Ethics in Heart-Centered Therapies

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Abstract: This course for psychotherapists of all specialties addresses a variety of ethics topics:

1) Informed consent
2) Competence
3) Dual relationships
4) Self-care
5) Fees
6) Documentation
7) Availability
8) Confidentiality
9) Multicultural competence
10) Self-disclosure
11) Integrating spirituality and religion into clinical practice
12) Mandatory reporting
13) Consultation
14) Identifying high-risk clients
15) Terminating psychotherapy
16) Expanded forms of “seeing” the invisible
17) Working with non-ordinary states of consciousness
18) Working with groups
19) Touch and body work
20) Working with children

Course Objective:
The purpose of this continuing education course is to increase the working knowledge about ethical issues and principles for mental health professionals, especially those utilizing Heart-Centered therapies. This article attempts to focus on the practical applications of these principles in practice.

Learning Objectives:
1. Identify three conditions under which crossing boundaries in psychotherapy might be ethical and appropriate
2. Understand the factors that therapists should consider regarding what and when to document
3. Name at least three essential areas of obtaining valid informed consent prior to providing services to a client
4. Know clearly the special ethical considerations when integrating spirituality and religion into psychotherapy, and when working with non-ordinary states of consciousness such as hypnosis

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Informed consent

Informed consent is a principle of ethical treatment based on the core value of self-determination. It is a basic value in the helping professions that the individual has the right to determine for him/herself the kind of treatment they receive, and indeed whether they participate in treatment at all. The individual requires, and deserves to have, adequate information to fully assess whether and how they wish to participate in treatment. Informed consent is basic to professional practice and has clearly been established as an important standard of care. Informed consent minimally should include a discussion of financial issues and the basic nature of the services that are and are not provided. It should address confidentiality and privacy issues, including the federal (e.g., HIPPA) and state statutory exceptions to confidentiality and privacy. Informed consent also should address who is and who is not a patient and what access to records patients or others will have. Informed consent is only possible when consent is given voluntarily by a person of legal age, mentally competent to refuse or consent, based on sufficiently thorough and accurate information in order to weigh the benefits and risks of treatment. The following categories of information should be included in initial intake paperwork, and easily available to clients.

1) On-call coverage. It is important to review any on-call coverage arrangements with all patients at the outset of the professional relationship. Who provides coverage, what their competence is, how to contact them, when it is appropriate to contact them, any fees involved and how confidentiality is addressed all should be discussed in advance.

2) Confidentiality. By openly addressing confidentiality issues during the informed consent process, and over time as they are relevant, the clinician develops a collaborative relationship with the client that is based on trust and an understanding of the parameters of the professional relationship. Confidentiality might include such measures as sound proofing the office, storing treatment records in a secure location, using passwords and other security measures with computers, not discussing confidential information in public or with
unauthorized people, and releasing only the minimum necessary information when responding to a lawful request for information.

3) **Clear disclosure of one’s training and experience** is a basic requirement of any professional. It is unethical to embellish or otherwise falsify one’s education, experience history, or qualifications whether it be with clients, third-party payers, or colleagues.

4) **Spirituality and religion**. Include questions about spirituality and religion in the initial intake paperwork and in the initial assessment of each client. This establishes as part of the informed consent that these issues are appropriate to be included in the therapeutic experience. Unless the mental health practice is clearly established as representing a parochial religious or spiritual point of view, inclusion of these issues should be generic and the therapist needs to carefully avoid allowing his/her own beliefs to contaminate the clients’ resolution of their spiritual struggles.

5) **Fees and policies regarding fees** need to be stated clearly at the outset. In fact, it may be very helpful to discuss these issues in the initial telephone contact even before actually meeting. For many clients knowing the fees charged for treatment, expectations for when payment is due, if the therapist works in-network, out-of-network or fee-for-service, if credit cards are accepted and related financial details, can impact an individual’s decision to enter treatment. A clear policy on missed appointment and late cancellation charges. This policy should be reviewed in the informed consent process. The policy used should be clear and fair. For example, does the therapist charge for the appointment time if the client cancels with more than 24 hours notice? If less than 24 hours notice is given, will the client be charged if the therapist can fill the time with another appointment? What if the client experiences a true emergency and how is this defined? Finally, the use of barter may be used at times if not exploitative or clinically contraindicated (APA, 2002, Standard 6.05). Further, it should be the client who requests a barter
arrangement, and there should be a clear, written contract (AAMFT, 2001, Principle 7.5).

6) **Conflicts of interest.** Informing clients of potential or actual conflicts of interest, such as financial interest in certain procedures, products or referrals, or religious interest in persuading a client to decide against abortion or divorce. A conflict of interest exists when the therapist’s personal, scientific, professional, legal, financial, or other interests or relationships impair their objectivity with the client, or when it may expose the client to harm or exploitation.

When therapists provide services to two or more people who have a relationship with each other (for example, couples, family members, or staff members of an agency), they should clarify with all parties which individuals will be considered clients and the nature of the therapist’s professional obligations to the various individuals who are receiving services. Therapists who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a therapist is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest (NASW, 2008, 1.06d).

7) **Mandatory reporting** requirements should be disclosed as part of the initial informed consent process. These requirements are set by law and vary by state.

**Competence**

It is the mental health professionals’ responsibility to represent themselves and to practice only within the boundaries of their education, experience, training, licensure or certification, and level of supervisory or consultant support. Failure to provide services within accepted standards, in other words incompetency, is the second most common form of ethics violation alleged in complaints to social work licensing boards (Strom-Gottfried, 2000). The most common alleged ethical failure is boundary violation.
One should refrain from making false, misleading, deceptive or unsubstantiated claims or statements in resumes, advertising and other means of soliciting clients. One needs to avoid setting unrealistic expectations for a prospective client in order to attract them to become a paying client, such as that the proposed therapy will cure a diagnosed disease or the presenting issue can be resolved in six sessions. In other words, the professional must not inflate their own competencies, nor those of the therapeutic modality to be offered.

**Dual Relationships**

Dual relationships are defined as engaging in the therapy relationship as well as one or more additional relationships with that individual or one related to, or closely associated with, the client. These might include other relationships that are social, business, sexual, or others. This is the area of boundary violation that creates the most trouble for mental health professionals. Of course, some dual relationships are clearly and absolutely forbidden; for example, any sexual interaction. Yet there are many others that fall into a gray area of maybe – maybe not. Examples of gray areas might be providing mental health services to someone who teaches at one’s children’s local public school, or to someone who works at one’s local bank, or someone who attends the same church or synagogue. Bartering for services is an example, in which you may find a way for an individual to obtain much-needed help but who is unable to pay for the service. The overriding criteria for appropriateness of these dual relationships is whether the client is potentially being exploited through the imbalance of power that automatically exists within your therapist-client relationship. In any case, the therapist is responsible for setting and communicating clear, appropriate, and culturally sensitive boundaries with the client.

Inappropriate dual relationships can involve current clients but also others: former clients, colleagues, assistants, supervisees and students, or clients’ family members. The NASW and APA further require that social workers and psychologists should not engage in sexual activities or sexual contact with clients’ relatives or other individuals with whom clients maintain a close personal relationship, due to the difficulty for the therapist and client to maintain appropriate professional boundaries and thus a
potential of harm to the client (NASW, 2008, Principle 1.09b; APA Code 10.06). Social workers and psychologists are also prohibited from providing clinical services to individuals with whom they have had a prior sexual relationship, or engaging in sexual activities or sexual contact with former clients except in extraordinary circumstances.

Boundaries help establish the ground rules for the professional relationship, and include dimensions such as time, location, touch, self-disclosure, personal space, money, and gifts, among others. It is widely accepted in the professional literature that each boundary may be crossed at various times without harm occurring. Examples may include accepting a small gift from a client at a holiday time, extending a session for a client in crisis, making a home visit to a terminally ill client, driving across a bridge with a phobic client, or touching a grieving client on the arm or shoulder. It is not just the therapist’s intentions, but also the anticipated perceptions of the client, that must be considered when determining whether to cross a boundary. Discussing the client’s level of comfort with boundary crossings before they occur is of great importance, and getting permission based on informed consent for the interaction vastly reduces the potential for an ethical breach.

Boundary violations involving intimate relationships are the most common misconduct within the realm of dual relationships. Any sexual relationship is clearly forbidden, but there are other less obvious nonsexual relationships that should be avoided. An example is friendship that involves sharing social outings together, be it parties, social events, or even conversations over coffee at a restaurant. Other examples might be gift giving or receiving frequent or elaborate gifts; personally identifying with a client’s situation and becoming overly involved in the client’s life decisions; expressing offensive or derogatory language verbally or in written form to or about a client. Questions for the mental health professional to ask herself are: Am I engaging in this activity with my client to satisfy my own emotional or dependency needs? Am I “rescuing” my client, that is, entering relationship activities that are codependent even though I have altruistic motives? Am I doing this because I feel awkward saying no to the client? Am I feeling at a loss to help the client clinically and therefore feel the need to “do something” to avoid
experiencing my own impotence or incompetence? Would I do this for any of my clients? How might the client interpret my behavior toward him?

**Self-care**

There are a number of factors that place mental health clinicians at increased risk for distress, burnout, compassion fatigue, and impairment. First, there are those personal attributes and histories which many clinicians have that contributed to their attraction to a helping profession, such as a tendency to “rescue” others and take responsibility for their plight. The very nature of the work, including dealing frequently with crisis, may result in both physical and psychic isolation (O’Connor, 2001). Some of our clients may not show demonstrable improvement over time or may actually worsen during treatment, leading to erosion of therapist idealism and causing stress. Vicarious traumatization (Pearlman & Saakvitne, 1995) is a risk, especially with some populations that are particularly challenging – for example clients at risk for suicide. Overburdened workloads or self-imposed unrealistic expectations may contribute to physical and emotional exhaustion.

Compassion fatigue, or secondary traumatic stress, is a potential result of the professional’s immersion in the suffering of those with whom they work. Compassion fatigue is generally observed to emerge rapidly in response to a current acute crisis intervention, and to diminish relatively rapidly as well. This condition is described in contrast to burnout, which is seen to be acquired more gradually with an accumulation of stresses, and for recovery to be gradual as well.

Examples of warning signs for burnout stress may include feeling bored, anxious, fatigued, uninterested or impatient with clients, and arriving late to, or canceling, sessions frequently. They may feel that what they do does not matter anymore, that they are ineffective or impotent to alleviate the suffering of those who come for help. Clinicians must also be alert to factors in their personal and professional lives that may put them at increased risk for impairment. These may include family and relationship stressors, financial difficulties, health concerns, aggravation with managed care, changes in their workload, and work with particularly challenging clients. It is important, of
course, to avoid negative coping behaviors such as avoidance, denial, professional isolation, and self-medicating through compulsive and addictive behaviors or substances.

A self-care program may include the use of personal psychotherapy and a peer supervision or support group, limiting the number of hours one works, taking time for personal pursuits and relationships, taking regular breaks from work and vacations, ensuring adequate diet, sleep and exercise, engaging in enjoyable activities and hobbies, varying one’s work activities, and striking a balance between different professional and personal activities over time (Sarnel & Barnett, 1998). It is a clear and overt value within the Wellness community that we all benefit from continued emotional healing and personal growth; transformational psychotherapy is a lifelong endeavor, and the best defense against professional distress, burnout, compassion fatigue, and impairment.

Fees

When deciding to raise one’s fees during the course of treatment adequate notice should be given and each client’s ability to pay the higher fee should be discussed. One option is to increase one’s fees for new referrals and keep the fees for current clients the same. Then, over time all clients will be paying the higher fee and the issue of creating a hardship for current clients will be avoided.

Address the issue of fees “as early as is feasible in a professional or scientific relationship” (APA, p. 1068). Since this is something that could impact the client’s willingness and ability to participate in treatment, such issues should always be discussed during the informed consent process. In fact, it may be very helpful to discuss these issues in the initial telephone contact even before actually meeting. For many clients knowing the fees charged for treatment, if the therapist works in-network, out-of-network or fee-for-service, when payment is due, if credit cards are accepted and the like, can impact an individual’s decision to enter treatment. As with all informed consent issues rather than assume the client’s awareness of such issues a frank and open discussion at the outset is always best.

A clear policy on missed appointment and late cancellation charges should be reviewed in the informed consent process. The
policy used should be clear and fair. For example, does the therapist charge for the appointment time if the client cancels with more than 24 hours notice? If less than 24 hours notice is given will the client be charged if the therapist can fill the time with another appointment? What if the client experiences a true emergency and how is this defined?

Finally, the use of barter may be used at times if it is not exploitive or clinically contraindicated (APA, Standard 6.05). Criteria for determining whether barter is ethically appropriate include whether it is essential to providing the service (the client cannot otherwise pay for services), negotiated without coercion, entered into at the client’s initiative, done with the client’s informed consent, and is an accepted practice among other professionals in the community (Reamer, 2003).

While the use of a collection agency is allowable it is recommended that prevention is often the best approach to these difficulties. Many clients may find the use of a collections agency an antagonistic act and may respond with the filing of ethics complaints and malpractice suits. This can prove to be even more costly to the therapist. Instead, establishing a policy for a maximum outstanding balance allowed and including this in the informed consent agreement may be a better course of action. Then, if for any reason the balance owed comes to this amount the therapist should further discuss this with the client, see what options exist for both payment and treatment and then proceed accordingly.

Possible options include meeting less frequently for a period of time, use of a payment plan, reducing one’s fee, providing a limited number of pro bono sessions or a referral to a provider or organization with a sliding scale or reduced fee structure. But, as always, care should be taken not to abruptly terminate a client’s treatment just for non-payment especially if the client is in crisis.

Therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals.

Documentation

When considering just what to document, how to document, and when to document, a number of factors should be considered. First, it is important to consider the possible uses of one’s documentation. We should keep in mind the use of
documentation for assisting us in providing good care, for assisting future treating professionals, to communicate among treatment team members, to supply colleagues providing coverage with enough relevant information so they may effectively address each client’s clinical needs, to demonstrate our reasonable good faith effort to meet the standards of care of our profession should this be questioned at a later date, and to meet relevant ethics, legal, and administrative standards. By doing so, we can make informed decisions about how detailed and comprehensive our records should be. Additionally, we must keep in mind who may have access to treatment records in the future. Anything included in a treatment record may be accessed by others at a later date to include the client, the client’s attorney, or others.

Documentation should be objective and factual; absent of personal opinions and value statements. Information not relevant to the purposes of the professional services being provided should not be included in the record, especially since one never knows who may have access to a record at a later date and such information might result in harm to the client. It is not only important to include in documentation those actions we have taken, but also those we have not (e.g., not hospitalizing a client, not referring a client for medication evaluation, etc.) and the rationale behind our decisions. All services provided, all contacts with a client, and all contacts with others about that client should be documented and maintained in the treatment record as well.

Record keeping is also an important risk management activity and is a legal requirement in many states. The debate over the necessity to keep records is over. It is now the standard of care. You must keep records and the better the records, the better the protection for the therapist.

Some practitioners believe that keeping records is dangerous because the records may fall into the hands of a wily plaintiff’s attorney who will use them against the therapist in litigation. But the absence of records is a sure loss for the therapist. Good records provide a shield that serves to protect the therapist who has engaged in good practice; not keeping records or keeping bad records places a weapon in the hands of the plaintiff’s attorney because the absence of records is considered a sign of sloppy or problematic professional practice.
That is not to say that records must be lengthy or detailed. However, they should allow the reader to understand what happened, why it happened, and where therapy was headed. It is important to keep in mind the unwritten rule of law that states, “If it isn’t written down, it didn’t happen.”

Licensing board complaints present the aggrieved patient’s perceptions of what happened in the treatment relationship. Often the therapist’s view of history is quite different. If the therapist cannot substantiate his/her version of events from the treatment record, the licensing board is more likely to accept the patient’s version.

Availability
Most therapists have clearly stated office hours during which they are available for appointments, and a means of answering telephone calls during those hours. While this is a good start, and would likely work well for most routine matters, it would not appear to meet the needs of those experiencing crises. It is suggested that some greater access be arranged such as by including an emergency telephone number or cell phone number in the voice mail message patients receive when trying to contact you. Then, if they still are not able to reach you some backup is suggested, such as also including a crisis hotline’s number or instructions to call 911 if an emergency exists and they cannot reach you. Even if you have a secretary or receptionist who answers your telephone, such arrangements would still need to be made to address crises after work hours and during weekends.

Confidentiality
As therapists, we do our best to treat information shared by clients as confidential through means such as sound proofing our offices, storing treatment records in a secure location, using passwords and other security measures with computers, not discussing confidential information in public or with unauthorized people, releasing only the minimum necessary information when responding to a lawful request for information, and the like.

Limits to the expectation of confidentiality include when the client consents to the release of information, when laws require it such as mandatory reporting requirements for suspected abuse
and neglect of minors, if the client raises his or her mental state as an issue in litigation, in dangerous situations where there is a duty to warn and protect, in response to a lawful court order, and in emergency situations.

**Multicultural competence**

Comas-Diaz and Caldwell-Colbert (2006) state: “Cultural competence can be applied to ALL individuals, because human interaction is anchored in a cultural context. Indeed, everyone has a culture and is part of several subcultures, including those related to age, ethnicity, gender, sexual orientation, race, religion/spirituality, national origin, socioeconomic status, language preference, ideology, geographic region, neighborhood, physical ability/disability and others.” No therapist can be expected to know everything about every group. But we can have an awareness of the importance of the multiple aspects of diversity addressed above.

**Self-disclosure**

Smith and Fitzpatrick (1995) highlight how the appropriate use of self-disclosure by the psychotherapist may be a very useful and powerful technique. They state, “The hallmark of appropriate self-disclosure is that it is done for the client’s benefit within the context of the therapeutic process. Used as a tool to instruct or illustrate, the therapist’s disclosure of some past event or problem can help the client overcome barriers to therapeutic progress.” (p. 503). The self-disclosure should never occur to meet the clinician’s needs for intimacy or other personal needs.

**Integrating spirituality and religion into clinical practice**

Recent studies have demonstrated that the integration of spirituality and religion into psychotherapy enhances treatment outcomes (Eck, 2002) and that there is a positive link between religion/spirituality and health and wellbeing (Hill and Pragament, 2003).

Tan (1994) highlights ways in which therapists can overstep ethical standards in integrating spirituality and religion into psychotherapy: therapists can exceed their competence; violate informed consent agreements; engage in inappropriate multiple
relationships; impose their own values and beliefs on clients; or overstep their role by espousing ecclesiastical authority or by performing religious rites.

Mandatory reporting

With regard to minors, all 50 states have laws that mandate the reporting of suspected abuse or neglect by a parent or caregiver (someone who is responsible for the child’s welfare). The U. S. Department of Health and Human Services has an excellent website, titled Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws that provides links to each state’s law. This site also provides useful definitions and discussions, as well as links to each state’s reporting agency and its toll free number along with other useful resources.

Despite general uniformity, there still remains variability between some states’ reporting requirements. This speaks to the question of just what constitutes abuse and neglect. Therapists should know how their state defines abuse and neglect and just when making a report is mandatory. When in doubt, it is strongly recommended that the professional call the local reporting agency, describing the situation and asking if based on the information provided a report is mandated.

It is also an ethical responsibility for professionals to report sexual misconduct or other ethical violations by a colleague. Many states have laws making this a legal requirement as well.

Consultation

Consultation is a basic risk management technique, as well as a way of increasing one’s competency. Consultation can be a powerful indicator that the therapist’s conduct was professionally appropriate. The standard of care typically used in malpractice cases and licensing board investigations is that of the “reasonable” professional. The 2002 APA Ethical Principles of Psychologists and Code of Conduct has defined “reasonable” to mean “…the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.”

Consultation with other knowledgeable practitioners demonstrates several important points: the therapist recognized a potential problem; the therapist did not act independently; the
therapist sought the assistance and input from other practitioners; and the therapist documented the nature and results of the consultation as well as the actions taken – or not taken – with the rationale for both.

Consultation can help to establish the standard of “reasonableness.” By consulting with others, therapists lend significant strength to their argument that they conducted themselves consistent with the standard of care. All consultations should be carefully noted in the patient’s records.

**Identifying high-risk clients**

Identifying high-risk clients and high-risk situations is an important aspect of prevention. Therapists should take great care to recognize the types of cases that pose the most serious risk and utilize increased risk management in such situations.

High risk situations may include, but are certainly not limited to, conflicts of interest, loss of therapist’s objectivity, treating patients with a litigious history, treatment involving disputes between parties and treatment involving custody matters. Most important, therapists should take great care when a therapy relationship becomes adversarial. Sometimes patient anger is an unavoidable aspect of good treatment, but even in these situations, recognition and discussion can decrease the risk that the therapeutic relationship will be damaged. Therapists also should take great care if a therapy relationship becomes romanticized.

Clients with borderline personality disorder (BPD) tendencies can be extremely difficult, high-conflict, highly litigious individuals. Patients who meet diagnostic criteria for borderline personality disorder (BPD) pose special challenges and risks: their affective instability, disregard for boundaries, primitive defense mechanisms and self-destructive behaviors (including self-mutilation and suicide attempts) increase the likelihood of being faced with an ethical or legal dilemma.

Establish clear expectations and boundaries with such clients:

a. Set clear, unambiguous boundaries with the patient from the very beginning of treatment.

b. Be clear with the patient about what sanctions will be enforced if the boundaries are not respected.
c. Develop a written treatment plan that clarifies the goals of treatment and who’s going to be doing what to achieve those goals.

d. Coordinate what you are doing with other healthcare providers, e.g., the patient’s psychiatrist. This will ensure continuity of treatment and preclude the BPD patient’s tendency to triangulate one provider against another.

e. Make it clear from the beginning that you are not the patient’s friend, mother, father or emotional punching bag. You will serve as their coach, mentor and therapist. Therapy is not purchased friendship. Therapy is about change. Your primary job will be to function as a catalyst for change.

The current authors respectfully disagree with this common sentiment: “Do not ever use regressive hypnotherapy with BPD patients; the latter will likely cause dissociation and decompensation. The patient may also be vulnerable to developing ‘false memory’ syndrome in that BPD patients have great difficulty differentiating between reality and projections/fantasies. Journaling, guided imagery, relaxation training and neurofeedback techniques are more appropriate strategies for dealing with intense affect with this population” (Shannon, 2007). We have found with numerous individuals diagnosed with BPD that age-regression hypnotherapy can be safe and effective when rendered with clear boundaries and emphasis on the client’s ultimate control of the pacing and content of the session. Perhaps the determining limitation in successful incorporation of regression hypnotherapy with such a client is how experienced is the therapist.

Terminating Psychotherapy

If it is clear that the patient is not benefiting from treatment, assert your ethical responsibility (and right) to terminate treatment with appropriate referral or hospitalization.

Terminations are an important part of the therapeutic process, and we have ethical responsibilities to terminate appropriately. The reality is that one third of all clients do not return to psychotherapy after one or two sessions, according to a federal study. Only 10 percent remain for more than 20 sessions.
Some simply stop coming, despite our recommendation of a “pretermination counseling process.” Multiple factors influence how long a client remains in psychotherapy. What are those factors and what can we do to facilitate successful separations? At the beginning of psychotherapy, and throughout the treatment, we have responsibilities to provide informed consent about psychotherapy. That is, we should educate clients about the process of psychotherapy, including the factors involved in deciding when to stop.

Ending therapy usually depends on the nature of the case, the condition of the client, the evolution and attainment of goals as set forth by the client and psychotherapist and the client’s financial situation (either personal or managed care limitations).

Our ethical responsibilities include the responsibility to terminate when the client no longer needs the service, isn’t benefiting or is being harmed by the service (APA, 2002, Standard 10.10a).

We are also responsible to make reasonable efforts to provide pretermination counseling and suggest alternative service providers as appropriate (APA, 2002, Standards 10.10c, 10.09 and 3.12). A new APA Ethics Code standard indicates that therapists have the right to terminate psychotherapy when they are threatened (10.10b). It is probably not appropriate to terminate when a client is in crisis. Clients usually either indicate that they will call to schedule the next appointment or cancel and do not reschedule. In addition, many people currently utilize psychotherapy in short installments and stop for a while and later return to either the same practitioner or to another. A key psychotherapeutic strategy is to review the presenting concerns, goals and progress from time to time. This helps clarify how much has been accomplished, as well as what still needs to be addressed and whether the client and psychotherapist collaboratively wish to continue or not.

When clients who seemed successfully engaged in psychotherapy stop coming, a note or call to provide them with options can yield helpful information. For example, contacting clients who have not returned may focus on concern for their current status; informing about new therapeutic modalities available since their previous sessions; asking whether they would prefer 1) to have their file terminated, 2) to come in for a
review and termination, or 3) to return to psychotherapy. Some clients may want you to hold their files because they hope to return, some may schedule appointments immediately because they had been meaning to call, or others may be ready for you to terminate their file.

**Expanded forms of “seeing” the invisible**

Therapists are trained and hopefully qualified to perceive psychic realities hidden from view at the superficial level of human interaction. One might “see” what lies behind the obvious; for example, recognizing the embedded unresolved birth issue in a client’s claustrophobia, or the repressed self-hatred in a client’s depression. At a deeper level, the therapist may be capable of perceiving the lingering energetic presence in a woman’s womb of a life that was miscarried previously – what is known as a “haunted womb.” Likewise, a therapist may be aware of energetic subtleties between people, invisible to the untrained eye; for example, recognizing the contagion of shock that pervades the interactive space between her traumatized client and herself.

Some therapists are capable of seeing the invisible energies within a client’s energy field, whether seeing the quantum radiations of a person’s “emotional body” (aura) or simply seeing right through their physical flesh. This is a refined form of seeing the subtle and invisible that can potentially benefit people. By studying the radiations, inner structure, or shock postures of the people that come to us, we gain knowledge that is valuable in facilitating their healing process.

An important question to consider, however, is: are we violating someone’s privacy by viewing their energy or reading the physical residue of past traumas? Because of the intangible nature of the “data” one is collecting about someone else in this way, the danger of projection is even greater than with interpretation of their words or deeds. For this reason, the more one utilizes ethereal information in the therapeutic milieu, the more important it becomes to obtain the client’s express permission, and to remain clear by doing one’s own emotional clearing work to minimize the contamination of one’s own projection.
Working with non-ordinary states of consciousness

When utilizing hypnosis or similar trance states in the therapeutic intervention, provide some description about the phenomenon of hypnosis that reflects your theoretical orientation, and this should be included in the initial informed consent materials. This might include such topics as (a) what it consists of, (b) how it is a frequently occurring state for some (like watching a movie, or a football game, etc.), (c) how it could be a natural coping mechanism for some, such as in dealing with emergency situations, or (d) that it can also happen spontaneously for some (highway hypnosis). Hypnosis could also be described as facilitating the development of new skills, behaviors, and thought patterns to be used in place of maladaptive ones, and that further practice strengthens the new learning. Also discuss the common fears - losing control, losing consciousness, risking being “trapped” in hypnosis, etc. Also, it could be emphasized that the individual can leave hypnosis at any point (like turning off a television set) (American Society of Clinical Hypnosis, 2009).

When the professional incorporates hypnotic experience in any group or public presentation, he/she needs to take care to ensure that it is done in such a way as to prevent or minimize risk to unknown audience participants. This might be accomplished by, for example, telling those who do not wish to go into hypnosis not to close their eyes, or by muting the induction part of a demonstration video.

Working with groups

The group leader should lead the group democratically, while maintaining the responsibility of leadership. One’s leadership should cultivate the free expression of group ideas and feelings, taking into account group dynamics, group energy, and balancing attention to individuals and to the group experience.

Group confidentiality should extend to all group members. Therefore, the group leader should remind the group of the importance of confidentiality, both for the social protection of the members as well as in order to establish the trust necessary for good group work. The group leader is responsible to announce the entrance of any potential new member to the
group, and to assure as much as possible an orderly completion for any group member who is terminating from the group. The group leader should explain the purpose of any audio or video recording that may occur, and only proceed after approval of the group members.

The group leader and the group participants establish a connection comprised of distinct, asymmetrical roles, which potentially fosters transference relationships. This means, among other things, that the leader gains a position of power over the group members, which must never be exploited for financial, political or sexual gain. This remains true even after a member has left the group.

**Touch and Body work**

Although many mental health professionals refrain from any physical contact with clients except for a handshake, there are certainly occasions on which non-sexual physical touch can be helpful to the client. Examples of touch intentionally employed as part of or adjunct to verbal psychotherapy might include a gentle touch on the arm or shoulder to convey empathy when a client is expressing grief, or a warm hug of greeting or farewell instead of the more formal handshake. Therapists should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact due to misinterpretation (examples included in the NASW Code are cradling or caressing clients). Therapists who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such contact, and to obtain client permission for the contact before it is implemented.

A more holistic inclusion of physical touch in psychotherapy is advocated by the United States Association for Body Psychotherapy (2007):

> Body psychotherapists recognize the intrinsic unity of the human being in our somatic nature. Body psychotherapists, therefore, work in ways that foster the integration of bodily sensation, thought, affect, and movement to promote more integral human functioning and the resolution of psychotherapeutic concerns. Body psychotherapeutic methods, including language, gesture and touch, when used in responsible, ethical and competent ways, make an essential contribution to the psychotherapeutic process by including the missing and often alienated aspects of our being which are rooted in our bodily nature and experience.
Psychotherapists should always obtain informed consent prior to using touch-related techniques in the therapeutic relationship, making every attempt to ensure that consent for the use of touch is genuine and that the client adequately understands the nature and purposes of its use. Therapists recognize, however, that the client’s conscious verbal and even written consent for touch, while apparently genuine, may not accurately reflect objections to touch of which the client is currently unaware. Knowing this, body psychotherapists should strive to be sensitive to the client’s spoken and unspoken cues regarding touch, and continue to monitor for ongoing informed consent to ensure the continued appropriateness of touch-based interventions.

A simple way of dealing with the consent issue is by adding a section to the standard informed consent that all clients should read and sign before the onset of therapy. Such a paragraph may include some of the following sentences (Zur, 2010):

Dr./Ms./Mr. xx may also incorporate non-sexual touch as part of psychotherapy. Sexual touch of clients by therapists is unethical and illegal. Dr./Ms./Mr. xx will ask your permission before touching you, and you have the right to decline or refuse to be touched without any fear or concern about reprisal. Touch can be very beneficial but can also unexpectedly evoke emotions, thoughts, physical reactions or memories that may be upsetting, depressing, evoke anger, etc. Sharing and processing such feelings with the therapist, if they arise, may be a helpful part of therapy. You may request not to be touched at any time during therapy without needing to explain it, if you choose not to, and without fear of punishment.

Working with Children

Consent for treatment requires the agreement of both the caregiver and the child. Children are more sensitive and vulnerable to adult inputs and the practitioner is therefore obligated to work with extra sensitivity and caution with young clients. Children, especially the very young may not be able to identify or articulate their problems; thus therapists often must rely on reports from caregivers, schools and social agencies to determine the nature, severity and extent of the problem. Practitioners need to be sufficiently trained to recognize that the child may not be the problem but rather the family, school, or agency may be the actual source of tensions that are expressed by the child’s symptoms or behavior. The child’s caregivers must be made aware of the limits of confidentiality regarding the
child’s issues as part of the informed consent process before commencing treatment; practitioners must explain the limits of confidentiality to a child as well. Therapists must advise a child that in the event issues arise where, in the practitioner’s best judgment and in a child’s best interest, the issues ought to be discussed with the caregivers or agency, a child will be informed of such an event before the issue is brought up to the adults.

References


Relevant Associations’ Codes of Ethics

- International Association for Group Psychotherapy and Group Processes (IAGPGP), Ethical Principles for Group Leaders – http://www.iagp.com/publications/codeofethicsforgroupleaders.htm
Test Questions (T or F)

1. Questions about spirituality and religion should be included in the initial intake paperwork and in the initial assessment of each client.

2. A barter arrangement with a client in lieu of payment for services is never ethically appropriate.

3. Inappropriate dual relationships can involve current clients but also others: former clients, colleagues, assistants, supervisees and students, or clients’ family members.

4. Compassion fatigue, or secondary traumatic stress, is a potential result of the professional’s immersion in the suffering of those with whom they work.

5. Vicarious traumatization is a clinical term for the universal experience of all psychotherapists.

6. Therapists can ethically accept rebates or bonuses for referrals to other therapists.

7. There is no evidence that the integration of spirituality and religion into psychotherapy enhances treatment outcomes.

8. One third of all clients do not return to psychotherapy after one or two sessions, according to a federal study.

9. When utilizing hypnosis or similar trance states in the therapeutic intervention, this information should be included in the initial informed consent materials.

10. A therapist who operates as a group leader potentially gains a position of power over group members which must never be exploited for financial, political or sexual gain. This obligation no longer applies after a member has left the group.

11. Notwithstanding a client’s conscious verbal and written consent for touch, body psychotherapists strive to be sensitive to the client’s spoken and unspoken cues regarding touch, and continue to monitor for ongoing informed consent to ensure the continued appropriateness of touch-based interventions.

12. Consent for treatment requires the agreement of both a child and their responsible caregiver.