Australian Institute of Professional Counsellors

Professional Skills Series

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YOUR FIRST CHOICE FOR A CAREER IN COUNSELLING

Managing Complex Ethical and Boundary Situations

Professional Skills Series

Supplementary Resources

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What Are Your Personal Values?

Introduction: *As helping professionals, it is important to reflect upon the make-up of your own personal value systems, at different times of your life. Just like life itself, values are changeable according to presenting circumstances and context, and as such, they may alter or change altogether over time. This reading provides useful information for counsellors (as well as all helping professionals) in relation to how values are formed and shaped over time, as a result of lived experiences. In addition to this, the author has included a range of activities and reflections to maximise the learning journey overall.*

Reading: Proctor, G. (2014). What are your personal values? In *Values and Ethics in Counselling and Psychotherapy* (pp. 11-15, 18-24). London, UK: Sage

Introduction

This chapter will encourage and suggest exercises for us to assess our own values and beliefs. It will touch on the notion of identity and the relationship between identity and values. It will consider how we perceive the values of others and whether sharing values is an important foundation of relationships. We will think about origins of values and the concept of 'conscience'. Each of the exercises will be illustrated by at least one of the four students completing them, so we learn more about each of their identities and values.

What Are Values?

I argue that every decision we make is underpinned by what we value in life: every action and inaction. Our values shape everything we do; they underpin human agency, choice and autonomy. Values express what it means to be human and make choices about our behaviour. Values are inescapable and inherent in our behaviour and everyday decisions. For **Sartre**, we are always engaged in a world of values saying, 'my acts cause values to spring up like partridges' (1943/2003: 62). Behaviour acquires value through the culturally agreed social significance of acts. Sartre explains: 'Values are sown onto my path as thousands of little real demands, like the signs which order us to keep off the grass' (1943/2003: 62). How much do you think values influence or even determine your behaviour?

Exercise

1. Think of the first decision or choice you made today.
2. Explore what your options were at the time.
3. Work out what value was behind you picking the option you picked.
4. Repeat for the next three decisions you made and see if there are any commonalities in the list of values you acquire.

Maxine

The first decision Maxine thought about was the decision on whether or not to turn up to the counselling course that morning. She had been very nervous and apprehensive and had identified that she was worried what her ex-counsel-lor and new tutor would think of her in this new context. She had felt fairly confident in their therapy relationship that her counsellor had liked her and she did not want this to change. However, Maxine did not want to discuss this situation with her peers or with her tutor so thought again what decision to discuss. She instead chose to talk about her decision about what to wear that morning. She noted that she hadn't wanted to look as though she had made an effort to dress up but wanted to appear informal and casual. She also noted that in one of her favourite tops, she was particularly aware of the shape of her breasts and she did not want to draw attention to this or for other students to perceive her as overtly sexual or sexually available so she rejected this option.

She was also aware she would be sitting still all day and wanted to wear something she felt comfortable in so did not choose a pair of trousers that were a little too tight around her waist. She identified that the values she had prioritised in her decision of what to wear were comfort, wanting to belong and not intimidate or distance people, and wanting to feel good about herself (feeling attractive but not overtly sexual which to her would feel desperate or needy as opposed to self-contained and content).

Rubina

Rubina could not decide what decision to discuss and finally decided to discuss the decision of what to discuss! She found it difficult to assess how much information she wanted to disclose about herself and her life, as she did in her work. She considered that the values important to her about this decision were privacy openness and humility. She was interested to think more about the value of humility and consider how much she felt vain and selfish to talk about herself, and concluded that this value was possibly much more deeply held and influential than she had previously realised. She decided that this course was an opportunity to challenge her usual mode of saying very little about herself.

We can see from these examples that our personal values are many and various and different ones may be prioritised at different times, de-pending on our physical and emotional needs at the time and the context of each decision.

Identity

To the extent that our values are personal to us (although developed intersubjectively), they are connected to how we describe or think about our identity. I see identity not as fixed but as developing and being actively shaped by us according to our values and in response to our context. The features or characteristics we think are important to describe ourselves reflect our values. Values are the root of ethical decisions and **Sartre** is adamant that there is no justification for our values; we are free to choose them. Our values, developed from our social intersubjective context, shape who we become and this in turn further shapes our values.

Exercise

This and the following two exercises came from Sue Woods, who worked with me on the School of Health's Postgraduate Certificate in Citizenship and Community Mental Health, University of Bradford. She works as a freelance creative writing facilitator with at-risk groups and in professional health training.

1. Choose three adjectives to describe yourself.
2. Which three adjectives do you think you would have chosen 10 years ago?
3. Which three adjectives do you think you would have chosen 15 or 20 years ago?

Anne

Anne completed the exercise above very quickly. Without hesitation she described herself currently as caring, responsible and fun. She thought more carefully about how she was 10 years ago and situated herself in recollecting that at that time her children would all have been in primary school and she was very involved in their everyday lives. She chose for that time: caring, exhausted and proud. Thinking back further, she reminded herself of her life 20 years ago, before she had become a mother, excited to have just met her husband and just begun her career in teaching. She chose for then: excited, loving and hopeful.

Tom

Torn spent a lot of time trying to work out which three adjectives to pick, finding great difficulty as he experienced himself as changing so much in his moods. After much deliberation he chose: self-confident, emotional and concerned. Thinking back to being 18 was a distressing thought for Tom as being diagnosed with a major psychiatric illness was not a positive experience for him, although the resulting medication did make his life temporarily easier. The adjectives he decided on were: unhappy, unconfident and worried. Finally thinking back to being eight years old was easier for Tom. He described himself aged eight as: carefree, emotional and interested.

The students spent much time discussing how they saw themselves and how this had changed over time, noting what characteristics had remained constant and which had changed or developed and why. They noted how their identities can be vulnerable to how others see or treat them, and also discussed with some sadness what parts of their identities they felt they had lost and would like to reclaim. They also noted how their descriptions of themselves were so dependent on their self-esteem and how positively or negatively they saw themselves at any one time. As a result, their tutor suggested a further exercise.

Exercise

1. Choose three adjectives to describe how you'd like to be.
2. Compare these to the adjectives you have chosen to describe how you think you are. If these are very different, this can be an indication of low self-esteem, whereas if they are similar, this suggests high self-regard or esteem.

The Students

The group discussed this exercise and its usefulness as a measure of self-esteem, and generally agreed they felt it was more useful to help them identify areas for self-development than to use as a measure. They discussed how it highlighted that their identities are connected to their values, with the characteristics they chose showing what they value, whether they are characteristics they would like or that they think they already have.

Identity and Roles

Our identity is also tied up in how we see ourselves in terms of the roles we fulfil. The roles that are central to our identity may say something about our values too.

Exercise

1. List all the roles that you have in life and list them in order of how central each is to your identity.
2. Write a poem, beginning each line with 'I am a ...'. Include all your roles; more than one can complete each line.
3. Think about how much this poem reflects your identity.
4. What aspects of your identity does it miss?

Anne

Anne listed in order of centrality to her identity: mother, wife, daughter, sister, friend, listener, Brownie leader, singer, swimmer, reader, cleaner, cook, ironer, tidier of clutter, appreciator of flowers, gardener, accountant, first-aider. She wrote the following poem:

I am a mother, a wife, a daughter and sister,
I am a woman in relationships.

I am a helper, a listener, a Brownie leader;
I am a singer, a swimmer, a reader and gardener;
I clean, I tidy, I iron, I count money and
I apply plasters to sores.

She reflected how much time she spends in her life fulfilling roles that are important to her sense of identity as a caring and nurturing woman. She also reflected that singing, swimming and reading are important pans of her identity that she rarely fulfils now, and decided she must prioritise these activities more highly. She was glad that the counselling course will involve a lot of reading and is determined to make time for this and be clear with her children that she is unavailable for their needs when she is focusing on this.

Origin of Values

How much do you think nature or nurture influences your values? What aspects of your context and culture most influence your values? For some, religion or spirituality is an important part of values and ethical beliefs. Values and beliefs influence each other such that behind each of your values you can find some beliefs about yourself, others and the world. In turn your values influence how you perceive yourself, others and the world.

Exercise

1. Consider yourself at the ages of 5, 10, 15 and 20 years old and list for each age all the influences on you (include significant people, institutions and broader cultural influences such as the media).
2. For each influence, list the values that you were taught.
3. Decide how important each of these values is to you still now.

Maxine

Maxine thought back to when she was five years old. At that time she spent most of her time with her parents, her aunt, uncle and cousins, and at school. The values taught all seemed similar from her family and were values of enjoyment and freedom. She remembered being allowed to watch a bit of television but limited to cartoons or children's programmes which she could not recall influencing her. By the time she was 10 years old, the influences on her had broadened. She was a keen gymnast and competed for her county, spending a lot of time with her gym teacher, who supported and encouraged her enormously, giving her the values of care, effort and achievement, and valuing her body. She also had friends from different schools through gymnastics. She played with a couple of other similar-age girls on her street who attended different schools, one of whom was of African-Caribbean descent, so she was also aware of different cultures. From these friends and their families, she came across the values of politeness, curiosity and respect for different opinions. At age 15, Maxine spent a lot of time with a few girlfriends who were interested in shopping and boys, from whom she learnt the values of appearance and covering up feelings. However, she also had other local friends who she relaxed with much more and learnt the values of having fun and being herself. She realised that nearly all the values she had learnt were still important to her now, depending on context and how she was feeling about herself. It made her wonder if any of her values were hers alone, as opposed to influences from other people. She considered whether her interest in other people is just her but realised that she has been influenced by others who have shared this value, such as her gym teacher.

Impact of Life Experiences on Values

Major events or changes can have big impacts on our values or be critical events in leading us to re-evaluate our values. For example, the experience of someone dying who was important to us can lead us to evaluate the impact of their values on us and can help us prioritise our values in considering

whether we are leading the life we want to live, having been reminded of the finiteness of life. Of course, the values we already hold also influence how we react and respond to such events.

Conscience

The conscience is often referred to as though it were a separate entity: we might say 'She has no conscience' or 'how does your conscience let you do that?' It seems to refer to the most strongly held values we have that influence our behaviour. Could the idea of a 'conscience' represent the way our most deeply held values influence us?

For Heidegger, we are called upon by the nature of our being to make our own choices, to choose to choose, and then we can have an individual conscience.

Exercise

1. List any behaviours that you think would be against your conscience.
2. How would you feel if you carried out each of these behaviours?
3. Can you remember a time when you acted against your conscience?
    i. Why did you do this?
    ii. How did you feel as a result?
    iii. How did you deal with this feeling?

Anne

Anne listed various behaviours as being against her conscience: killing, stealing, hurting someone else, lying and breaking a promise. She remembered a time when she stole a sweet from a shop when she was seven, but decided she was too young then to think fruitfully about this now. She then considered a time when she felt she had broken a promise to her mother to always look after her father when she had gone. She thought about how guilty she had always felt about putting her father in a care home when he had dementia and was unsafe on his own, and she felt it would be too much and possibly dangerous for her children (who were young at the time) for her to bring him to live with her. As she reflected on how guilty she has always felt as a result, she decided she had probably never really dealt with this feeling; it just returned intermittently with all the same intensity. She was tearful when relating this experience and no reassurance from the other students that she had done what she could seemed to reassure her. She realised how deeply she felt the guilt as she had acted against such a deeply held value to her, of caring for those close to her and keeping promises.

Rights

We live in a legal framework of rights and responsibilities, with legislation such as the human rights framework. Legislation uses the discourse of rights and responsibilities to enshrine moral duties in law.

Exercise

1. What do you think should be the human rights of every individual?
2. List these in order of priority so if there is a conflict between rights you know which you would prioritise.
3. What do you think should be our responsibilities?
4. Are there any circumstances in which, or for any individuals, you believe these rights or responsibilities should be waived?

Tom

Tom considered the rights he would defend and begins with the right to life and the freedom to make our own choices about how to live that life. He continued with the rights to follow a religion of our own choosing, the right to choose our own sexual orientation and sexual expression without discrimination, and after a little thought about how he would exclude the rights of people to have sexual relationships with children, he adds the condition of not impeding the freedom of others. He started to think of the kind of life he believes everyone in the world should be able to live whilst knowing that many currently do not. He added the right to have enough money to live on, and the right to have enough food, water, comfort and warmth. He then began to think more psychologically about welfare and added the right to be free from fear of violence.

Finally, he thought about a life of flourishing rather than just existing and added the right to be occupied in productive and valued activity, the right to friendships and valued relationships, and the right to choose whether or not to reproduce.

Tom wondered about how to prioritise among all these rights and considered Maslow's (1943) hierarchy of needs, where our needs move up the hierarchy when the lower needs are fulfilled. According to Maslow's hierarchy, basic survival rights would have to be prioritised above rights to flourish. Tom was clear that we all have responsibilities not to impede the rights of others and more actively to help others to access their rights and be able to flourish.

Maslow's hierarchy of needs (1943)

- Self-actualisation
- Esteem
- Belongingness and love
- Safety
- Physiological

Tom was unsure when these rights or responsibilities should be waived, and worried about what this would mean to designate a group of people to not have these rights. However, he did think there is a limit to how much children can be expected to be autonomous individuals with rights and responsibilities, suggesting instead that adults have a particular responsibility to protect the future rights of children for them. He considered people with dementia and people with mental health problems and thought that there are perhaps some circumstances in which people may not have the capacity to make autonomous decisions and therefore need to be protected.

Values, Beliefs and Judgement

Judgement can occur when we believe others to hold different values from ourselves. It can be difficult to hold values for ourselves without judging those who hold different values. It is important for us to be aware of our own basis for judging others, so we can question these judgements, try and understand why another's values are different from ours and work to prevent acting unfairly. If we can deduce the beliefs behind our values, this can sometimes be an easier basis from which to understand different beliefs of others and thus be able to accept different values.

Exercise

1. What values do some other people hold that you strongly disagree with?
2. When you meet someone who seems to hold a value that you strongly disagree with, how do you feel about them?

3. Think of an example of this situation:
    i. Do you have any understanding of why this person held such a value?
    ii. Does your understanding change your feelings towards them?
    iii. How did your feelings towards them influence how you acted towards them?

Maxine

Maxine considered the value of having fun, which is important to her. She remembered a conversation with another woman who goes to a yoga class with her who questioned why Maxine had a hangover during yoga and why she would drink to the extent of her feeling poorly the following day. Maxine interpreted this question as this woman not valuing having fun as she generally found her very serious and completely focused on healthy living to the exclusion of all else. After this challenge, Maxine had avoided her. She realised how much she has kept away from her after assuming that this woman did not share her value about having fun and also realised she had made a lot of assumptions about this woman's values and why she challenged Maxine's hangover. Other students suggested that this woman may have had her own historical reasons for questioning Maxine's drinking, perhaps having a history of drinking too much herself and seeing it as progress to move to a point of prioritising looking after herself by not drinking. Maxine realised that, for her, having fun is a key value connected to looking after herself, as it is about valuing her freedom from being controlled by or having to answer to anyone else. She wondered whether on this level she actually shared a value with the woman at yoga and decided she would like to speak to her more to understand better her questioning of Maxine's drinking.

Summary

This chapter has been designed with the hope of stimulating you to think about your own values and underlying beliefs about yourself, others and the world. The exercises demonstrate how our values shape our interactions with the world and others and are foundational in our decisions about how we live our lives. Our relationships provide sources for the origins and development of our values, and then our values inform our choices in relationships. Values are intrinsic to notions of identity and the various roles that we fulfil. This is one area where values are relevant to therapy, with respect to therapist identities and how we define ourselves. For example, do you call yourself a counsellor or a therapist, and why? It is likely that behind your answer to this question lie values that are important to your identity. What kind of therapist, or counsellor do you define yourself as? If you identify with a particular approach to counselling or therapy, what led you to this particular approach? Again, it is likely that your values lie behind your answers to these questions. This leads us to the following chapter, which looks specifically at our values in the context of being a counsellor or psychotherapist and how these relate to ethical practice.

Power, Privilege, and Ethics in Couple and Family Therapy

Introduction: *This reading explores in detail the concepts of power and privilege within therapeutic relationships and family therapy theories. It further provides additional information in relation to some of the important underpinning ethical principles for consideration, within this professional context. The authors also take the time to touch on the connection between privilege and identity as well as intersectionality. By striving to improve upon our understanding within this space, professional workers will be better placed to increase their own self-awareness in relation to how concepts such as power and privilege may be impacting upon them, as well as their interactions with others.*

Reading: Murphy, M. J., Hecker, L. (2017). Power, Privilege, and Ethics in Couple and Family Therapy. In *Ethics and Professional Issues in Couple and Family Therapy* (2nd ed.) (pp. 99 - 116). New York, NY: Routledge.

Sam is a newly licensed therapist and is working with a couple, Chris and Jessie. The couple has been referred to Sam by the Department of Human Services (DHS) for abuse and neglect of their 4-year-old child, Kendall, who has been removed from the home. Chris and Jessie assert that they never abused their child and that they love Kendall very much, although they admit that Jessie can get quite angry at times, to the point of throwing things. The incident that prompted a call to DHS was that Kendall fell out of a second-story window of their home and suffered severe injuries. Other DHS allegations made upon investigation are that the home was unkempt and that there was not adequate nutritional food in the home for Kendall. Jessie stays at home to care for Kendall while Chris works outside the home.

Introduction

Power, privilege, and ethics permeate all therapeutic encounters. Each of these constructs is complex and multifaceted, which can make it difficult to know how to address and integrate into therapy sessions. Further, because of the overlap in the constructs themselves, it can be hard to recognize and distinguish in the therapeutic process. For these reasons, in this chapter, we first define power, briefly discuss the integration of power in family therapy theories, and then discuss power in the therapeutic relationship as it relates to ethical principles. Next, we explore the definition of privilege, tying privilege to identity and intersectionality. Then, we briefly explore some implications of identity as related to gender, race, class, sexual orientation, and ability. Finally, we return to the idea of intersectionality for some ways that it may impact the scenario described above.

Power

Power is a multidimensional construct that has been defined in many different ways by theorists and researchers over the past several decades (e.g., Cromwell & Olson, 1975; Foucault, 1977; French & Raven, 1959; Hare-Mustin, 1991; Knudson-Martin, 2009). Power exists in relationship between at least two people, as it suggests difference between two (or more) people in some way. Some postmodern definitions of power include the ability to create and make meaning that is differentially held by certain groups of people (Foucault, 1977). Modernist definitions of power include the ability to impose one's will (Blau, 1964), ability to reward another for their behavior (French & Raven, 1959), ability to make decisions (Cromwell & Olson, 1975), and so on. Therapists have power in relation to clients with their ability to provide a diagnosis (or not), the ability to guide the therapeutic conversation in a certain direction (or not), the ability to decide how therapy will unfold, and their role as the expert, among others. Clients hold power as well; for example, they can decide whether or not to follow advice or directives given by the therapist, they may decide to drop out of therapy (even if court mandated), they can write online reviews of therapy, not pay their bill, come late to sessions, or even take legal action against the therapist. Likewise, a child who refuses to leave the car to come into the office for

a therapy session or has a tantrum in session holds power. Thus, power is a multidimensional concept; it can be related to a person's characteristics (e.g., gender, race/ethnicity), but can shift with context and relationships. There is a noticeable power shift when therapy that was office-bound becomes in-home therapy; the clients gain some power because they are in charge of their home context, but the therapist can also be seen as gaining power in that they now hold more realistic information about the client's home life. As can be seen, power has many definitions; it certainly impacts participants in the therapeutic process.

Power in Couple and Family Therapy Theories

The concept of power is not ubiquitous throughout couple and family therapy (CET) theories. One could argue that structural family therapy was the first to consider power (Minuchin, Montalvo, Guemey, Rosman, & Schumer, 1967), at least in terms of reinforcing boundaries and supporting hierarchy between generations. Minuchin and colleagues (1967) believed that power in the family should rest with the parents, and that dysfunction occurs when children hold an inappropriate amount of power in relation to their parents. Structural interventions were developed to enhance the appropriate power structure in the family, but did not consider power as an organizing principle within the parental subsystem (Walsh & Scheinkman, 1989). Strategic family therapists also viewed hierarchy as important in families; again, dysfunction is seen when there is an imbalance in the parent—child hierarchy (Haley, 1976).

In terms of therapy, feminist therapists were the first to apply the idea of power to gender in relationships (Hare-Mustin, 1978). Feminist therapists advocate for CFT theories to be viewed through a feminist lens, which would add an analysis of power to traditional theories. Feminist family therapy also stands on its own as a viable approach to infusing an understanding of power dynamics into clinical work; several current researchers and therapists incorporate power into their approaches. For example, Knudson-Martin and Mahoney's book titled Couples, Gender, and Power (2009) provides a research-based model for addressing gendered power in couples' relationships. Similarly, Haddock, Zimmerman, and MacPhee (2000) have developed a gender equity guide that clinicians and supervisors can use to ensure that they are adding a feminist lens to their clinical work. In addition, narrative therapists consider societal power and power in terms of meaning making in their therapeutic approaches. White and Epston (1990), for example, discuss how we, as therapists, can "consider the broader sociopolitical context of the person's experience" (p. 18); they argue that dominant discourses shape the possibilities that clients see for themselves.

Feminist therapists would say that it is highly problematic to fail to consider power dynamics when seeing clients (Kaschak, 1990). Therapists who do not consider or address power issues are taking a stand to uphold the status quo. Given the research establishing links between power imbalances, such as the demand-withdraw pattern, and negative relational outcomes, including a higher risk of divorce (Gottman, Coan, Carrere, & Swanson, 1998) and domestic violence (Berns, Jacobson, & Gottman, 1999), feminists see an ethical mandate for therapists to address power differentials, both within intimate and family relationships, as well as the connection between relationships, families, and larger society.

Power in the Therapeutic Relationship

Because power occurs in relationships, power dynamics are found throughout the therapeutic realm. Most apparent is the relationship between therapist and client. If nothing else, therapists have more power than clients by virtue of their role as a therapist; the role of therapist, at a minimum, includes the fact that the therapist is educated about relationships and may have a license to practice therapy. The therapist gets paid; money is valued by our culture, and is indicative of a one-way relationship on some level. Therapists have the ability to define reality—in this case, mental health. Many clients at-

tend therapy seeking answers to their problems, and presumably therapists can provide those answers, perhaps in the form of a diagnosis. Diagnosing can affect a client's life—sometimes for the better, if such a diagnosis brings relief to the mystery surrounding symptoms and relationship dynamics. Alternatively, a diagnosis can bring shame in being labelled with a mental disorder, or hassle for clients if their jobs are dependent on them being free from a diagnosable mental illness. For example, a pilot who is diagnosed with a mental illness may not be able to fly should the employer learn of the issues (the pilot asking their spouse to take on the diagnosis for insurance purposes also has some interesting power implications!). The potential impact therapists can have on clients' lives is tremendous. Therapists can intervene with a suicidal client and save a life, a therapist can provide much-needed support to clients going through the depths of a depression, or a probation client may return to therapy if the therapist deems them noncompliant with therapy. Therapists can decide whether or not to include children in therapy, but in one early study (as noted in Chapter 10) children were allowed only 3.5% of the spoken words (Cederborg, 1997)! Clearly, therapists' power, by virtue of their role, can be seen as helpful or harmful. There is tremendous responsibility that goes along with the power in the role of the therapist.

Boundaries, Conflict of Interest, Exploitation

One could argue that professional codes of ethics are really about appropriate management of power afforded to therapists via their professional role. Some of the specific provisions in the codes appeared because of misuse of power. For example, the mandate not to have sex with clients came from abuse of the power in which therapists violated a client's world of intimacy, safety, trust, and physical being. Similar scenarios include supervisors having sexual intimacy with supervisees when a training relationship has been established. We may strongly agree as a field that sexual intimacy with clients and students is never acceptable because in these cases the client or student is both in a vulnerable, one-down power position. Part of the responsibility of the therapist is to protect the best interests of the client, regardless of the therapist's sexual desires. Therapists are responsible for setting the limits and boundaries on their relationships, especially when those relationships can benefit the therapist, to the detriment of the client, student, or supervisee, who may not feel as if they can say "no" to a request by the therapist.

Multiple Relationships

First, therapists must be mindful of multiple relationships and the impact this may have on the therapeutic relationship, as well as client outcomes. Couple and family therapists are trained to think systemically about impacts of actions on others in multiple ways; most clients are not likely to think in this manner so part of a therapist's role is to foresee potential negative implications of therapist (and client) actions. One common example is when clients want to be friends with the therapist after therapy has ended. Different professions' codes of ethics may or may not address friendship after termination as a possibility, but it is the therapist's responsibility, via their role and expertise on relationships, to foresee how a friendship may impact the (former) client. As much as a friendship may be desired by both parties, the therapist knows that it is not advisable to form a friendship after therapy ends, for that friendship effectively terminates any future therapeutic relationship that the (former) client may desire. Even if the therapist and client were to discuss this as a possibility, and the client dismisses a future therapeutic relationship as a possibility, the therapist is then in a position to decide if they want to exert their power in deciding not to develop a friendship with the client. This may be a unilateral decision, yet may also be in the client's best interest, even if the client does not agree at the time. Context can also affect navigating this dynamic, as those living in small rural areas will inevitably encounter clients in the community.

Client Autonomy in Decision-making

Clients have the right to decide what is best for them, and to make decisions for themselves, ideally

with the therapist's support in evaluating the pros and cons of their decisions. Some codes of ethics explicitly articulate that therapists make it dear that clients are responsible for making major life decisions, such as whether to many or divorce. Therapist cannot overestimate the power they have in telling clients, for example, that they should divorce (or stay together). The therapist's expertise inherent in that role sets the stage for clients making decisions based on therapists' recommendations. Even an exploration of divorce at the therapist's suggestion, as in "Have you considered divorce as a possible solution?" may be interpreted by the client as suggesting divorce. Therapists can listen carefully to clients' understandings of what is said in session, and make corrections if it is apparent that the client misunderstood the therapist's words.

Therapeutic Relationship Benefits Clients

The various mental health codes of ethics have some language asserting that therapists continue therapeutic relationships only as long as the client is benefitting from the relationship. On the surface, this seems to make sense, yet it can be difficult to ascertain when therapy is no longer benefitting clients. Clients may initially make great progress; yet, if they do not, therapists can continue to work with clients trying different approaches, techniques, and interventions with the hope that clients will change or improve. A common situation is one in which a client comes in to therapy to "vent"; the client may experience relief from this venting, and the therapist can continue to collect fees from clients, leading to a mutually beneficial arrangement. However, "venting" may be difficult to justify clinically; the therapist is the one responsible for assessing the progress of therapy and determining whether therapy should continue. Might it be a therapeutic issue instead that the client has no one else to confide in? Considering the larger picture of therapeutic progress is an ethical use of power by the therapist.

Conflict of Interest and Exploitation

Using relational ethics as a guide (Shaw, 2011), therapists can be mindful of what may benefit them in relation to clients, and take steps to prevent even the "misperception" of actions that benefit the therapist to the detriment of the client, such as conflicts of interest or exploitation of clients and others. Conflicts of interest can be particularly difficult for the couple and family therapist to realize, as there may be a benefit for clients in addition to a benefit for the therapist. For example, let's imagine a therapist hears that a client's car has broken down, and further, the therapist knows that the client's car has had repeated mechanical problems. The therapist subsequently refers the client to the auto-repair shop, which is owned by the therapist's spouse. The intention here by the therapist may be noble and may indeed help the client get their car fixed; however the therapist stands to benefit financially, albeit indirectly, from the client's business at the auto shop. Furthermore, if the car is not repaired to the client's satisfaction, or if the client feels as if they were overcharged, then this could have a negative effect on the therapeutic relationship.

Supervision Boundaries

In terms of supervision, supervisors can keep in mind their influence over supervisees; indeed, the relationship between supervisor and supervisee could possibly be at higher risk for blurred boundaries than is the case for therapist—client relationships. Supervisees may be on more friendly terms with their supervisors; it is not uncommon for supervisors and supervisees to attend the same professional events, professional get-togethers, or go for lunch together. Depending on the supervisor's theoretical orientation, the supervisor may know some personal information about the supervisee that is helpful in furthering the supervisee's clinical skills, yet the boundary between supervision and therapy may blur, to the point where it is uncomfortable for the supervisee. Ultimately, the supervisor is responsible for evaluating the supervisee's clinical work so the supervisor is challenged to be sure that they can be as objective as possible in their evaluations, above and beyond the personal relationships that can occur between supervisor and supervisee.

Authorship

One other area in which the therapist's role may impact students is regarding authorship. Therapists in academia are frequently under pressure to publish, as publication is tied to salary increases, tenure, and/or promotion. This situation can set up a scenario of a conflict of interest, or exploiting a student so that a faculty member either accepts authorship credit when it may not be warranted, or places one's name in authorship order that is not reflective of the faculty member's work on the project. Faculty may exploit students' naiveté about how authorship order is determined, or they may count on a students' unwillingness to challenge authority. Any of these possibilities is an abuse of power of the role of faculty.

Power Between Clients

When working with two or more clients, therapists need to be aware of power differences between clients. Therapists can be mindful of power that exists between partners or spouses, between siblings, between a child and a parent, etc. Power differentials between clients can occur on many levels including income; decision-making around finances, household chores, parenting, and spending time with family and friends. A more direct indicator of power differences between clients is how they handle conflict, including yelling, withdrawing, hitting, threatening, and using other indicators of violence. Unfortunately, despite the high incidence of abuse in intimate relationships, many therapists still do not conduct a routine assessment of violence when working with couples (Schacht, Dimidjian, George, & Berns, 2009). Given the high possibility of violence, it is easy to see that therapists have an ethical responsibility to consider power in relationships, assess for power use in relationships (including domestic violence), as well as to intervene regarding power issues.

Privilege

Privilege can be defined as a set of invisible benefits experienced by members of dominant social groups; privilege is created through and supported by larger systems which benefit members of one group to the detriment of members of other groups (McIntosh, 2008). Certain dominant groups can be said to inherit privilege; privilege is not something that persons actively pursues. Indeed, part of having privilege is having to work very hard to see the privilege that one has. Privilege is built on unseen structural advantages; therefore, it does not feel any "different" to be privileged than not to be privileged. The other side of privilege—oppression—involves members of non-privileged "out" groups experiencing roadblocks or barriers that are supported by larger systems. When a person experiences oppression, they feel it because by being silenced, degraded, or limited in opportunity. As a result, it is much easier to identify oppressive experiences versus privileges held. Therapists—who have power by virtue of their role as therapists—have an ethical responsibility to examine the privilege that they have in relation to their identity, which occurs in addition to the power that comes with the therapist role.

Peggy McIntosh (2008) has been extremely influential in developing the concept of privilege, particularly White privilege. In her seminal work, she provided a list of benefits she receives on a daily basis because of White privilege—benefits that she is unaware of unless she stops to think about them—based on the colour of her skin. An example of White privilege is not having to think that my race, as a White person, has anything to do with me being stopped by the police. Since then, other lists of privileges have been developed, for example, in relation to gender, with men receiving benefits in relation to women. Male privilege is manifested in many ways, including being paid more for the same job, being interrupted less frequently, and being taken more seriously than women. One danger in separating out these parts of our identity is that it can set up a competition of sorts—questions can be raised such as: who is most oppressed, White women or Black men? Given the complexity of privilege and oppression experienced by any one individual, the concept of intersectionality can be a help-

ful way of understanding parts of identity for both the client and the therapist that impact the therapeutic relationship (Case, luzzini, & Hopkins, 2012).

Identity and Intersectionality

Intersectionality refers to "privileged and oppressed social identities that interact simultaneously within each individual" (Wise & Case, 2013, p. 23). One way of understanding identity as it relates to privilege is to examine one's own social location in a number of categories: race, gender, employment, class, sexual orientation, religion, ability, appearance, etc. (Totsuka, 2014). Privilege is associated with the dominant aspects of each of these categories: White, male, employed, middle/upper class, heterosexual, Christian, able-bodied, attractive, etc. When examining ourselves, we are likely to experience a combination of privileged and non-privileged identities. Moreover, our experience of these identities is likely to be brought to the foreground in certain day-to-day interactions whereas some fade to the background. This is particularly relevant for therapists as they develop relationships with clients. Each relationship (and set of relationships) is unique. Each relationship brings forward parts of the therapist's identity that interacts with the client's identity in unique ways. It is an ethical imperative that therapists understand the interplay of identities that play out in addition to the power therapists have by virtue of their role. If we were to consider the complexity of intersectionality and various other ways therapists have power, we can see how traditional ethical decision-making models fall short because they cannot account for all of the relational possibilities we may encounter based on power and privilege.

Microaggressions are those seemingly small transgressions that occur in day-to-day interaction that are demeaning and insulting and are directed toward members of marginalized groups; these have been shown to have a deleterious effect on the therapeutic relationship (Constantine, 2007). As can be imagined, therapists' microaggressions can have negative effects on clients and on the therapeutic relationship; they indicate to clients that therapists are not culturally attuned to them as people. Originally, the term was used to refer to mini aggressions made by White people toward people of color, particularly African Americans. Over time, the definition of the term has expanded to include insults and derogatory comments toward any member of an oppressed group. In terms of ethics, therapists need to be vigilant about avoiding microaggressions in all aspects of life, but particularly when providing therapy.

As has been discussed, power is present in all relationships. Furthermore, we carry privilege with us in relationships, although how this privilege plays out can be different depending on the relationship. When a therapist is working with clients, they can assume that the client has had their own experiences of privilege and oppression that they bring to the therapeutic relationship. The picture gets further complicated when there is more than one client in the room—that is, when therapists are working with couples and families. Not only can we assume that power is present in all relationships, but we can assume that power dynamics are impacting clients' presenting problems (Parker, 2009). As mentioned in Chapter 13, from a social constructionist perspective, therapists need to consider the larger sociocultural context in which clients (and the therapist, as well as the treatment system) are embedded. Below, we describe some examples in which ethical issues arise when considering gender, class, race, sexual orientation, and ability.

Gender

Feminist therapists consider gender to be an organizing principle in understanding client concerns (Dickerson, 2013). Several theorists suggest that power be considered a central concept in addressing couple concerns (Esmiol, Knudson-Martin, & Delgado, 2012). Therapists, however, may be reluctant to address gendered power in relationships because of a concern of imposing values on clients. However, therapists guide clients in a direction no matter which intervention they are using; for some

reason, power disparities associated with gender seems to be a topic that makes some therapists uncomfortable (Parker, 2009). If therapists do not address gender dynamics because of their own discomfort with the topic, then power dynamics in relationships will remain unexamined, thereby upholding the status quo.

Incidentally, it is often assumed that only men hold patriarchal views about women and relationships; however, research suggests otherwise. In a study of interruptions of men and women clients, therapists (of either gender) were found to interrupt women clients three times more than men clients (Werner-Wilson, Price, Zimmerman, & Murphy, 1997). Indeed, gender impacts the process of therapy, the conceptualization of therapy, and the outcome of therapy. Ethically, therapists do not have the option of ignoring gender; gender is so embedded within cultures across the world that it can be difficult to see and talk about. Therapists, by virtue of their role, have the ability to decide the direction of therapy—they can decide to be collaborative or not; they can decide to explore certain topics to the exclusion of other topics. They can interrupt women clients more frequently than men clients. It is incumbent upon the therapist to attend to gender issues in therapy.

Class

There have been calls for therapists to address class issues in therapy (Kim & Cardemil, 2012; Liu, 2011). Class, or socioeconomic status, is a complex issue that again shifts depending on context. Our values can be greatly impacted by class, although class can be one of the most difficult characteristics to identify in self and others. Socioeconomic class can be associated with a combination of the following: income, education, job classification, access to wealth and resources, and upward mobility. One common value related to class that emerges in therapy is education. For example, many parents bring minor children to therapy out of a concern for truancy or poor grades, and the fear this creates in terms of prospects for the child's future, including college. Therapists may be likely to value education, since earning a master's degree is a requirement of licensure. Therapists who question or do not support parents' concerns about a child's truancy may have difficulty explaining this position to the parents or colleagues. Valuing education is very much a middle-class or upper-class value, a value that is not embraced by all. Similarly, there may be concern for safety of children when parents do not provide fresh fruits and vegetables to children. Again, access to fresh (wits and vegetables is a middle-class value, not to mention the reality that many lower-class families do not have access to nor can afford to provide fresh fruits and vegetables to their children. Therapists and protective services workers who adhere to this expectation are practicing from a middle-class value system.

Race

At the writing of this chapter, racial tensions in the United States are running high. Therapists bring their experiences of race to the table when working with clients; therapists need to be aware of clients' possible experiences with race, which may be different from their own experiences. Even if therapist and client are of the same race, there may be other issues related to race or ethnicity that may be at play, and may subtly impact the therapist—client relationship. Non-White therapists may have experiences of being oppressed because of their racial/ethnic group. When working with majority clients, therapists of color may need to take extra steps to demonstrate the validity of the therapist role. Moreover, majority White clients may have assumptions or beliefs about their therapists that may impact the therapeutic relationship. Therapists in this situation may face ethical dilemmas in, for example, responding to a client's racial comments directed to the therapist. The therapist must quickly decide how to handle such comments, including how this impacts the therapeutic relationship.

Because White therapists have privilege, they must work to be aware of their privilege and the impact this has in the therapeutic relationship. Therapists have an ethical responsibility to educate themselves about their clients' racial history, while holding this knowledge tentatively, as this knowledge may or may not apply to individual clients. Katz and Hoyt (2014) found that automatic or implicit bias

against Blacks had a negative impact on the therapeutic bond, as reported by therapists. Even if race is not directly or indirectly related to the presenting problem, clients of color may have questions about the White therapist's ability to understand their lives and culture. That is, clients may fear that their therapist will be racist (Awosan, Sandberg, & Hall, 2011). Racial questions may subtly impact the therapeutic relationship.

Minority therapists working with minority clients must also be aware of their own privileged positions. Factors such as skin color, immigration history, and class may impact the therapeutic relationship. Experiences of oppression between oppressed racial groups may be similar in some ways, yet also significantly differ so as to create misunderstandings. Yet, there is also the possibility that having some understanding of culture and similar oppressive experiences is helpful to clients.

Majority therapists working with majority clients may also face ethical dilemmas in responding to client comments. There can be an assumption—by both the therapist and the client—that because there is a shared dominant racial background, both will share sociopolitical views. Assumptions that all White people share the same belief glosses over other differences, such as ethnic background, class, gender, etc.

Sexual Orientation

Sexual orientation can be a divisive topic for therapists. According to a recent study by McGeorge, Carlson, and Toomey (2015), 20% of a sample of American Association for Marriage and Family Therapy (AAMFT) members thought that conversion therapy was ethical, despite research and ethical codes to the contrary. Here, assuming therapists are heterosexual, power and privilege combine to affect a negative impact on clients seeking conversion therapy. Therapists have an ethical responsibility to share research with clients, as well as to follow ethical codes to not harm clients—even if a client requests conversion therapy. Aside from conversion therapy, therapists can keep up-to-date on how to provide lesbian, gay, bisexual, and transgender (LGBT)-affirmative therapy; one crucial step is acknowledging heterosexual privilege (McGeorge & Carlson, 2011). Even with legalization of gay marriage at the federal level in the United States, members of the LGBT community will undoubtedly still face discrimination that impacts their lives and relationships.

Religion

Although the number of people identifying with a particular religion is declining, a vast majority of people (therapists and clients included) identify with a religion. Much has been written about how therapists tend not to bring up or address religion with clients. Yet, it still behoves therapists to acknowledge their own religious identity, and to grapple with the privilege tied to that identity if it is Christian. Although there are sometimes stark differences in beliefs depending on denomination, identifying as Christian in United States culture is still privileged. Therapists who are Christian can unwittingly bring beliefs and expectations around their identity into the therapy room, even if religion is not being directly addressed. Clients who are non-Christian, who identify as Wiccan, Jewish, Muslim, Buddhist, or atheist may have to justify their beliefs or traditions if they are different from the therapist's beliefs. Values such as the sanctity of marriage, when life begins, and what happens after death are commonly tied to religious beliefs. Even if therapists do not currently identify as religious, beliefs tied to religion are often embedded in understandings of what is healthy for individuals and relationships.

Ability

Ability refers to a number of areas, including physical ability, mental ability, mobility, ability to read, etc. To navigate the world with full abilities is to not have to worry about how to navigate steps into the therapist's building, whether there will be available materials printed large enough to read and/or available in Braille, or whether corridors are wide enough for a wheelchair to easily pass through, etc. Therapists are privileged when it comes to ability if they do not have to think about any of these things

(and much more) on a daily basis, yet they must be prepared to work with clients impacted by difficulty with abilities. As well, this is part of being culturally competent, to be able to work with clients who are impacted by ability status, either as part of a presenting problem or not.

A Return to Intersectionality

It is difficult to capture the complexity of intersectionality within the boundaries of this chapter. The risk in discussing each identity characteristic independently is that the intersections with other characteristics are overlooked. It may be helpful to return to the scenario at the beginning of the chapter to explore further some intersectionality possibilities as it relates to power and privilege.

Suppose that Sam, the therapist in the case scenario, is a White, female, upper-class, heterosexual therapist. Chris is White, male, heterosexual, and lower class and Jessie is Latina, female, bisexual, and lower class. What issues of power and privilege may be at play? Sam has power by virtue of the therapist role; it could be said that by working within the DHS system, she has more power because this couple is mandated to attend therapy. Sam's report to the court about Chris and Jessie's progress in therapy may be very influential in deciding when and if Kendall is returned to the home. Therefore, Sam's understanding of the presenting problem, along with her understanding of Chris and Jessie and the dynamics of their relationship becomes critical. How might privilege play a role between Sam and her clients? Sam is White, as is Chris; although they are both privileged by their race, Jessie is Latina, and her experiences as a Latina depends on many factors, including the geographical area they are located in, her or her family's immigration experience, her family's knowledge and understand of her bisexuality, and her role as mother to Kendall. The decision for Jessie to stay home to care for Kendall could be influenced by job opportunities, affordability of child care, religious beliefs, etc. Chris may have privilege in being male in not understanding how the house could be such a mess when Jessie has been home all day. Further, Sam is upper class, which is a privileged position that may make it difficult for her to understand her clients' lives; she may be likely to connect the events that led up to Kendall's removal from the home exclusively to personal decisions as opposed to considering larger sociopolitical factors that shape her clients' lives—in this case, power and privilege may have life-changing impacts on families, including the decision to remove a child from a home. These are only some possibilities for therapists to consider regarding their own identities, as well as their clients' identities as related to power and privilege – which of course are related to the concerns that bring them into therapy.

What Can Therapists Do?

It is clear by now that therapists have an ethical responsibility to address power and privilege in therapy. What are next steps in addressing these issues? We suggest that embracing a new view of ethics, taking action, and continually learning are steps therapists can take in ensuring that power and privilege are integrated throughout the therapeutic endeavor.

Ethics of Care and Relational Ethics

Given that there are power dynamics at play in all relationships, and given that there are multiple levels of interconnections—between individuals, couples, families, and the larger socio-cultural-political landscape, the question is: where do we go from here? One possibility can be found in the ethics of care. According to Held (2006), ethics of care involves:

- The compelling moral salience of attending to and meeting the needs of particular others for whom we take responsibility,
- The valuing of emotion in understanding and deciding what actions to take, and
- Respecting the claims of particular others with whom we share actual relationships (pp. 10-11).

This view suggests that instead of valuing objectivity, independence, and autonomy, we consider ourselves as being in relationship, valuing emotions, and considering the perspective of those for whom we are responsible. Not to deny and move away from the power inherent in therapeutic relationships, this approach calls for embracing relationships in a way that demonstrates for understanding of and respect for the perspective of the other.

An ethics of care perspective values emotions, and in particular, values *empathy* as a way of connecting ourselves with others (Slote, 2007). If we have more empathy with those who we know rather than those we do not know, then there is a responsibility to learn more about those we do not know; this becomes particularly important for therapists who are working with clients who are, in some significant way, different from themselves.

Embracing an ethics of care perspective can be tremendously helpful in fostering empathy and responsibility, particularly in relationships in which we care for others, as with the therapeutic relationship. One shortcoming of an ethics of care approach is that it fails to integrate a consideration of power within the caring relationship. A relational ethics perspective is one possibility that could be incredibly helpful in navigating the complex dynamics in therapeutic relationships, as context, power, relationships, and dialogue are considered central. Indeed, relational ethics involves a way of being that allows for complexity in relationships, while also considering the larger community in which we are all embedded. A relational ethics perspective (Bergum & Dossetor, 2005) suggests that we:

- Take responsibility for the way our communications shape others understandings,
- Build relationships based on curiosity, openness, respect, and an under-standing of the meaning making process,
- Participate in meaning making in ways that allow for creating inclusive positions,
- Understand how our positioning contributes to the creation of social reality, and
- Transparently share our positions of power and their impact on moral decisions that are made, ideally collaboratively.

Taking Action

Therapists can actively address issues of power and privilege in the therapy room. Therapists have this responsibility because of their role as therapist and the associated power that goes along with it (Awosan et al., 2011). Not only must therapists introduce power and privilege as topics in session, they must actively intervene in social processes (Knudson-Martin et al., 2015). Therapists may need extensive training to be able to discuss these topics, as they are sensitive, and may be seen as irrelevant by clients. It can be difficult to know how to intervene. Keeling and Piercy (2007) explored therapists' attention to gender and culture in clinical scenarios. Participants reported seeking balance in addressing these issues; their decisions to raise these topics depended on ethical factors such as client safety, clients being perceived as judgmental, and clients mental states. Regardless, some assert that therapists have an ethical imperative to address power and culture in therapy (Esmiol et al., 2012). Having a transparent conversation about privileged and oppressed identities can be one way for therapists to incorporate discussions of power into their therapeutic work (Hernandez & McDowell, 2010).

At a minimum, therapists need to be culturally attuned in order to work ethically with clients (Brown & Pomerantz, 2011). It can be argued that to ignore clients' culture is to practice unethically. Cultural competence can be a component of overall clinical effectiveness (Imel et al., 2011). One pro-posed solution is to match clients on certain characteristics, such as race or gender. Although there are conflicting results on this issue, a recent study found no overall support for matching therapists and clients on gender and race (Johnson & Caldwell, 2011).

Continually Learn

There will never be a time when therapists are finished with their quest to be culturally competent. This stance indicates that therapists must continually and actively be learning about power, privilege, and culture. Stepping outside one's comfort zone on a regular basis is a way to challenge oneself. This may be entering an unfamiliar setting to learn about customs and mores of another culture; engaging in conversation about controversial topics with persons different from oneself—with a goal of understanding the other rather than reifying one's own position; taking a class to learn about recent research as related to power dynamics; consulting with col-leagues about ethical dilemmas faced around power and privilege; and reading professional literature. Not only must the therapist learn about others, the therapist must challenge self to acknowledge one's privilege and examine one's own participation in maintaining oppression (Hernandez-Wolfe & McDowell, 2012). Issues of power and privilege are too important in our and our clients' lives to think that we are immune to the larger social context in which we are embedded.

Conclusion

We have argued that therapists have an ethical mandate to attend to power and privilege in their clinical work. Given the complexity of these topics, there are numerous ways that power can play in the therapeutic realm. Self-awareness of one's own identities related to privilege and oppression is important, as is directly addressing these issues in therapy. Relational ethics offers an ongoing perspective and way of being that challenges therapists to reflect on the influence they have in relation to others – both inside and outside the therapy room.

Ethical Decision-Making in Confidentiality Dilemmas

Introduction: *When faced with a complex ethical dilemma, helping professionals are encouraged to take the appropriate steps toward informed and ethical decision making. Although the 'correct' outcome is not necessarily a direct result of undertaking ethical decision making, implementing this process allows all parties to see, that the helping professional has done everything within their capacity, to reach the most considered and ethical outcome possible, within the presenting circumstances. To assist in building upon knowledge within this space, this reading provides some sample case scenarios to consider alongside of several models of ethical decision-making. Having the ability to consider individual narratives, as well as apply models of ethical decision making to them, will greatly assist readers to enhance their confidence and knowledge within this context.*

Reading: Kampf, A., McSherry, B., Rothschild, A. & Ogloff, J. (2017). Ethical Decision-Making in Confidentiality Dilemmas. In *Confidentiality for Mental Health Professionals* (pp. 93-116). Brisbane, Australia: Australian Academic Press.

Lack of awareness or misunderstanding of an ethical standard is not itself a defence to an allegation of unethical conduct (Australian Psychological Society, Code of Ethics, p. 10).

As any mental health professional knows, it is one thing to review ethical and legal principles in the abstract and quite another to rely on them to make decisions when actual situations arise. The appropriate course of conduct and decision-making is governed by a variety of influences, including legal principles and ethics codes. Samuel Knapp and Leon VandeCreek (2003), in introducing their book on the 2002 revision of the American Psychological Association's Ethics Code, state: 'Ethics Codes of professions are, by their very nature, incomplete moral codes' (p. 7). Drawing on the information covered so far in this book, the aim of this chapter is to move from the abstract to the concrete, and in so doing model decision-making processes for mental health professionals to assist them in dealing with issues pertaining to confidentiality. To achieve this aim, two situations are identified in which mental health professionals face ethical dilemmas in relation to client or patient confidentiality.

The first situation pertains to a request for a psychiatrist to release information about a patient to the patient's employer. In the second case, the clinician wrestles with issues pertaining to the patient's risk of harm to third parties. Once the cases have been presented, information is provided to work through the dilemmas using a model for ethical decision-making presented in Figure 7.1. It is hoped that these exercises will assist mental health professionals to incorporate a systematic decision-making framework in their consideration of confidentiality-related ethical dilemmas. The exercises will also provide a good opportunity to learn how the principles that have been discussed throughout this book apply to actual dilemmas.

It is necessary to note a few general matters before proceeding. First, by their very nature, ethical dilemmas may not always have a single 'correct' outcome. Rather, some number of alternatives will inevitably arise to address such matters. Each alternative will have strengths and weaknesses. It is incumbent upon mental health professionals, therefore, to explore the options available and to evaluate the consequences and implications of each one before deciding how to proceed.

While it is possible that the decision reached by the mental health professional ends up being the 'wrong' decision, it is far worse, legally and professionally, to be negligent by not having gone through a careful decision-making process before arriving at a decision.

Second, as has been the case throughout this book, the challenge exists to state both principles that

cover the law and ethical principles relevant to the different mental health professionals across different circumstances. As always, it is incumbent upon mental health professionals to be familiar with the code of ethics and their underlying values and principles governing their professions when considering ethical matters. Moreover, it is helpful for mental health professionals to have a working understanding of the relevant legal principles pertaining to confidentiality to guide their practices. The previous chapters have set out the relevant ethical and legal principles. As always, though, the information provided in considering the ethical dilemmas in this chapter is general in nature.

Third, it is important and helpful to seek professional advice from colleagues, superiors, professional bodies, indemnity insurers and legal counsel to assist in decision-making. Of course, time permitting, the more serious the situation, the longer the consultation should be. It is also prudent to document the information and advice received.

A MODEL FOR ETHICAL DECISION-MAKING

Mental health professionals, who may be highly skilled and knowledgeable in their fields, often approach matters that require ethical decision-making in an unsystematic and unsophisticated manner. Very often, by using a systematic model of decision-making, the most appropriate resolution of ethical dilemmas becomes apparent.

In reviewing a number of different ethical decision making models for mental health professionals, Samuel Knapp and Leon VandeCreek (2003) identify five steps shared by the various approaches:

- identification of the problem;
- development of alternatives;
- evaluation of alternatives;
- implementation of the best option; and
- evaluation of the results.

In addition to these steps, Knapp and Vande-Creek propose that additional steps or factors are required to deal with emotional and situational factors, and point to the need for an immediate response in emergency situations. With respect to decision-making in emergency situations, the authors wisely suggest that mental health professionals should anticipate the sorts of ethical situations that may arise and develop ethical action plans to implement should the need arise. Without such already-established plans it may be too late or difficult to reasonably consider alternatives prior to needing to act in an emergency situation.

A useful model for decision-making that will be employed in this chapter is based on the model developed by Shane Bush, Mary Connell and Robert Denny (2006) as well as the work of the Canadian Psychological Association (2001). Drawing on the work of Knapp and Vande-Creek (2003), Bush, Connell and Denny incorporate the five general steps noted above into their model. In addition, they outline the following three steps:

- consider the significance of the context and setting;
- identify and use ethical and legal resources; and
- consider personal beliefs and values.

The Canadian Psychological Association (2001) adds that the individuals and groups potentially affected by the decision should be identified and that the problem should be construed in accordance with the relevant ethical issues and practices being considered. Incorporating all of these steps, the

model to be used in this chapter is presented in Figure 7.1. The steps will be defined as the example cases are resolved.

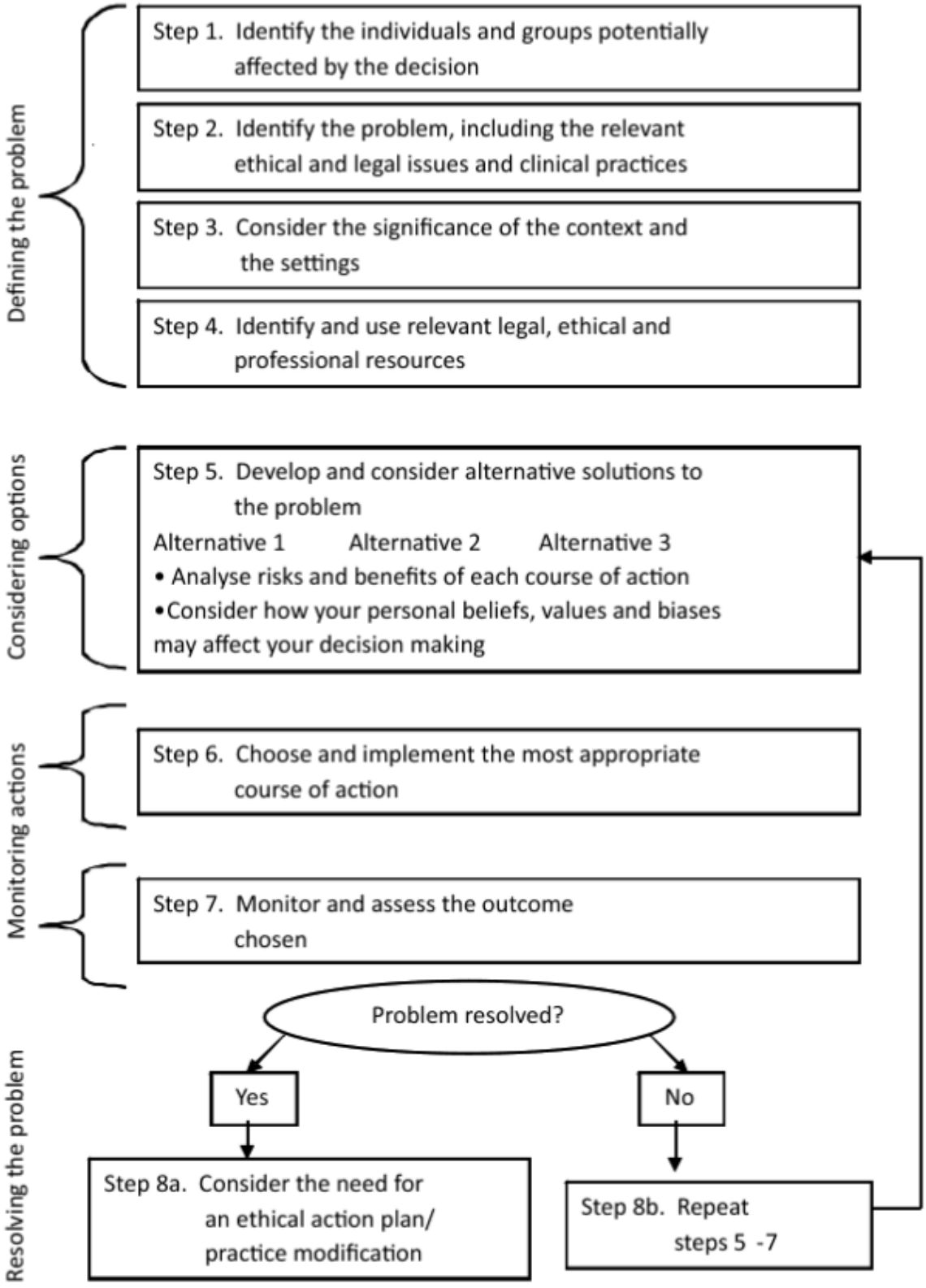

Figure 7.1 Decision-making model for resolving ethical decisions

SAMPLE CASE SCENARIOS

In this section, two sample cases are presented. More detail will be provided as we work through the first case since this provides the first opportunity for practical application of the information pertaining to confidentiality reviewed throughout this book. Less detail will be required in the second case since the overarching principles will have been addressed in greater detail in the initial case.

For both case scenarios, Figure 7.1 should be referred to in order to see how the decision-making model and the questions posed throughout it are employed to guide the decision-making process. The aim of these exercises is to help you apply the information from this book in order to resolve actual dilemmas that may arise in your own practice.

Case 1: Requests for Obtaining Confidential Client Information

When Belinda was 17 years old she was admitted to the local Child and Adolescent Mental Health Service. Her parents reported that she was acting strangely, believing things that were not true. She was paranoid, became estranged from her friends and was reclusive. Upon examination, she was diagnosed with a psychotic illness not otherwise specified. Over time, the psychiatrist who treated her, Dr Waters, believed she had experienced the first episode of a schizophrenic illness. Belinda was in hospital for three weeks. Her symptoms stabilised and she was able to return home. She continued to see the mental health service on an outpatient basis. In the intervening two years, Belinda was hospitalised on three occasions. From the time she was 19 years old until she was 23, she had no further periods of hospitalisation, but was treated by Dr Waters on an outpatient basis.

Belinda was well enough to work and she obtained employment as a clerk in a department store. Things went well for her for several months and she was promoted to a supervisory position. Soon after, she began to deteriorate. She was once again paranoid and was unable to go to work. When she missed work, she obtained a medical certificate from Dr Waters, in-dicating she was unwell. As is the usual case, Dr Waters did not write the nature of Belinda's illness on the note; however, the letterhead on which the note was written indicated that Dr Waters was a psychiatrist.

When Belinda returned to work, the human resources manager asked to see her. Given that Belinda had acted strangely at work before she took time off, the human resources manager wanted to ensure she was fit to work. Belinda assured her that she was but declined to discuss the nature of her illness. She returned to work.

From the medical certificate Belinda provided, the human resources manager knew that she had been in the care of a psychiatrist. To allay her concerns, the manager telephoned Dr Waters, having obtained the telephone number from the certificate. The human resources manager told Dr Waters that Belinda worked for the store and that she was concerned about her capacity for work. The manager stated further that if she could not confirm that Belinda was fit to work, the store would be forced to let her go. Dr Waters wanted to be supportive of Belinda to help her keep her job.

How should the psychiatrist proceed?

Drawing on the decision-making model outlined in Figure 7.1, Case 1 will be analysed and resolved below.

Defining the Problem

The first four steps of the decision-making model provide an opportunity for the clinician to carefully define the nature and scope of the problem, as well as identify the resources necessary and available to assist them in resolving the dilemma. Each of these steps will be reviewed in turn.

Step 1: Identify the Individuals and Groups Potentially Affected by the Decision
In this dilemma, first and foremost Belinda, as the traditional patient or client, will be affected by Dr Waters' decision. Second, Belinda's employer may be affected by the decision. Third, Dr Waters will of course be affected by the decision and what she decides could affect the therapist-patient relationship she has with Bel-inda. Finally, although it is not specified in the scenario description, other individuals such as Belinda's family members or dependents may be affected by Dr Waters' decision.

Step 2: Identify the Problem, Including the Relevant Ethical and Legal Issues and Clinical Practices
Given that this book focuses on confidentiality, it almost goes without saying that confidentiality is the central ethical and legal issue in this and all of the other scenarios. Specifically, though, the ethical issue is whether Dr Waters should share information regarding her opinion of Belinda's capacity to work with the human resources manager. The legal issue is whether the information Dr Waters has regarding Belinda's health is protected under the state privacy legislation and, if so, whether and under what circumstances the information may be shared with the manager.

Step 3: Consider the Significance of the Context and the Settings
The situation is one in which the human resources manager is requesting information that is not consistent with the purpose for which it was initially collected – that is, for the health care of Belinda. The context in which the manager is seeking the information is highly unusual. To the extent that the employment is important to Belinda, however, the situation is significant. It is also worth noting that this situation is not an emergency.

Step 4: Identify and Use Relevant Legal, Ethical and Professional Resources
Dr Waters has a number of resources at her disposal:

- the relevant ethics code provisions:
  - 'Psychiatrists shall hold clinical information in confidence' (The RANZCP Code of Ethics, Principle 4);
  - 'Confidentiality cannot always be absolute. A careful balance must be maintained between preserving confidentiality and the need to breach it rarely in order to promote the patient's best interests and/or safety and welfare of other persons' (The RANZCP Code of Ethics, Principle 4.5).
- the relevant Privacy Act and any other related Acts (e.g., Health Records Act) in her state;
- she can raise the matter with colleagues for advice;
- she can contact her medical indemnity insurer for legal advice; and
- she can consult a lawyer.

For the purposes of these exercises, it is assumed that in the information gathering phase, mental health professionals will have had an opportunity to explore their options for action with the various people noted above, and that they will have relied on the other resources as well.

Considering Options

Step 5: Develop and Consider Alternative Solutions to the Problem
Step 5 requires the clinician to begin to consider the alternative solutions to the dilemma. In demonstrating this process, we will review the relevant principles as we discuss the possible courses of action that Dr Waters may choose to follow.

Alternative 1: Do Not Disclose the Information

The general rule in considering matters pertaining to confidentiality is that the information obtained in the course of a clinical service is confidential. As such, the clinician must not share information about the patient or client, or even acknowledge that the individual is or has been their patient or client. As the ethical principles quoted above make clear, however, 'confidentiality cannot always be absolute'. Thus Dr Waters will need to determine whether Belinda's situation is such that an exception to the general rule might apply.

The usual circumstances in which confidential health care information may be shared occur when the purpose for sharing the information is consistent with the reason the information was initially obtained. In Belinda's situation, she has obtained psychiatric care from Dr Waters to treat her psychiatric illness. Given that the request by the human resources manager to obtain information about Belinda's care is to satisfy employment demands, the request is not consistent with the original purpose for which the information was obtained. Using this rationale, the first alternative is for Dr Waters to refuse to share the information with the human resources manager. Moreover, since the clinical relationship between Dr Waters and Belinda is confidential, Dr Waters may decide not to even acknowledge that Belinda is her patient.

Based on this alternative, Dr Waters may respond to the human resources manager: 'I am not in a position to even confirm that the person you are asking about is a patient of mine and certainly I would be unable to disclose any information to you about her, even if she was a patient of mine.'

Analyse risks and benefits of this course of action. The risk of this course of action is that Belinda may end up losing her employment because the human resources manager has not been assured that Belinda is fit to work. The benefit, however, is that Dr Waters will have protected Belinda's privacy by not revealing any information about the therapeutic relationship or any health information about Belinda. Moreover, by Dr Waters holding Belinda's information in confidence, she will ensure that Belinda trusts her, which will in turn protect the therapeutic relationship.

Consider how your personal beliefs, values and biases may affect your decision-making. In this scenario, Dr Waters has been providing psychiatric care to Belinda for several years; therefore, she will doubtless want to help Belinda. As such, it may be tempting to engage in a dialogue with the human resources manager to help protect Belinda by saving her job. Thus it will be tempting to share relevant information in a way that would serve to help Belinda maintain employment.

Alternative 2: Share the Information

While the first alternative may initially seem to be the only 'correct' course of action, the matter is perhaps more complicated than it first appears. Indeed, the language from the ethical principles for psychiatrists is somewhat broad, providing that 'A careful balance must be maintained between preserving confidentiality and the need to breach it rarely in order to promote the patient's best interests and/or safety and welfare of other persons' (The RANZCP Code of Ethics, Principle 4.5). Dr Waters may need to ask whether it is in the 'best interests' of Belinda or other persons that she lose her job.

Further, it may be argued that Belinda waived her right to complete confidentiality when she requested that Dr Walters prepare the medical certificate that she submitted to her employer (that is, she implicitly consented to share information indicating that she was unwell and being treated by a psychiatrist). This is particularly the case since the letterhead indicated that Dr Waters is a psychiatrist. However, the information in the letter was limited in scope so that the extent to which the confidential information was shared was also limited.

Dr Waters is concerned that Belinda may lose her job, which has been an important part of her recovery. She realises that the human resources manager was calling to follow-up the medical certificate she completed. In this alternative, if she believes that it is in Belinda's best interests not to lose her job, Dr Waters may elect to provide information to the human resources manager to assure her that Belinda is fit for work. A complication would occur, of course, if Dr Waters does not believe that Belinda is fit for work and that the work would detrimentally affect her psychiatric wellbeing.

Analyse risks and benefits of this course of action. The risk with this course of action is that by electing to communicate with the human resources manager about Belinda, Dr Waters has violated Belinda's confidentiality. The benefit with this alternative is that Dr Waters believes she is protecting Belinda's employment.

Consider how your personal beliefs, values and biases may affect your decision-making. Dr Waters' beliefs and values will influence her decision-making. It is apparent that she is balancing her obligation to protect Belinda's privacy and the confidentiality of her treatment against the need to assure the human resources manager that Belinda is able to work, despite her illness.

Alternative 3: Compromise by Deferring the Decision to Belinda

Drawing on the need to balance two or more competing interests, which is typical in resolving ethical dilemmas, Dr Waters may contemplate a third alternative, one that offers a compromise to the first two courses of actions discussed. For this alternative, Dr Waters realises that she owes a duty of confidentiality to Belinda and that to share any information with the human resources manager may be seen as a violation of that duty. Although she did prepare the medical certificate, at Belinda's request, Dr Waters took care not to state the nature of the illness. From the letterhead the human resources manager discovered that Belinda was being treated by a psychiatrist, but that was the limit of the confidential information that was shared to that point.

The human resources manager clearly has concerns about Belinda's fitness to return to work. Therefore, Dr Waters may decide that since Belinda essentially holds the right of confidentiality, it must be her decision whether to allow Dr Waters to share any information with the manager. The extent to which patients value confidentiality varies, and it likely varies across situations as well. For example, while people may share confidential information with their friends, they may choose not to do so with their coworkers or employers. Therefore, it is always prudent, if possible, to check with patients to obtain an explicit indication of the value they place on confidentiality in particular situations.

For this third alternative, Dr Waters may decide to let the human resources manager know that she is unable to discuss any information pertaining to Belinda without first contacting her to seek her consent. Dr Waters could then contact Belinda to let her know that the human resources manager has been in touch. Dr Waters could engage Belinda in a dialogue about what, if any, information should be shared with the manager. They could agree on the limitations of confidential information that would be shared. For example, they could agree that Dr Waters would not reveal that Belinda has been diagnosed with schizophrenia or how she is being treated. Assuming Dr Waters believes that Belinda is now fit for work, they could agree that Dr Waters simply inform the human resources manager that Belinda has been in her care but has now recovered and is able to work. They could also agree that Dr Waters could further inform the manager that she will continue to see Belinda to assist her in maintaining her wellbeing. Dr Waters could also suggest that the manager contact Belinda to discuss the matter directly with her.

It is the case with this alternative that should Belinda decide she does not consent to Dr Waters sharing any information about her, Dr Waters will have to respect her wishes and not provide any information to the human resources manager.

Analyse risks and benefits of this course of action. This course of action minimises the risk of Belinda losing her job since the human resources manager could be assured that she is fit for work. Similarly, this alternative reduces or eliminates the risk of Dr Waters violating Belinda's right to confidentiality by revealing confidential information to the human resources manager without her consent. The benefit of this course of action is, therefore, that Belinda is likely to maintain her employment, assuming the human resources manager is content with the information shared by Dr Waters, with the minimum disclosure of Belinda's confidential health care information. Moreover, given protections afforded under legislation to people with disabilities, including mental illnesses, it would be difficult for the employer to dismiss Belinda due to a mental illness, as long as she was able to satisfactorily carry out her employment duties.

Consider how your personal beliefs, values and biases may affect your decision-making. For this course of action, Dr Waters' feelings of obligation to her patient can be respected while still helping to achieve the goal of assisting Belinda to maintain her employment.

Step 6: Choose the Most Appropriate Outcome

Alternative 3 appears to be the most appropriate course of action, particularly where the psychiatrist believes that Belinda is fit for work. This alternative allows the psychiatrist to share a limited amount of information, as agreed to by Belinda, to help preserve Belinda's employment. As such, the confidential information Belinda does not want shared – including, perhaps, the nature of the illness and other personal details – is held in confidence. Yet, enough information is shared with the human resources manager to hopefully preserve Belinda's employment.

Monitoring

Step 7: Monitor and Assess the Outcome Chosen

Having decided to proceed with the third alternative described above, Dr Waters would need to begin to implement the plan. She would need to contact Belinda and explain the options available to her. Assuming Belinda would consent to Dr Waters sharing the limited information with the human resources manager, Dr Waters could then contact the manager. Dr Waters would need to monitor whether the limited information Belinda has agreed to share – that she has a mental illness for which she has been successfully treated, that Dr Waters believes she is fit for work and that Dr Waters will continue to treat and monitor her – would satisfy the human resources manager at this point. If not, Dr Waters will need to reconsider her decision.

Resolving the Problem

Assuming Belinda and the human resources manager are satisfied with the planned course of action, the ethical dilemma should be resolved satisfactorily.

Step 8a: Consider the Need for an Ethical Action Plan or Practice Modification

Dr Waters would need to consider that when patients request medical certificates or letters for employers, they should be informed of the possibility that the employer may then learn that they have been in the care of a psychiatrist. This would hold true for other mental health professionals as well. In many circumstances, the patient could then opt to ask a general practitioner to prepare the certificate, given that most often the general practitioner and specialist mental health professional will be in communication about the patient's situation. If the pa-tient does not mind the employer learning that they have been cared for by a mental health professional, then the mental health professional should discuss with the patient the nature of information to be shared in the medical certificate or note.

Step 8b: Repeat Steps 5-7

Steps 5 to 7 would need to be revisited if in the course of implementing or monitoring the situation

Dr Waters realised that the plan was unsuccessful or inappropriate.

Case 2: Divulging Confidential Information to Protect Third Parties

Sebastian was a voluntary patient at the local Community Mental Health Service where he was seen regularly by Dr Suresh, a clinical psychologist. Sebastian was 31 years old and had a history of psychiatric illness. He received a disability support pension and lived in supported accommodation. While Sebastian had a history of making threats and becoming enraged, the psychologist did not believe that he had ever assaulted anyone. Similarly, although he was uncertain, the psychologist did not believe that Sebastian had a criminal history. Sebastian had a history of self-harm, including an occasion 18 months ago when he was rescued by staff after cutting his wrists and overdosing on benzodiazepines.

Dr Suresh found that, over the past three months, Sebastian was finding it increasingly difficult to control his anger. In particular, he was making threats to harm others. While the threats were diffused, he had targeted a young man, Adam, who had been living in the same accommodation until two weeks ago.

On the most recent occasion that Dr Suresh saw Sebastian, he was guarded on interview and initially downplayed the level of anger and distress he was experiencing. He exhibited delusional thinking, believing that others had targeted him and were conspiring against him. This was consistent with his past history of symptoms while he was unwell, although Sebastian had not verbalised such thoughts for more than two years.

Consistent with previous paranoid thinking, Sebastian expressed the belief that some co-residents were 'spies', placed there to monitor him. Over time, he admitted that he felt as though he was 'at the end of his rope' and ready to give up. He felt he was destined to end his own life. Again, this was consistent with previous suicidal thinking evidenced by Sebastian. However, unlike previous occasions, Sebastian discussed a desire to 'take someone with him' this time. When Dr Suresh queried this thinking, Sebastian replied that 'they' had caused him so much pain, he wanted them to know how he felt when he was targeted. Initially Sebastian denied having any particular person in mind. When pressed, though, Sebastian named the young male co-resident Adam, whom he had previously targeted.

Dr Suresh employed the HCR-20 violence risk assessment measure (Webster, Douglas, Eaves, & Hart, 1997) to assist with determining Sebastian's level of risk for engaging in violence. Based on the information available, Dr Suresh formed the belief that at the present time he posed a high risk of harm to others and, in particular, to the co-resident Sebastian named Adam.

How should the psychologist proceed?

Defining the Problem

As discussed with Case 1, the decision-making model requires the clinician to carefully define the nature of the dilemma, including the significance and context of the situation. These initial steps also make mental health professionals evaluate the legal, ethical and professional resources available and required to resolve the dilemma.

Step 1: Identify the Individuals and Groups Potentially Affected by the Decision

Dr Suresh has an ongoing, voluntary, therapeutic relationship with Sebastian. As such, Sebastian will be clearly affected by Dr Suresh's decision. The former co-resident whom Sebastian has targeted may also be affected by Dr Suresh's decision. As always, the clinician, Dr Suresh, will be affected by the decision, particularly in light of his relationship with Sebastian.

Step 2: Identify the Problem, Including the Relevant Ethical and Legal Issues and Clinical Practices
Although the case pertains – broadly speaking – to confidentiality, the narrow ethical issue to be addressed in this scenario is whether Dr Suresh should use information held in confidence to try to 'protect' the third party, Adam. There is a related legal issue: could Dr Suresh and/or the mental health service for which he works be civilly liable should he decide to protect Sebastian's confidentiality and Sebastian attacks and injures Adam? Conversely, there is a risk that Sebastian might take legal action against Dr Suresh and the mental health service if Dr Suresh decides to violate his confidentiality, and Sebastian believes it was wrongfully done. However, if Dr Suresh warns Adam or takes any measures to control Sebastian, Sebastian might lose his trust in Dr Suresh and no longer talk with him about why he is experiencing anger and distress.

Step 3: Consider the Significance of the Context and the Settings
Given Dr Suresh's conclusion that 'at the present time he posed a high threat of harm to others and, in particular, to the co-resident Sebastian named – Adam', the situation is serious. Indeed, Sebastian may cause harm to Adam or to someone else. Of concern as well is that should Dr Suresh violate Sebastian's confidentiality, their therapeutic relationship may be irrevocably harmed. The context is that Sebastian has been deteriorating and has expressed suicidal and homicidal ideation. This is in light of Sebastian's ongoing psychiatric illness.

Step 4: Identify and Use Relevant Legal, Ethical and Professional Resources
In this situation, Dr Suresh may consider the following:

- the relevant Australian Psychological Society ethics code provisions, which are as follows:
  - 'Psychologists safeguard the confidentiality of information obtained during their provision of psychological services' (The APS Code of Ethics , Standard A.5.1)
  - 'Psychologists disclose confidential information obtained in the course of their provision of psychological services only under any one or more of the following circumstances … (c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information' (The APS Code of Ethics, Standard A.5.2)
  - 'Psychologists inform clients at the outset of the professional relationship, and as regularly thereafter as is reasonably necessary, of the: (a) limits to confidentiality; and (b) foreseeable uses of the information generated in the course of the relationship' (The APS Code of Ethics, Standard A.5.3)
  - 'When a standard of this Code allows psychologists to disclose information obtained in the course of the provision of psychological services, they disclose only that information which is necessary to achieve the purpose of the disclosure, and then only to people required to have that information' (The APS Code of Ethics , Standard A.5.4)
  - 'Psychologists ensure consent is informed by: … (h) explaining confidentiality and limits to confidentiality' (The APS Code of Ethics, Standard A.3.3)
- the Privacy Act in his State
- raising the matter with colleagues for advice
- contacting his professional indemnity insurer
- consulting a lawyer, including the legal department representing the mental health service.

Once again, for the purposes of these exercises, it is assumed that Dr Suresh will have had an opportunity to explore his options for action with the various people noted above, and that he will have relied on the other resources as well.

Considering Options

Step 5: Develop and Consider Alternative Solutions to the Problem

Alternative 1: Do Not Disclose the Information

For the first alternative course of action, it is al-ways useful to consider the effect of maintaining confidentiality. As indicated above, the general principle regarding confidentiality, as reflected in The APS Code of Ethics, is that '(p)sychologists safeguard the confidentiality of information obtained during their provision of psychological services '(Standard A.5.1). Adhering to this general rule, Dr Suresh might choose to continue treating Sebastian with the aim of helping him to manage his risk through treatment. Based on this alternative, Dr Suresh may wish to increase the frequency of his contact with Sebastian to help manage the risk.

Analyse risks and benefits of this course of action. The risk of this course of action, obviously, is that Sebastian may end up causing harm to someone, particularly Adam. Because Dr Suresh has recognised that Sebastian poses a 'high risk' of causing harm to others, he may feel professionally responsible for not doing more to protect others, and for ensuring that Sebastian does not detrimentally affect his own life by harming others. In addition, as pointed out in chapter 5, although there is no common law 'duty to protect' third parties in Australia, it is conceivable that given the right set of facts, a court could find that a therapist is liable for the harm that ensues as a result of the foreseeable actions of a psychiatric patient.

While it is possible that some risks might arise from Dr Suresh's decision to maintain confidentiality and to continue to treat Sebastian, some possible benefits might also unfold. In particular, Dr Suresh will be able to maintain a therapeutic relationship with Sebastian. This relationship, and the treatment that Dr Suresh could provide, might serve to reduce Sebastian's level of risk while helping to ensure a stable, long-term therapeutic relationship. Finally, Dr Suresh's decision to maintain confidentiality is consistent with The APS Code of Ethics, which does not require a psychologist to share confidential information to protect third parties, but allows them to do so.

Consider how your personal beliefs, values and biases may affect your decision-making. Dr Suresh will doubtless have a desire to preserve the therapeutic relationship with Sebastian. How-ever, in trying to preserve the relationship, he may be overly confident in his ability to monitor Sebastian and prevent him from causing harm to a third party. Thus, Dr Suresh will need to keep an open mind about the likelihood that he will be able to provide adequate treatment and monitoring to manage Sebastian's risk. Dr Suresh will also need to consider his own attitudes towards the police and other relevant authorities in deciding how to proceed.

Alternative 2: Share the Information to Protect Third Parties

Dr Suresh could consider taking steps beyond ongoing treatment to reduce Sebastian's risk of harming Adam, or other people. To accomplish this, he may consider breaching information held in confidence to try to contain the level of risk that he believes Sebastian presents, thereby protecting Adam. To this end, Dr Suresh may elect to contact the police or other authorities to share his concern that Sebastian may harm others. In addition, he may decide to try to contact Adam to let him know that he may be targeted by Sebastian for harm.

When deciding to undertake this course of action, Dr Suresh would need to consider whether he is in fact violating Sebastian's confidentiality. For example, The APS Code of Ethics, Standard A.3.3, requires that '(p)sychologists ensure consent is informed by: … (h) explaining confidentiality and limits to confidentiality'. Moreover, The APS Code of Ethics, Standard A.5.3, provides that ' (p)sycholgists inform clients at the outset of the professional relationship, and as regularly thereafter as is reasonably nec-

essary, of the: (a) limits to confidentiality; and (b) foreseeable uses of the information generated in the course of the relationship'.

In accordance with these standards, if Dr Suresh informed Sebastian as part of the initial informed consent process that he may need to share confidential information should Sebastian present a risk of harm to identified third parties, then electing to share the information to protect the third party will not be seen as an improper breach of confidentiality. This is particularly true if Dr Suresh reiterated the fact that the information discussed may not be held in confidence once Dr Suresh commenced evaluating Sebastian for the purpose of the risk assessment.

Specifically, The APS Code of Ethics, Standard A.5.2, considers the grounds upon which information may be disclosed by psychologists as follows:

(p)sychologists disclose confidential information obtained in the course of their provision of psychological services only under any one or more of the following circumstances… (c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information.

Thus, to disclose the confidential information to the police and/or to Adam (if Dr Suresh can contact him) requires Dr Suresh to be satisfied that not only is there a high risk of harm, but that the harm is 'imminent', the third party to be protected is identified and the risk of harm can only be averted by the psychologist disclosing the information.

Finally, once the psychologist makes a decision to share the confidential information, the psychologist must 'disclose only that information which is necessary to achieve the purpose of the disclosure, and then only to people required to have that information' (The APS Code of Ethics, Standard A.5.4). As such, Dr Suresh might inform the police of something similar to the following:

I am a psychologist employed by X service. I have a patient, Sebastian [surname], whose behaviours have been escalating and I believe he presents a high risk of harming an identifiable person (Adam [surname]). He has a mental illness that is contributing to this condition. As a result, it is my opinion that he may harm someone, most likely Adam, whom he has targeted.

In addition to the above, the psychologist could share details about the patient's address, but must not share information about the particular nature of Sebastian's mental illness or any other information obtained in confidence that is not relevant for the police to assist with Dr Suresh's request to help protect Adam.

Analyse risks and benefits of this course of action. There are a number of risks associated with this course of action. First, it is questionable what the police would be able to achieve. While they do have powers under all of the state and territory mental health Acts to apprehend people who they believe are mentally ill and require treatment to protect them from harming themselves or others, police have few other options for how to proceed in cases where people are making vague threats to harm others. Second, Sebastian may become angry with Dr Suresh and refuse to continue to see him therapeutically. Similarly, Sebastian's trust in mental health professionals, generally, may be affected. Third, although Dr Suresh has judged Sebastian as being a high risk of harming others, that does not mean Sebastian will actually end up harming anyone. Thus, the therapeutic relationship – and Sebastian's confidence in mental health professionals – may be jeopardised unnecessarily. Finally, should Dr Suresh decide to share some of the confidential information pertaining to Sebastian, Sebastian may make a complaint, or take legal action, against Dr Suresh for breach of confidentiality.

The benefit of this action is that Dr Suresh may be able to help Sebastian contain his level of risk by

having the police become involved. This, in turn, may help to protect Adam, assuming Sebastian would have engaged in violent or threatening behaviour against him. Moreover, this course of action would be in accordance with Dr Suresh's ethical obligations.

Consider how your personal beliefs, values and biases may affect your decision-making. Dr Suresh will need to monitor his own beliefs, values and biases to help ensure that his decision to disclose confidential information is made independent of his own biases. For example, he will need to consider whether his decision to share the confidential information is based on any of his own biases. For example, is he afraid of Sebastian, or does he mistakenly believe that mentally ill people are always violent?

Alternative 3: Compromise to Help Manage Sebastian's Level of Risk

For this alternative, Dr Suresh may consider a situation where he chooses to arrange for an involuntary hospital admission for Sebastian. In this scenario, Dr Suresh may elect to share con-fidential information about Sebastian in order to help arrange a period of involuntary hospitalisation. To this end, Sebastian may draw upon a psychiatrist member of his team to arrange for an involuntary hospitalisation. Dr Suresh will need to share enough information with the treating psychiatrist to assist him or her with making a determination about whether Sebastian might meet the criteria for involuntarily hospitalisation.

The mental health Acts across the states require that a medical practitioner (and sometimes other health practitioners) needs to examine the individual to determine whether, in their professional opinion, the patient suffers from a mental illness, presents a risk of harm to himself or herself or others, or is unable to care for himself or herself or will deteriorate significantly without the involuntary treatment.

As with the second alternative, Dr Suresh's actions as described here would not contradict his ethical obligations if he ensures that the risk is imminent, the victim is identifiable and the risk cannot be averted by some other means that would not necessitate breaking confidentiality. He would also need to ensure that the only information revealed is that which is necessary to assist the psychiatrist with obtaining the information necessary to conduct an assessment of the patient's suitability for involuntary hospitalisation.

Analyse risks and benefits of this course of action. There are two general risks associated with this proposed course of action. First, it may not ultimately serve to protect third parties from Sebastian since he may not be found eligible for involuntary hospitalisation (although this is unlikely given the facts, Sebastian's history of psychiatric illness and Sebastian's current symptoms). Second, Sebastian may take offence with Dr Suresh's decision to share confidential information with others in order to protect possible third parties. The benefits of this action are that Sebastian may in fact be hospitalised or treated on a community-based order that assists him to restore his mental well-being over time, thereby also reducing the level of risk he poses to third parties including Adam. The related benefit is that while Dr Suresh is sharing some information obtained in confidence, the information is being shared to assist Sebastian in his care – not to warn the police in order to somehow protect third parties including Adam. Also, the information Dr Suresh is sharing is shared with a psychiatrist who is also obliged to maintain confidentiality.

Consider how your personal beliefs, values and biases may affect your decision-making. Considerations in this section are similar to those discussed for the previous two alternatives. For this alternative, Dr Suresh will have to consider his own views regarding involuntary treatment. Some people have misgivings about compelling treatment, which is typically forced medication. Dr Suresh would have to

consider the extent to which any such views are balanced against the need to reduce the likelihood that Sebastian may harm Adam, or some other person.

Step 6: Choose the Most Appropriate Outcome
On balance, the first alternative, to maintain confidentiality and to try to reduce Sebastian's risk by continued treatment, is unlikely to be suitable given Dr Suresh's own conclusion that Sebastian poses a high risk of harm to others, particularly Adam. Dr Suresh's ability to treat Adam satisfactorily given the description of his presentation and mental state is tenuous at best.

While the first alternative course of action discussed may not be sufficient to avert harm, the second course of action may be too extreme under the circumstances. Given Sebastian's history and mental state, particularly in light of his current behaviour and di, ordered thinking, he would likely meet the criteria for involuntarily hospitalisation. As such, contacting the police or informing the intended victim, Adam, of the pending risk would not be seen to be the only means by which the 'immediate and specified risk of harm' to Adam could be 'averted'. Indeed, Sebastian is a known patient to the mental health service where Dr Suresh works. Dr Suresh would have ready access to psychiatrists or other suitable medical practitioners such as registrars or advanced trainees who can assist with a determination of whether involuntary hospitalisation or at least a community-based order is appropriate. Of course, if involuntary hospitalisation is not possible, or Sebastian's risk of harm to Adam could not be contained and eventually reduced through involuntary treatment and/or hospitalisation, Alternative 2 may become necessary.

Based on the considerations above, the third course of action would appear to satisfy Dr Suresh's need to reduce Sebastian's level of risk to protect Adam, while still preserving must of the confidential information revealed in the therapeutic relationship. Moreover, the purpose for which the confidential information was obtained through the therapeutic relationship – that is, to assist Sebastian with his mental and psychological wellbeing – is quite consistent with the ongoing provision of mental health treatment to Sebastian, albeit involuntary.

Monitoring

Step 7: Monitor and Assess the Outcome Chosen
Monitoring would be necessary and helpful in this situation to ensure that Sebastian's level of risk is being managed and that, whichever alternative course of action is in place, Adam is not likely to be harmed.

Resolving the Problem

If Sebastian's level of risk is managed and reduced without him causing harm to Adam, or other third parties, then the immediate problem will be resolved. If not, the information below will need to be considered to modify the plan of action.

Step 8a: Consider the Need for an Ethical Action Plan or Practice Modification
First, there is a need to ensure that Sebastian's level of risk is being managed and hopefully reducing. Second, should it be found that Sebastian does not satisfy the requirements for involuntary hospitalisation or treatment, Alternative 2 would need to be reconsidered and likely adopted. Third, even with treatment, Sebastian's level of risk to Adam may not reduce sufficiently prior to discharge, thereby necessitating the consideration of following the second alternative.

Step 8b: Repeat Steps 5-7
Steps 5 to 7 would need to be reconsidered if in the course of monitoring the situation it was found that the plan was not successful or appropriate.

Conclusions

As suggested by the information presented in this chapter, employing a comprehensive decision-making model to assist with considering ethical dilemmas provides a useful mechanism for mental health professionals to decide how to act on a case-by-case basis. Furthermore, as the two exercises revealed, the process of considering and resolving ethical dilemmas regarding confidentiality is fluid and complex. The mental health professional needs to consider the various ethical and legal principles in order to arrive at an appropriate and effective resolution.

While it may not always be clear exactly which alternative course of action will be 'correct' under the circumstances, the structured decision-making process ensures adequate consideration of the factors that mental health professionals most consider prior to making a decision on how to proceed in the most appropriate manner. Ongoing monitoring is then required, along with modification of the plan or implementation of alternative courses of action as necessary.