which case confidentiality can lawfully be 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 do not meet the requirements of imminent, serious physical harm threatened to another.



If the therapist believes that a child is in danger, this necessitates a Suspected Child Abuse Report to the proper authorities.

Case Study #2: Safeguarding Client Records

Gary is an LCSW who works for a foster family agency. He frequently transports written client records 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 define 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, an LCSW, 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.

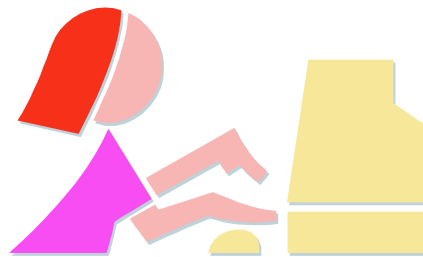


Discussion

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, an MFT, 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 MySpace.com. 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 on MySpace 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 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 harm 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. 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. An alternate approach to this situation would have been to treat this problem in the context of family therapy. If this approach had been taken, a "No Secrets" policy could 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. This would have allowed the therapist to request that the child share the information in a family session, or the therapist would share the information for the purpose of advancing the goal of better communication 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.

References

- i AAMFT Ethical Standard 2.1
- ii AAMFT Ethical Standard 2.2
- iii AAMFT Ethical Standard 2.3
- iv AAMFT Ethical Standard 2.4
- v AAMFT Ethical Standard 2.5
- vi AAMFT Ethical Standard 2.6
- vii NASW Ethical Standard 1.07 (a)
- viii NASW Ethical Standard 1.07 (b)
- ix NASW Ethical Standard 1.07 (c)
- x NASW Ethical Standard 1.07 (d)
- xi NASW Ethical Standard 1.07 (e)
- xii NASW Ethical Standard 1.07 (f)
- xiii NASW Ethical Standard 1.07 (g)
- xiv NASW Ethical Standard 1.07 (h)
- xv NASW Ethical Standard 1.07 (i)
- xvi NASW Ethical Standard 1.07 (j)
- xvii NASW Ethical Standard 1.07 (k)

- xviii NASW Ethical Standard 1.07 (l)
- xix NASW Ethical Standard 1.07 (m)
- xx NASW Ethical Standard 1.07 (n)
- xxi NASW Ethical Standard 1.07 (o)
- xxii NASW Ethical Standard 1.07 (p)
- xxiii NASW Ethical Standard 1.07 (q)
- xxiv NASW Ethical Standard 1.07 (r)
- xxv NASW Ethical Standard 1.08 (b)
- xxvi California Business & Professions Code 4982(m)
- xxvii California Business & Professions Code 4992.3(m)
- xxviii California Civil Code 56.11
- xxix California Civil Code 43.92(a)
- xxx California Civil Code 43.92(b)
- xxxi California Evidence Code 1014
- xxxii California Evidence Code 1015
- xxxiii California Civil Code 43.92
- xxxiv Tarasoff v. Regents of University of California

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