CLINICAL RELATIONSHIPS

CLIENT SELF-DETERMINATION

A standard that strongly reflects the mental health counselor's commitment to a client is that of client self-determination. Counselors have an obligation to support and assist clients in accomplishing their goals, only deviating from this when a client's goal puts them or others imminently at risk. Defining risk can be difficult—most mental health counselors cannot argue that suicide or homicide presents a clear risk to the client or to others. Other client choices, such as staying in an abusive relationship or living in squalor or on the streets may challenge a counselor's personal values and sincere desire to protect; also known as "professional paternalism." However, in the absence of clear and present harm, the client has a right to choose his or her own path and make his or her own decisions, whether we agree or disagree.

ASSIGNMENT (Self-reflection and/or Group Discussion)
Look up "professional paternalism." Make note of key points.
Aside from the examples listed above, what other situations can you think of that are harmful behaviors? (Those that fall outside the mandatory duty of intervening/reporting, such as suicide, homicide; the intention of harm to self or others)
To get you started: severe eating disorders, fire-starting, driving under the influence of drugs or alcohol…
How would you address these concerns with your client?
Would the use of a specific treatment plan with a compliance element be helpful? If the client agreed to the plan and the compliance…
Do you think they would tell you if they were out of compliance?
If they told you, what would you do?

THE THERAPEUTIC RELATIONSHIP

- The Therapeutic Relationship: assisting or attempting to assist an individual with emotional, behavioral, or mental issues.

SAMPLE IDEAS / SAMPLE TEXT TO EXPLAIN COUNSELING IN GENERAL AND THE CLINICAL RELATIONSHIP

- Counseling, as in the context of a therapeutic relationship, does not guarantee saved marriages, continued employment, social acceptance, or elimination of presenting symptoms. Nor, is it a guarantee that symptoms won't worsen.
- Many clients remain "stuck" due to external influences beyond the therapeutic relationship or lack of commitment to explore options and try alternatives.
- You, as the client, are ultimately responsible for change or non-change.
- Everyone has periods of time in their life of difficulty, change and transition, when personal issues affect their work and relationships. Issues such as family,

marital, career, financial, physical, abuse of alcohol/drugs, or a variety of mental issues

- Counseling can help with incongruent thoughts, difficult relationships, career issues, over-whelming emotions, fears, disturbing memories, bad habits, confusion, chemical dependencies, violence and anger issues, adjustment issues and depression
- It is a multi-level process that requires you to have the ability, desire and willingness to see yourself objectively.
- Drugs & alcohol create false realities and self-images, interfering with the underlying issues and the ability to gain deeper insights. Individuals actively using drugs or alcohol must go through assessment and be referred to a recovery program, or Chemical Dependency Counselor first.
- Mental struggles can be physical, psychological, emotional, intellectual or cultural. There are no discrimination barriers to private pain.
- Counseling provides options for change. Change can be the catalyst for growth and personal maximization.
- You will benefit the most from counseling if you explore options and pursue solutions to your hopes and aspirations.
- The input and active participation from you, the client, is essential in order to ensure your individuality and personal style.

ASSIGNMENT (Self-reflection and/or Group Discussion)

Being able to explain to a client, in a few words, what counseling is; what counseling is about, is needed.

Add as many other general statements about counseling as you can to the above list.

What would your “90 second” explanation be? Write it down.

BUILD TRUST WITH CLIENTS

To help build a trusting therapeutic relationship, discuss with your client:

- The guidelines for counselor/client affiliation, such as professional practice boundaries and client rights
- Review fees for professional service
- Discuss mental health treatment protocols
- Share under what circumstances confidentiality can legally be breached, such as reporting child abuse

Building trust:

- Avoid intimidation or abusing professional authority
- Work at partnering with clients.
- Be consistently on time, returning phone calls and responding to other communication

- Be authentic about advocating on behalf of client
- Encourage clients to ask questions and seek out answers regarding their medical treatment as an active member of their health care team
- Teach assertiveness and encourage questions, and model behavior
- Understand your professional limitations and make referrals whenever necessary
- Check in frequently with client about their perceptions of treatment progress

FAITH BASED COUNSELING
There are many associations and articles on the Internet regarding religious and faith-based counseling.

Faith-Based Counseling is an approach to therapy that includes insights of theology and spirituality which are integrated with the principles of psychology to help individuals, couples, families, and groups. Different from other forms of counseling, faith-based counseling is guided by the conviction that emotional illnesses are best healed by taking into consideration both the wisdom of spiritual teachings and the knowledge of human psychology.

CAVEAT: If you are a faith-based counselor, offered counseling that incorporates a specific faith, make sure your consent form includes this information.

ASSIGNMENT (Self-reflection and/or Group Discussion)
Research two associations that are relevant to the type of faith-based practice you offer. Explore their code of ethics. Training programs. Philosophy.
Web search these key words: faith-based [insert specific faith] counseling consent form sample.

HUMOR AND THERAPY

The goal of counseling is to help clients feel better and act differently. All models of counseling attempt to reach this goal by creating interventions that focuses on one of four areas: feelings, behaviors, thinking, and/or biochemistry. Humor can effect changes in all four areas.

Humor as a Therapeutic Intervention
The use of humor in counseling requires the counselor to:
Have humor in their repertoire and be willing to risk using the humor
Have the ability to assess a client's level of humor and their openness to it

Be prepared to respond to a client's negative reaction to humor

CAVEAT: The counselor must avoid gratifying his or her own need to be humorous and focus on how humor will be helpful to the client. As with all therapeutic interventions the counselor must ask, "How will this humor help my client?" Use humor which is genuine and congruent with who the counselor is as a person.

Planned Spontaneity

- Many counselors argue that to be effective, humor must be spontaneous. Humor indeed must be spontaneous; however, it there can be "planned spontaneity."
- Effective therapeutic interventions are planned in that the counselor is trained to offer facilitative responses to the client. At any moment during treatment the counselor selects a particular response based on his or her knowledge of the client and what interventions might be effective with a particular client.
    - The above concept applies to the use of therapeutic humor. The counselor, to be effective, must be prepared with "humor tools" such as cartoons, anecdotes, jokes, puns, signs, props, etc., which illustrate a wide range of psychological issues.
    - However, the way in which these tools are utilized to intervene therapeutically with a particular client is based on the counselor's understanding of the client and the timing of the intervention.

ASSIGNMENT (Self-reflection and/or Group Discussion)
The use of humor in therapy would depend on the type of counseling, the setting, the diagnosis, theoretical orientations, and counselor's personality?
Give examples for each of these. Which would be conducive to humor; which would not.
Do you think humor can be planned? (Planned spontaneity)

CONFIDENTIALITY: KEY POINTS

CAVEAT: there are many more ethical points on confidentiality, but here are some of the key points. It is the reader's responsibility to know all ethical and legal guidelines regarding confidentiality

Confidentiality is an ethical concept, and simply put, means that what is shared within the therapeutic relationship will not be voluntarily disclosed by the counselor. Confidentiality is essential because it fosters trust, which is the bedrock of the therapeutic alliance. Privilege is a legal concept that protects clients from their counselor being forced to disclose confidential information. Privilege is distinguished from confidentiality in that disclosure is typically involuntary.

In other words, confidentiality "binds" the counselor not to reveal client material even if the counselor feels "inclined" to do so. Privilege protects client information from inappropriate disclosure when pressed by legal authorities.

- Counselors should not discuss confidential information in any setting unless privacy can be ensured. Counselors should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.
- Counselors should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders counselors to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, they should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.
- Counselors should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Counselors should review with client's circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the counselor-client relationship and as needed throughout the course of the relationship.
- Counselors should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders counselors to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, they should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

BASIC CONFIDENTIALITY POLICIES

- Counselors should respect clients' right to privacy. They should not solicit private information from clients unless it is essential to providing services or conducting counseling evaluation or research. Once private information is shared, standards of confidentiality apply.
- Counselors may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.
- Counselors should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. (To prevent harm to a client or other).
- In all instances, counselors should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made.

- Counselors should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether counselors disclose confidential information on the basis of a legal requirement or client consent.

CONFIDENTIALITY AND INSURANCE COMPANIES

- Counselors should not disclose confidential information to third-party payers unless clients have authorized such disclosure.
- Counselors should protect the confidentiality of clients when responding to requests from members of the media.
- Counselors should protect the confidentiality of clients' written and electronic records and other sensitive information. Counselors should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.
- Counselors should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

ASSIGNMENT (Self-reflection and/or Group Discussion)
Web search with these key words: Mental health confidentiality case examples
Take the time to read a few of these examples. Personally reflect on or discuss with colleagues.

CLINICAL RELATIONSHIPS AND PROFESSIONAL BOUNDARIES

Our profession is a unique profession, as we have previously discussed. Vulnerable clients plus therapeutic and interpersonal challenges equals boundary issues.

There are five common boundary crossing or boundary violation themes:
1) Intimate relationships
2) Personal gain and benefit
3) Emotional dependency needs
4) Good intention gestures
5) Unanticipated circumstances

It’s not hard to understand why counselors can find themselves in sticky situations, simple stumbles, and slippery slopes. Many things can trip us up: mental mistakes, personal biases, limited perspectives, convincing rationalizations, accidental blunders, the client’s diagnosis, hidden agendas, blurred roles, conflictual relationships, difficult clinical settings, etc.

The necessary intensity of a therapeutic relationship may tend to activate intense emotional, dependency, sexual, and other needs and fantasies on the part of both the client and the counselor, while weakening the objectivity necessary for good therapy.

BOUNDARY VIOLATIONS

Boundary violations are the wrong, unethical, and possibly illegal behaviors between a counselor and the client. Self-interest or personal gain by the counselor is present in boundary crossings. This self-interest has nothing to do with being paid for services rendered, nor the personal satisfaction a counselor can feel from doing their job well; these are exploitive. Boundary violations are reflected in self-interest(s) gained by a counselor at the expense of their client. There is exploitation.

CAVEAT: A client's consent is never a defense with boundary violations, because of the respective roles. The counselor has the fiduciary responsibility to act in the best interests of the client and boundary violations reflect self-interests. When a counselor exploits a client it is universally regarded as unethical, is considered in every jurisdiction to constitute malpractice, and in some states certain types of boundary violations are a criminal offense. Clients are harmed by boundary violations. Injuries include sexual dysfunction, anxiety disorders, psychiatric hospitalizations, increased risk of suicide, depression, dissociative behavior, internalized feelings of guilt, shame, anger, confusion, hatred, inability to trust and feelings of worthlessness and humiliation. Clients are harmed by boundary violations.

BOUNDARY CROSSING

Boundary crossings are defined as non-exploitive deviations from standard practice. What is “standard practice” or counseling norm? It is counseling a client in an office; counselor and client working together in a private setting. Boundary crossings may encompass benign and beneficial departures from established counseling norms. There is a virtual explosion of healthy controversy and thoughtful writings on the issue. Is it possible to tell which boundary crossings are therapeutically helpful; which are therapeutically contra-indicated as harmful; which might be common or even unavoidable in certain communities, settings, or cultures? The meaning of boundaries and their appropriate application can only be understood and assessed within the context of therapy.

THE CONTEXT OF THERAPY CONSISTS OF FOUR MAIN COMPONENTS: CLIENTS, SETTING, THERAPY, AND COUNSELORS.

- Client factors include culture and history–including history of trauma, sexual and/or physical abuse, age, gender, presenting problem, mental state, and type and severity of mental disturbances, socio-economic class, personality type and/or personality disorder, sexual orientation, social support, religious and/or

spiritual beliefs and practices, physical health, prior experience with therapy and counselors, etc.

- Setting factors include outpatient versus inpatient; solo-practice versus group-practice; office in medical building versus private setting versus home office; freestanding clinic versus hospital-based clinic; privately owned clinic versus publicly run agency, as well as the presence or proximity of a receptionist, staff, or other professionals. It also includes locality: large, metropolitan area versus small, rural town; affluent, suburban setting versus poor neighborhood; or university, school or other academic settings; culturally-bound settings, major urban settings, remote military bases, prisons, or police department settings.
- Therapy factors include: 1) modality: individual versus couple versus family versus group therapy; short-term versus long-term versus intermittent therapy; 2) intensity: therapy sessions several times a week versus once a month; population: child versus adolescent versus adults; 3) therapeutic orientation: psychoanalysis versus humanistic versus group therapy versus body psychotherapy versus eclectic therapy. In addition, there are therapeutic relationship factors such as the quality and nature of the therapeutic alliance (secure, trusting, tentative, fearful, or safe connection). Intense and involved versus neutral or casual relationships; length: long term relationship versus the beginning of therapy versus middle of therapy versus towards termination of therapy. Other relationship factors include idealized or transference relationship issues, familiarity or distanced, presence or absence of dual relationships and type of dual relationships, if applicable.
- Clinician factors include culture, age, gender, theoretical philosophy, therapeutic orientation, faith and belief issues, scope of practice (training and experience).

BOUNDARIES AND DUAL RELATIONSHIPS

The prohibition against dual relationships, originates from two sources:

1. Appropriate concerns with the power differential between counselors and clients along with the appropriate attempt to protect clients from harm or exploitation.
2. Traditional counseling emphasis on neutrality and transference work and the concern for the impairment of a counselor's judgment.

Many sources warn counselors about the dangers of dual relationships:

- Professional organizations, consumer protection agency (state licensing boards), and, in some states, legislative laws, agree completely with counselor-client prohibitions of sexual relationships due to exploitation and client harm as the basis for all these protective policies and guidelines.

As mention previously, boundary crossings occur when we deviate from standard norms, but we do so for the client's benefit–the boundary is changed to assist the client. Such crossings have the potential for creating a dual relationship, but it is not a dual relationship "in and of itself" because the purpose of the boundary crossing is therapeutic. The purpose is relevant to theory orientations and the boundary crossing is discussed with the client and informed consent obtain.

ASSIGNMENT (Self-reflection and/or Group Discussion)
Is it possible to tell which boundary crossings are therapeutically helpful?
Which are therapeutically contra-indicated as harmful?
Which might be common or even unavoidable in certain communities or cultures?

BOUNDARY CROSSING PLAN

You can create a boundary-crossing plan (not unlike a suicide safety plan) or an addendum to your consent regarding planned boundary crossings. And of course, document–document–document. Remember, boundary crossings are not necessarily boundary violations.

DIMINISH RISKS

- Clear expectations and boundaries, whenever possible, strengthen the therapeutic relationship. This is especially important in situations where out-of-therapy contact cannot be closely controlled
- Obtaining informed consent, sticking to time limits, protecting confidentiality (and explaining its limits), and documenting case progress (including being explicit about any overlapping relationships) diminishes the risk of misunderstandings between client and counselor

SAMPLE TEXT FOR A BOUNDARY CROSSING AGREEMENT

CAVEAT: For use in your own setting, forms must be personalized to reflect your state's relevant laws, ethical requirements for your licensing, and your own actual policies.

Text could include:

[Counselor] and [Client] have agreed to an intervention that will occur [state the location] for the purpose of helping the client with [state the condition].
Counseling outside the office is not a dual relationship nor is it unethical.
This type of counseling can enhance trust and therapeutic effectiveness, but can also detract from it and often it is impossible to know that ahead of time.
It is the client's responsibility to communicate to [counselor] if this intervention, done in the above stated location, becomes uncomfortable for you in any way.
[Counselor] will always listen carefully and respond accordingly to your feedback; take appropriate steps to clarify, modify or withdraw from any situation that might be interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time.

REMEMBER TO:
Include appropriate lines for signature and date
Keep a copy od any document that was signed by a client in the client's file (hardcopy or electronic)
Copy to client optional, unless they request a copy

ASSIGNMENT (Self-reflection and/or Group Discussion)
What statements would you change?
What additional statements would you add?

NON-SEXUAL DUAL (MULTIPLE) RELATIONSHIPS
Non-sexual dual relationships are not necessarily unethical or illegal. Only sexual dual relationships with current clients are always unethical and illegal. Non-sexual dual relationships do not necessarily lead to exploitation, sex, or harm. Almost all ethical guidelines do not mandate a blanket avoidance of dual relationships; however, all guidelines do prohibit exploitation and harm of clients.

GUIDELINES FOR NON-SEXUAL DUAL RELATIONSHIPS IN PSYCHOTHERAPY

- Develop a clear treatment plan for clinical interventions, which are based on the context of therapy (the type of therapy intervention) and intervene with clients according to their needs
- There are situations where the treatment plan may require a dual relationship, and other times it should be ruled out; as a competence counselor, you need to know the difference
- Always take into consideration the welfare of the client, effectiveness of treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment. These are the paramount and appropriate concerns
- Remember that treatment planning is an essential and irreplaceable part of your clinical records and your first line of defense
- Consult with clinical, ethical or legal experts in very complex cases and document the consultations well
- Attend to and be aware of your own needs through personal therapy, consultations with colleagues, supervision or self-analysis
- Discuss with your clients the complexity, richness, potential benefits, drawbacks and likely risks that may arise due to dual relationships
- Make sure that your treatment plan include the risks and benefits of dual relationships and that they are fully explained, read and signed by your clients before you implement them
- Make sure your clinical records document clearly all consultations, substantiations of your conclusion, potential risks and benefits of intervention,

theoretical and empirical support of your conclusion, when available, and the discussion of these issues with your client

ASSIGNMENT (Self-reflection and/or Group Discussion)
Which therapeutic orientations might utilize dual relationships as an element of therapeutic care?
Internet search for information about "community assertiveness programs" and "social clubs" –what do you think? Can you come up with other examples like these?
Is it possible to tell which clients a dual relationship could be therapeutically helpful?
What client conditions would make a non-sexual dual relationship therapeutically contra-indicated as harmful?
Which might be common or even unavoidable in certain communities or cultures?

DUAL (MULTIPLE) RELATIONSHIPS

SAMPLE TEXT FOR DUAL RELATIONSHIP CONSENT
CAVEAT: For use in your own setting, forms must be personalized to reflect your state's relevant laws, ethical requirements for your licensing, and your own actual policies

- Not all dual or multiple relationships are unethical or avoidable
- Therapy never involves sexual or any other dual relationship
- [Counselor] has assessed carefully before entering into a non-sexual and non-exploitative dual relationship with [client's name]
- [name of community/town] is a small community and many clients know each other and [counselor] from the community
- [Counselor] will never acknowledge working with anyone without his/her written permission.
- Many clients choose to see [counselor] as their therapist because they know him/her from the community or from other clients
- [Counselor] has discussed with client the potential benefits and difficulties that may be involved in dual or multiple relationships
- Dual or multiple relationships can enhance trust and therapeutic effectiveness, but can also detract from it and often it is impossible to know that ahead of time
- It is the client's responsibility to communicate to [counselor] if the dual or multiple relationship becomes uncomfortable in any way
- [Counselor] will always listen carefully and respond accordingly to your feedback
- [Counselor] will take appropriate steps to clarify, modify or withdraw from any situation that might be interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time

ASSIGNMENT
DUAL RELATIONSHIP CONSENT SAMPLE TEXT
What would you change? Delete? Add?

What sample text in the above consent do you strongly agree with? Why?
What sample text do you strongly disagree with? Why?

CLIENT ATTITUDES THAT CAN CAUSE PROBLEMS

- Yearning to be an “insider”
- Feeling “someone owes me”
- Black and white view of things
- Demanding to be believed
- Insatiable neediness
- Over-generalizations
- Over-dramatized responses
- Poor and confused boundaries
- Diffused sexuality

CLINICAL RELATIONSHIPS AND SUICIDE RISK

Law and Ethics in Suicide Intervention: Suicide is not only one of the riskiest cases for a counselor clinically and spiritually, but legally as well. Professional clinicians are increasingly at legal risk for the suicide of their clients and patients. Indeed, the clinician working in an inpatient or restrictive treatment setting has a strong duty to intervene in the life of someone judged to be a substantial risk for suicide. In contrast, a pastor in a church setting may be ethically and morally, but not legally, bound to a duty of suicide intervention.

CLINICAL RELATIONSHIPS AND HOMICIDE RISK

Since it is impossible to predict with 100% accuracy dangerousness ahead of time, violation of a client's confidentiality must be undertaken with great care and in consultation with others.
The art of counseling involves learning to discern what a client is really saying.
When someone says, "I wish I (or someone else) was dead" are they talking suicide or homicide or just expressing frustration with their current stress levels or relationship difficulties?

FEATURES OF DANGEROUS
Immediate danger signs of imminent violence:
Motor activity is irritable with an inability to be calmed
Verbal indicators such as threats when stated loudly, defamatory statements, and sexual verbal aggression
Nonverbal indicators include glaring eyes, demanding demeanor, tense, forward-leaning posture, and a hyper-alert state

ASSIGNMENT (Self-reflection and/or Group Discussion)
How do we distinguish between the client who vents in scary ways and those who may carry out their threatening words?

NOTE: See the ASSESSMENT section for more detailed information on assessing suicidal, homicidal behaviors and issues of dangerousness.
CLINICAL RELATIONSHIPS
CONFRONTING THERAPY IMPASSE
The counselor's best understanding of the situation suggests a course of action—but it still unclear, but to not move ahead on the contemplated action may close the door to the counselor's own creativity, intuition, and ability to help; but, to refrain from the contemplated action may interfere with the client's progress and recovery.

When an impasse is reach, it is helpful to consider these options:

- Carefully review your work with a client, this can help in finding a way pass an impasse.
- Was there something the client said or did that say that didn't seem to fit or make sense?
- Is there an issue that needs to be clarified with the client?
- Has the client said or done something that cast confusion and diminishes understanding of what is going on?

Counselors should ask themselves if the contemplated action is consistent with the welfare of the client?

CAVEAT: Complex legal issues may make this consideration more difficult. In some instances, a counselor may take an action that may not be construed by all concerned as clearly consistent with the welfare of the patient. A counselor may be legally required to report that the client has engaged in child abuse or has threatened to kill a third party, even though some therapists may believe that such reports are not consistent with the welfare of the patient.

Consent

- Is the contemplated action consistent with the basic informed consent of the client?

- All action by the counselor must be carefully considered in light of its consistency with the client's autonomy.

See the impasse through the client's eyes

- Empathize imaginatively with the client
- Regardless of the theoretical soundness, intended outcome, or intervention sophistication, consider how the client might understand or view the situation.
- Consult with colleagues. Talk with the client.

CAVEAT: Counselors-in-training may cling to theory, intention, and technique as a way of coping with the anxieties and combat the overwhelming responsibilities of the therapeutic venture. Seasoned therapists may rely almost exclusively on theory, intention, and technique out of learned reflex, habit, and the sheer weariness that approaches burnout. There is always risk that the counselor will fall back on repetitive and reflexive responses that verge on stereotype. One way to help avoid responses that are driven more by anxiety, fatigue, or similar factors is to consider carefully how you, the counselor, would think, feel, and react if you were the client.

CLINICAL RELATIONSHIPS AND ERRORS

DEFINITION OF AN ERROR

Medical Error definitions can be defined and governed by various entities such as state legislatures, mental health associations, and best practice institutions; for the purpose of preserving the health, safety and welfare of the public.

Medical errors can occur at any point in treatment,
even in preventive care and are not limited to patient/client injury or death

As more and more mental health clients are being treated for complex physical and mental co-occurring conditions, mental health counselors often work with teams of intervention specialists. Also, counselors are increasingly in contact with mental health clients who are following medication protocols and other medical therapies; many of which are potentially lethal when taken improperly.

Examples of Medical Error Harm include:

- Permanent loss of trust by client/patient
- As a result of medical error, mental health clients can:
- Lose trust that their personal information will be properly shared.
- Lose trust in the psychological or medical community due to the medical team's inability to share information pertinent only to specific team members.

A medical error is, not necessarily the failure of a planned intervention, but it is the use of a wrong plan that causes an adverse event or near miss that is preventable under the current state of knowledge

- Counselors have serious responsibilities to their clients, colleagues, and to the mental health profession. The focal point of these inter-related responsibilities is a fiduciary relationship in which the client places trust in the counselor with the expectation that the counselor is working in the client's best interest. This expectation is the foundation of a therapeutic relationship.
- Through the therapeutic relationship each party assumes separate and distinct roles. The counselor bears the burden of accountability within the relationship because they assume the expert role; this creates a power differential within the relationship. By virtue of expertise through education, degree, license, skills, and experience, counselors have the positional power setting the stage for potential misuse of power.
- With any position of power comes the risk for abuse that can range from minor improprieties to gross misconduct and crime.

Greatest risk for committing medical error occurs through:

- Multiple professional involvements
- Misdiagnosis
- Intimidation
- Over treatment
- Lack of involvement

When counselors do not maintain appropriate boundaries, the following common medical errors can occur:

- Inappropriately shares or distorts information
- Attempts to treat out of their realm expertise
- Does not consult with medical professionals
- Does not thoroughly collect background histories
- Does not thoroughly complete assessments
- Assigns an incorrect, or false diagnosis
- Recommend inappropriate or dangerous treatment protocol

Negligence can occur when the counselors is:

- Overly fatigued; In a hurry; or, Inattentive and distracted
- Do not access and/or thoroughly review client records
- Negligent in not writing, recording, reading or sharing critical reports, reviews or correspondence
- Not paying attention to laws and regulations regarding confidentiality and consent
- Counselor is physically or mentally ill
- Not providing an adequate physical professional environment
- Imposing religious or spiritual beliefs on to clients
- Lacking in follow-up; or, Habituated Behavior
- Negligent in gaining correct medication information

- Slow response and follow up with regard to client or calls or crisis
- A lack of concern for the client's well being
- Inattention to, or minimization of client concerns and self-reporting
- Poor communication with clients, their families or other treatment team members
- Disregard for professional boundaries
- Lack of Knowledge

INTENTIONAL HARM

Intentional harm can be considered a crime when counselors mindfully:

- Become romantically and/or sexually involved with clients.
- Romantic or sexual innuendos are medical errors.
- Falsely bill and/or charge fees to clients or insurance
- Administer inappropriate or grossly wrong methods of treatment
- Fail to contact medical personnel or law enforcement when clients threaten to, and or actually harm themselves or others
- Fail to report child abuse or make other appropriate reports to monitoring agencies or personnel.
- Prescribe medications without sufficient licensing or expertise
- Abandon Clients. It is imperative that mental health professionals do not abandon their clients due to failure to pay or incompatibility; it is the professional's job to transition clients and pursue alternative treatment avenues before closing a case
- Falsify records; or, Breach confidentiality
- Falsely claim curative abilities

COMPETENT COUNSELORS FOLLOW THESE GUIDELINES

- **Best practice knowledge:** It is important that licensed mental health practitioners, through various ways, stay current in their psychotherapy practice.
- **Professional development:** Professional development includes but is not limited to on-going consultation and supervision, peer review, course work, certification training, seeking additional schooling through graduate degree work or academic participation, professional membership and periodical reading.
- **Current laws and regulations:** Regulations regarding the practice of psychotherapy change. It is best to keep abreast of these changes through legislation and association participation. Every state has a state website that provides information on proposed laws.
- **Necessary certification training:** Certification is usually required before practicing a new psychotherapeutic technique. It is always best to affiliate with other practitioners who are participating in the same type of protocol.
- **Thorough client social histories or background information:** Medical error occurs when medical or mental health practitioners do not diagnosis and treat

from the same back ground information. Obtaining releases of information is essential when providing and coordinating appropriate client service.

- **Consultation with colleagues/experts:** Experts are fundamental reality checks for mental health practitioners.

WHAT ABOUT APOLOGIZING?

In the mental health and healthcare profession, there is a concern about apologizing to clients (or patients) for mistakes. Apologies can make someone feel vulnerable. If I apologize what could happen? Will the apology be accepted or will it make things worse? Will the apology come back to hurt me as an admission of guilt in a formal licensing complaint or lawsuit? Admitting mistakes can be difficult. However, it can come down to intention versus impact. If what you are apologizing for was intentional then being fearful of apologizing as an admission of guilt has merit. But most of the time our actions, in words and deeds, are not done with the intention of harm, but rather impact others in a way we did not anticipate. Research, and common sense, suggests that an apology can help heal the effects of inadvertent or unintended mistakes. Many states have passed "I'm sorry" laws to encourage healthcare providers to promptly and fully inform clients and patients of errors and to apologize when warranted, and other states are considering such laws. This law protects the apologizer from being held to an admission of guilt because of the apology. Research further suggest that ethical complaints, that were considered, but never filed, were not filed because of an apology by the counselor to the. As counselors in the mental health profession, we understand the healing powers of words. Apologizing is a personal, intimate act that can calm hurt feelings, restore rapport, and opens the possibility of honest dialogue. However, deciding whether or not to apologize requires careful consideration of many factors. I encourage all counselors to make the decision to do so thoughtfully, cautiously, and with the advice of consultation.

ASSIGNMENT (Self-reflection and/or Group Discussion)
Does your state have healthcare related "I'm Sorry" laws and legislation?

PROFESSIONAL BOUNDARIES SELF-ASSESSMENT

Below are red flags that professional boundaries may be compromised. Some relate to you and some to clients.

- As you honestly answer the following questions yes or no, reflect on the potential for harm to your client.

- ✓ Have you ever kept a secret with a client?
- ✓ Have you ever adjusted your dress for a Client?
- ✓ Has a client ever changed a style of dress for you?
- ✓ Have you ever received a gift from a client?

- ✓ Have you shared personal information with a client?
- ✓ Have you ever bent the rules for a client?
- ✓ Have you ever given a client a gift?
- ✓ Have you ever visited a client after case termination?
- ✓ Have you ever called a client when "off duty"? -Have you ever felt sexually attracted to a client?
- ✓ Have you ever reported only the positive or only the negative aspects of a client?
- ✓ Have you ever felt that colleagues/family members are jealous of your client relationship?
- ✓ Do you think you could ever become over-involved with a client?
- ✓ Have you ever felt possessive about a client?

ASSIGNMENT (Self-reflection and/or Group Discussion)
Answer the above questions.
What other questions can you come up with?
Think of a difficult counseling situation (or find a case example on the Internet regarding boundaries/clinical relationships)
Explore all the ways you can think of that would make the situation worst.
Explore all the best practice approaches to the same situation.