

Ethics for Mental Health Professionals: Concepts and Current Developments
Course # AL15
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3 Credits

Course Overview

The online course “Ethics for Mental Health Professionals: Concepts and Current Developments” helps mental health professionals become more aware of the ethical dimensions of practice. Counselors and therapists deal with ethical questions in their daily lives on a regular basis, even if they don’t always stop to think intentionally about choices as ethical decision-makers. Professionals working with clients who are often fragile and vulnerable must cultivate a keen awareness of ethical issues. This online course begins by presenting a basic outline of ethical theory and explores principals which guide ethical thinking.

Learning to recognize an ethical dilemma and utilizing a simple process to sort out choices are central to this course. There are abundant examples, case studies, and scenarios to help illustrate the principles in concrete ways.

There is in-depth consideration of mental health advance directives, which are becoming increasingly available as more states create legislation providing for patients to indicate their wishes concerning treatment. There is, as well, consideration of ethical dimensions of therapy conducted via the internet. This online course offers practical and useful ways to become more intentional about ethical awareness so that the mental health professional can become more comfortable recognizing ethical dimensions of practice, and choosing their best moral response.

Syllabus

Course Overview and Learning Objectives
Ethical Concepts
Making Ethical Decisions
Unique Features of Mental Health Ethics
Ethics in the Practice of Counseling, Therapy and Social Work
Advance Directives in Mental Health Care
Ethical Issues with Electronic Therapy
Everyday Ethical Dilemmas for Mental Health Professionals
Ethical Concerns on the Horizon

Learning Objectives

Upon completion of this course, learners should be able to:

1. develop ethical decision making skills by learning a four step process for identifying and resolving ethical dilemmas.
2. discover how the four step process for identifying and resolving ethical dilemmas is applied to real life situations faced by the mental health professional
3. understand ethical theory as a foundation to making moral decisions and as a guide to acting on what we believe is right and wrong
4. identify the four cornerstones of ethical principals underlying all decisions in medical and mental health ethics
5. identify and understand ethical dilemmas faced by counselors, therapists and social workers.
6. develop awareness of ethical dilemmas as they occur in therapeutic practice

7. identify current ethical issues raised by electronic therapy, mental health advanced directives and medical technology.

What is Ethics?

Ethics concerns how we make moral decisions; how we know and act on what we believe to be right and wrong. Now, much of the time we know the choice is obvious; some things we simply know are wrong. It is wrong to lie, to steal, or to murder.

Other times, however, it is not always so easy to know what to do. Sometimes we may face situations in which the right thing to do is not immediately clear, or the right thing may have some bad consequences. One of the classic questions that ethicists ask their students goes like this: How would you respond if you were living in Europe during WW II, and you had hidden Jews in your basement? A Nazi official comes to the door and asks: do you know where there are any Jews? Well, of course most people say they would lie to him. So even if we live by a rule that we don't lie, there may be situations we can think of in which to do so would cause a problem. To do so would serve another good purpose. So, if we lie in this kind of situation, we may be choosing to protect people at risk, to prevent harm rather than obey the rule that we will never tell a lie. In this kind of case two moral goods are coming into conflict. One good is to tell the truth. The other good is to protect persons. When we are forced to make a choice between two good things; between two claims which compete, we are facing an ethical dilemma.

Now, most of the time we don't have to stop and think about what is the right, or the good thing to do. Most of us in every day situations know how to act. If a clerk in a store gives me too much change, say \$20 extra, I might be tempted to just keep it, but I know that the right thing is to point out the mistake and return the money.

Other, everyday kinds of ethical choices may be less obvious. We may choose to have lunch today at a fast food restaurant, and some would say our choice has ethical dimensions that can affect the entire planet. We are likely going to eat meat, we will be using lots of paper, and Styrofoam, and other disposable items which require resources to produce, and create huge amounts of waste. What we eat, what we wear, how we are transported from place to place—these are all daily choices that can be seen as choices with an ethical dimension.

Now, when ethicists get together, they talk about different kinds or types of ethics. The kind of ethics we are considering today is what we call normative ethics, that is, we are thinking about what is right or wrong in particular situations. We are sorting out the ethical way to think and act. And, our discussion today centers on a particular kind of normative ethics, that is: applied ethics. Ethics in mental health is a type of medical ethics: a kind of applied ethics. Other examples of applied ethics would be business ethics, or legal ethics.

Medical ethics is often in the news. Just over the past few months we have seen much attention given to issues such as stem cell research and cloning. And, within medical ethics, mental health ethics is a subspecialty. And in mental health ethics, we find some of the most complex and perplexing ethical issues in all of health care.

Ethical Theory

Consequentialist Theories

Philosophers like to think and write about ethical theory. Ethical theory helps us in two ways. To begin with, for those times in which we already know right and wrong, we already know what to do; ethical theory can help us think carefully about why one choice is right and the other choice is wrong.

On the other hand, ethical theory is particularly helpful when we are faced with dilemmas. We can't tell immediately what is right, or we find that our thinking about right and wrong in a certain situation may differ from a colleague; there may be more

than one good or right solution. Or, it may be that all the solutions that we can see have some bad consequences.

So this is where theory helps. Too often our ethical thinking sort of comes out of the gut, it is intuitive, it is a response we instinctively make to particular people and situations. Our gut-feeling may often serve us well, however to be consistent, and to communicate our views thoughtfully, ethical theory is helpful. So, here is a very brief overview of ethical theory.

One broad category of ethical theory is about what we call consequentialist theories. These theories are teleological. These theories look at the result of an action; the end result; the consequences to assess whether the action is right or wrong. Rather than thinking about the act itself, we look at what happens as a result of the act. You probably remember studying about utilitarianism, which promotes the most good for the most people. This is a teleological theory.

An example of consequentialist theory in mental health care might be a situation in which I am working with a patient who I know hates to be hospitalized. However, we may have reached a point where I believe hospitalization is necessary. And, while I wish to honor the patient's wishes and desires, and I know that he will not want to go into the hospital: I am making a choice based on what I believe to be the best consequences. Honoring his wishes and desires is overridden by my belief that the end result will be better if the patient goes into the hospital.

This kind of ethical thinking often comes into play when we look at how resources are distributed. There is never enough money to provide adequate care for all the persons who need mental health treatment, so somehow, whether intentionally, or haphazardly, dollars get sorted out and allocated. Very often the goal in doing so becomes to do the most good for the most people in the long run. This kind of goal is a consequentialist goal. So consequentialist theory looks at the consequences, rather than the act itself.

Rule Based and Agent Focused Ethics

The second broad category in ethical theory is rule based ethics. These kinds of ethics center on the act: what the person is doing. One of the most famous philosophers in all of Western history is Immanuel Kant. He developed and articulated what we call deontological ethics. That is, duty based ethics. Kant's thinking is based on the idea that we have obligations, we should always do our duty, and follow certain rules. Some acts are simply always right, and we must always do them. Some acts are simply always wrong, and we must never do them. No matter what the circumstances, no matter our relationships to the persons involved, no matter the consequences. For example, we must always tell the truth, even if it be hurtful. Kant would say, in the strictest interpretation of the question we posed a few moments ago, that if the official comes to our door and says: Do you know where any Jews are hidden, that we must tell the truth. Even if it means those persons may lose their lives.

Kant's famous categorical imperative states that we ought always to act in ways that we could say that others should do the same in the same circumstances. In other words we ought always do what we would want others to do in the same situation. We ought always, as well, treat persons as ends in themselves, and never simply as means. Respect for persons is valued highly in this thinking. And, of course, most of us would agree with that principal today.

Kant's high moral standards are admirable, but we can quickly see that his strict interpretation can be difficult to carry out in everyday living. Some philosophers have subsequently re-defined and re-interpreted some of his thinking so that one can find contemporary ethicists who value rules and duties, but are willing to consider other factors at times. So, following rules and meeting obligations are part of an important ethical theory.

The third broad category I'd like to mention briefly are ethical theories (this is really a group or theories) that focus on the agent. That is, the person making a choice and acting. This category includes what we call virtue ethics, feminist ethics and ethics of care.

Some of these ethicists say that instead of thinking about the consequences, or instead of thinking about duties and obligations we do better to think in terms of the kinds of persons we are. We focus on the character of the people involved, and we consider the value of certain virtues such as honesty, wisdom, courage, and integrity.

Many contemporary ethicists, including feminist ethicists, or proponents of the ethics of care, and virtue ethics, believe it is important to consider a variety of factors in making ethical decisions. The context of a situation, the nature of the relationships involved, the effect the decision will have on family or community, the need and the desire to care for those close to us that we care about in particular—these are all ethical concerns in theories that focus on the one acting, the agent who makes the decision.

There is, of course, much more we could say about ethical theory, however we can see that there are fundamental differences in how people think about ethical dilemmas. People of good-will with good hearts may see the same situation in vastly different ways, as they see it from differing perspectives, and with differing interests.

Even with careful intentional study of ethical theory, and careful exploration of the ethical dilemma, the fact remains that each of us brings who we are to the discussion. My history within my family of origin will affect how I see and think about ethical dilemmas. My relationships with others, my religious faith, or my lack of faith, my values and beliefs about what it means to be a human being and how humans should treat one another, and be with one another—all these factors come into play, and are most often unspoken and unacknowledged. This is not bad, simply something we want to be aware of, as we approach the process of making ethical decisions.

Ethical Principles

Let's think for a few minutes about basic ethical principles, actually principlism is one kind of ethical theory and is the one most often used in medical ethics. It is based on four fundamental principles that most persons can agree are important. The first of these, no doubt you have heard of, autonomy, which means simply respect for persons. This is part of the result of the patient rights movement, which we have been aware of over the past 30 years or so. But, it is also very much an American value that we honor individual rights. Autonomy in healthcare means that persons must be free to make choices and this is not as simple as it sounds. People must be able to make choices without being unduly influenced by others and when we make choices we need to have real choices. So, people need to be capable of understanding alternatives and choosing for themselves based on their own beliefs and values. It is the responsibility of the healthcare provider to make sure that the patient or the client understands what the choices for treatment are, understands what the benefits of the treatments are, what risks might be involved in various treatments, so that people can make their own informed choices for themselves. This may sound nice and neat in theory, but in fact we all know from our experience, simply as having been patients going to the doctor that it's often not quite so simple.

If I have a headache, it is easy for me to make a choice to take an aspirin; however, if I go to see my physician and I am diagnosed with cancer, there may be three good choices of treatments, but I may be so frightened and so upset that I have a hard time really thinking through choices, understanding alternatives, and making a decision. So, while one of our goals as providers is to honor patient autonomy, we need to remember that sometimes patient autonomy is complicated and that we need to be comfortable at times when folks ask for and need guidance in making decisions. If I am choosing a treatment for cancer, I certainly want to know what my doctor considers a good choice in my situation. Respecting patient autonomy means that I must respect the informed

competent choice made by a person even if I do not agree at all. If someone has truly made a choice that is based on good information, has chosen among several alternatives and has made a choice for himself without being influenced unduly, then I must respect that choice even if I personally think it is a very foolish choice.

Respect for autonomy also means appropriate protection for persons who are unable to make their own decisions and we all know that we often work with folks whose ability to make a decision, to make an autonomous choice is compromised by mental illness. So, part of our duty, so to speak as healthcare providers, is to make sure that persons who really cannot make their own decisions are cared for in appropriate ways.

The second of the four basic principles is called beneficence and this simply has to do with doing good, promoting the welfare of another, acting in the best interest of the person whose care we are interested in. A corresponding principle is nonmaleficence, which is a big fancy word that means simply, do no harm. It means acting in ways to avoid or prevent harm to another. Now beneficence and nonmaleficence often go together. While, it may be obvious that we all want to do good and avoid harm; in real life there are often some rough edges here. Often doing good may entail some harm. If I need surgery, I will probably agree to it; however, I can reasonably expect to have at least some pain, lose some days at work, spend some time recuperating when I do not feel so well. So, while the surgery may be for a good purpose, beneficence, perhaps to remove the diseased gallbladder or a tumor, I will experience some discomfort in the process which may be seen as a harm, and it may well be that I will need more treatment following surgery, which could have unpleasant side effects. It is often the case that to achieve a good we must go through something painful or difficult.

Therapists often see this in their work. The emotional pain involved in working towards health is a similar example. Questions about beneficence and nonmaleficence often arise in end-of-life issues. Is it better to treat aggressively, which is usually thought of as a good thing or is it better at times to withhold treatment? Is treatment itself sometimes harmful? These are interesting questions and they help us to see interplay between beneficence and nonmaleficence.

The fourth of the ethical principles is justice, which of course has to do with treating persons fairly and equally. Justice most often in caring for persons with mental illness comes into play when we think about access to resources and equal treatment. While there are many theories of justice and how we can think about what is fair, the question of who gets treatment and who does not is a difficult one in mental health. There often seems little justice in how the benefits are distributed among people in need. There are also concerns about how mental health benefits compare with benefits for other kinds of illness; this too is a justice issue.

So, we have four principles which are often used as guidelines in helping people think about ethical dilemmas and make ethical decisions: Autonomy, Beneficence, Nonmaleficence, and Justice.

Four Step Process

Now that we have a framework around ethical theory, let us think about how we go about making ethical decisions. One way would be to go to the library and check out a volume of Kant or maybe John Stewart Mill, but that is not perhaps the most appealing or efficient way to organize our thinking.

Art Caplan, Ph.D., who is the Director for the Center for Bioethics at the University of Pennsylvania suggests a basically simple process. (1) We begin with assembling the facts. We talk to those involved in the ethical dilemma and we gather information so

that we are sure that we can really understand the question and the perspective of each person involved. The patient's perspective, the caregiver's view, and the vision of the family may be vastly different.

After we have gathered the information, (2) we look for the dilemma. Where exactly is there a conflict? Are two goods, i.e. two right things bumping into one another? Does everyone involved agree about where the conflict lies?

And then we (3) look to the principles; autonomy, beneficence, nonmaleficence, and justice to sort out the values involved. We examine the options for resolution asking about various courses of action and how they embody the principles, and we think about the consequences of each choice. We examine the need to balance burdens and benefits.

Finally, what we (4) look at is how to implement a choice. If, for example, the best choice is hospitalization for an extended period and the cost is prohibitive, we need to think about other choices that we can realistically expect to see implemented. The bottom line asks, "How can we best balance benefits and burdens of various possible choices to arrive at a morally reasonable decision?" Of course, this process looks complex and lengthy but it need not be so. We do not have to spend hours on each step, but it is a way for us to think through carefully and adequately, and if you think about the process you will see that there are bits and pieces of various theories at play as we sort out ethical dilemmas.

Case Studies Using the Four Step Process

The Maturana Case

Let us look at a couple of cases to see how the process of making an ethical decision works out. The first case is about Claude Maturana. He is schizophrenic, he is in his 40s, and is in prison in Arizona for murdering a teenage boy in 1990. His past is somewhat unclear. His court appointed attorney has pieced together parts of his story. He was born in the United States to French parents who died when he was 12. He has stated that he has a wife and children. The existence of an ex-wife has been confirmed, but she cannot be found. Maturana says he has served with the US Air Force, The French Foreign Legion, and something he calls the Natural Navy. His criminal record dates back to 1980 when he was sentenced to a Texas prison for stealing a truck. He has also served time for burglary and aggravated assault. When he was released from prison in Texas, he soon turned up in Arizona, where he and another man took a 16-year-old boy into the desert, shot him, slit his throat, and dumped his body in a water tank. The other man involved received a life sentence, Maturana was sentenced to death.

Maturana's mental state was questioned before his trial, when he told his lawyer he was hearing voices and having hallucinations. A psychologist testified that Maturana's thinking was clear enough to understand the proceeding and he was judged competent to stand trial. He was later declared incompetent. Under Arizona law, Maturana was then confined to a special prison wing of the state hospital where he will remain until he is returned to competency.

Psychiatrist Jerry Dennis prescribed a regimen of daily tranquilizers, which maintain his equilibrium, but do not improve his mental state. Dennis says Maturana is not suffering, he is not agitated, not self injurious, does not present danger to himself or others, but he is seriously mentally ill. Dennis says Maturana has chronic paranoid schizophrenia. He states he is an agent of the world police and he frequently speaks in numbers and initials. However, the hospital administrator believes it would not require much treatment to raise Maturana to a legal level of competency; all that is required is that he understand he is convicted of a crime, that the penalty he has received is death, and that he will die. He does not have to be cured to meet the standard.

Some of those involved in this case believe that Maturana is faking it because he knows if he is given appropriate medications he will die. The problem is that the psychiatrist

Dr. Dennis refuses to give him these medications or offer psychotherapy that would help Maturana meet the standard of competency. Dennis maintains that he is abiding by the AMA ethical guidelines which advise physicians not to participate in executions or treat prisoners to restore competency. The American Psychiatric Association has similar guidelines. Prison officials have attempted to find a doctor who will treat Maturana to restore competency, but so far no one has been willing.

The ethical dilemma here is clear: to treat or not to treat this patient. We begin by looking at the facts of the case. The patient is convicted of a crime, he is on death row, and the patient is seriously mentally ill. The patient is unable to understand the sentence, his penalty, and what it will mean. Another important fact in this case is that no doctor will treat him. So, the dilemma is a conflict between treating a patient, generally considered to be a good thing, a beneficent act, which would restore in some measure the patient's autonomy. On the other hand, if the patient is treated, the patient's death sentence will be carried out. Certainly, to treat means to do no harm in medical practice; however, treating in this case would lead directly to a harm.

Another dilemma arises when we consider questions about justice and the death penalty. So, the principles that are involved in this case center on the autonomy of the patient, his capacity to make decisions, to understand what is happening to him. Of course his autonomy, and informed consent, do not extend to allowing him to refuse to be executed when he has been convicted of a crime, but for legal reasons he needs to be capable of understanding what is going on.

In the 1986 case, the US Supreme Court in a decision Ford versus Wainwright prohibits execution of inmates who have been ruled too mentally incompetent to understand their conviction and subsequent punishment. So, we have questions about beneficence and nonmaleficence, doing good and not doing harm, the patient's autonomy. And then, professional codes of ethics come in to play which generally prohibit treating a person in this kind of situation.

If we go with the beneficent principle, we treat the patient and he will die. If we look at nonmaleficence, we do not treat the patient, we permit him to continue in his state of mental illness and he may continue to live. So, when we move toward looking at our options in the resolution of this case, we really have only two options; treat the patient or do not treat the patient. There is no clear ethical choice here in terms of treating or not treating. If we want our patient to continue to live, we sacrifice his mental health and do not treat him. On other hand, if we treat the patient he will very likely be executed.

The Forester Case

Daniel Forester, a 47-year-old man is admitted to a psychiatric hospital for severe depression. A once successful owner of a small business, Mr. Forester had become depressed following the failure of his business and a messy divorce from his wife of 18 years. His ex-wife and children now live in another city. His only visitor was a younger sister who seemed concerned about her brother's condition out of a sense of family obligation rather than genuine love for him.

His depression was complicated by the recent diagnosis of a rare form of leukemia for which there was only palliative treatment and no known cure. Burdened by the loss of his business and family and by his illness, Mr. Forester's depression had progressed to the point where he was refusing all medications, all food and water, in the hope that he would die. I.V. therapy had been started and Mr. Forester was receiving antidepressant medication through the I.V. After a period of time his depression had not improved. The physician hoped that his nutrition could be maintained by forced feedings and his hydration maintained by the I.V. until the antidepressants had time to take effect. Force feeding Mr. Forester was difficult for the nurses caring for him. A nurse attempted to put food in his mouth, he spit it out and turned his head away. A nasogastric tube, that is an NG tube, was placed and liquid supplement was given to Mr.

Forester. Despite the fact that his hands were tied and he was restrained in bed, he always managed to dislodge the NG tube. So, the tube had to be put in again each time he was fed and this required sedation. Every time food was offered to him, the nurse had to call for help. It took 3 or 4 people to hold him down while the NG tube was put in and he was fed.

After a few days of this, the nurse noticed there were bruises on his face, his jaw, his neck, and his arms from this repeated procedure. The nurse went to her supervisor who assured her that the patient would thank her and the other nurses when he got over his depression. The nurse was told that these bruises were really inconsequential considering the necessary nutrition that was being supplied.

This is a complicated and difficult case; let us begin by looking at the facts. The patient is severely depressed following the loss of business and family. It is important to remember, as well that the patient has a terminal illness; there is no cure for the form of leukemia he is suffering from. The patient is alone; there is no significant family support. While his sister may visit on occasion, he has no children or wife who are close by and in close contact. Another fact is that the patient is refusing food and has made it clear that he wishes to die. The patient is also receiving antidepressant medication by way of an I.V.

The dilemma centers around the patient's wish to refuse food and die. The nurse and the doctor want to continue feeding him, to keep him alive until the antidepressant medication can help him feel better and help him feel less depressed. So we have a conflict between the patient's wishes and the wishes of the doctor, who is treating Mr. Forester.

Several ethical principles come into play here. Autonomy is obviously the first one we consider. The patient has made a choice, he may be depressed but he has made a choice. He has experienced significant loss and is facing his own death from the leukemia that he is suffering from. The patient's autonomy has clearly been seriously violated in this case by the forced feedings through I.V. which provides medication and the NG tube which is repeatedly inserted. When we look at beneficence, we have a nurse who believes that feeding a patient and giving him medication is a good thing, but the manner in which she is required to give him feeding and medication is difficult for the nurse to carry out and it is not being experienced as a good thing on the part of the patient. So we have to question whether any good is being accomplished by the nurse forcing the foods and the medications. Certainly the patient does not experience this as helpful.

When we turn to nonmaleficence, we have a nurse who is administering treatment that she really believes, in this case, is causing harm and we have a patient who is experiencing this treatment as harmful and we have to ask if this patient is being treated with respect and justice. We have two options, we can continue to treat this patient, force food and medication, or we can allow the patient to die. Those are harsh and difficult choices. To implement these choices would require asking nurses to continue carrying out these orders, forcing the food and forcing the medication. Certainly they will be uncomfortable with this, but we will continue to treat with the notion that the patient would eventually improve and be grateful for their having done so.

On the other hand, implementing the patient's choice, allowing the patient autonomy would mean that the nurses could discontinue their aggressive care and simply offer palliative treatment with an eye toward keeping the patient as comfortable as possible, caring for whatever needs came up, attending to his physical, emotional, and spiritual needs during the time left to him. To treat or not to treat, to force medication, to force food in a patient who is terminally ill poses very complicated ethical dilemmas.

Complex Ethical Issues

One of the places that professionals look for guidance for ethics is in the professional code of ethics for the various organizations. Professional organizations provide standards of ethical practice, and standards for care.

These codes of ethics, and standards of care provide excellent guidance for members of each profession. These codes are generally available on-line in most cases, or available to members of professional organizations. You are most likely familiar with the code which applies to your particular practice. And, this is a good place for guidance in ethics.

Ethics for the mental health care provider poses some of the most interesting and complex ethical discussion in all of medical ethics.

The very notion of mental health and mental illness are ideas which carry meaning, and such meaning may well be coated with values, associated with things we want, or things we want to avoid. Things we consider good or that we consider bad. We all know that what qualifies as mental illness may change with each new edition of the DSM. Categorizing, diagnosing, and treating mental illness is not quite so simple as diagnosing and treating pneumonia or diabetes.

There have been voices over the past 30 years or so who have questioned the very existence of mental illness. A well-known anti-psychiatry movement has asked: what is normal and what is illness? Some have said mental illness is a myth; that mental health care providers are really just dealing with persons who have problems with their personal or social lives. Others have countered with the view that mental illness is very much an illness, a painful and debilitating situation which has been a part of humankind for centuries.

So philosophers may not always agree on what mental health means, or what mental illness means. There may be disagreement about desirable behavior, acceptable behavior, and other questions which arise in theoretical discussion. Of course there are physical illnesses which carry meaning in our society too, as we all know. I remember when I was a child, no one would say the word "cancer" out loud. I remember hearing the church ladies whisper that so and so had "C-A". Such discussion is not limited to mental illness. However, the continuing social stigma around mental illness makes these questions more pointed and problematic. And these are questions with an ethical dimension.

Informed Consent and Surrogacy

There are several ethical concepts that have particular relevance in mental health care and one of these is around informed consent. Informed consent is not simply a piece of paper to ask a patient to sign. Informed consent is a process and it is by no means a simple process. We think back to our comments a few moments ago about autonomy. Informed consent is essential for genuine autonomy to be carried out. The patient must be informed. The patient must know about treatment options, risks and benefits, and it is the health care provider who is responsible to ensure that the patient understands each option as fully as possible. For informed consent to be genuine, the patient must not be unduly influenced or coerced to make a particular decision. And patients have a right to appropriate guidance from health care professionals.

Making sure that our patients are consenting with full understanding can be a challenge and there are of course times when patients are unable to make decisions for themselves and this is when we begin thinking about surrogates. A surrogate is a substitute, i.e. another person who makes decisions on behalf of someone who is unable to make decisions for himself or herself. The surrogate or the proxy may be chosen by the patient prior to a time when he is unable to make or communicate decisions. The surrogate might be named through an advanced directive such as a living will or a health care power of attorney. The surrogate may simply be the next of

kin. If a patient has not appointed or chosen someone to make decisions on his behalf, in many states the next of kin is authorized to do so. The surrogate may be a court-appointed representative, i.e. a guardian.

Now when a surrogate is called in to make decisions for someone who is unable to make his or her own decisions, there are two ways that can happen. The first kind of surrogate decision is what we call substituted judgment and this happens in situations in which the surrogate knows the patient, has some understanding of the patient's values, so that the surrogate can reasonably know what the patient would probably choose, and substitute his judgment for the patient. There are, however, times and situations where we do not have any idea what the patient might wish for or value. This would be the case with patients who are mentally retarded or with young children. So, the surrogate makes a decision on what we call a best interest standard; a decision based on what we believe to be in the best interest of the patient.

Case Scenarios of Informed Consent

(1) In working with a 16 year old girl, I learn that she is sexually active. Her parents call me and ask for information about their daughter. This is a difficult one, because what I believe to be ethically appropriate may not be what I'm required by law. Legally, a 16 year old is under age and her parents would have the right to information about her medical records. However, I would not respond directly by answering their questions. I would begin by talking with their daughter, with the girl about her behavior and include in that conversation the fact that she may want to talk with her parents about her sexual behavior. This may be very difficult for many teenagers, and I certainly understand that. But, I would begin the conversation with the girl about responsibility and her sexual behavior. I would not directly tell the parent everything that the girl had told me. 16 year olds are under age, and can not legally give informed consent, unless of course they have been emancipated or are in some other situation where they are no longer under age, with regard to their parents giving consent.

But, a helpful concept when dealing with children, older children and adolescents is the notion of assent, rather than consent. I would not have a conversation with these parents without the girl's assent to my having such a conversation. And, I would be very careful about revealing details. I would try to be supportive of everybody in the situation, keeping in mind that my patient is the adolescent girl.

1. I talk with the girl about responsible sexual behavior, including having a discussion with her parents. I refuse to answer the parent's question directly. (Right answer)
2. I answer the parents question and tell them all about their daughter's sexual behavior. (Wrong answer: I should talk with the girl first.)
3. I refuse to take calls from the girl's parents. (Wrong answer: their daughter is under age and they have legal rights to information, even though there may be serious ethical concerns about revealing information about her.)

(2) My patient has been severely depressed for a very long time, and none of the available medications seem to be helpful. Her psychiatrist suggests ECT treatments, and my patient is extremely fearful of such treatments. However her parents and husband are strongly urging her to have the treatments. My concern is, of course, primarily for the patient, and in this case for her exercise of genuine autonomy.

When we talk about informed consent, we recall that our patient needs to have as much information as possible. She needs to understand the risks and benefits of each possible treatment choice, so she can make a decision based on what is right for her. I would also spend some time with her talking about her fears and encourage her to discuss her fears with her physician. It would not be appropriate, ethically for me to say: yes or no, you should or should not have the treatment. I should not be making that decision for her.

1. I am concerned about her exercise of genuine autonomy, and encourage her to speak for herself about her fears so the physician can address her concerns. (Right answer)
2. I "take sides" with her family, and push her to have treatments. (Wrong answer: her autonomy must be respected.)
3. I tell her not to have the treatments if she is so scared. (Wrong answer: the patient may need support and information to deal with her fears, if she is to make a truly informed choice.)

(3) My patient sees Dr. J., and he is involved in carrying out research on a new medication for depression. My patient is excited about being in a research study, but in talking with her about it, it becomes clear that she has not really understood the protocol, and she doesn't realize that in a double-blind study, she has only a 50% chance of receiving the new medication. She clearly believes that she is certain she is taking this medication. Informed consent for research with human subjects is a lengthy, complicated process. Dr. J. should have and perhaps did spend a great deal of time going over the informed consent forms with this patient. If he did not, then someone acting on his behalf, perhaps a research nurse should have done so. It should have been made clear the patient that she had a 50% chance of taking a placebo, rather than a new medication.

However there seems to have been a serious misunderstanding. It is not my responsibility to see that the patients in this research group have been adequately informed and given appropriate consent. However, I'm concerned enough to call the doctor and let him know what I have heard from this patient. It is his responsibility to be sure that his patients fully understand what the research involves. I am aware that this is a serious issue and could jeopardize the doctor J's study and work with his new treatment. And that he should have an opportunity to correct the patient's misunderstanding as the first step. I would call the local institutional review board only if the patient continued to misunderstand; if even after several conversations with her physician she clearly did not understand the process and protocol that she was involved in.

1. I explain to her how double-blind studies work, and that she may or may not be receiving the study drug. (Wrong answer: it is not my responsibility to ensure informed consent for another person's study.)
2. I call Dr. J. and tell him of my concerns. (Right answer: it is his responsibility to be sure his subjects understand fully what the research involves.)
3. I call the local Institutional Review Board and report Dr. J. (Wrong answer: though this is clearly an ethical violation, Dr. J should have opportunity to correct the patient's understanding as a first step.)

Confidentiality

Another very important issue in providing Mental Health Care centers around confidentiality. As you well know, confidentiality is important for the efficacy of a therapeutic relationship. However, health care providers must acknowledge the difficulties of guaranteeing absolute confidentiality. Given the complexities of data linkages and the difficulty of controlling access to data contained in medical records, the provider has an obligation to do everything possible to control how data is stored and used; but it is sometimes impossible to guarantee absolutely that confidentiality will always be maintained. There are certain conditions under which confidential information may no longer be confidential. One of the most famous cases in all of medical ethics comes from this particular area. It is known as the Tarasoff case. It is about confidentiality and the duty to warn. Some of you may have heard of the Tarasoff case without knowing what actually happened.

Here is the story. In October of 1969, Prosenjit Poddar killed Tatiana Tarasoff. Her parents alleged that 2 months prior to that, Poddar had confided his intention to kill

their daughter to a psychologist employed at a hospital in Berkeley, California. That psychologist asked the campus police to check it out. The police briefly detained Poddar but released him when he appeared rational. The physician who was working with the psychologist said that no further action needed to be taken to detain Poddar. No one warned Tatiana. On August 20, 1969, Poddar received outpatient therapy and informed his therapist, the psychologist mentioned, that he was going to kill an unnamed girl, readily identified as Tatiana; when she returned from her summer trip.

The therapist consulted his superiors and they decided that Poddar should be committed. The campus police were notified. Poddar was picked up by the police but the police were satisfied that he was rational and when he promised to stay away from the girl, they released him. The director of the department of psychiatry at the hospital asked the police to return the therapist's letter requesting commitment and directed that letters and notes be destroyed. The case centered around the failure to warn Tatiana or her parents of the danger. When she returned from her trip, Poddar persuaded her brother to share an apartment with him near her residence. He went to her home and he killed her.

The majority opinion in this case Justice Tobringer states: "When a therapist determines . . . that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim from such danger. . . . this may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. . . ."

The Tarasoff case established an important circumstance in which confidentiality not only maybe breached but legally maybe required to be overridden. If someone is in danger, if a threat has been made, then that person must be warned of the potential danger. Other circumstances in which confidentiality maybe overridden include circumstances where a court order may compel a provider to testify although there may, in some jurisdictions, be legal protections for the therapist-client relationship.

There are also life and death situations that compel a provider to override confidentiality for the protection of the patient or others; a patient may be suicidal or a patient maybe threatening to harm another. Abuse of another person must be reported to authorities in most areas, particularly the abuse of children or the elderly. So there are several situations in which mental health care providers not only may, but must override confidentiality for the protection of other persons. So, health care providers are ethically obligated to inform patients of the limits of confidentiality.

One of the important initial therapist discussions with patients concerns this area. While it is important for therapeutic reasons to offer the patient assurances that his private life will remain private, it is important for the integrity of the therapist to be open about the possible circumstances under which confidentiality may be overridden by other more pressing situations.

Case Scenarios of Confidentiality

(1) In scenario number one, we have a new patient who expresses excessive concern about confidentiality, apparently fearful that anything she says to her therapist may not be kept confidential. The therapist response should be... This is one of those places where we need to remember how important it is in our first or an early session with the patient to clarify the limits of confidentiality. No one can ever guarantee that confidentiality will always be absolute. There may be situations where we are compelled by law to report things that we learn in the context of a session. There may be times when we do not have absolute control over where the data in our office ends up, or how it may be used. The fact that insurance companies may have access to data; the fact that data linkages may not be as secure as we like all pose risks.

So while we want to assure our client that we have high regard for her concern:

promising absolute confidentiality is an impossibility. And we should never try to guarantee that, but should work with our client so that we can understand each other, and know what the limits are. Assuring the client that we would always be as careful as possible and respectful as possible about her concerns. Respect for the patient's autonomy requires that we take this seriously and that we do our best to make sure that in fact our conversations are as confidential as possible.

- 1. Promise that everything will be kept confidential. (Wrong answer: no therapist can guarantee such because the therapist may learn of abuse or threat to others that require breaking confidentiality.)**
- 2. Assure patient that every possible safeguard is in place, but there may be situations in which she can't guarantee absolute confidentiality, and explore with the patient the nature of her concerns about confidentiality. (Right answer.)**
- 3. on't dwell on the patient's concerns, move quickly to other issues so the patient can't spend too much time thinking about these worries. (Wrong answer: the patient's concerns are real and valid.)**

(2) In this scenario, I learn that my patient is HIV positive and he tells me he has not told his live-in partner. Sometimes there is not one clear, right or wrong answer in a situation like this, but rather a series of steps we should go through to be respectful and treat everybody involved ethically. I would begin by addressing the issue with the patient and encourage him strongly to inform his partner of what is going on and what the risk may be. I would offer to be present for that conversation and be supportive in any way possible. I would not immediately call in and report him. There may be in some jurisdictions laws that require reporting clients who have sexually transmitted diseases, but I would not take that step until I had first worked with my client about his telling his partner himself. I would not violate my client's confidentiality or privacy by informing the partner directly. That would not serve beneficence or nonmaleficence in any way, with regard to my relationship with my client. Nor would that be respectful of his autonomy. So, I would strongly urge my client to tell his partner himself, and offer him all the support possible for doing that. I think that would be the ethical response in this situation.

- 1. I address the issue directly with the patient, and strongly encourage him to tell his partner, offering to be present, or available for that conversation. (Right answer.)**
- 2. I call the county health officer and report the patient. (Wrong answer: one may need to do this, but the first step should be to work with the patient to tell the partner himself.)**
- 3. I call the partner before the patient has had time to return home, and tell him that his partner is HIV positive. (Wrong answer: other steps should be taken before violating the patient's confidentiality.)**

(3) The patient I saw earlier this morning expressed serious suicidal intentions, including a definite plan. He has now left the office, refusing to promise not to harm himself, and refusing a contract for safety. Again, there is not one simple right or wrong answer, but rather a series of things we must take into consideration. When a suicide threat is this clear and explicit, I would immediately call local law enforcement to inform them of the patient's intentions and his whereabouts so they could see he got the help he needed by taking him probably to a local hospital.

I think part of what I would do would be to call the patient's spouse and warn her about what may be happening. This would depend on the type of relationship I had with the patient, what I knew of the spouse. If I knew her and knew something of their relationship I would probably warn her, but I would not abdicate my responsibility for his well-being, and shift responsibility directly to the patient's wife. I would take his threat seriously, even if he had made threats like this before, and had been bluffing before. I don't think that we can assume that this is the one time he will or will not

carry through with it. So, I would begin by protecting him by calling law enforcement and then take further steps from that point.

1. I call his wife and warn her that he is in danger. (Wrong answer: I am responsible for his well-being and best interest, and may not shift such responsibility to patient's wife.)
2. I call local law enforcement and inform them of the patient's intentions, knowing they will pick him up and take him to a local hospital. (Right answer.)

(4) There are several therapists in your office. One afternoon one of them says, "I saw Jane coming out of your office today. She used to be married to my brother, and I was very fond of her. What is going on with her?" This is easy. Jane's confidentiality has to take precedence over any kind of friendly relationship you might have with another therapist. So, you just simply remind the other therapist that you can not talk about Jane's situation. If this is somebody the therapist had a relationship with, then he may want to contact her for old time sake or whatever. But, you can not and will not say anything about why she is in your office.

1. You tell him quietly, in the privacy of your office, what is troubling Jane. (Wrong answer: you do not violate her confidentiality.)
2. You explain to him that while you know he is concerned about her, you cannot talk about her situation. (Right answer.)
3. You suggest he give her a call to see how things are going with her. (Wrong answer: the fact that he saw her in the office may be understood as the impetus for the call, if he really cares about her, then one would assume they had stayed in touch.)

Competency, Capacity and Cultural Diversity

One of the questions that comes up over and over in terms of ethics for mental health care providers concerns competency and capacity, i.e. questions about a person's ability to make decisions. Competency is a legal term. Persons are assumed to be competent to make their own decisions until a judge rules otherwise. On the other hand, capacity is a clinical term, which refers to a person's ability to make decisions. And making decisions of course, is based on autonomy. Patients have the right to make their own decisions; but we all know that a person's capacity to make decisions can fluctuate or waver. It may come or go depending on the person's illness. Capacity may need to be reevaluated periodically. Capacity is not absolute. I may have the capacity to drive a car but I do not have the capacity to fly an airplane. Capacity may be specific to a particular situation or circumstance.

Many ethicists would agree that capacity may be tied to the degree of risk that is the patient. The patient may have the capacity to consent to taking an aspirin but not have the capacity to refuse a life saving surgery. In other words, the higher the risk, the greater concerned for intact capacity. If I am going to give my patient a Tylenol when she says she has a headache I will probably not take time to do an extensive assessment of her capacity to make that decision. On the other hand, if I have a patient who needs surgery for a life threatening condition and the patient refuses surgery in the face of all kinds of information made available then I might wonder about her capacity if she seems unable to comprehend that without the surgery she may lose her life. So if it is a higher risk procedure then we pay more attention to the intact capacity.

The President's Commission on Bioethics says this. "For patients to participate effectively in making decisions about their health care they must possess the mental, emotional, and legal capacity to do so. Decision making capacity is specific to the particular decision and depends not on a person's status or on the decision reached but on the person's actual functioning in situations in which a decision about health care is to be made." Capacity means ongoing assessments at times.

Another issue I would like to mention just briefly with regard to ethics and mental health concerns diversity. It is ethically appropriate for caregivers to include careful attention to and respect for the patient's ethnic, cultural, gender, religious and racial background. Ignoring differences in these areas constitutes unethical practice. It is important to take into account what these dimensions of people's lives mean for them and how they affect people's functioning and relating to one another.

Managed Care, Patient Relationships and Research

Another issue that comes up in everyday practice that I would like to mention has to do with Managed Care. Managed Care is so much fluctuating and so different in different areas that I would like to only say in general and in brief that Managed Care may mean in some areas that provision for compensation may be quite restricted for Mental Health Care for many patients. And, one of the things that codes of ethics for most practitioners require is that we advocate for greater access to care for patients in our communities, whether we work through changing laws, changing insurance regulations, or supporting patient advocacy organizations.

Many of the less dramatic kinds of ethical issues arise regularly in practice. A couple of examples of these may have to do with the relationships of the people that we are seeing in therapy. Suppose you have been seeing a woman for several weeks and her husband comes in for a session or two and then he calls and wants to see you individually as well. This may be therapeutically awkward and potentially fraught with ethical difficulties. Or, suppose you are seeing a couple for therapy together and then there is a divorce and one of the couple asked you to testify in a divorce proceeding.

These kinds of things may come up regularly, or perhaps you have a patient who is always late, who does not bother to call and cancel an appointment that she is not going to be able to come to. Responsible handling of these day-to-day situations involves ethical choices.

We may see patients who are involved in research projects because many protocols are going on all across the country where physicians or therapists maybe doing research. There are safeguards in place to protect human subjects in research and it is appropriate for us to be very careful to make sure that all of these safeguards are in place. Informed consent for patients who are part of research must be thoroughly carried out. Patients must be fully informed of their rights, risks, and possible benefits if they choose to become research subjects in human research protocols.

Case Scenarios for the Practicing Professional - I

(1) My patient has recently been released from a psychiatric in-patient hospital. She describes seeing other patients in restraints for hours, with little attention to their well-being. Clearly, what she is describing is an ethical problem, but I need to think carefully about the limits of my responsibility in following through with this information. I may choose to do nothing, or I may choose to call and report this hospital to the appropriate accrediting agency. If, as someone who sees myself as an advocate for people with mental illness, I might decide that it's worth investigating. And, my first step might be to call and talk to an administrator at the hospital about these allegations, and my concerns. The hospital has ethical obligations to follow rules about restraints. And, there may be more to the story than the patient who told me about this was aware of.

The hospital administrator should have an opportunity to address the issue. I think I would do this based on my concern as an advocate for persons with mental illness. However, I think it's important to keep in mind that I could, ethically interpret my role more narrowly so that I didn't feel an obligation to contact anybody in this kind of situation. I think it would depend on the kind of information I had been given, how well I know my patient and what kind of violations of restraint laws were being reported to me.

1. I call the hospital and speak to an administrator about these allegations and my concerns. (Right answer: the hospital has ethical obligations to follow rules about restraints. The patient who reported violations may not have been fully aware of the situation. The hospital administrator should have opportunity to address the issue.)
2. I call local authorities to intervene. (Wrong answer: the allegations may not be accurate, and the hospital personnel should have opportunity to respond to the charges.)
3. I report the hospital to the appropriate accrediting agency. (Wrong answer: again the allegations may not be accurate, and the hospital should have an opportunity to respond.)

(2) A woman in my Sunday school class calls to make an appointment, saying she trusts me and wants to see me for therapy. This is a difficult situation, and one that we may encounter often in private practice. We meet people in many places, they get to know us a little bit and then decide we are just the therapist they need. When you are in an ongoing setting with someone, such as a Sunday school class, a church, or a club that you may be a part of, then you are going to be dealing immediately with the problem of dual relationships. Our codes of ethics generally speak to this and discourage dual relationships. I would probably confront this issue directly with this woman and explain this to her. It may have not occurred to her that this could be a problem. But, I would talk it over with her and let her know why such a relationship could well be unethical and inappropriate and probably not in her best interest therapeutically if I am going to be seeing her in church, at a club house, or wherever else we may run into one another.

1. I make an appointment for her right away. (Wrong answer: I explain the problems of dual relationships, boundaries, etc, and refer her to another therapist.)
2. I put her off, telling her I am booked up for three months, and have no time. (Wrong answer: the patient should be told accurately and fully why such a relationship is unethical and inappropriate.)
3. I explain to her that seeing patients in therapy with whom one has another relationship (such as in the same SS class) is problematic for several reasons, including ethical reasons. (Right answer.)

(3) I have been seeing a patient for 2 years on a monthly basis, and she has worked hard and made good progress in her therapy. Her financial situation changes drastically, and she is unable to pay for treatment. She offers to clean my home once a week in exchange for therapy. I might be sorely tempted because I really hate to clean house. However, we need to be very cautious about bartering arrangements. Some codes for some professionals explicitly prohibit any kind of bartering. Other codes are a little more lenient, suggesting if bartering is a commonly accepted practice, a local practice that is a standard in our community, we might be willing to consider it.

However, even if that were the case in my community, I would not enter into a bartering arrangement that involved a client coming into my home. Working around my office, providing other goods or services might be more acceptable, but to have the client actually come into my home would exceed any kind of acceptable boundaries. So if she insisted she wanted to barter for therapy, and if I were comfortable with some form of bartering, I would then have a discussion with her about another way to cover the cost of her treatment rather than cleaning my house.

1. I gladly accept, as I hate to clean house. (Wrong answer: bartering for services is potentially problematic, particularly involving a patient coming into one's home. There may be certain situations in which barter might be acceptable in communities where such practices are common, however it is generally considered unethical to barter for therapeutic services.)

2. I tell her that I have a certain amount of time each week for patients who cannot pay the full rate, and I offer to hold one of these slots for her as soon as one becomes available. (Right answer.)
3. I tell her that bartering for services is ethically inappropriate, and I wish her well in finding other ways to continue therapy. (Wrong answer: this constitutes a form of abandoning the patient, and may be harmful to her.)

(4) A new patient that I have been seeing learned where I go to church, and has been attending my church for several weeks now. He stays around after services are over just to talk to me. Again, this is difficult. Dual relationships are a problem, and I have to wonder if those of us who live and work in small towns run into the same people over and over, more often than people who live in big cities. I could just stand around and chat with him, thinking that befriending him might be helpful. But, this isn't fair to me, it's a blurring of boundaries and it runs a risk.

I think I would wait until he next had an appointment in my office and rather than having a conversation about the issue at church, where other people may overhear. When he came to my office I would explain to him what the dilemma was, how I saw that as an ethical problem. And, I'd say to him: Next time I see you at church I'll just say hello to you, and you can say hello to me. But we will not have time or opportunity to sit around and chat personally. We need to keep the boundaries clear, even if we are attending the same church.

1. I gladly stay around and chat with him, thinking that such befriending is helpful in his therapy. (Wrong answer: the boundaries are becoming blurred and the ethical difficulties of dual relationships are a big risk.)
2. I change churches. (Wrong answer: the patient needs to understand the potential ethical problems of the current situation, and the therapist should not have to change churches.)
3. I address the issue in the next appointment in my office with this patient, explaining to him that when I see him at church I will say hello, and nothing more, there will be no opportunity for personal chats. (Right answer.)

(5) I work in a large mental health center, and I've noticed lately that the therapist in the office next to mine seems to have been drinking at work. I have smelled alcohol on his breath several times, and wondered if he might be drinking at work. This one can be personally pretty difficult to confront, but I think that the ethical approach would be to begin by having a conversation with this person; confront him directly with my suspicions. Give him an opportunity to say what might be going on. I might be willing to help or offer support in what ever way I might be able to. I would not immediately go and tell the supervisor, unless I had a conversation with my fellow therapist and had seen that he had not sought help or done anything to change the situation. I would then feel that I would be compelled to report to the supervisor what I had seen. And then let the supervisor take it from there.

1. I confront him directly with my suspicions, giving him an opportunity to seek treatment and take appropriate measures for his own well-being. (Right answer.)
2. I tell our supervisor what I have seen. (Wrong answer: the first step should be to address the other person directly.)
3. I call the state licensing board and report him. (Wrong answer: the first step should be to address the other person directly.)

(6) The local town council has received funding to establish a residential home for adolescents who have been discharged from psychiatric hospitals. You know that no one wants this facility in their neighborhood. And, there is a public hearing on the issue. Well, it might be easy to stay away and not get involved in local politics. People tend to have strong feelings about these kinds of issues.

However, our codes of ethics generally expect us to act as advocates for the mentally ill. And, based on that, we might suggest the ethical response would be to go to the hearing and speak on behalf of the proposal. Depending on your situation, you might even be willing to suggest that you would be comfortable with such a facility in your own neighborhood. You certainly would not want to go to the meeting and speak against having the facility in your town, expressing fears about property values. Part of our role as mental health care providers is as advocates for those who need our services.

1. You stay away; you don't want to get involved in politics. (Possible wrong answer: most codes of ethics for professionals say that therapists should advocate for patients.)
2. You go to the hearing and speak on behalf of the proposal, suggesting that you would be comfortable with such a facility in your own neighborhood. (Right answer: as the therapist is ethically obligated to advocate for patients.)
3. You go to the hearing and speak against having the facility in your town, fearful of property values being affected adversely. (Wrong answer: you are to advocate for patients.)

(7) You are just out of graduate school, and currently working in a large mental health clinic. Your supervisor suggests that your spouse, who is an attorney, may want to help with some legal advice over dinner at her house. Well, it would certainly be nice to have dinner at the supervisor's house. However, this clearly seems to be a supervisor using power in order to get some free legal advice. It's a violation of ethical boundaries. It's a violation of the supervisor's role as someone who has power over the persons she is supervising. Such a request is unethical, and while it may be very awkward to refuse; the request is unethical and inappropriate.

1. You readily and gladly accept the dinner invitation; after all, what's the harm in your spouse offering a little free legal advice in exchange for a nice dinner. (Wrong answer: there is a clear conflict of interest, and the supervisor is taking advantage of her relationship with you, this is unethical.)
2. You tell her that your spouse is out of town, works late every night, whatever excuse you can think of to avoid the dinner. (Wrong answer: you need to address an unethical request up front.)
3. You explain that you feel such a request is unethical and inappropriate. (Right answer.)

(8) Your patient is either always late, or fails to show up for his appointments. You have lost several hours time because of him over the past few months. Such behavior is going to occur regularly in private practice and is more than a little annoying. It might be tempting to simply say to the secretary: don't let him back on my book. However, the ethical response would be to sit down with this person (if you can get him to keep an appointment), and explain your policies about missed appointments; which you have done in your initial appointment, but he hasn't remembered that. So you need to clearly remind him what is expected of him, and what your expectations in this relationship are.

I do think the therapist has a right to autonomy, as well as the patient. So, when the therapist is being treated with less than respectful response from the patient, then it's not inappropriate, when every possible measure has been taken to talk this through, to sort it out and to work something out with the client. I think that it's fair and ethical for the therapist to set some limits around what will or will not be expected in terms of showing up for appointments on time.

1. You tell the office secretary not to give him any more appointments, without explaining the reason. She is to tell him that you are unavailable. (Wrong answer: this issue needs to be addressed in the initial appointment, so that expectations are clear, and that he will understand that he is expected to compensate you for missed appointments.)
2. You explain your policies about missed appointments to him in the initial appointment so he understands clearly what is expected. (Right answer.)
3. You refer him to the local mental health center; let them deal with his irresponsible behavior. (Wrong answer: you need to address the issue with him.)

(9) You see a paid advertisement in the local newspaper in which a therapist in your town guarantees results, and includes personal testimonials from former patients. While I am sure you would be alarmed at such an unethical practice, but the question is: what do you do about it? Is it your responsibility, as someone who reads the newspaper, to report this to a state licensing, ethics committee? Or, is it your responsibility to call the therapist and discuss this advertisement.

This is a difficult one, because while we are seeing unethical behavior; the role of a therapist or counselor in dealing with that is problematic. I think it would depend on lots of things, and we might need more information about the person who has run the ad, as well as your role and your practice in this town to say with certainty what should be done. I think if you are not comfortable about calling or confronting about this issue, you would not be acting unethically if you simply didn't do anything.

1. You report this to the state licensing agency. (Wrong answer, at least initially, as you should call and discuss this kind of advertising with the therapist.)
2. You call and the therapist refuses to discuss the advertisement with you, so you then call the state ethics committee governing your practice. (Right answer.)
3. You send all your difficult patients to him so you won't have to deal with them. (Wrong answer: the other therapist is acting unethically by advertising.)

(10) As a volunteer at the local homeless shelter you meet dozens of people in need of mental health care. You know they have resources, no insurance, no way to find the help they need. This is not a clear cut ethical or unethical one thing that you can or should do. Certainly, as an advocate for the mentally ill, you feel a need to practice ethically and do something. So, there may be several choices and you may decide to pursue one or more of these at the same time.

You might talk to the shelter manager and point out some ways that he could find help for these folks that wouldn't cost money. Perhaps there is a clinic somewhere that could see them. If there is no such clinic in your area, you may choose to call some folks together and organize a local volunteer clinic in which therapists can donate a few hours a month to help these people. Or, you might at the same time be in touch with local and state authorities expressing your concern and support for whatever measures there may be to provide assistance and access to mental health care for the homeless. The ethical response would be to do something, but the circumstances would need to help you sort out which would be the best way to provide help for these folks.

1. You suggest to the shelter manager that he pursue help for these folks. (Possible right answer.)
2. You organize a local volunteer clinic in which therapists can donate some time to help these folks. (Possible right answer.)
3. You write to local and state authorities expressing your concern, and support for measures to provide assistance and access to mental health care for the homeless. (Possible right answer.)

Case Scenarios for the Practicing Professional - II

1. After two years of hard work and therapy, Ashley is ready to taper off her visits. In

gratitude she offers her therapist the use of her condo at the beach for a week. The therapist refuses her offer, explaining he is unable to accept such a gift. The therapist has acted ethically in this case because Ashley's gift is far too generous for him to accept. It may be acceptable to receive small gifts at times from grateful patients but a gift of this size, which would be worth perhaps several 100 or even 1000s of dollars is far too large for him to accept.

His accepting this may in fact alter their relationship. It may make a difference in how they might relate in the future if she decides to re-enter therapy. It has to do with the boundaries between the therapist and the client. So he would I am sure, explain very gracefully that accepting the gift is impossible and so he has acted ethically in his decision.

2. About Bert. Bert is being treated for depression. He refuses medications saying his pastor does not believe that such medication is consistent with the religious beliefs of their church. The pastor believes that prayer and talk therapy will be sufficient and Bert agrees, but his counselor is insistent on medication. I think the counselor is not acting ethically appropriately in this situation. If you look down at #7 we have a situation about Stuart who was Jehovah's Witness. He has been in an accident and needs a blood transfusion. He is awake and alert and refuses to accept treatment with blood or blood products. The emergency physician honors his request. It has been well established legally that adults may refuse treatment based on religious beliefs. So if we are going to be consistent then we need to be aware that Bert's refusal on the same basis needs to be honored. Of course if we were treating a child whether for depression or whether for an accident that was in need of blood transfusion, we would be in a different situation. But an adult who is competent to make a refusal based on religious beliefs; the belief should be honored.

3. Peter is terminally ill with a respiratory condition. He is on a ventilator and is comatose. His wife and children asked the doctor to withdrawal all treatment. The physician agrees. This physician has acted ethically. It has long been established in medical practice that with the terminally ill patient, the next of kin in conversation with the doctor may make such of decision to withdraw treatment. If the patient himself is able to communicate then he of course would be consulted about the decision but in this case Peter is not able to have a conversation with his doctor. So his wife and children then would be presumed to know what his wishes would be and the physician would agree with them and withdraw treatment.

4. Janet tells her counselor she cannot make up her mind about having ECT, which her physician recommends. She begs her counselor to make the decision for her and her counselor tells her that of course she should have ECT. This counselor has not really acted ethically in making this decision for her. The counselor's role might be more beneficial if she were willing to help Janet to gain more information, learn more about ECT, so that she can make her own informed decision and such a practice would support her autonomy. Her decision needs to be her own. She should not turn to the counselor and accept the counselor to make the decision for her; that would be an ethical.

5. Richard has lost his job. He wants to continue therapy. He offers to do grounds maintenance around the office and exchange for his therapy and his therapist agrees. This is a situation if someone bartering for treatment. Bartering is strictly forbidden in some codes of ethics. So you may want to consult the code that covers your particular practice; however, in some circumstances some codes of ethics will say that bartering may be acceptable at times. If in your community it is a customary practice then you may decide that bartering for therapy in this situation would be acceptable. Particularly since Richard is offering to work around your office rather than in your home or closer to where you live. Working around your office may well be an acceptable barter for Richard's treatment.

6. Mary has finished treatment for cancer and she is grateful to her oncologist. She sends him a gift certificate for \$50 for a local restaurant. He accepts the gift and enjoys the dinner. Many institutions, hospitals, and clinics and so forth have actual cost price limits on what is acceptable as a gift and in many cases that is \$50. This is not a very large gift actually. The treatment is complete and presumably the relationship with Mary and her physician has ended. I think that most ethicists would agree that in this situation, it would be acceptable for him to enjoy the dinner and accept the gift. That would be an ethical practice.

7. We have already talked about Stuart who is a Jehovah's Witness and the emergency physician who honors his request.

8. Geraldine has an advance directive. She has signed a living will, which states that she does not wish to be kept alive by extraordinary means if she is dying. She has cancer now and is in the end stages. She refuses further treatment beyond comfort care. But Geraldine's doctor insists on continuing treatment. Geraldine's doctor is acting unethically in this situation. He is violating her autonomy. She has clearly stated her wishes in her advance directive and she has made it clear that she does not want further treatment. When her doctor insists on continuing treatment, he is not only violating her autonomy, he is potentially doing harm and there are some situations in which he could actually be accused and be guilty of assaulting his patient who has refused treatment.

9. Kenneth is psychotic. He is refusing to take his medication. The nurse administers his medication against his wishes because his wife insists. This one is almost too brief for us to make an assessment. There are some folks who would say that forcing medication on Kenneth will enable him to restore him autonomy and he may well turned around and thanks the nurse for giving him his medication. To make an assessment here we really need more information about Kenneth, about his history. We need to know if he has an advance directive which speaks to medication. We need to know what his past experience has been, when he has been hospitalized and has refused medication. We need to know why his wife is insisting. We need to know if she wants him medicated for reasons of her own or if it is in his best interest. We simply do not have enough information to make a good decision about whether this is ethical or unethical. So I would probably put not sure in this situation.

10. Ann's supervisor at the mental health clinic asks Ann to stay late and see two extra clients so he can leave early to play golf. Ann readily agrees because she needs a good recommendation. Clearly the supervisor's request is not ethical because the supervisor is taking advantage of the power differential between the one who is supervising and the one who is being supervised. Ann probably does not feel that she really has a choice and so she agrees, whether she really wants to or not. So the supervisor's request is unethical.

11. Renee's mental health advanced directive states that she refuses all antipsychotic medications. She is now hospitalized in a state of psychosis. Her physician decides to honor the advance directive and does not order antipsychotic medication. This physician has acted ethically. It is a decision she had made presumably while she had capacity; a decision that she had thought about carefully and made what would be a reasonable choice for her. And the physician should in fact honor her choice even if he might prefer clinically to give her medication. She has gone to the trouble to make an advance directive and that should be honored.

12. Robert's managed care plan will only pay for inpatient care. Robert is fragile and needs therapy but if his counselor sees Robert in her office, she will not be compensated by the insurance company. So the counselor arranges for Robert to be hospitalized. This is a difficult one. One could argue either way. We might say if we were approaching this from a consequential perspective that the end result would be the primary thing to attend to, so that we would go ahead and hospitalized Robert, so

that he can get the treatment he needs. So that the consequences of our choice would be beneficial to Robert that is to have him hospitalized so that he could be treated. However, on the other hand if we are going to follow rules carefully, we would have to acknowledge that Robert may not really need to be hospitalized. And then perhaps we might wonder if this could be insurance fraud. If we are going to hospitalize the patient, he really does not need to be hospitalized. So this was complicated on balance. Robert's best interest, what is beneficial to Robert, should probably be the deciding factor. I would probably say that what the counselor has done in this case is in fact ethical at least marginally ethical.

Types and Forms of Advance Directives

I would like to spend a few minutes talking now about mental health advance directives. Traditional advance directives are now widespread. Every state has provisions for advance directives. These have generally been most helpful during end-of-life decision-making, though they may speak to other situations, as well.

There are two types of advance directives. One is a what we know as a living will which allows someone to say what she does not want or does want if the condition terminal, and if the patient is unable to make or communicate decisions. These would be decisions about ordinary versus extraordinary care. Decisions about nutrition and hydration; those sorts of things.

The other type of advance directive is the health care power of attorney which allows someone to appoint a decision-maker, that is a surrogate to make decisions for health care only. So the surrogate needs to know what the person wants, values, etc. because the surrogate has broad discretion, and can usually make lots of decisions on behalf of the patient who can no longer make or communicate decisions. The health care power of attorney is usually a family member, but not always. So, these two types of advance directives have been in place in most areas for a number of years. And, more and more people have signed these advanced directives.

In some states these documents are assumed to include mental health care. Some states say so specifically, a few exclude mental health treatment specifically. You may want to get a copy of the advanced directives for your state, so you can be familiar with these documents.

In recent years there has been the development advance directives specifically designed for mental health care. There are documents now in about a dozen states that allow a person to make some choices about mental health treatment at a time when the person is functioning well; decisions and choices to apply to some future time when the person may not be capable of giving consent or of making reasoned choices.

All the states which have such laws establish the right of persons with mental illness to state their wishes about psychiatric treatment. In some states the range of treatments one may specify is restricted to only in-patient treatment, medication or ECT. Other states have laws which are broader and refer to all forms of psychiatric care.

For information about mental health advance directives in your state, you can contact the Protection and Advocacy System which is on the web. The Bazelon Center for Mental Health Law also provides information about psychiatric advance directives at www.bazelon.org/advdir.html

Generally there are two forms for mental health advance directives. The first is a directive which permits the person to state wishes and preferences. The second is the opportunity to appoint a surrogate or proxy for decision-making; a mental health care power of attorney.

When a person's capacity to make or communicate decisions deteriorates, if the person is unable to evaluate information, give truly informed consent which requires a measure of understanding of options, or when a person is unable to communicate decisions, then the proxy speaks for the person, or we look to the document which states preferences for guidance.

Generally, these advance directives for mental health offer an opportunity to designate which mental health treatments or interventions one consents to, which interventions are not consented to, and other information about the person which may be helpful. For example, a person may specify which medications are helpful, and which medications are less helpful. She may note that a particular medication causes undesirable side-effects, or that she is allergic to a medication. She may mention her experience with various dosages and which seems most helpful. She may state that she refuses ECT, or she may say that she wants someone to notify her religious or spiritual counselor.

A person can give direction for helpful interventions during times of crisis. She may specify that calling a particular friend or relative is helpful. She may say a darkened room is helpful, or that certain kinds of soft music is calming. She may request prayer at such times. She may have a tape or CD that is beneficial. But unless we have some written direction, this type of information might not be available.

The mental health advance directive allows the person to specify who she wishes to be informed of her condition, and who she specifically does not want to be informed. When we have this information already recorded we may not need a release to call the persons that we wish to contact.

There may be information in the advance directive about hospitalization; which facility she prefers, which she does not want to enter. She may state how long she is willing to stay, i.e. a certain number of days. She may include instructions about who should care for children or pets that may be in her home.

The advance directive can include naming a surrogate, that is a health care power of attorney who will be expected to carry out the person's wishes, or if the wishes are unknown, to act in her best interest. The proxy or representative is to be the advocate for the patient.

Most states require that a valid mental health directive be witnessed by two persons and be notarized.

Should a patient change her mind about these instructions during a period of decision-making capacity, the directive can be revoked or changed. All those who have copies (family, friends, physician, a therapist) need to be told so that copies can be destroyed. If the patient wants to make changes, she should replace the old documents with new ones, and be sure that all those involved are aware of the changes.

Ethical Considerations for Advance Directives

There are several ethical considerations around mental health advance directives. One of the ethical difficulties with mental health advance directives lies in the question of capacity or competence. Determining a patient's capacity to make an advance directive in the first place may be questionable. If capacity was compromised, the documents may not be considered valid. Capacity is not always easy to determine, it may waver, and it may be a somewhat subjective assessment.

And then the question of capacity to determine when to implement the directive arises. When is the patient sufficiently compromised in decision-making capacity for the advance directive to take effect? Suppose the patient is clearly lacking capacity today, but tomorrow she may have capacity. The fluctuating nature of capacity both to make, and carry out mental health advance directives is potentially a difficult ethical issue.

Yet another difficult ethical dilemma may arise if a patient decides to revoke the directives at a time of illness. If a patient needs treatment and then suddenly decides to revoke her advance directive and refuse treatment, is the revocation permitted? Some state laws speak to this issue, and do not permit an incompetent patient to revoke an advance directive. Other state laws are silent on this point.

If, for example, a patient knows she is prone to discontinuing her medications, she may wish to make sure that her advance directive includes careful instructions so that she may not be allowed to discontinue her medication. She may know that she will, in a crisis, insist that she doesn't want her medication, even though she knows that she needs to be taking it.

When such questions arise, one may consider the wisdom of what ethicists call a "Ulysses clause" You may remember the Greek hero, Ulysses who was aware that the Sirens could lure him to sail his ship to the rocks and be destroyed. To avoid being captivated by the Sirens, and lured to his death, Ulysses ordered his crew to tie him to the mast of the ship, and keep sailing past the Sirens even if he begged them to let him loose. Hence the term "Ulysses clause" which states that if one should change his mind during a crisis, such a change of instructions is to be ignored. Capacity concerns and how to assess are often complex ethical concerns.

Some states, such as Oregon, are specific about determining capacity, stating that capacity must be determined by a judge or two physicians. But designating who should decide may not simplify the process of deciding.

Another ethical problem arises if the patient should simply refuse all psychiatric treatment; if a patient has filled out an advance directive which says, no treatment. If a physician believes the patient is better served by over-riding the advance directive, in some situations, this may happen. If the patient is a danger to self or others, if the patient meets standards for involuntary commitment, then the advance directive may not be honored. In emergency situations, where life or health is endangered, physicians may treat without consent. Of course such treatment in emergency situations is currently standard. However, the question of such treatment overriding an advance directive raises new questions.

These documents are fairly new, and courts have not ruled conclusively concerning conditions under which mental health advance directives may be overridden. It may well be that courts will honor the well-established right of patients receiving treatment for physical illness to refuse treatment. It is possible that court-decisions will continue to provide for care for patients who are dangerous to themselves or others. Thus far there is at least one federal court decision dealing with mental health advance directives. In Vermont, there is a law allowing physicians to go to court to nullify mental health provisions in an advance directive if the treatment chosen does not result in the patient's condition improving.

The plaintiff in this case had been diagnosed with a serious mental illness. She was involuntarily given medication, in direct contradiction of her express wishes in her Durable Power of Attorney for Health Care. The question was whether the state could override the power of attorney document with involuntary psychiatric medication in a non-emergency situation. Would persons with mental illness be given the same protection as advance directives offered for others? Or would the nature of her illness mean that her wishes and desires became invalid?

In Oct. 2001 a federal Magistrate Judge ruled that this provision is discriminatory, in violation of the Americans with Disabilities Act. In other words, the patient had the right to refuse medication. One may find such a verdict problematic from a clinical perspective, even if the patient's rights to express her wishes, and have her wishes honored, was carried out.

We can be sure that questions about advance directives and how they are used will continue to come up. Thinking about balancing benefits—giving a patient's autonomy or honoring patient's wishes might well come into conflict with what we believe to be the best choice clinically. The burden of denying a patient autonomy must be considered along with the possible benefit of unwanted treatment. This is at the crux of ethical dilemmas, balancing benefits and burdens to make choices in situations with no clear or obvious solution.

Advantages of Mental Health Advance Directives

There are some ethical advantages to mental health advance directives. There are times when patients may be hospitalized when necessary without having to go through a complicated commitment process. Their families may be notified, as the instructions state in the advance directive. The advance directive may also contain useful information for doctors and nurses who might be caring for a patient in the hospital.

At this time one of the most important benefits of these documents lies in their value for the conversations they encourage between patients and health care providers, as well as patients and their advocates, their family or friends. They allow persons to think about, and discuss, what they wish to happen in the future. They allow providers to hear a patient's wishes and desires at a time she is stable and capable of thinking clearly and communicating her thoughts and feelings. Such a process promotes patient autonomy and empowers the patient to take a greater role in her care. Supporting and encouraging patients to consider such documents when appropriate may well be one way mental health providers can act to promote beneficence for patients.

Since most states at this time do not have a mental health advance directive, one role we may play as providers is to participate in the creation of such laws in our states. Careful design of advance directives can prevent confusion, and other problems down the road. Mental health professionals may be serving not only their patients, but their own interests by contributing to the creation of responsible, carefully written documents.

We will surely be hearing more and more about mental health advance directives in the future. Likely more and more states will be providing for such directives. The ethical dilemmas created by mental health advance directives are potentially difficult, however the empowering of patients, the greater likelihood of careful conversation about treatment issues, and the enhanced patient autonomy mean that mental health care providers need to be supportive of the creation and implementation of such directives.

Case Scenarios of Advance Directives

(1) My patient brings a copy of a mental health advance directive to my office and asks my opinion. It may be the first time I have ever seen such a document. These are very new for many folks and many of us may not be familiar with what a mental health directive looks like. It might be easy to dismiss her concerns and tell her that she doesn't need to have such a document, that she can trust me and her physician to take good care of her.

However, I think that a more appropriate answer would be to see this as an opportunity to have an important conversation with my client or my patient. We could talk over what type of treatment she does or does not want, if she should be hospitalized. We could talk over what helpful interventions we might find that would be particularly important to her. We could have an opportunity to discuss who she would like to have notified or who she does not want to have notified, should she be hospitalized. We might discuss medications; which ones have been particularly helpful for her, and which medications she may be allergic to or experience side effects with. I think the mental health advance directive is an important tool for conversation about a patient's desires and a patient's wishes. And, such a conversation serves to empower a patient and promote her autonomy.

1. I tell her she doesn't need such a document, that she can trust me and her physician to always take good care of her. (Wrong answer: patient autonomy means she should have every opportunity to express her treatment preferences.)
2. I look it over with her and we talk together about what information she might want to include in her advance directives. (Right answer.)
3. I tell her I don't know anything about such documents and she should consult her attorney. (Wrong answer: her attorney may or may not be knowledgeable about such matters, and may not be helpful. As her therapist, you are likely to be more helpful in guiding and supporting her in filling out an advance directive.)

(2) My patient is currently hospitalized, and is psychotic. He refuses to take medication. What should hospital personnel do? This is one of those situations when we look at our ethical process, where we can only say we need more information. We don't know what the history is with this patient. We don't know who his surrogate decision maker is. We don't know if he has a mental health advance directive. We don't have enough information to be able to say: yes or no – hospital personnel should force medication.

There are times when that is the appropriate response, because giving medication may allow the patient to return to a state where he is autonomous and can make decisions for himself. On the other hand, he may have made it clear in an advance directive that he never wants to receive such medication. So we really don't have enough information to say what is or is not ethical in this situation.

Hospital personnel should:

1. Force the medications even though the patient refuses. After all, he is currently not capable of making such an important decision. (Possible right answer: depends on other factors including his medical history, his surrogate decision-maker, whether he has a mental health advance directive.)
2. Discharge the patient to the care of a relative. (Wrong answer: his well-being must be primary.)
3. Continue to try to persuade him to take his medications. (Possible right answer: depending on factors mentioned in "a".)

What is E-Therapy?

One of the newest areas of mental health care comes with the advent of the internet. There is now widespread use of the internet for providing mental health care. There is more than a little controversy about such practices. Some professionals do not believe it is ethical to carry out therapy through electronic means. Others find limited usefulness in some situations. There are a number of web-sites which offer various forms of counseling. However one may feel about electronic interaction in a therapeutic context, such practices have caught on in some circles and we need to think about the ethical implications.

First, there are a number of websites which deal with these issues in depth. One may begin by looking at the International Society for Mental Health Online which offers information as well as links to other helpful sites.

What exactly is electronic therapy, also called e-therapy, cyber therapy, or online therapy? Essentially it is an interaction between a therapist and a client or patient which occurs by way of a computer linked to the World Wide Web.

Some practitioners are careful to note that it is not actually therapy in a traditional,

clinical sense in which one sees a professional, is assessed and diagnosed, or treated. Some authorities such as John Grohol, see e-therapy as similar to "coaching" in which one person is available to help guide another with particular specific concerns such as relationship issues.

Some sites refer to their services simply as "psychological advice" in which a person sends a question and receives a reply. They do not presume to offer "therapy." Other practitioners do not shy away from practices which look more like traditional counseling, except that the therapist and patient never meet face to face.

Such a process can happen several ways. The therapist may send e-mail and the patient responds by e-mail in an ongoing therapeutic conversation. There is, of course, a delay between e-mail communications. Other forms of e-therapy may include simultaneous communication through chat. There may even be groups established through chat. Web messaging, internet phone, or videoconferencings are also possibilities.

There are a number of sites available for e-therapy, a term coined by Dr. Grohol. I will use the term to refer to all forms of internet interaction between therapist and client. There are individual counselors working independently, and there are large clinics in which a number of counselors participate. Of course they need not be in the same location; these clinicians may be working from anywhere in the world.

Potential Advantages of E-Therapy

Those who advocate the use of e-therapy point out several advantages. Many persons live in remote areas not well-served by mental health practitioners. E-therapy may simply be all that is available to some persons. Or there may be a situation in which a person who is well-known locally may feel uncomfortable consulting a mental health provider. Suppose, for example, you are the only counselor in a small town. Perhaps a local minister may feel the need for some help, but be unwilling to be seen coming into your office, or having the office staff, who may be members of her church, knowing she is in therapy. Possibly the town physician may feel uncomfortable seeking therapy in a similar fashion. In some situations confidentiality issues discourage persons from seeking help.

There may, as well, be people who are painfully shy, who have no access to transportation, people who have no insurance and find the lower costs of e-therapy more affordable. There may well be many folks who would turn to an e-therapist for help when they are unable or unwilling to seek help in traditional ways.

Other persons may appreciate the flexibility involved. One can write to the therapist at her convenience, and then respond to the reply any time. Making appointments for a very busy person can be a problem with an already overbooked schedule, which of course may be a therapeutic issue in itself.

E-therapy can be convenient in terms of time. It provides the client with the opportunity to think about a response rather than speaking immediately. This may be helpful or not, depending on circumstances. Anyone engaging in e-therapy needs to be able to be really honest with herself and her feelings, and be willing and able to express that through typing. Of course people benefit most if they are comfortable expressing themselves this way, by way of electronic media, if someone can't type, or doesn't own a computer, there is an automatic barrier.

Other benefits include the ability to keep a written record of the conversation; one may save or print the communication and so it's easy to refer to previous comments which may be helpful. Another benefit is that some persons are able to be more honest when they aren't sitting face-to-face with another person. It may be easier for some folks to talk about issues they feel are deeply personal and private, such as sexual concerns, through the computer screen.

Ethical Concerns with E-Therapy

Even with many potential benefits, there are a number of concerns of an ethical nature which raise questions about e-therapy.

To begin with, many persons are concerned that e-therapy may be less useful or helpful than meeting with a patient in person. The lack of body language, facial expressions, and other cues to communication may be a big hindrance to the therapeutic process. A process that is less clinically helpful may raise ethical concerns.

Confidentiality, of course, is always an ethical issue for mental health providers. However in on-line communication there may be additional reasons to worry. It is possible that the e-mail detailing one's innermost thoughts and cares could be sent to the wrong person if one hits "SEND" at the wrong time, or to the wrong address. Or a copy of such communication may be accidentally sent to another person. One may have worries about others having access to her computer or e-mail. Not everyone is surrounded by family or friends who have high respect for privacy. The client would need to be very careful about securing communication for herself.

The security of transmitting e-mail can be questioned. Everyone has heard horror stories of e-mails being sent awry and ending up in unpredicted places. There may be snoops, or hackers who can access e-mail. According to John Grohol, there is currently no federal penalty in the US for opening someone's e-mail and reading it. Regular mail or telephone communications are protected by law, but not e-mail. E-mail at one's place of employment may be particularly vulnerable, as the company actually owns the computer, and hence whatever is stored in it.

Because of these concerns, patients should be very careful to inquire about the security of the site they are using. There are a number of ways to increase security, and the mental health provider is ethically responsible for taking all reasonable measures to make the communication secure.

Other confidentiality concerns arise regarding the identity of the persons involved. One might easily assume a fictitious name or identity and seek therapy under false pretenses. The provider needs a way to confirm who he or she is working with. Likewise the patient has a right to know who she is working with, and to know that person's credentials. Such information may be exchanged during a telephone call.

Safety concerns are ethically very significant with on-line encounters. If your client sitting in your office is suicidal, you know how to handle it. But if your on-line client is suicidal, or threatening to harm another person, your ethical responsibility as a therapist can become very complicated. How do you see that the person gets the appropriate, immediate help she needs?

We may also have serious concerns about legal requirements for reporting information concerning possible child or elder abuse. We may be ethically obligated to act on behalf of persons who may be in danger, but if we don't have enough information about our patient and her location, it may be very difficult to carry through.

One solution is to require that clients provide a physical address so that the therapist can intervene by contacting local authorities for assistance. Such information needs to be obtained early on in the relationship, and the therapist may consider it a requirement for patients to provide such information. Of course, the client could provide false information, but the therapist needs to make the best possible good faith attempt to verify and obtain this information for emergency purposes

Ethical concerns about informed consent may arise. In a face to face encounter, the therapist can explain to the client the nature of the relationship, what the expectations of each party are, and how the process will be carried out. Ethically, it is the responsibility of the provider to make sure the recipient understands the consent

process, and all questions are answered. In an on-line situation, simply asking a patient to read a consent and reply affirmatively may be inadequate to ensure that the patient understands fully what is involved.

There are ethical concerns as well about the efficacy of the process. At this point there is very little research to confirm the view that e-therapy is clinically helpful. Some surveys of clients have shown a high percentage of persons believing that they have benefited. More research is needed to establish the effectiveness of e-therapy. In the meantime, we need to remember that a practice which may ultimately prove to be unhelpful is not ethical. Until research documents that e-therapy is harmful, we may proceed with caution.

Ethical considerations often coincide with legal considerations. Given the nature of the world-wide web, this is an area of serious concern. Some ethicists recommend that both the therapist and patient reside in the same state so that state laws governing such encounters may be applicable. However that may not be realistic. One may find that clients are quite literally all over the world, living not only in the US, but in many other countries as well. Clients may choose therapists who live in any number of other countries. One need only the ability to communicate in the same language to enter into a web-based relationship.

So, legal concerns are a problem. As clients and therapists come from anywhere in the world, we need to keep in mind that there are no international laws governing such work. There are no national laws; in fact, these are state laws, so that even within the United States, one may well imagine clients and therapists all over the place. Therefore, it is very important to acknowledge that if there are problems which may lead to litigation, there may be very little legal protection for either party.

Consequently clients need to assume a high level of responsibility in choosing a competent and well-qualified therapist so that potential problems will be minimized. Providing ethical care is the responsibility of the therapist, but given a wide variety of legal jurisdictions, problems could easily arise.

Payment for services raises other ethical questions. E-therapy is often less expensive than traditional therapy. Some sites even offer free therapy. Fees are by no means standard, and potential patients should check on this carefully.

Most therapists will accept payment by credit card, but such a transfer of information needs to be secure. One may choose to relay this information by telephone. But, some persons are not comfortable giving credit card information. Whatever form of payment there need to be safeguards to that the therapist is appropriately compensated.

Professional Codes and E-Therapy

Professional codes of ethics have long governed mental health practice. Codes which speak specifically to the practice of on-line therapy are in their infancy. Information about individual codes for various professional groups may be found on-line, and some of these now include information and guidance specific to on-line therapy.

The American Counseling Association now has a "Special Section" devoted to ethical standards for on-line counseling. These documents speak to concerns about privacy and confidentiality, reminding therapists that secured sites are to be used, and that clients can be fully informed of potential problems with confidentiality in e-therapy. The limits of confidentiality need to be carefully spelled out.

Concerns about identification are addressed. The code requires that professional counselors make available information about who they are. Counselors need to inform clients if there is supervision, and how transcripts may be used. Counselors are required to identify clients, and verify such identification for emergency purposes.

A waiver concerning the limits of confidentiality is recommended as part of the informed consent process. Clients who refuse to consent are referred elsewhere. Development of an appropriate in-take process is important so that clients may fully understand the limits of on-line counseling. Clients need to be fully informed of possible limitations and risks.

The American Counseling Association states, "Professional counselors ensure that clients are intellectually, emotionally, and physically capable of using the on-line counseling services, and of understanding the potential risks and/or limitations of such services." Meeting this high ethical and clinical standard is essential for responsible practice. Further considerations about client's competency to consent are included. (This document is available online, at the American Counseling Association site.)

For better or worse, various forms of internet therapy are likely here to stay. As mental health professionals, we are responsible for maintaining high standards of ethical practice whatever form of therapy is offered. In those areas where legislation may be under consideration to regulate e-therapy, advocates of responsible, carefully written legislation can come from the community of mental health professionals.

It is our ethical responsibility to educate persons about the benefits and risks of e-therapy and to assist persons in assessing what is most appropriate for their needs. As practitioners of e-therapy, we are obligated to maintain the same high ethical standards which govern more traditional therapeutic practice.

Case Scenario with E-Therapy

Your patient tells you her sister has been in therapy on-line, and it sure saves her money. Your patient is wondering if it would be a good idea for her to find an on-line therapist, and do her therapy by e-mail. This is a difficult one too. I think that the ethical response is to talk it over thoroughly with your client, pointing out to her the advantages, as well as the disadvantages and drawbacks by having therapy by electronic means. Pointing out, as well, the lack of legal protection, should anything go wrong. I'm sure it's never comfortable to have a client come in and say, "I'm thinking of leaving you so I can find a less expensive way to be in therapy." But, I think it's important as part of our role of advocates to be sure the patient is well informed about the choice she may be facing.

- 1. You tell her that sounds fine. (Wrong answer: patients need to be very cautious about entering into therapy on-line, and she need to check out security, credentials, and other factors before they sign up.)**
- 2. You talk it over with her, pointing out the advantages, as well as disadvantages of on-line therapy, including the lack of legal protection should anything go wrong. (Right answer.)**
- 3. You warn her away from on-line therapy. (Wrong answer: it may be that she would find it beneficial if carefully managed.)**

Questions and Answers

Now let us look at some questions that have been submitted by therapists who have been in practice for many years.

Question: The therapist is faced with the dilemma that his/her own orientation is to long-term therapy, but the client's insurance will only cover short-term treatment. What should he/she do?

Reply: This kind of dilemma recurs over and over in practice. There are several choices, none of which are ideal. One choice is to refer the client to someone who can probably better meet the needs as provided for by the insurance company. Another choice is to

adapt somehow your time with the client so that you will in fact be compensated, because this is an ethical issue too. Therapists should not be doing therapy for free. Another possibility is to negotiate with the client so that the client may be able or willing to pay more out of pocket to cover for the difference in what the therapist believes the client needs in terms of sessions and what the insurance company is willing and able to pay. It would not be ethical for the therapist to simply go ahead with long-term therapy and bill the client without having a conversation about this problem early on so that whatever needs to be negotiated and worked out can be.

Question: The client's managed care only covers five sessions of marital therapy, but more sessions if the treatment is for individual therapy. Should the therapist diagnose and bill for individual therapy even if the actual counseling is for marital therapy?

Reply: This is another tough kind of dilemma that shows up on a regular basis for many therapists. We can approach this from at least three different directions. To begin with we might look at this from the perspective of a consequentialist. If you recall our talk about ethical theory, this is a theory that looks at the end results. So, if we want to achieve the most good, to do the least harm then we might feel comfortable to go ahead and bill for individual therapy because the end result in doing so will be better for everyone involved. The couple will benefit from more time and therapy and the therapist will benefit by being paid.

There is a problem here, though. If we fudging on billing we need to think about whether that problem is outweighed by the benefit that the people involved could gain by being in therapy more for a longer period of time. So, there is problem using a consequentialist approach to this. A deontologist would say we need to follow the rules and the rules say you cannot bill for what you are not actually doing. So, a deontological perspective on this question would leave an ethicist saying no as much as we might like to provide more help for this couple we are limited by what will be covered by the insurance. So, we have here then a legal versus an ethical problem. What may be ethically appropriate and what might be legal may be at odds in this situation. And I think this is something that therapists need to sort out for themselves in terms of what they value and what their goals are with therapy, with the clients they are working with.

Question: A client wants a copy of his/her therapy records, but you, as therapist know that some of your remarks will be misinterpreted and harmful to the client. What should the therapist do?

Reply: In many jurisdictions the client may well be legally entitled to see a copy of the records. There may be some benefit from the client looking at his records. The client may gain insight, may gain trust for the therapist, and may learn more about the entire process. On other hand there is a potential for harm if a client sees his/her records. The records may well be misinterpreted and this could lead to many problems.

The autonomy of the patient would say that he has a right to see his records; however, therapists are often concerned that the records may be misinterpreted. One option would be to offer to prepare a summary for the client, which many clients would happily accept as a way to know what is in the records without going through everything in detail. If the client insisted on reading the record; if I were the therapist, I would invite him to read it with me present so that we could talk over anything that was not clear, that he did not understand, or had questions about. I will be very reluctant simply to hand over the record to the client without some sort of protection for myself against the possible misunderstandings that could occur.

Question: As a therapist I feel a duty to warn the spouse of a client that they are in danger. What should I tell the client about my plan to warn the spouse and what is the standard by which I am require to warn, i.e., how much evidence or information do I need to judge that the client poses a sufficient danger?

Reply: This is a really difficult question; we all know that many clients regularly make threats, particularly when they are angry. So, if we warned everybody for every possible action we would have chaos. However, we know based on the Tarasoff case there is legal duty for us to warn when we believe there is genuine danger. When that happens, it is basically a judgment call. It depends on how well you know your client, something of your client's history, how serious you believe this threat to be, how likely he/she may be to carry it out. If you decide to warn, you could save a life. You could prevent harm and provide a benefit to the person who may be at risk or you might destroy or damage the therapeutic relationship. There is some risk either way. If you choose not to warn the person who may be in danger, you are taking a huge risk.

So, whether or not to warn the client, it is hard to say. If you recall when we looked at our ethical process, it begins with gathering facts and I would suggest that we need more information than we have in this brief question to make an assessment. We should be very careful with these kinds of issues because we do have a duty, a legally established duty to warn people when they are in danger. We might add as well that if we believe the threat to be serious and we believe someone is in danger, we should call local authorities, as well as the person who has been threatened.

Question: I am counseling with a parent who reports abuse of a child, but who says that another therapist has already reported them to child protective services. What should I do?

Reply: I would go ahead and call, and make the report anyway. We cannot be actually be certain that we are being told the truth. It may be that our client does not want this reported and so was trying to prevent us from reporting it. Obviously our client knows that the reporting is a requirement. I would call anyway; it can do no harm and perhaps may do some good.

Question: A client is about to talk about either abuse or danger to another. I do not have enough information yet to cause me to feel a duty to warn. I want to stop the client and explain if they reveal abuse to me, I am required to report. Should I do so or should I let the client continue speaking?

Reply: First, I would like to remind you that your initial visit or at least a visit early on in your relationship should have clarified these kinds of things. When you talk with a new client about your expectations for the relationship and about what are the limits and the boundaries, confidentiality is one of the areas that should be covered. While you are in this situation though we need to address the question of what you do when the conversation is in the midst of, perhaps revealing abuse or danger to another person.

If you stop him to remind him that you may need to report what he is about to say, you in fact be contributing to the harm of another person if your client decides to clam up and say nothing more about the question. If you do not stop him on the other hand and let him tell you what he is about to say, your subsequent reporting may in fact save harm from happening to another person. You may be protecting somebody. I would probably be inclined, based on the ethical choice here to take the risk of violating confidentiality with the client so that he could go ahead and tell whatever he needs to say and then I would probably report if I felt a duty to report what he had just described.

Question: When does a counselor or therapist cross the ethical boundary by accepting a client for treatment who clearly has a problem that is not in the ability of the professional to treat, i.e., accepting a client for treatment to build a private practice when it is not in the best interest of the client?

Reply: Building a private practice can be tough and so there may be times when all of

us are tempted to treat anybody who walks in the door; however, our professional codes of ethics and standards of practice would say that we should not take on a case or situation that is beyond our ability to handle well. I do not want my family practice doctor doing heart surgery if I have a cardiac problem. So, I think that the client should be referred to someone with expertise in that particular area in this situation.

Advances in Medical Technology

Thinking ethically means thinking ahead. Medical advances in technology have often out-paced ethical thinking. It is important that we look at some of the ethical implications of newly-emerging medical developments. One area of particular concern involves the mapping of the human genome, and efforts to identify and locate genetic predispositions to various illnesses, including particular behaviors or mental illness. There are numerous ethical concerns about how such information may be gathered and stored, how this information might affect employment or insurance, about possible genetic treatments or preventive measures in mental illness, and the societal implications concerning the use of genetic information.

Responsible ethical practice means that we think ahead so that accepted norms and legal safeguards will be in place for the benefit of patients and their care-givers.