Ethics and Boundaries in Clinical Practice

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Material and wording is for training purposes and does not have full completeness of the statutes or agency policy. In making a clinical decision or prior to taking action, you should refer to agency policy, state/federal statutes and consult with your supervisor for complete information.

Think of Ethical Dilemma at Work

- Remember an ethical dilemma you dealt with at work (or someone else’s)*
  - Ethical dilemmas not exceptional, but expectable
  - Sometimes we don’t recall ethical decision-making because we’ve internalized ethical principles to such extent we don’t stop to consider whether the decision we have made has ethical ramifications
- Were you able to resolve it?
- How were you able to resolve it?
Ethics in Clinical Practice: Learning How to Draw the Line

What is Ethics?
- Morals/principles are basis for ethics
  - Ethics are moral values/guiding principles in action
- Professions use ethical principles to develop ethics codes to guide the conduct of their members
- Ethical code is a set of rules that define allowable actions or correct behaviors...doing the right thing in a given circumstance
  - Challenge comes in determining the right thing
- Right and wrong is in the action, not the result

Ethics Help Us Professionally
- Increase the awareness of our professional responsibilities to clients and colleagues
  - Put aside own interests, including right to follow one’s own values/principles, in order to take care of the best interests of the client and public
- Manage challenges of increasing work demands and complexities of client issues
- Develop strategies when ethics and values conflict with professional expectations and responsibilities
- Help us to honestly reflect on any biases, risk factors and blind spots that may exist for us
As Ethical Decision Makers...
- Client-centered
- Collaborative
- Trauma-informed
- Do no harm to client
- Practice focused on client needs
- Remove or minimize coercion
- Empathic and empowering vs. enabling and rescuing

Challenge of Ethical Self-Reflection
- Use ethical self-reflection as a way to learn about ourselves as ethical decision makers
- We are likely to be influenced by our cultural background, beliefs, our professional role, organizational culture, stereotypes/biases
- When client’s values conflict with our personal and professional beliefs, do we consciously consider whose interests are being served?
- Recognize our individual style or pattern that filters into our response to ethical dilemmas

Key Concepts
- Privacy
- Privilege
- Confidentiality
Privacy
- Right of individual to choose what others beyond the provider may know about them and under what circumstances
- HIPAA Privacy Rights exceptions
  - In referral or emergency situations
  - Ask what do they need-to-know to do their job?
  - Ask yourself what do you want them to do?

Privilege
- Privileged communication is the conversation that takes place within context of a protected relationship between clinician & client
- Privileged communication is a legal concept protecting the right of clients to prevent testimony in a court proceeding
- WI Statutes specifically include physicians, nurses, psychologists, social workers, professional counselors and marriage and family therapists

Confidentiality
- Safeguards clients from unauthorized disclosure of information given in therapeutic relationships
- Ethical and legal responsibility for professionals
- Covered under WI Administrative Code Treatment Rights, Chapter 51 Statutes and case law
- Clinical, legal, ethical, cultural and safety issues must be considered when sharing any confidential info
  - Balance of respect for client confidentiality and concern for clients’ and others’ safety and welfare
- We can protect client confidentiality and still exercise good clinical judgment
Rationale for Confidentiality

- To encourage clients to fully and freely disclose to therapists to ensure they receive the best care
- With expectation information won’t be disclosed to their disadvantage
- Everything is presumed confidential unless there is a specific reason to breach
- Wisconsin has *broad and liberal* interpretation in favor of *protecting* client confidentiality

Universal Values
Ethical Codes

Ethical Standards and Principles

- *Ethical standards/rules* based on principles of right and wrong + professional duties/obligations
- Principles promote values (trust, fairness, kindness) → doing more than bare minimum
- Ethical standards are used by members of profession to determine the right course or action in a situation by providing *general* guidelines (but not practical ethical decision making)
- Ethical decision making is *cognitive* process using logical and rational criteria to reach a decision
Professional Values Guide Our Practice

- Mental health and substance use treatment not “value-free”
- Your values are your personal & professional standards of right and wrong and serve as your basis for making ethical decisions
- When you elect to become member of a profession, you are agreeing to comply with standards of that profession including code of ethics and values

Universal Values*

- **Autonomy**: respect for client’s freedom of choice & action, promote self-determination, empowering decision making so free as possible under the circumstances
- **Beneficence**: help others/do good, prevent harm
- **Non-maleficence**: don’t hurt anyone including risking harm to others, avoiding unnecessary/unjustifiable harm
- **Justice**: be fair by giving equally, treating others justly
- **Fidelity**: trust/keep promises/realistic commitments
- **Discretion**: respect privacy
- **Loyalty**: don’t abandon
- **Stewardship**: conserving resources

Ethical Codes

- Ethics codes (NAADAC, NASW, APA, LPC, AAMFT)
  - Principle-based ethics founded on core values
  - Some aspirational, others enforceable guidelines for professional conduct
  - Don’t include federal laws or case law
- Codes and standards inform rather than determine our ethical decisions and clinical conduct
- Ethical codes and standards cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities in clinical practice
Informed Thinking

- Finding relevant ethics codes, legal standards, policies/procedures doesn’t tell us the most ethical approach to specific situation, but will guide us
- What guides our decision making?
  - Are we rule-based/standard of care or ends-based/greatest good for the most people
  - Are we willing to acknowledge we don’t have all the answers and are open to feedback (humility)
- Finding the information does not mark end of the process, but rather the beginning of informed thinking about the specific case

Reflect on Your Risk Tolerance

- Resolving ethical dilemmas involves risk tolerance
- What is my comfort level with risk for client and yourself to achieve a goal or purpose?
- How comfortable am I with uncertainty & ambiguity?
- Is my personal and professional tolerance for risk similar or different?
- Am I guided by deontological principles (rules) or teleological principles (consequences)?
- What were the contributing factors when my risk tolerance may have been too high or too low?

Ethical Issues in Mental Health and Substance Use Work

- Confidentiality in situations of potential risk
  - Duty to protect and warn (beneficence for community)
  - Suicidal crises (beneficence for client)
- Ethical issues around forced treatment/detentions
- Respect for client’s autonomy vs. paternalism or “clinical authority”
- Respect for client’s ethnicity, culture, practices
- Boundary crossings involving self disclosure, dual roles/relationships
Ethical Challenges in Clinical Care

- The way to comply with ethical standards may not be easy or readily apparent
- Ethical dilemma = two competing/conflicting standards may appear equally appropriate
- In certain cases, we may need to construct or create a solution instead of looking for the enforceable standards in our ethics codes
- No outcome conforms to all ethical principles in code of ethics

Case Example
Your client has been brought to your agency by her concerned father. She tells her father to leave before she is willing to talk with you. She says she was brought to a nearby hospital emergency room by police “because they are stupid and they thought I was suicidal, which I am not.” She was seen by a doctor there and then she walked out; it is not clear if she was discharged or just left. Her father persuaded her to come to clinic to get help. She refuses to allow you to talk to her father or call the other ER or speak to her psychiatrist. She says that she just broke up with her boyfriend, was at his apartment and upset. She threatened to take a handful of pills and he called the police who took her to the ER and called her father. She is now okay and wants to go back to her own apartment.

How Would You Proceed?
- What ethical issues are involved if you…
  - Talk to her father, or
  - Call the other ER, or
  - Talk with police who brought her to hospital ER?
- What justification/s (your need to know to do your job) would you use to talk with father & ER?
- What justification/s suggests you should not?
- What are the ethical, legal, clinical or policies you need to consider in your decision?
**Analysis Involves Asking Questions**

- What is this case about, what is at issue and where is the conflict?
- What do we know about other paradigm cases like this one and is there a clear precedent?
- Ask yourself, “If I engage in this action will it be in my client’s best interest?”
- Asking questions helps the clinician to think clearly about what is at issue and identify best course of action available to them

**Why Worry About Ethics and Boundaries?**

Because we will “get it wrong” if we do not think about the issues ahead of time

**We Intend to Do the Right Thing**

- Issue is NOT malevolence or bad intentions
- Problem is unintended consequences
- Confusion over ethical and boundary issues
- Dilemmas or conflicts between competing goods
- “Right thing to do” often confuses legal, policy and ethical issues
- Community-based, recovery-focused programming complicates ethics & boundary issues compared to traditional inpatient/outpatient treatment
Vulnerable to Justifications

- We are conscientious, caring professionals committed to ethical behavior, but…
- We get tired, afraid, under pressure or in conflict
- We can lose perspective, get confused or angry
- Rationalization and thinking errors can fool us by making something unethical seem ethical
- None of us is infallible so we are vulnerable to justifying our behaviors

Justify Behavior as Ethical

- It’s ethical as long as no one complains about it
- It’s ethical if supervisor says it’s okay
- It’s ethical as long as we can say
  - “Anyone else” would have done the same thing
  - “It came from the heart (or gut)”
  - “I just knew that’s what the client needed”
- It’s ethical if we could not (or did not) anticipate the unintended consequences of our acts

How We Think and Make Decisions

- Intuitive
- Automatic
- Emotional
- Rapid

How we should think to make decisions

- Slow down to make good ethical decision
- Avoid “all or nothing” thinking
- Generate lots of alternatives to avoid overconfidence and oversimplification
- Outcome may feel ambiguous or uncertain

Pope, Sonne & Greene, 2006
Self-Awareness/Self-Reflection

- How do our own needs/issues contribute to these situations?
  - Making any decision reduces anxiety, but not always best decision
- Do we integrate colleagues into this process or isolate ourselves professionally attempting to work through these issues on our own?
- Do we actively reach out to and use our co-workers to assist us in promoting highest possible standards of ethical conduct and practice?

Beware of Common Ethical Traps

- Objectivity trap: over-identifying or over-invested with affected client, family, community
- Value trap: Clinician’s values about who should be served
- Circumstantialities trap: the belief substance use counseling is a unique circumstance (magnitude of the problem, lack of resources and support services, etc.) so traditional values and practices do not need to be followed

Pay Attention to Career Risk Points

- Recent graduate, inexperienced with ethics and boundaries, new to functioning independently,
- Mid-age when personal/professional goals may not have panned out, divorce/family problems
- Older therapists have come to see themselves as “evolved” beyond questioning or as having earned some sort of “senior pass” giving the freedom to do things their own way
We plan from the mountain, but work in the swamp

In workshops like this everything is clear and pristine and it is obvious what to do and what is right. But when we are with consumers we descend into the swamp where it is hard to see where paths lay and what direction we are really following. Yet it is in the swamp where we do our work.

Adapted from Don Schoner

Practical Application: Ethical Decision-Making Model

Ethical Dilemma
Ethical Decision Making/EDM
- Ethical dilemmas = when two competing principles need ethical decision-making model to promote critical thinking and reflection
- Move ethical decision making from intuitive towards cognitive by offering step-by-step approach
- Needed when clinical, legal, risk management overlap
- Most professional codes don’t provide a EDM model or strategies when facing ethical dilemma
- Which EDM model you use isn’t as important as having one when facing ethical choices

Recognize an Ethical Issue
- Most critical step is to recognize the problem
  - State the ethical issue or question
  - Identify the competing values and principles
  - What makes it an ethical problem?
- If the decisions at hand are a simple matter of right and wrong, no process of ethical decision making required
- Is it a legal or technical decision, complaint or performance issue?
  - Is this your/my decision to make?

Identify Stakeholders
- Client (focus on primary stakeholder first)
- Family/friends, natural supports
- Involved clinical professionals
- You, your practice, agency/organization or hospital
- Legal systems
- Community/public safety
- Perspective-taking using empathy
**Good Ethics Start with Good Facts**

- “She took a bunch of pills”
  - How many, what kind, in front of whom, context
- “He threatened to shoot himself with a gun”
  - Did he have a gun? Was it loaded? Who did he make the threat to? In what context? What happened next?
- “He became violent”
  - What did he do, describe behaviors? Was anyone hurt? How did it start, how did it end?

**Gather Facts to Define Ethical Issues**

- Review the available, relevant information
  - Don’t jump to conclusions or proceed without facts
  - Clarify any assumptions you are making
- Ask who, what, when, where, why & how questions
- Facts may be difficult to find because some not immediately available
- Test for right vs. right values = ethical dilemmas
  - Short term benefits vs. long term consequences
  - Client autonomy vs. beneficence or nonmalefeasance
- What ethical guidelines are relevant to this situation

**Identify the ethical, legal, policy and clinical issues guiding this decision**

- Ethical Issues/Code: two good or right core values are in conflict with one another?
- Legal Issues: what laws and liabilities apply?
- Agency Policy: what are my agencies practices/processes and values that apply?
- What do I feel is clinically best for the client?
- What is the ethically right thing to do?
Consider What is at Stake
- Which stakeholder’s interest is most important and why? What is the highest value?
- Which alternative will cause greatest good or least harm to stakeholders?
- Identify consequences: magnitude and probability of good or bad outcomes?
- How much risk is the right amount to take?
- Perspective-taking – try to see things through the eyes of those affected individuals

Brainstorm/Evaluate Options
- Look for applicable precedents and outcomes
- Evaluate options
  - Discard options which you can’t put into action
  - Which will produce most good & do least harm?
  - Which option best addresses situation?
- Frame a preliminary response
- Seek out advice and wisdom of others

Use the Rule of “3”
- Ethics practice is a “team activity”
- Try to discuss difficult decisions with at least 3 colleagues, supervisors, advisors, experts
  - Why did you choose these colleagues & not others?
- Involving colleagues does not guarantee ethically correct decisions, but being unwilling or uncomfortable to involve colleagues suggests a problem with the decision
Test Options
- Outcomes: More beneficial outcome than other alternatives?
- Transparency: Would you or agency be concerned if decision appeared as top story in news?
- Rationality: Could you present rational explanation of decision to others, colleagues, supervisors?
- Switching places: How would I feel if someone did this to me?
- Values: Is decision consistent with my organization's values and mission?
- Authority: What does/would the organization's ethics officer or legal counsel say about this decision?

Be Aware of What Gets in the Way
- We are not sure what the "right thing" is
- Easier to think about how it will go right than how it will go wrong
- Thinking it through too hard, too long, too complex
- Often we are getting some benefit when not doing right thing (whether we wish to acknowledge it or not)
- Causes problems with co-workers and even supervisors and other stakeholders

Keep Your Ethical Bearings
- Clinicians should keep their clinical hat on while focusing on their ethical compass
  - Clinical hat = err on side of responsibility to care for the client
  - Ethical compass = what is the right thing in the context of the current situation
- You may lose your “ethical bearings”
  - Internal and external pressures from other departments, agencies or professions
  - Farther you are from your “clinical home-base,” the easier it can be to lose your ethical bearings
Implement, Monitor & Document

- Review and take action
  - Take time to rethink or reconsider
- Identify what lesson(s) have been learned for the future
- What, if anything, could be done differently the next time a similar situation arises
- Ask is there a way to implement this so that it has the effect of making this problem less likely to occur in the future?
- Document as appropriate for future reference

EDM Model Review

- Always ask, “is it an ethical issue?”
- What are the competing ethical principles?
- Identify emotions and biases in decision-making
- Consider range of possible solutions + pros/cons
- Ask yourself what are my reasons for prioritizing one competing value over another
- Construct or create a solution to work through dilemma vs. finding answer in code or law
- Consult with others/supervisors
- Implement, document and monitor to evaluate

Confidentiality

Exceptions
Confidentiality

- Safeguards clients from unauthorized disclosure of information given in therapeutic relationships
- Covered under WI Administrative Code/Treatment Rights, WI Stat. Chapter 51 and case law
  - Ethical and legal responsibility for professionals
  - Clinical, legal, ethical, cultural and safety issues must be considered when sharing any confidential info
  - Balance of respect for client confidentiality and concern for clients' and others' safety and welfare
- We can protect client confidentiality and still exercise good clinical judgment

Rationale for Confidentiality

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HIPAA

- Health Insurance Portability and Accountability Act of 1996 limits disclosure of sensitive information including HIV status, substance use and mental health treatment, domestic violence, sexual assault
- Confidentiality regulations enforced by federal law
- HIPAA permits disclosure of client information without consent to coordinate treatment and in case of emergency
- Sharing clinical information is central to the effectiveness, efficiency and quality of client care
Confidentiality regulations are established in the “Confidentiality of Alcohol and Drug Abuse Patient Records Act” (42 CFR Part 2). These regulations acknowledge the complex legal and social issues surrounding the effective and efficient treatment of this type of disorder. This additional layer of protection is intended to encourage those with a substance use disorder to seek treatment (otherwise, protections would not extend beyond those afforded by HIPAA allowing potentially damaging information accessible to law enforcement, legal system, insurance organizations).

Withhold vs. Share?

- HIPAA & 42 CFR Part 2 are intended to support (not impede) the appropriate exchange of client information.
- There may be a tendency among providers to withhold client information that actually should be shared, often out of a simple misunderstanding of the rules and regulations.
- When information that should be shared is withheld, the effectiveness, efficiency, and quality of care can be significantly diminished.

Exceptions to Confidentiality

- Duty of confidentiality not absolute & must give way to protect client or community from immediate danger.
  - “Only exception is if the client is in imminent danger of harming self or others in a life-threatening manner.”
  - “Administrators, senior clinical supervisors should make decision if client’s right to confidentiality is to be compromised.”
- Confidentiality can be broken in cases of child or elder abuse, gravely disabled (involve supervisor/manager).
- Protective privilege ends when public peril begins.
- Challenge is boundary keeps changing.
4 C’s Confidentiality Exceptions

- Consent
- Court order
  - Subpoena must be issued by judge
- Comply with law/mandatory reporting
  - Child abuse
  - Caregiver misconduct
  - Elder/adults at risk
- Communicate threat

“Dangerous Patient Exception”

- Duty of confidentiality gives way to duty to warn
- Harm must be imminent (very likely to occur in near future)
- Victim does not need to be identified directly since WI duty is owed for “generalized statements of dangerous intent”
- Exception broadly encompasses duty to protect, warn and take all steps reasonably necessary including protecting yourself

Before Breaching Confidentiality

- How immediately dangerous is situation?
- What biases do I have (if any)?
- What actions are reasonable?
- What are consequences of breach?
- Don’t cave into anxiety and make hasty decision
- Use consultation whenever possible
- Document decision making process
Duty to Protect and Warn*

Duty to Protect and Warn

- Final Tarasoff decision in California
  - Clinicians, who know or should know of client’s dangerousness to identifiable person/s, have obligation/duty to take all reasonable steps to protect potential victims
  - Defined duty more broadly as duty to protect
  - Duty comes out of special relationship of trust and confidentiality between clinician/client
  - Breaking confidentiality is not only way to protect so clinician should consider other steps

“Special Relationship”

- Under law, no duty to protect potential victim from negligent or intentional behavior of another but...
  - Law makes exception when a special relationship between parties incurs a duty to control conduct of or protect another person
  - Declaring professional relationship as “special” undermines what makes it special – trust and confidentiality
  - Duty to report applies to both mental health and substance use counselors

*DTPW Applies to both mental health and substance abuse counselors
WI Duty to Protect and Warn

- Schuster v. Altenberg, 144 WI 2d 223, 1988, case law decision by WI Supreme Court
- Clinician may be liable if they fail to take action that is reasonably necessary to prevent individual, who poses foreseeable danger, from causing harm to self or to public at large
- Expanded existing duty to protect and warn to both identifiable victim/s and to all victims in the “zone of danger”

Ethical-Legal Issues

- Courts have forced “solution” to ethical dilemma by imposing legal duty
  - Obligation to use reasonable care to protect victims
- Clinician owes duty of care to all who are foreseeably endangered by conduct of client
- Have to make choice between fundamental ethical principles which underlie practice of mental health and substance use treatment
  - Fidelity/trust, loyalty, discretion – confidentiality
  - Non-malfeasance – minimizing/preventing harm

Clinical Teeter Totter

- Balancing right of clients to confidentiality against duty to protect 3rd parties from potential violence from clients
- Start with client privacy outweighing public peril
- Re-balance competing interests of confidentiality with public protection
- Public peril is higher priority than preservation of client trust & confidentiality, so teeter totter shifts
- Mental health/substance use professionals have duty to their client, but also have duty to others
- Confidentiality must give way to public safety
Wisconsin Case Law

- Wisconsin case law says, if there is foreseeable danger, the clinician needs to inform and take action to protect unforeseeable victim/s.
- Foreseeability:
  - Used when certainty is not available
  - Reasonable anticipation of harm or injury likely to result from certain acts or omissions
  - Greater safety concerns are...the fewer confidentiality protections

Applying Foreseeability in Practice

- Law does not require clinicians to foresee all events that are possible, only those that are reasonably foreseeable.
- Behavior you believe will happen in the future in the context of what you have been seeing/hearing
- Information allows you to break the seal of confidentiality creating an exception to privilege
- Consult supervisors and co-workers
- Must defend foreseeability in your clinical note

Who Could be Warned?

- How is warning issued and to whom?
- Identifiable victim/s or family/friends
- Law enforcement, schools, employer
- How much information is shared?
- Warning is one component of discharging duty
- Protective actions also need to be taken by clinician
- Often clinicians act too quickly & unreasonably complying with legal duty over ethical duty and may face liability for violating client privilege
Tell Client about Warning?

- No legal duty to tell client
- Inform client about types of situations where information may be disclosed
- Give notice at beginning of treatment about professional duty to inform when potential for danger (informed consent)
- Remind client *during* treatment of professional duty if indicated

Alternatives to Breaching Confidentiality

- Hospitalization or other secure setting (Detox)
  - Voluntary or involuntary
- Intensive outpatient or day treatment
- Change or shift focus of treatment
- Change or increase medications/monitoring
- Collateral sessions with social supports
- Regular check-ins, safety planning, restricting access to lethal means
- Managing/monitoring risk and safety plan
- Document protective actions taken to decrease risk

Warn vs. Assess/Manage Violence

- Most errors are clinical and not failure to warn
- Overemphasis on threats & warnings with less attention to assessment and treatment
- Tend to warn vs. use therapeutic interventions to manage and treat violence
- What is required is risk assessment for violence and implementation of protective action plan to manage risk of violence
Clinical Challenges

- No clear clinical standard of care exists for accurate prediction of violence because of the difficulty predicting dangerousness
- Breach of confidentiality disrupts therapy alliance
- Detriment to ongoing therapy because clients won’t disclose violent thoughts/fantasies
- Anxiety over legal sanctions for failure to anticipate violent acts leads to over-predictions of violence

Positive Use of Warnings

- May keep clients from carrying out violent acts which could result in being incarcerated
- Responding to client’s “cry for help”
- Reporting serious threat shows clinician cares enough to set limits on self-destructiveness and demands client act responsibly

Boundaries
Professional Boundaries

- Boundaries = “professional property lines”
  - Line between self of the client and self of clinician
  - Not clear/bright or hard and fast
  - Depends on type and stage of treatment
- Where we have limits and limitations
  - Skill of knowing and understanding our limits
- How and when we let people into our professional space, whether physically or psychologically
- Clinicians understand concept of boundaries, but using it as a skill in clinical practice more challenging

Function of Boundaries

- Needed to make relationship safe between people with different power and influence
  - When roles are clear, anxiety is reduced
- Protects client/consumer
- Protects professional
- Protects therapy relationship
  - Safe, consistent, reliable and sustainable
  - Serves as role model for clients
- To enhance our ethical awareness-ongoing questioning/responsibility for welfare of client

A Continuum of Professional Boundaries

- Under-involved
  - Distancing
  - Disinterest
  - Neglect
  - Detachment
  - Client feels rejected abandoned,
- ZONE OF HELPFULNESS
- Over-involved
  - Boundary Crossings
  - Boundary Violations
Under-Involvement

- Lack of preparation for session
  - Unfocused, superficial content of sessions
- Failure or delays in returning phone calls
- Decrease of frequency/length of sessions
- Adversarial relationship with clients
  - Disrespect, cold/detached, labeling
- Abandonment
  - Precipitous, unprocessed terminations
  - "Firing of client" in a crisis or emergency
- High caseload, burnout, lack of supervision

Over-Involvement

- Desire to help, save, rescue clients
- Over-identification with client’s issues
- Strong attraction to client’s personality
- Clients enjoy feeling “special” or making clinician feel special/revered, “guru”
  - More available, longer/more frequent sessions
  - Promotes excessive client dependency

Blurry Boundaries

- Saying “yes” or feeling obligated to say “yes”
- Pleasing, victim role, sacrificing, often leads to resentment and more invalidation
- Gives message it’s ok to violate your boundaries
- Being too responsible for others can lead to burn out
- Too much empathy - taking on moods and feelings of others makes it difficult to see yourself as separate and distinct from others
- Not expressing your wants, preferences or needs
- Overstepping others’ boundaries
**Professional Manages Boundaries**

- Clinician sets rules and expectations of space, time, focus and roles in professional relationship
  - Power imbalance
    - Clinician has power and control
    - Clinician recognizes vulnerability of client
  - Client not aware of need for boundaries or be able to defend themselves from violations
- Fiduciary duty to act in the best interest of the client, based on needs, not wants
- Rights of client respected and honored

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**Healthy Boundaries**

- Help client exercise personal autonomy and self-determination
- Help client see themselves apart from illness
- Invite and value consumer input & participation
  - Accept individual emotions and disagreements as personal expression vs. pathology
  - Interest in hearing client’s experience of urge to use, psychosis, depression and not just responding by increasing medication, labeling or hospitalizing
- Helps clinician minimize use of involuntary, coercive or intrusive actions

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**Boundaries Building/Sustaining**

- Managing boundaries somewhat like walking a tightrope, trying to get a balance between various different elements
- The line is ever-changing...the skill is learning where to draw the line
- Boundaries essential part of clinical work
  - To serve as a role model for clients
  - To avoid feeding into clients’ vulnerability
  - To build independence and empower clients
  - To provide professional oversight/objectivity while providing treatment
Unavoidable Dual Relationships

- Small communities, towns, villages with few mental health resources - unplanned/inevitable personal and professional involvement
- Multiple roles/dual relationships exist between clinician and client/family members
- Being provider vs. being agent of social control
  - Reporting violations as basis for return or jail
  - Court-ordered treatment, detentions/extensions
- Consumers as colleagues: peer specialists, paraprofessionals or volunteers

Unintentional Boundary Issues

- Same neighborhood, place of worship, social events, funerals, celebrations, support groups
  - Self-disclosure
  - Friend vs. friendly
- Ethnic, faith-based, cultural, LGBT communities
- AA, NA, Al-Anon recovery groups
- Patronize same businesses or recreational sites
- Boundary adaptations for overlapping and dual relationships
- Prior discussions about chance meeting

Trauma-Informed EB Practice

- Trauma = assault on body, feelings, thoughts
- Ethics/boundary issues magnified in trauma work
  - Trauma treatment – “First do no more harm”
- Risk of re-traumatization for client
- Risk of vicarious traumatization for clinician
  - Perspectives/beliefs altered by repeated and prolonged exposure to trauma of others
- Clinicians with secondary traumatic stress, burnout, ethical exhaustion, moral distress increased risk for boundary violations
**Culture Counts**

- Educate yourself about the norms and customs
  - Eye contact, personal space, time, client/clinician sharing personal information, gift giving/receiving
- Openness/informality, shared meals, rituals, singing, touching and storytelling occurring outside of the traditional office or clinic setting
- Consult to learn what boundary issues you might encounter and how they can be best resolved in a culturally appropriate manner
- When boundary issues arise, work with client to resolve them as mutual learning experience

**Managing Boundaries of Privacy**

- Sharing networks: recovery, residential, inpatient
- Co-participating in support, faith, work groups
  - Challenge client/clinician privacy boundaries
- Unintentional or accidental self-disclosure
- Feel inhibited to talk openly in front of current, former and future clients about own difficulties
- Fear of disclosing information that could undermine authority and skills or burden others
- What information willing to disclose and how to make decisions about intentional self-disclosure

**Self-Disclosure**
Mode of Therapy

- CBT therapists view self-disclosure as technique to enhance working alliance, modeling behavior, instilling hope and trust.
- Humanistic therapists see self-disclosure as way to express authenticity, positive regard for clients.
- Psychodynamic therapists least inclined to self-disclose, concerned transparency may interfere with therapy, not wanting to impose their ideas or values on clients who they represent as authority.
- Is self-disclosure always therapeutic because it shows authenticity, transparency and trust?

Intentional Self Disclosure

- Justified as therapeutic technique for modeling behavior, giving hope and building trust.
- Providing lesson to help clients feel better by seeing others went through similar crisis and recovered.
- Do you use self-disclosure cautiously, after carefully analyzing boundary and dependency needs of clients?
- Do you use self-disclosure less as you gain more clinical experience?

Expert-by-Experience

- Lived experience
  - Personal experience with substance use who after recovery trained to become therapists.
  - More faith in therapists who were living examples that recovery was possible.
- Greater ease and sensitivity in recognizing when clients break rules.
- Sharing experience allows for more tolerance and to better understand difficulties clients encounter during treatment.
Possible Challenges

- Project own experiences/feelings onto clients
- Lose perspective
  - “Difficult to detach from your own experience”
  - May interfere with ability to look critically at interventions
    - “If this helped me, it’s best solution for this client”
- Never certain what kind of impact disclosure has on clients and the motives behind questions

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Excessive Self-Disclosure

- Is it disclosed for purposes of client or clinician?
- Is it the type of communication that should be disclosed to client given mental illness/substance use disorder or context of the current treatment?
- How does disclosure help with treatment?
- How does client’s perception of what is disclosed differ from clinician’s?
- Could self-disclosure fuel client’s perception of “specialness” or relationship outside of treatment?
- Assessed risk or downsides? Consult/supervision

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Proper Use of Self-Disclosure

- Sparingly, selectively and strategically
  - Appropriate to developmental stage of client and client/clinician relationship
- Should only involve material clinician has worked through and has under emotional control
- Clinician needs to provide opening for client to link disclosure to their own experience
- Confidentiality is not reciprocal, so client under no obligation to keep shared info secret
- Re-disclosure may harm you/agency’s reputation
Self-Reflection on Self-Disclosure

- What information are you willing to disclose?
  - Relapses, breaking abstinence or dissatisfaction and interpersonal problems
- How do you make decisions about intentional disclosure?
- How do you behave in alternative role/setting?
- Few guidelines about self-disclosure & rules for managing privacy in contemporary ethical codes

Boundary Crossings and Violations

- Brief “excursions” across boundaries which may be inadvertent, thoughtless, or even purposeful if done to meet a specific therapeutic need
  - Activity that moves clinician from an objective position
  - May compromise trust and professional judgment
- Giving or receiving token gifts and disclosure of small bits of personal information
- May result in return to established boundaries and should be evaluated for potential negative consequences and implications
Risk of Boundary Crossings
- Clinician (consciously or unconsciously) may be using professional relationship to meet their personal needs at expense of clients/families
- Has difficulty with limit-setting/need-to-please
- Not aware of their own boundaries due to burnout, ethical exhaustion, moral distress, trauma
- Do harm by accident - helpful in intent, but harmful in effect
- Rationalization effect, "It couldn't happen to me"

Impact of Boundary Crossing
- Major boundary crossings almost always preceded by series of minor boundary crossings
- Harder to maintain boundaries when boundaries have previously been crossed
  - Takes more effort to enforce causing more problems and undermining confidence and authority of your unit, team or program
- "Least restrictive" in community mental health work means you need to ensure everything is as secure and "boundaried" as possible

Increased Risk When Client in Crisis
- Power and control imbalance between clinician and client greater if client in crisis
  - More vulnerable, less able to defend themselves and may struggle with own boundaries
  - Clinician may use self disclosure to help
- In-home/community-based programs less formal or structured than offices or agency
- Boundaries may blur when interacting with police, families/supports, community responding to crisis
**After a Boundary Crossing**
- Review your professional judgment and conduct
- Debrief event at next scheduled session
- May defuse potential for harm
- Document and consult via supervision,
  - Details of event
  - Reasoning, judgment and decision-making that went into choice of intervention
- Helps safeguard treatment from distortion or derailment
- Ensures not misunderstood by client or agency or regulatory licensing board

**Boundary Crossings vs. Violations**
- Crossings may be in the interest of the client
- Violations are harmful (crossings) to the client
- Avoidable dual/multiple relationships
- May be a “slippery slope” between boundary crossings and boundary violations
  - Meaning misinterpreted by client
  - May have unintended consequences
  - Clinician believes client benefits when not the case
- Judgments need to be made on a case-by-case basis given contexts and situation-specific facts

**Be Aware of Thinking Errors**
- Boundary crossing is a static, isolated event
- Crossing a boundary with client has same meaning as doing same thing with someone who isn’t a client
- Our understanding of a boundary crossing is the same as a client’s
- A boundary crossing that is therapeutic for one client will also be therapeutic for another client
- If we don’t see any self-interest, conflicts of interest, unintended consequences or potential downsides to crossing boundary, then there aren’t any
### Ask Yourself One Simple Question…

- “How comfortable would I feel explaining this entire situation to my boss and the rest of my team in full unedited detail?”
- If you would feel uncomfortable, or would feel the need to edit some of what happened, then a boundary has probably been crossed.
- *Red flags should pop up when you say (to yourself)*
  - “This person will be different”
  - “This circumstance doesn’t qualify as a role conflict”
- *Pause...* ask yourself, “how will this help my client?”

### Boundary Violations

- Common boundary issues: sexual, physical, social, financial
- Common themes in violations
  - Unmet intimacy needs
  - Exploitation
  - Emotional and dependency needs
  - False sense of altruism
  - Professional secrecy

### Subtle Warning Signs

- Appears harmless, begins in innocent situations
- Not recognized or felt as a violation until something goes wrong
- Pay attention to “red flags”
  - Do you make your client feel special so you avoid confrontations?
  - Do you enter into self disclosure and if so what’s your professional reason for doing so?
  - Do you make your own rules/substitute your own?
  - Do you avoid bringing this case to supervision?
Boundary Crossing Goes Wrong
- Monitor situation carefully vs. denial/avoidance
- Be open and non-defensive, avoid “pathologizing”
- Talk with experienced colleague who can provide honest feedback
- Listen carefully to client and try to see it from their point of view using empathy
- Keep accurate records as situation evolves to make sense of situation and find ways to respond
- If you believe you have made a mistake consider apologizing

Apologize?
- We are fearful it’s the same as admitting guilt
- Can make us feel vulnerable
- Can help heal effects of purposeful or inadvertent professional mistake (“I’m sorry” laws)
- Partial/qualified apology may be worse than none
- Apology should be clear, direct, personal, sincere

Document Your Decision-Making Process in Clinical Note
- Decision-making process is more closely scrutinized than decision itself
- Good clinical note lives on as a “second witness” to what actually happened and the process used by clinician
- Demonstrates you performed your professional duties and obligations according to standards of care
Minimize Risk of Boundary Violations

- Be alert to potential or actual conflicts of interest, remembering often it does not seem wrong at first
- High volume of cases, burnout, lack of supervision, desire to be liked, feel helpful or competent
- Ask, “whose agent am I?”
  - Is this what a clinician does? Is this what I usually do?
- Be aware of unmet needs in your personal life
- Avoid professional isolation in your clinical work
  - Use supervision and consultation
- Focus of clinical relationship should be on the client

Boundary of Informed Consent

- Legal and ethical procedure to ensure client knows all risks/costs to treatment through communication and clarification
- Provide informed consent as soon as possible regarding nature of treatment, potential risks/benefits, alternative or no treatments, exceptions to confidentiality
- Fee arrangements, summary of HIPAA, notice of Privacy Practices
- Review exceptions to confidentiality when there is risk of suicide or violence during treatment

Guide to Avoiding Boundary Pitfalls

- Stick to therapeutic contract
  - Is this for me or the client?
- Be emotionally present
  - Avoid excessive or inappropriate self-disclosure
- Avoid business relationships with clients
- Know protocol for gift giving and receiving (culture?)
- When communicating with clients be cordial and polite, don’t use terms of endearment
- Keep work on the unit/office
- When in doubt, get consultation and document
Practice Ethical Awareness

- Work challenges can overwhelm, drain, distract us and lull us into “ethical sleep”
- Develop a refined “ethics radar” which increases our ability to detect and respond to ethical issues
- Practice continuous alertness and mindful awareness of the ethical implications of what we choose to do and not do in our practice and life
- Recognize and address ethical issues and challenges as they come up in our work (not later)

Enhance Your Ethical Sensitivity

- Use empathy by imagining other perspectives
- Step back from a situation to determine whether it has ethical implications
- Use moral terminology to discuss problems and issues/avoid euphemisms
- Refuse to excuse unethical misbehavior
- Practice humility/openness to other points of view
- Encourage and model ethical behavior to build ethical environments at our workplace
Self-Care

- Effective self-care is an essential precursor to ethical conduct (balance does not mean doing everything)
- Physically, emotionally, spiritually depleted clinician most vulnerable to using clients to meet unmet needs
- Use rigorous self-monitoring to identify when
  - Moving into periods of heightened personal vulnerability or
  - Entering zone of ethical vulnerability in your relationship with one or more clients
- Self-awareness + self care → good ethics and healthy boundaries

Elevate Level of Your Ethical Practice

- Get ethically educated...more about skill than character
- Use mentors to provide sounding board/advice
- Get to know yourself by practicing self-monitoring
- Ask for help: seek consultation for complex cases
- Learn to tolerate ambiguity/uncertainty
- Protect yourself: don’t be alone when you are in zone of vulnerability
- Accept responsibility for your choices
- Live with and learn from your ethical decisions

How to Apply Ethical Decision Making Steps in Clinical Practice*

*Excerpts from Fred Reamer and Kenneth Pope

Ethical Decision Making Models
How to Use Decision Making Tools

- The following ethical decision-making steps are accumulation of models in the literature and based on a best practice approach.
- Models can serve as guides in the use of critical reflection and informed judgment when facing complex and competing interests.
- Steps may be helpful in working through ethical dilemmas in real life clinical practice.

#1 What is the Ethical Dilemma, Question or Concern?

- State as clearly as possible what the problem is and why it is a problem.
- Professional values that are in conflict, personal values may be influencing, conflict between the two.
- “What is my immediate reaction or instinct for the best way to address the ethical dilemma?”
- Tight schedules, eagerness to solve problem can rush us past this step of clearly understanding the ethical challenge which is needed for best approach.
- Anticipate who (else) will be affected by decision.

#2 Who (if anyone) is the Client? Who are Involved Stakeholders?

- Ambiguity, confusion or conflict as to who is the client/s and who are the stakeholders.
- Family, couple, group, minor or adult under guardianship.
- Another clinician or staff person.
- Stakeholders could be family, police, hospital, community, your agency.
- Is there divided loyalty or conflict that might influence our judgment/who is paying our fee.
#3 Do We Have Needed Expertise?
- Assess our areas of competence, knowledge, skills, experience (do no harm, risk management)
- Are we well prepared to handle this situation?
- What steps, if any, could we take to be more effective?
- Is there anyone available to step in and do a better job?
- Do you feel comfortable going to your supervisor or professional colleague to discuss possible ethics and boundary dilemmas with clients?

#4 Review Relevant Ethical Code
- Consult code of ethics/guidelines for ethical practice
  - Identify sections that are applicable to this dilemma
  - Does Code provide direction and guidance?
- Does situation involve conflicts within or between ethical standards and other legal requirements?
- In what ways, if any, do ethical standards seem helpful, confusing or outdated when applied?
- Would it be helpful to talk with an ethicist or member of local professional organization?

#5 Review agency, legal, cultural standards
- Consult best practice standards and applicable agency policies
  - Was this issue addressed through informed consent?
- Are there legal considerations? Consult attorney?
  - Does relevant legislation/case law support or allow most ethical response to situation or seem to work against or even block most ethical response?
- What are some of the social, cultural, religious factors affecting situation? Could our biased view affect how we think through this ethical dilemma?
#6 Consider Personal Feelings, Biases or Self-Interest
- Does dilemma make us angry, sad, fearful?
- Do we want to please someone?
- Do we desperately need to avoid conflict?
- Do we fear choosing most ethical path will get us into trouble, be second guessed by peers or hard to reconcile with law or ethics code?
- Will doing the right thing cost time, money, friends, referrals, prestige, job or license?
- Being honest with ourselves can help us avoid rationalizing away the most ethical response.

#7 Available Options, Risks/Benefits
- What are some of the available options or choices for resolving the dilemma?
- What steps do I need to take to minimize risk and not compromise my ethical responsibilities?
- Consult with colleague, manager/supervisor or someone who has expertise and experience
- Does the context of practice make a difference?
- Discuss dilemma with client where appropriate
- Consider the impact on the therapeutic relationship

#8 Develop Courses of Action
- What possible ways of responding to this situation can you imagine? What other alternative approaches
- Look for applicable precedents at your agency
- Don’t quit too soon, keep searching for best response
- What are the immediate & longer-term consequences for each person including client, family, self, agency?
- What are risks and benefits, pros/cons, unintended consequences for each course of action?
- Frame a preliminary response
#9 Perspective-Taking
- Adopt perspective of each person who will be affected can change our understanding
  - What would each person consider most ethical response?
- Compensates for distortion that comes from seeing things only from our perspective
- “Double-standard” of morals: holding others’ explanations to higher standard than we use for our own explanations

#10 Decide What to Do
- Review (or reconsider) and take action
- Once we decide on course of action, take time to rethink it...giving us one last chance to make sure we have best possible response
- Assume responsibility for consequences
- Document the ethical decision-making process
  - Helps us to remain clear what went into our decision
- Modify if necessary and make changes
- Monitor and evaluate the impact of the decision
  - What happens afterwards