CHAPTER 4

ETHICAL AND LEGAL ISSUES IN FAMILY AND COUPLE THERAPY

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Family and couple therapy is a branch of psychotherapy that works with multiple clients' relationships with one another in order to nurture growth and change. This type of psychotherapy conceptualizes the origin of conflict as being dysfunctional interactions within the family or couple system. This approach to psychotherapy also emphasizes relationships as important factors in attaining and maintaining mental health. At any given time, over 1.8 million people participate in marriage and family therapy (American Association for Marriage and Family Therapy, 2018). Family and couple therapy is a growing field, and this treatment is helpful and necessary for numerous families and couples experiencing conflict and distress related to relationship difficulties. Although this treatment is highly sought out and very needed, not all clinicians are trained to provide effective family and couple therapy. In addition to possessing the necessary clinical expertise to effectively offer these treatment services, it is crucial that family and couple therapists are knowledgeable about ethics and legal issues relevant to their work. This chapter addresses the ethics and legal issues for family and couple therapists to take into consideration, including competence; multicultural awareness; informed consent; boundaries and multiple relationships; and legal issues related to confidentiality and its exceptions, the duty to warn, and child custody issues.

CLINICAL COMPETENCE

Before providing couple and family therapy services, it is essential that mental health clinicians first develop the clinical competence needed to provide these services effectively (see Chapter 26, this volume). Competence is defined by Epstein and Hundert (2002) as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community served" (p. 226). Similarly, Haas and Malouf (2005) described competence as possession of the requisite knowledge, skills, attitudes, and values, as well as the ability to implement them effectively for the benefit of the client. More specifically, Rodolfa et al. (2013) presented a model of competence for the practice of psychology that includes the following six domains: scientific knowledge, evidence-based decision making/critical reasoning, interpersonal and cultural competence, professionalism/ethics, assessment, and intervention/supervision/consultation.

Understanding Competence

The development of each clinician's clinical competence begins in graduate school with academic course work and supervised clinical experience (see Chapter 26, this volume). It does not stop there,

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however, because attaining and maintaining competence is an ongoing endeavor that each clinician must work at on an ongoing basis throughout the course of his or her career. Competence should not be seen in all or nothing terms; one is not either fully competent or completely incompetent. Competence falls along a continuum and has many elements to it, with each one potentially falling at a different place along that continuum. One may possess a certain degree of competence in some aspects of practice and different levels of competence in others. Additionally, one may be considered competent at one point in time and not at others; without adequate ongoing efforts, competence can deteriorate and knowledge and skills can become obsolete over time (Neimeyer, Taylor, Rozensky, & Cox, 2014).

Rather than asking if one is competent, it is more appropriate to ask if one is sufficiently competent in the use of the specific treatment techniques and modalities relevant to the client's treatment needs and if one is sufficiently competent in the treatment of the client's particular presenting problems. Thus, clinical competence should not be considered from a global or holistic level but more specifically as it is relevant to treating a particular client.

Although many of the competencies (i.e., areas of knowledge, skills, and abilities) that are associated with being an effective individual therapist are relevant to clinical work with families and couples, they are not sufficient for practice as a family or couple therapist. Mental health clinicians seeking to treat families and couples will need to significantly add to their general competence in order to provide effective treatment in the specialty area of family and couple treatment.

As addressed in Standard 2.01, Boundaries of Competence, of the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (APA Ethics Code; APA, 2017a), psychologists should provide services to populations and in areas only within the limits of their competence. Competence can be understood in terms of three distinct obligations that clinicians accept in treating clients. These three obligations include becoming familiar with professional and scientific knowledge, acquiring professional skills, and finally, knowing when it is appropriate to make referrals to other professionals when one does not have the skills or ability to perform work in a competent manner (Dean, 2010). When treating families and couples in psychotherapy, it is important that clinicians possess the specialized knowledge, skills, training, and experience needed to provide effective treatment.

Clinicians who treat families and couples need to have adequate education, training, demonstration of skills, and licensure as a minimum level of competence in treating these populations. Training programs currently determine methods of assessing students in different competency areas, including family and couple therapy. Additionally, most programs offer academic courses in the treatment of families and couples, and many graduate students are given the opportunity to work clinically with these populations during their training. Ideally, therapists can gain this real world experience prior to treating families or couples independently once they are licensed. Yet, licensure should not be misconstrued as implying clinical competence, as it only implies that the clinician possesses the necessary general competence to practice psychology independently. Family and couple therapists should work to continually enhance the knowledge relevant to competence as a family and couple therapist through ongoing professional education, staying current with the professional literature, and by contributing to the field by engaging in research and scholarship that enhances our knowledge base.

Acquiring professional skills. Initially, these skills may be developed through supervised clinical experience during a therapist's training. For practicing family and couple therapists, the development and enhancement of these skills may be achieved through participation in advanced specialty training and certification programs in family and couple therapy that include supervision and evaluation of relevant clinical skills.

The American Board of Professional Psychology (ABPP) recognizes 14 specialties in the practice of psychology. ABPP defines a specialty as an "area in the practice of psychology that connotes special competency acquired through an organized sequence of formal education, training, and experience" (ABPP, 2015, paragraph 5). Furthermore, in addition

to having a recognized set of competencies, each specialty has its own identified "requirements for education, training, experience, research bases of the specialty, practice guidelines. . . ." (paragraph 5). Couple and family therapy is one of the 14 specialties in psychology that are recognized by the ABPP. Although board certification is not required to practice couple and family psychology, with licensure being the only requirement to practice independently, board certification sets the standard for recognition of advanced competence in specialty areas. Thus, board certification provides a recognized standard for demonstrating advanced competence in couple and family therapy.

While psychologists may demonstrate their specialized competence in couple and family therapy through board certification by ABPP, several training and certification programs exist that provide mental health clinicians the opportunity to develop specialized knowledge and skills relevant to family and couple therapy. For example, clinicians can become trained and then certified or credentialed in emotionally focused therapy (see Chapter 18, this volume) or the Prevention and Relationship Enhancement Program (see Chapter 19, this volume) in treating couples; or the Incredible Years series programs (see Chapter 21, this volume), parent–child interaction therapy (see Chapter 23, this volume), Family Check-Up and Everyday Parenting (see Chapter 24, this volume), or Triple P Positive Parenting Program (see Chapter 25, this volume) in treating families. These are just a few of the many types of available empirically supported couple and family therapy approaches in which one may become certificated or credentialed. Additionally, clinicians should engage in ongoing efforts to maintain and build upon their competence and to stay current with the latest developments in the field, including seeking consultation with experts in various aspects of practice, participating in continuing education courses, and immersing themselves in the current research literature relevant to family and couple therapy.

Self-assessment of competence. When a mental health clinician does not possess the needed competence to provide the treatment services necessary to meet clients' treatment needs, it is often in the clients' best interest to refer them to a professional who possesses that needed competence. Often, however, whether a clinician should treat a particular family or couple or refer them to a colleague for treatment is not clear. Careful and honest reflection on one's ability to effectively treat the family or couple is of great importance for meeting one's ethical obligations and for ensuring that clients' treatment needs are appropriately met. Yet, mental health clinicians, like all health professionals, demonstrate great difficulties with accurate self-assessment. Clinicians tend to overestimate their abilities and to be unaware of difficulties or deficits in their competence (Dunning, Heath, & Suls, 2004; Kruger & Dunning, 1999). Thus, self-assessment alone is insufficient and clinicians must actively utilize consultation with colleagues to help determine the appropriateness of treating certain clients.

Although it is important for clinicians to engage in self-assessment and utilize consultation regarding all populations treated, family and couple therapy involves specific concerns that become very relevant to assessing competence in a continuous and conscious way. APA Ethics Code Standard 2.04, Bases for Scientific and Professional Judgments, requires psychologists' work to be based upon established scientific and professional knowledge. In addition to the need to remain current on empirically based treatments related to family and couple therapy, multicultural biases; prejudices; implicit and explicit beliefs; and personal values, morals, and life experiences come into play strongly when working with families and couples. Standard 2.06 of the APA Ethics Code, Personal Problems and Conflicts, states that psychologists must be "aware of personal problems that may interfere with their performing work-related duties adequately" (APA, 2017a, p. 5) and in a competent manner. For psychologists to remain competent, it is recommended that they address these different areas by using supervision and consultation and by being open to colleagues' feedback and guidance. In Standard 2.03 of the APA Ethics Code, Maintaining Competence, it is stated that psychologists should make ongoing efforts throughout their careers to develop and maintain their clinical competence

and effectiveness. This continuous process of self-assessment, consultation, and the development of ongoing competence is critical for the effective treatment of couples and families in therapy.

Couple and Family Therapy Competencies

Competencies related to family and couple therapy are unique and different from the competencies required to conduct effective individual psychotherapy. As discussed previously, competence in individual therapy is necessary but not sufficient for the practice of family and couple therapy, due to the unique nature of family and couple work. The field of family and couple therapy is highly specialized; thus, clinicians should be knowledgeable about family and couple systems theories as well as specific family systems therapy concepts and treatment implications such as triangulation, boundary permeability, alignments and coalitions, and paradoxical tasks in the therapy (Bowen, 1978; Haley, 1976; Minuchin, 1974; see Chapter 7, this volume).

Families and couples often seek treatment when their family or dyadic system becomes dysfunctional, and cases should be conceptualized using a systems perspective throughout the entire course of treatment. In this type of specialized treatment, the family or the couple—rather than a specified individual—is the client, and clarifying the clinician's obligations to each party from the outset is vital for treatment to be effective (Fisher, 2009). A systems perspective should permeate case conceptualization, assessment and diagnostic issues, treatment planning, interventions, and even considerations regarding termination of treatment when working with families and couples. Additionally, family and couple therapists should be knowledgeable of and competent in the use of the treatment skills demonstrated to be relevant to the effective treatment of these clients (see Chapter 26, this volume, for detailed information on these competencies).

MULTICULTURAL COMPETENCE

In all psychological treatments, multicultural considerations should be used as a lens through which to view every clinical case (see Volume 2, Chapter 26, this handbook). Its implications are so important in work with clients that multiculturalism is considered to be the fourth force in psychology, with psychoanalysis, behaviorism, and humanism being the first three forces (Pedersen, 2001). Multicultural considerations should be integrated into all clinical work in order to strengthen clinical conceptualizations and treatments, regardless of the clinician's theoretical orientation. Principle E of the APA Ethics Code, Respect for People's Rights and Dignity, directs clinicians toward being aware of and respecting cultural, individual, and role differences and considering these factors when working with clients to avoid participating in activities or treatments based on prejudices, biases, or stereotypes. Additionally, in 2003 the APA published the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists, further reinforcing the importance and value of including multiculturalism in all clinical interactions. In 2017, APA updated these Guidelines in order to reconsider diversity and multicultural practice, with intersectionality as its primary purview (APA, 2017b) The APA Multicultural Guidelines recommend that all psychologists (whether they are involved in education, training, research, practice, or organizational change) work toward knowledge of themselves and their own cultural identities, as well as knowledge of other cultures, in order to provide clients with the most appropriate, relevant, and effective services possible (APA, 2003, 2017b).

The development of multicultural competence is built upon self-awareness of biases, and this examination is a dynamic rather than a static process. Sue et al. (1998) defined *multicultural competence* as the development of cultural knowledge, cultural skills, and cultural awareness so as to intervene effectively. *Cultural knowledge* is understood to be the ability to gather meaningful facts to increase comprehension about one's own and others' cultures, *cultural skills* consist of the abilities to intervene in effective and competent ways regarding culture, and *cultural awareness* is defined as the ability to accurately understand a cultural situation from the client's perspective as well as an awareness of the clinician's implicit biases

and privileges present in that cultural situation (Pedersen, 2001).

Multicultural Knowledge With Families and Couples

To develop multicultural competence with families and couples, clinicians must understand families through the lens of their self-views, beliefs, cultural backgrounds, and family interactions and practices (McGoldrick, Giordano, & Garcia-Preto, 2005). Gathering this knowledge does not stop with being aware of clients' cultures; clinicians must be aware of the role of their own identities and beliefs and how they intersect in complex ways with how clinicians view and interact with families and couples in treatment. It is important to understand cultural attitudes toward families and couples as well as differing definitions of normality and dysfunction (McGoldrick et al., 2005).

Developing specific cultural knowledge is essential when working with families and couples. Therapists in the United States are frequently taught treatments that are rooted in Eurocentric frameworks and thus prioritize Western values, often failing to address important differences among cultures (Kelly, Maynigo, Wesley, & Durham, 2013). For example, when working with Asian Indian American families in therapy, one should inquire about gender roles and the role of the extended family in the treatment process. Additionally, an intergenerational or structural theory or framework may be particularly helpful for many Asian Indian Americans, considering the influence of the extended family and concerns related to family rules, boundaries, and roles (DuPree, Bhakta, Patel, & DuPree, 2013). Similarly, when treating African American families or couples, it is essential that the clinician be aware of how larger systems affect the family structure and may lead to mistrust within the family or couple system, in the relationship with the therapist, and in the larger societal system (Kelly et al., 2013).

Clinicians also need to be aware of empirically based knowledge when working with lesbian, gay, bisexual, transgender+ (LGBT+) couples and families. There is a perception that the norm is White, Westernized, heterosexual, and cisgender (i.e., being assigned at birth to the gender one later identifies with); therefore, it is crucial for clinicians to seek out literature on the treatment of people who identify as LGBT+ in terms of development and identity (Martell, 2015). It is also necessary for clinicians to possess knowledge of the larger societal forces that these families and couples are dealing with, so as to provide competent treatment by taking broader systemic influences into consideration. Additionally, when providing family or couple therapy to LGBT+ populations, clinicians need to self-reflect upon biases, stereotypes, and privileges they may hold and consider how these may impact their perceptions of and interactions with these clients.

These examples highlight the importance of developing culturally sensitive practices that incorporate knowledge about cultures. It is also valuable to note that although gaining specific knowledge about each client's reference group is helpful, it is important not to make assumptions based solely on research and to always check in with the particular family or couple in treatment to understand their specific cultural experiences.

Multicultural Skills With Families and Couples

Hays (2001) provided a framework for therapists to better recognize and understand individual and cultural influences as a dimension of psychotherapy work. This model is referred to as the ADDRESSING framework and it recommends that clinicians take into consideration a combination of information about age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender with all clients (Hays, 2001). Using this framework promotes culturally sensitive practices that should enhance psychotherapy skills with families and couples, as it will likely result in an increased awareness of who one's clients are; the forces or stressors they are dealing with; and their worldview, perceptions, and experiences.

The use of culturally sensitive skills should begin with the initial assessment of each family and couple. It is recommended that clinicians approach this work in interactive and supportive ways, assessing clients' worldviews rather than

making judgments about clients' beliefs, values, and practices based on their identified or observable individual factors as well as cultural differences (Ibrahim & Schroeder, 1990). Upon initial assessment, clinicians may use scales such as the Scale to Assess World View (SAWV) to help clients to clarify their own cultural worldviews and to help the family or couple therapist to understand them (Ibrahim & Schroeder, 1990).

Multicultural Awareness With Families and Couples

When treating families and couples, it is important to continuously check in with one's self and with clients to confirm that conceptualizations and interventions are culturally sensitive, relevant, and appropriate. It is also important that family and couple therapists understand their personal values, biases, and privileges and how they may impact their view of and interactions with clients, their judgments about treatment goals, and their choice of interventions.

To achieve and maintain cultural competence, it is crucial that clinicians continuously explore their own individual and relational assumptions in terms of questions related to cultural values, gender role biases, traditional versus egalitarian family roles, infidelity, divorce, and other mores and cultural customs. These ideas are likely to change throughout one's lifetime, and thus the examination of personal values is a dynamic and ongoing process that requires honest reflection and can be aided by consultation with colleagues.

INFORMED CONSENT TO COUPLE AND FAMILY THERAPY

The doctrine of informed consent is based on the premise that each client has the right to receive and understand information about the professional services being offered that is sufficient to enable the client to make an informed decision about participation. Historically, physicians provided treatment without first seeking patients' consent. Physicians possessed knowledge and expertise, evaluated their patients, and determined the treatments and interventions that they deemed to be in their patients' best interests. Over time, as some patients perceived themselves to have been harmed by their physicians' actions, they filed malpractice suits against their physicians. When the courts ruled in the patients' favor, awarding damages to them, these legal rulings created precedent and altered professional practice standards. The rulings of these lawsuits have created the doctrine of informed consent as it is known today, and many of the standards from these legal rulings have been incorporated into the requirements found in licensing laws and ethics codes (Barnett, Wise, Johnson-Greene, & Bucky, 2007).

Ethics Standards and Requirements

The APA Ethics Code (APA, 2017a) addresses informed consent requirements for psychologists in several relevant enforceable standards. Standard 3.10, Informed Consent, requires that psychologists first obtain the informed consent of participants before providing them with any psychological services, "except when conducting such activities without consent is mandated by law or governmental regulation . . ." (p. 6). Standard 10.01, Informed Consent to Therapy, clarifies the need for informed consent by stating that the establishment of this consent should occur as early as is feasible in the treatment process and that the clinician should inform clients about (a) the nature and anticipated course of therapy; (b) fees and financial arrangements; (c) any involvement of third parties; (d) confidentiality and its limits; (e) the nature of any experimental or unproven treatments or techniques, potential risks, and treatment alternatives that are reasonably available; (f) the right to refuse participation; and (g) the licensure status of the clinician, including whether he or she is a trainee and practicing under another individual's license, in which case the clinician should also share the name of his or her supervisor with the client. Additional information to be shared in the informed consent process includes (a) the clinician's credentials, training, and experience relevant to the professional services

being offered; (b) scheduling and cancellation policies; (c) emergency contact information; (d) any recording (audio or video) of treatment sessions; and (e) termination or transfer of clients.

Further, for the informed consent process to be considered valid, four criteria must be met. First, the informed consent must not be coerced; it must be provided voluntarily. Second, the individuals involved must be competent (emotionally, intellectually, and legally) to provide consent. Third, therapists must actively ensure clients' understanding of that to which they are agreeing. Finally, the informed consent must be documented. Merely having a verbal agreement about the parameters of the treatment to be provided is insufficient (Snyder & Barnett, 2006).

Snyder and Barnett (2006) reported that informed consent is an ongoing process that has the benefit of "promoting client autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision making, and enhancing the therapeutic alliance" (p. 37). Furthermore, the information sharing component of the informed consent process helps in demystifying psychotherapy, reducing apprehension and anxiety clients may have, and increasing their investment in the treatment (Beahrs & Gutheil, 2001).

It is also important that cultural and other diversity issues be integrated into the ongoing informed consent process, with the process being modified to meet each participant's needs. As Pope (1991) explained, the informed consent process must be customized to meet each individual person's needs. For example, how one typically conducts the informed consent process may need to be modified with people for whom English is not their first language, for those who are visually or hearing impaired, and for those whose cultural norms may require the inclusion of others in the informed consent process (e.g., community elders, extended family members, religious leaders).

Informed Consent and Assent

When someone is not able or authorized to give her or his own informed consent, assent is sought. Individuals who are not legally authorized to provide their own informed consent include minors (although the age of majority varies by jurisdiction and there are exceptions in some jurisdictions; e.g., for minors who are married, have a child of their own, or are in military service) and individuals who do not have the intellectual capacity needed to fully participate in the informed consent process, such as people who are intellectually disabled or suffering from cognitive impairment due to mental illness, head trauma, or dementia.

Assent is a process of sharing information with an individual and providing information about the treatment to follow so that the individual is as well informed about it as is possible (Kuther, 2003). Even if someone does not have the right or ability to give their own consent, receiving this information at the outset of the professional relationship is important for the reasons mentioned above regarding informed consent.

With minors, even when not legally authorized to provide their own informed consent, the assent process needs to be tailored to each person's developmental level and level of understanding (Koocher & Daniel, 2012). As minors' age and developmental level increases, their ability to participate more actively in this information sharing, discussion, and decision-making process increases. Minors as young as 12 years of age often possess the ability to understand the consequences of their decisions, including health care decisions (Redding, 1993). At increased developmental levels, minors develop the capacity to understand the information presented, to express preferences, and to comprehend the likely outcomes of their decisions (McCabe, 2006). Thus, even when minors are not afforded the legal right to give their own informed consent, the assent process should be modified to include seeking and considering minors' preferences regarding treatment plans and related issues. Important reasons for including minors in the informed consent and assent processes include (a) demonstrating respect for minors and their autonomy, (b) helping to promote the therapeutic relationship and alliance, (c) helping to empower minors on their own behalf, and (d) promoting minors' active participation in the treatment process (Lind, Anderson, & Oberle, 2003).

TREATING MULTIPLE INDIVIDUALS IN FAMILY AND COUPLE THERAPY

In contrast to individual psychotherapy, in family and couple therapy there is not a single individual who is identified as the client. Thus, as Fisher (2009) stated, clinicians should not ask the question "Who is my client?" Because couple and family therapists are treating multiple individuals, the issue of who the client is becomes rather complex. Answers may vary depending on therapists' theoretical orientation, their manner of conceptualizing family and couple therapy, and the wishes and preferences of those seeking and participating in the treatment. Some may view the family or the marriage or the couple itself as the client. Thus, the client may be a relationship or a family unit.

Clinicians should not rush to view the individual who contacts them to initiate treatment as the client. Often, one member of a family or one partner in a couple will contact a clinician to seek out family or couple therapy. Although seeking treatment and initiating contact are important, they do not by themselves create a therapeutic relationship or contract. The interests, goals, objectives, and welfare of all individuals involved in the treatment should be considered by the clinician. Consistent with the goals of the informed consent process, a treatment agreement should be developed with the active participation of all individuals involved. If one or more members of the treatment constellation are not in agreement with the proposed treatment plan or the parameters of the treatment relationships and process, these disagreements must be discussed fully and work must be done to reach consensus before proceeding with initiating treatment.

These recommendations are consistent with Knapp and VandeCreek's (2003) guidance stating that before initiating treatment, therapists should first "clarify their roles and relationships with all parties" (p. 148). It is important not to assume that one family member holds decision-making authority or to collude with existing patterns of family functioning that may be part of the issues that brought them to treatment. When sharing the ground rules of couple or family therapy with clients, a widely accepted technique is to avoid keeping secrets belonging to one family member from the others and to state that all individual communications in between treatment sessions will be shared with the other family members at the next treatment session (e.g., Kuo, 2009; Margolin, 1982). The therapist will inform all individuals involved in the treatment of this rule and obtain their acceptance of it during the informed consent process.

Rather than asking "Who is the client?", "What are the client's expectations and needs?", and "What are the therapist's obligations to the client?", Fisher (2009) recommended modifying these questions and instead asking "Exactly what are my ethical responsibilities to each of the parties in this case?" (p. 1). Considering this question will help ensure that each person's needs and interests are given attention during the informed consent process. Additionally, children's and adolescents' desires may often be overlooked in family therapy, with parents taking the lead in expressing treatment goals as well as in providing consent to treatment. It is the family therapist's responsibility to ensure that each person is given a voice and that each person's needs and best interests are considered. This may prove to be challenging, especially when there are competing needs and interests expressed, or in situations wherein one or more family members are not willing participants in therapy. Special care should be taken to address each person's needs and to obtain their informed consent or assent to the treatment.

Consistent with the above principles, the APA Ethics Code (APA, 2017a) in Standard 10.02, Therapy Involving Couples and Families, requires that

> When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (pp. 13–14)

Boundaries

Boundaries are described as the ground rules of the professional relationship. As Smith and Fitzpatrick (1995) explained, boundaries provide "a therapeutic frame which defines a set of roles for the participants in the therapeutic process" (p. 499) and they "provide a foundation for this relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest" (p. 500).

In couple and family therapy, relevant boundaries may involve touch, time, space, location, self-disclosure, and gifts, among other issues. As Gutheil and Gabbard (1993) first articulated, boundaries may be avoided, crossed, or violated. To avoid a boundary is to never engage in behaviors associated with it. For example, for a family therapist to never share any personal information about herself or himself in any way would be to avoid the boundary of self-disclosure.

To cross a boundary is to traverse the boundary but to do so in a clinically relevant, meaningful, and appropriate manner. Thus, if a family member asks if the therapist has worked with families before, it would be relevant and likely helpful for the therapist to share some information about his or her professional education, clinical training, and relevant experience. In fact, this form of self-disclosure could appropriately be included in the informed consent process. Crossing the boundary of self-disclosure could also involve the therapist sharing something about herself or himself personally that is relevant to the client's treatment issues, with the goal of sharing this information to assist the client toward her or his treatment goals. Sharing generally about the challenges a clinician had with his or her adolescent child in the past and how working on respectful, open, and honest communication on a regular basis proved to be helpful for them could be a powerful and meaningful intervention for the client.

In contrast, boundary violations involve traversing a boundary but doing so in a manner that is not motivated by the client's needs or best interests, is not clinically relevant to the client's treatment goals or plan, is likely to be exploitative or harmful to the client, violates cultural or other norms for the client, or is unwelcomed by the client (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007; Zur, 2007). A therapist extending the time of a treatment session to discuss his or her own personal life or issues with a client that the therapist finds interesting and relates to would likely be a boundary violation in that this action appears motivated by the therapist's needs and interests, is not directly related to the client's treatment needs or treatment plan, and is not likely to benefit the client.

Thus, boundary crossings may be quite appropriate and even necessary for the effective conduct of couple and family therapy. To avoid all boundaries in an effort to prevent any possible ethical transgressions is not only impractical, it likely would result in a rather sterile therapeutic environment and an ineffective treatment alliance (Zur & Lazarus, 2002). Boundaries are a normal part of all relationships, but they must be managed effectively and with thoughtful intent. When applied in this manner, they are an essential part of treatment. Touching a grieving client on the arm or shoulder, extending the time of a session when a family member is in crisis, and scheduling a family therapy session in the clients' home when one family member is bedridden are examples of appropriate and clinically relevant boundary crossings.

Multiple Relationships

Multiple relationships are formed when a mental health clinician enters into a second relationship with a client in addition to the treatment relationship. Examples can include business, personal, social, romantic, and other relationships. A therapist also engages in a multiple relationship when accepting into treatment an individual with whom she or he has previously been in another such (business, personal, social, romantic, etc.) relationship. The APA Ethics Code (APA, 2017a), in Standard 3.05, Multiple Relationships, makes it clear that not all multiple relationships need to be avoided, only those that hold significant potential for exploitation of, or harm to, clients. However, Standard 3.05 also explains that

> A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's

> objectivity, competence or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. (APA, 2017a, p. 6)

The APA Ethics Code (APA, 2017a) also makes clear that psychologists may never engage in sexual intimacies with current clients (Standard 10.05) or with relatives or significant others of current clients (Standard 10.06), may not provide therapy to former sexual partners (Standard 10.07), and may only enter a sexual relationship with a former client under the most rare and unusual circumstances as articulated in Standard 10.08. The goal of each of these standards is to ensure that psychologists' objectivity and judgment do not become impaired and that clients are not exploited or harmed. It is essential that clients and prospective clients trust that psychologists will prioritize clients' welfare and that all decisions and actions by the psychologist will be motivated by clients' treatment needs and best interests.

Conflict of Interest

To help family and couple therapists make decisions about which multiple relationships are likely to be helpful and appropriate and which ones should be avoided, the APA Ethics Code states in Standard 3.06, Conflict of Interest:

> Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation. (APA, 2017a, p. 6)

This guidance is consistent with the recommendations made above and can form the basis of an ethical decision-making process when making decisions about whether to engage in certain boundary incursions or multiple relationships. Family and couple therapists should also consider Standard 3.04, Avoiding Harm, and Standard 3.08, Exploitative Relationships, when making these decisions.

LEGAL ISSUES IN FAMILY AND COUPLE THERAPY

There are several issues relevant to the practice of family and couple therapy that are regulated by state laws. These include the licensure law (and related regulations) in the clinician's state of licensure as well as additional laws passed by the state's legislature that are relevant to all licensed health professionals in that state. Examples of these laws include legally mandated exceptions to confidentiality such as the requirement to report suspected abuse or neglect of a minor client; the duty to report suspected abuse or neglect of older adults or other vulnerable adults; and laws relevant to the duty to warn and protect when threats of harm are made regarding other individuals to the family or couple therapist. Other laws pertain to clients' involvement in legal proceedings and the ability to share treatment information with other health providers. Each of these should be reviewed with clients as part of the informed consent process. Because the exact wording and requirements of these laws may vary by jurisdiction, it is recommended that family and couple therapists educate themselves about such laws in their state of licensure. These typically can be found on each licensure board's website.

Exceptions to Confidentiality

Confidentiality is defined as "the secret-keeping duty that arises from the establishment of the professional relationship psychologists develop with their clients" (Younggren & Harris, 2008, p. 589). Without an assurance of confidentiality, clients may not feel safe enough to open up and do meaningful therapeutic work. Yet, confidentiality is not absolute and exceptions to confidentiality exist. These exceptions attempt to strike a balance between the need for privacy—to encourage potential clients to feel safe enough to seek needed treatment—and the need to protect

vulnerable individuals from harm. Individuals are typically considered vulnerable when they rely on others for their day-to-day care or protection. Examples include minors as well as adults who do not live independently and rely on others for their ongoing care. Family and couple therapists are required to inform clients of all required exceptions to confidentiality at the outset of the professional relationship. Informing clients of the confidential nature of treatment as well as the limits to this confidentiality is a crucial part of the informed consent process.

Child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (U.S. Department of Health and Human Services, 2010) defines *child abuse* as "any recent act or failure to act on part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation" or "an act or failure to act which presents an imminent risk of serious harm" (para. 2). *Neglect* is defined as "a failure to meet the child's basic needs, e.g., not providing enough food, shelter or basic supervision, necessary medical or mental health treatment, adequate education or emotional comfort" (APA, 2015, para. 3).

In 2012, U.S. state and local Child Protective Services (CPS) received an estimated 3.4 million referrals of children being abused or neglected. Of the child victims, 78% were victims of neglect; 18% of physical abuse; 9% of sexual abuse; and 11% were victims of other types of maltreatment, including emotional and threatened abuse, parents' drug or alcohol abuse, or lack of appropriate supervision (U.S. Department of Health and Human Services, 2012).

It has been found that mandated reporting issues negatively affect family therapists' abilities to maintain a systemic focus (Strozier et al., 2005). Thus, it is important for family and couple therapists to remain aware not only of the mandated reporting laws in their practice jurisdiction but also the impact of reporting on the therapy relationship in order to competently protect and treat their clients.

Elder adult abuse and neglect. *Elder abuse* and *elder neglect* are defined respectively as intentional or unintentional actions that cause harm or create a serious risk of harm to a vulnerable elder by a caregiver (Bonnie & Wallace, 2003). State laws on this issue vary, with some referring only to older adults and others addressing vulnerable adults in general. Additionally, some state laws mandate the reporting of suspected abuse and neglect, whereas others also include self-neglect and exploitation of these individuals.

Between 7.6% and 10% of vulnerable adults are subject to abuse, neglect, self-neglect, and/or exploitation each year (Acierno et al., 2010). Due to the high prevalence of these experiences, in working with families or couples it is likely that therapists will come into contact with these difficult situations at some point in their careers. It is important for family and couple therapists to be aware of the statistics as well as the warning signs of elder abuse. As in other legal scenarios, it is crucial for therapists to competently assess all relevant clients for signs of abuse and neglect, have knowledge of mandated reporting laws, and be sensitive to the impact that reporting suspicions of abuse and neglect may have clinically on families and couples.

Duty to warn and protect. The *duty to warn and protect* applies to situations wherein a client makes a threat to do harm to an identifiable victim or group of victims. *Warning* involves making a good faith effort to contact the intended victim and *protecting* involves contacting the police. However, each state has its own laws on these matters, with some having a duty to warn law, some having a duty to protect law, some requiring both, and some states not allowing clinicians to breach confidentiality in these situations (Werth, Welfel, & Benjamin, 2009). In many jurisdictions, the duty to protect allows clinicians to address dangerousness in treatment (e.g., intensifying outpatient treatment, seeking hospitalization, modifying medication treatment). If such actions remove the chance of the threat being acted upon, the clinician does not need to breach confidentiality by warning the potential victim (Werth et al., 2009).

Unfortunately, as Kämpf, McSherry, Thomas, and Abrahams (2008) reported, these laws are often highly complex, leading to frequent misunderstandings among mental health clinicians about their

responsibilities in these situations. Additionally, Pabian, Welfel, and Beebe (2009) found that 76.4% of psychologists they surveyed "were misinformed about their state laws, believing that they had a legal duty to warn when they did not, or assuming that warning was their only legal option when other protective actions less harmful to client privacy were allowed" (p. 8). Because these decisions are often complex and can have significant implications for the parties involved, it is recommended that family and couple therapists familiarize themselves with relevant state laws and utilize consultation and ethical decision-making models when responding to these situations.

Additional Legal Issues in Family and Couple Therapy

Additional legal issues that are likely to arise in the practice of family and couple therapy involve providing treatment when child custody issues are present and responding to subpoenas and court orders. These are such common occurrences that each family and couple therapist is advised to be prepared for these eventualities.

Child custody. In treating families with minors, therapists must be cognizant of custodial issues. It is important to clarify custodial rights from the outset, obtain documentation of these rights (e.g., a copy of a court order), and to only provide treatment to minor clients with appropriate legal authorization. Additionally, doing this work requires the therapist to ask important legal questions such as "Who will participate in treatment?", "Who has the right to consent to treatment?", "Who will pay for treatment?", "Who has the right to release records?", and "Who has access to the information about therapy?" (Lebow & Rekart, 2007). When treating families who are going through or considering divorce, a treatment contract that clarifies the nature of the professional services being provided is essential to include in the informed consent process.

Family or couple therapists should make it clear at the outset of treatment that psychotherapy is being provided, that this therapy does not consist of a child custody evaluation, and that no recommendations for custody will be made in court. This is essential because the roles of treating therapist and forensic evaluator are very different roles that are inconsistent with each other. Family and couple therapists are their clients' advocates; they accept clients' statements at face value and work with the goal of assisting clients to achieve their stated goals. Forensic evaluators, in contrast, should be objective third parties with the goal of evaluating everyone in the family unit so that recommendations regarding the child's best interests may be made to the court. Serving in both capacities for a family or couple creates an inappropriate conflict of interest that jeopardizes the caring relationship and trust needed to be an effective therapist as well as the objectivity and neutrality needed to be an effective forensic evaluator.

Subpoenas and court orders. Other scenarios that may potentially arise when providing family or couple therapy involve responding to subpoenas and court orders. Without a court order, therapists do not release confidential information about clients unless there are specific releases of information that the clients have approved in writing. When court orders are mandated, therapists should inform the family or couple of the nature of the order as well as the limits of confidentiality before proceeding. Furthermore, family therapists may only provide testimony on the treatment they have provided, what has been reported to them and by whom, and what they have observed. They should not make child custody recommendations or give opinions on legal matters, since they have not conducted an objective evaluation of each of the parties involved.

Court orders are issued by judges and must be complied with or the therapist may risk the consequences of being held in contempt of court. Subpoenas, however, are issued by attorneys. Although they cannot be ignored, therapists should not immediately comply with them by releasing ordered treatment records. Subpoenas do not carry the weight of court orders, and there are several possible ways of responding to them without releasing confidential client information without the client's permission. An important first step when receiving a subpoena is to contact one's

own attorney for guidance on how to respond to it. Additional guidance is provided in the APA Committee on Legal Issues' publication on strategies for dealing with subpoenas (APA Committee on Legal Issues, 2006).

RECOMMENDATIONS FOR THE ETHICAL AND LEGAL PRACTICE OF FAMILY AND COUPLE THERAPY

As has been highlighted previously, multiple ethical, legal, and clinical challenges are associated with the practice of family and couple therapy. However, with forethought and ongoing attention to the issues addressed in this chapter, family and couple therapists may competently assist their clients in a manner consistent with the highest standards of their profession. Specific recommendations to consider include the following:

- Be sure to possess needed competence before providing clinical services to families and couples. Obtain the necessary scientific knowledge and develop the required clinical skills to effectively provide clinical family and couple therapy services. If unsure of the competencies needed to work with these populations, review relevant practice guidelines and consult with colleagues who possess recognized expertise in family or couple therapy.
- Attend to multicultural competence as an essential element of one's professional competence overall. Obtain the needed education, training, and supervised experience to effectively work with clients from a wide range of backgrounds. Be aware of one's own biases, prejudices, and privileges, along with stereotypes one may hold, and how they may impact one's interactions with clients. Remain open to alternative family and couple constellations and multiple ways to engage in healthy relationships. Be sure to address diversity, in all its forms, as it may be relevant in work with clients.
- Provide every client with the opportunity to give her or his fully informed consent to all treatment services before treatment is initiated. Help clients understand treatment options and alternatives available to them and their relative risks and benefits. Ensure that clients understand what they are agreeing to and that their consent is provided voluntarily. With families and couples, it is important to address in advance how individual communications with the therapist between sessions will be handled, including whether they will be kept secret or shared at the next treatment session.
- With clients who do not have the legal right to provide their own consent to treatment, including minors, obtain their assent by explaining the parameters of the proposed treatment and including these clients in informed consent discussions and decision making to the extent that their developmental level and level of understanding allow.
- With families and couples, conceptualize informed consent and assent as ongoing processes that assist the therapist in clarifying clients' expectations and needs and the therapist's obligations to each of the individuals involved.
- Be cautious about multiple relationships with families and couples. It may be common to treat an individual who seeks family or couple therapy as the client. Clarify all roles and relationships from the outset and be sure to remain objective and impartial in this new role, clarifying the identity of one's client (e.g., the family, the couple). Make the treating therapist's role clear and state that a forensic evaluation is not being conducted.
- Become familiar with all the laws and regulations in one's practice jurisdiction that are applicable to family and couple therapy. Give particular attention to mandatory reporting requirements regarding the suspicion of abuse and neglect of minors and other vulnerable individuals, including elderly and/or developmentally delayed adults who rely on others for their day-to-day care and well-being, and duty to warn and protect laws that are relevant to client threats to harm identifiable individuals. Be mindful of legal definitions and thresholds for taking action. The requirements of these laws, definitions of key terms, and thresholds for taking required action vary by jurisdiction. Whenever faced with these

situations, consult with experienced colleagues and utilize an ethical decision-making model for assistance in determining the most appropriate course of action.

- When minor children are to be involved in treatment, clarify custodial arrangements by obtaining official documentation that specifies each parent's rights regarding health care decision making before treatment begins. Never treat minor clients without the appropriate legal authorization to do so.
- Be cautious about releasing confidential information and taking all reasonably available steps to protect client confidentiality. When requests for treatment information are received, confer with clients to determine their preferences. Do not release confidential information unless ordered by a court to do so or if the client provides written authorization to do so.

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