Ethical and Clinical Practice Guidelines

For Psychotherapists and Counselors

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Guidelines

1. Bartering p. 2
2. Confidentiality p. 4
3. Dual Relationships p. 7
4. Ethical Risk Management p. 9
5. Fees p. 13
6. Gifts p. 16
7. Record Keeping p. 18
8. Subpoenas p. 21
9. Termination p. 23
10. Touch p. 25

These guidelines are meant to be aspirational and general, as they may not apply in certain states, professions, situations and for all clients and settings. Clinical and ethical applications of these guidelines must always take into consideration client, setting, therapy and therapist factors.

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1. BARTERING

- In planning on entering into a bartering agreement, therapists must take into consideration the welfare of the client, his/her culture, gender, history, condition, wishes, economic status, type of treatment, avoidance of harm and exploitation, conflict of interest and the impairment of clinical judgment. These are the paramount and appropriate concerns.
- Make sure that the client involved in the negotiation fully understands and consents, in writing, to the agreement.
- Include the bartering arrangement in the document that explains the payment agreement and have the client sign the appropriate informed consent.
- Make sure that your office policies, when appropriate, include the risks and benefits of bartering and that they are fully explained to, read to and signed by your clients before you implement them.
- The bartering arrangement must be well documented in the clinical notes.
- Make sure that the bartering agreement is consistent with and is not in conflict with the treatment plan.
- It is important to realize that bartering can be counter-clinical in some situations, such as with borderline clients or those who see themselves primarily as victims.
- Do not let fear of lawsuits, licensing boards or attorneys determine your fee agreements, treatment plans or clinical interventions. Do not let dogmatic thinking affect your critical thinking. Act with competence and integrity while minimizing risk by following these guidelines.
- Remember that you are being paid to provide help and care not to practice risk management.
- Differentiate when and what types of bartering are best suitable to each client and situation.
- Consult with clinical, ethical or legal experts in complex cases and document the consultations in your clinical notes.
- Attend to and be aware of your own needs through supervision and consultations.
- At the heart of all ethical and clinical guidelines is the mandate that you act on your client's behalf and avoid harm. That means you must do what is helpful, including bartering, when appropriate.
- Keep excellent written records throughout treatment if or when problems and complications arise with regard to the bartering agreement.
- Evaluate the effectiveness and appropriateness of the bartering arrangement regularly and change it if necessary through discussion with and, hopefully, consent from your client.
- If complications, negative feelings or disagreements arise due to the bartering agreement, discuss it with your client, get consultations and change it in a way that will be most helpful to the client and conducive to therapy.

**Online course on Bartering:**

2. CONFIDENTIALITY

- **Confidentiality** is considered the cornerstone of the psychotherapeutic relationship. Without an expectation of confidentiality why would any patient or client divulge to a mental health professional his or her most sensitive issues and secrets? Yet, absolute confidentiality does not exist. At best we may promise relative confidentiality. And we are still able to provide quality clinical services to individuals in need despite the ever-present tension between keeping things in confidence and disclosing information when deemed necessary.

- **Privacy, Confidentiality & Privilege:** Privacy, confidentiality, and privilege are different but related concepts that are of great importance to every mental health professional and to those we serve. Without an adequate understanding of these concepts we risk engaging in unethical, illegal, and potentially harmful behavior. Privacy is a basic right granted to all our citizens; confidentiality is an ethical concept pertaining to the psychotherapeutic relationship; and privilege is a legal concept regarding who has the right to release confidential information.

- **Limits to confidentiality:** While most consumers believe that everything they share with their psychotherapist is confidential, a number of limits to confidentiality exist to include mandatory reporting requirements for suspected child abuse and neglect; vulnerable adult reporting requirements that may include suspected abuse, neglect, self-neglect, and exploitation of the elderly and other individuals dependent on others for their care; and duty to warn and protect requirements regarding threats to harm others made in treatment. (For an update on the Tarasoff ruling in CA and how it affects clinicians, go to: [http://www.drzur.com/tarasoff.html](http://www.drzur.com/tarasoff.html).)

- **Informed Consent:** Just how we address the limits of confidentiality through the informed consent process is of great importance and has significant implications for how the therapeutic process transpires. Informed consent is an ongoing process that should begin at the outset of the professional relationship. The client must be competent to consent, consent must be given voluntarily, and we must ensure that the client understands what s/he is agreeing to. (For an online course that includes the Office Policies Form, go to: [http://www.drzur.com/informedconsentcourse.html](http://www.drzur.com/informedconsentcourse.html). For Essential Clinical Forms go to: [http://drzur.com/forms.html](http://drzur.com/forms.html).)

- **Minors, Families, and Groups:** When working with minors, families, and groups, there are a number of special issues that must be addressed up front
that concern confidentiality expectations. While minors may not legally be able to consent to their own treatment, we still must explain relevant treatment information to them in a manner they can understand. With families and groups, clients need to understand that one person cannot waive privilege for another.

- **Minors and Laws:** Understanding the relevant state laws is important when working with children and adolescents since their confidentiality rights may vary depending on age and other circumstances. In some jurisdictions minors over age 16 may consent to their own treatment and decide who may have access to treatment information. Additionally, 'mature' or 'emancipated' minors (typically those who are married or in the military) have the same rights as adults to consent to treatment.

- **Office Practices:** A thorough understanding of effective office practices is essential for preventing inadvertent breeches of confidentiality. Important steps include soundproofing, record storage and disposal practices, the use of technologies to include computers and fax machines, and the training of staff not to release confidential information without specific authorization.

- **Forensic Settings:** Knowledge of privilege rights and related procedures is essential when working in the forensic setting and in any situation involving the courts. While we must comply with a court order from a judge, psychotherapists do not necessarily need to comply with a subpoena. We also have the opportunity, through an attorney, to file a motion to quash a subpoena or to have a judge do an in-chambers review of records to see if they are relevant to the legal proceeding before ordering their release.

- **Technology:** The use of technology brings with it a number of important confidentiality challenges and concerns that each mental health professional should be aware of and address prior to using these technologies. The use of password protection and encryption are useful for protecting computer records. If your computer is networked or connected to the Internet, the use of firewall and virus protection are important to help prevent unauthorized access to and release of confidential materials in your computer. Ensuring care when punching in fax numbers and the use of a cover sheet stating the confidentiality of the materials being sent are useful as well. (For an online course on Telehealth that discusses confidentiality considerations in e-therapy, go to [http://drzur.com/telehealthcourse.html](http://drzur.com/telehealthcourse.html).)

- **Insurance and Managed Care:** Working with insurance and managed care companies brings with it additional risks to clients' confidentiality. Understanding how insurance carriers may share and release information sent to them has a great impact on how we document our services and just
what we share with them. We should share only the minimum amount of information needed to meet utilization review requirements knowing that once we share the information the ability to control who has access to it is out of our hands.

- **Court Ruling & Case Law:** Court rulings, such as Nagle v. Hooks and Jaffe v. Redmond, have significant implications for each practicing mental health professional who endeavors to protect a client's confidentiality. In divorce/custody situations in court, a court-appointed guardian becomes the child's holder of privilege in the context of the legal situation. In Federal courts clients retain their privilege rights, and one cannot be ordered to share information about or from their psychotherapy. Knowing this is vital for ensuring we do not violate the rights of those we are trying to help.

- **Consultations:** Consulting with experts can help you navigate the ethical and legal complexities of confidentiality and help you assure that you practice within the reasonable standard of care of your profession.

**Online course on Confidentiality:**

http://www.drzur.com/confidentialitycourse.html
3. DUAL RELATIONSHIPS

**Treatment plans:**
- Develop a clear treatment plan for clinical interventions that is based on the context of therapy. As indicated above, the context includes client, therapy, setting and therapy factors. Client's personality, culture, DX, gender, etc., are of the highest importance in determining the TP.
- Intervene with your clients according to their needs, as outlined in each of their treatment plans, and not according to any graduate school professor's or supervisor's dogma or even your own beloved theoretical orientation.
- Some treatment plans may necessitate dual relationships; however, in other situations dual relationships should be ruled out. Make sure you know the difference.
- If planning on entering a dual relationship, you must take into consideration the welfare of the client, effectiveness of treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment. These are the paramount and appropriate concerns.
- Do not let fear of lawsuits, licensing boards or attorneys determine your treatment plans or clinical interventions. Do not let dogmatic thinking affect your critical thinking. Act with competence and integrity while minimizing risk by following these guidelines.
- Incorporate dual relationships into your treatment plans only when they are not likely to impair your clinical judgment or create a conflict of interest.
- Do not enter into sexual relations with a client, as it is likely to impair your judgment and nullify your clinical effectiveness.
- Remember that treatment planning is an essential and irreplaceable part of your clinical records and your first line of defense.
- Consult with clinical, ethical or legal experts in very complex cases and document the consultations well.

**Prior to and during therapy that includes dual relationships:**
- Study the clinical, ethical, legal and spiritual complexities and potential ramifications of entering into dual relationships.
- Attend to and be aware of your own needs through personal therapy, consultations with colleagues, supervision or self-analysis. Awareness of your own conscious and unconscious needs and biases helps avoid cluttering the dual relationship.
- Before entering into complex dual relationships, consult with well-informed and non-dogmatic peers, consultants, and supervisors.
- When you consult with attorneys, ethics experts and other non-clinical consultants, make sure that you use the information to educate and inform yourself rather than as clinical guidelines. Separate knowledge of law and ethics from care, integrity, decency and, above all, effectiveness. Remember you are paid to help and heal, not to protect yourself.
- Discuss with your clients the complexity, richness, potential benefits, drawbacks and likely risks that may arise due to dual relationships.
- Make sure that your office policies include the risks and benefits of dual relationships and that they are fully explained to, read by and signed by your clients before you implement them.
- Make sure your clinical records document clearly all consultations, substantiations of your conclusion, potential risks and benefits of intervention, theoretical and empirical support of your conclusion, when available, and the discussion of these issues with your client.

**Clinical integrity and effectiveness:**
- Remember you are setting an example. Model civility, integrity, emotionality, humanity, courage, and, when appropriate, duality.
- As a role model, telling your own stories can be an important part of therapy. Make sure that the stories are told in order to help the client and not to satisfy your own needs.
- Remember that you are being paid to provide help. At the heart of all ethical guidelines is the mandate that you act on your clients' behalf and avoid harm. That means you must do what is helpful, including dual relationships, when appropriate.
- Answer clients' basic and legitimate questions about your values and beliefs, including your thoughts on dual relationships.
- Continue to keep excellent written records throughout treatment. Keep records of all your clinical interventions, including dual relationships, additional consultations and your own and your clients' assessment of treatment and its progress.
- Regularly evaluate and update your approach, attitudes, treatment plans and, above all, effectiveness.
- If you find yourself in a dual relationship which either is not benefiting the client or is causing distress and harm, or has unexpectedly brought about conflict of interest, consult and, if necessary, stop or ease out of the dual relationship in a way that preserves the client's welfare in the best possible way.

**Online course on Dual Relationships:** [http://www.drzur.com/drcourse.html](http://www.drzur.com/drcourse.html)
4. ETHICAL RISK MANAGEMENT

- Always do whatever it takes to help clients while insuring that you do no harm to them in the process.
- Never exploit a client. Place the clients’ interest above your own and avoid situations where there are conflicts of interest.
- Always show respect for your clients, taking care never to humiliate them or assail their dignity.
- Place clients' welfare above your fear of boards, courts, ethics committees and attorneys. Putting your fear above clinical effectiveness is immoral, unethical and may be illegal.
- Remember - you are not paid to practice defensive medicine or risk management. Your duty is to help clients with the concerns and problems they are paying you to remedy.
- Intervene with your clients according to their problems, concerns, needs, gender, personality, situation, venue, environment and culture.
- Provide a safe and trusting place for healing and growth. Cold, distant, disconnected and punitive relationships do not promote healing and are likely to harm clients.
- Protect and respect the clients' privacy and confidentiality unless by doing so you would fail to safeguard the client, community, society, etc., from harm or as required by the law.
- Intervene with your clients in a way that is most likely to be clinically effective. Do not intervene according to any graduate school professor or supervisor's dogma or even your own beloved theoretical orientation. In other words, different problems often require different clinical interventions. Technical eclecticism is often the most helpful approach.
- Be aware of the standard of care in your community. This is often referred to as the usual and customary professional standard of practice in the community. It has been described as the qualities and conditions that prevail or should prevail in a particular mental health service. The standard of care is the standard that a reasonable and prudent practitioner follows and is based on community and professional standards.
- Adhere to the following different components or aspects of the standard of care:
  - Statutes, such as the child or elder abuse reporting laws.
  - Licensing boards' regulations, such as those on supervision.
  - Ethical principles of your professional associations that are most
relevant to your practice and/or profession.
  o Case law, such as the duty to warn.
  o Consensus of the professionals and the community as often articulated in professional literature or continuing education workshops.
  o Official guidelines published by professional associations, such as guidelines for child custody, record keeping or forensic evaluations.
  o Professional literature regarding recent research findings, new theoretical developments, etc.
  o Professional standard practices within certain established theoretical orientations, such as psychoanalytic, humanistic or cognitive behavioral therapy.

- For each client develop an individualized treatment plan which articulates:
  o Presenting problem or the problem(s) you are attending to.
  o The objectives of treatment. Developing short, intermediate and long-term goals may be beneficial in some cases.
  o The means employed to achieve these objectives and the theory, research or philosophy that guide you in choosing the intervention.
  o Ways to assess the effectiveness of the intervention.

- Make sure to update the treatment plan, as necessary.

- Keep good records. Your records are extremely important from clinical, ethical, legal and risk management points of view. Make sure that your records include:
  o Informed consents and office policies
  o Initial and updated treatment plans
  o Records of consultations, tests, etc.
  o Releases or authorization to release information
  o Important phone conversations, correspondence, e-mails and faxes to and from clients
  o Details about termination, who initiated it and how was it was carried out
  o Referrals to medication evaluations and other tests and evaluations, other mental health professionals, twelve step or drug and alcohol rehabilitation programs, physicians, dieticians, physical training, smoking cessation programs, attorneys and other resources
  o HIPAA compliance when applicable

- Consult with experts and educated colleagues for their input and assistance in complex and unusual cases. Choose an expert in the area and topic of the consultation. Differentiate between clinical, ethical and legal concerns and choose your consultants accordingly. Document the consultation in your
clinical notes. Of course, it is just as legitimate to seek risk management consultation, as well.

- There are several types of cases or situations that merit our special attention and higher level of cautiousness because historically they have presented challenges to therapists. Some of these types of cases are:
  - Child custody
  - Repressed memory
  - Domestic violence
  - Child abuse

- There are several types of clients and Dx that merit our special attention. Some of these are:
  - Borderline Personality
  - Repressed memory
  - Paranoid
  - Suicidal and homicidal
  - Antisocial
  - Drug and alcohol addiction
  - Clients with a history of litigation
  - Multiple Personality and other dissociative disorders

- Never have sexual contact or sexual relationships with current clients.

- Be very careful and cautious before entering into sexual relationships with former clients. Seek ethical, clinical and legal advice before entering into such relationships.

- Handle clients' debts with sensitivity. Be very cautious before resorting to debt collection agencies as it may trigger clients' complaints to licensing boards.

- Practice within the limits of your expertise and within your scope of practice as determined by your education, supervised training and clinical experience.

- Work collaboratively with other health care providers or other professionals when appropriate.

- Respect and protect clients' confidentiality, privacy and autonomy unless by doing so you would fail to safeguard the client, community, society, etc., from harm or as required by the law. Obtain releases before releasing information.

- Terminate thoughtfully. Prepare for termination and offer referrals and follow-ups when appropriate. Document clearly: who initiated it, when, the nature of the discussion, and potential referrals. Summarize the whole treatment in the records: what was achieved, to what extent, what was not
achieved according to the last treatment plan.
- If the client terminates abruptly against your clinical judgment: Send a polite letter expressing your concerns in a clinically appropriate and sensitive way. Offer to continue therapy or to refer the client to another therapist. Add that you will be willing to help with the transition to another therapist if the client requests it. (Of course, get a written release before you discuss the case with anyone.)
- Follow your state, professional and ethical rules and guidelines about supervision. Remember that you are responsible for the welfare of your supervisees' clients.
- Collect and document collateral information when appropriate.
- Prevent your own burnout by creating balance in your life. Such balance includes balance between professional work, familial, recreational, communal, political and/or spiritual activities.
- Be thoughtful with boundary crossing, such as home visits and other out-of-office experiences, gifts, bartering, touch, and self-disclosure. Document these interventions and, when appropriate, include them in the treatment plans and ground them in a theoretical orientation.
- Be thoughtful with dual relationships. While many forms of dual relationships are unavoidable, ethical and potentially helpful, therapy never involves sexual or exploitative business relationships. Document all dual relationships; include a statement on dual relationships in the office policies and the informed consent; and consult on complex cases. Avoid dual relationships that, in your assessment, may result in a decrease in objectivity or clinical judgment.
- Pay attention to vicarious liability, such as renters or co-workers.

**Online course on Ethical Risk Management:**
5. FEES

- Money is one of the more complex issues facing therapists and clients, especially at the beginning of treatment, and many therapists tend to avoid exploring this important topic.
- Money is one of the most important parameters that define psychotherapy. Gutheil and Gabbard write, "Money is a boundary in the sense of defining the business nature of the therapeutic relationship. This is not love; it's work" (1993, p. 192). Thus the fee and fee arrangement are important determinants of the nature of the therapeutic process and the boundary of the patient-therapist relationship.
- In the section on 'Fees and Billing' in therapists' office policies, therapists should try to clearly provide details explaining the following: fees, consequences of missed sessions, late cancellation, debt collection policies, insurance reimbursement, etc.
- Therapists should try to come to an agreement with their clients as soon as possible on the fee structure. Some of the most common options are:
  - Full fee
  - Sliding scale
  - No fee
  - Bartering for goods
  - Bartering for services
- While most therapists come to an agreement on a certain fixed rate, others agree on a rate that fluctuates with clients' income or other considerations. Regardless of what the arrangement is, therapists should try to document the agreement and, when necessary, its rationale. At times signed consent by clients is advisable.
- The sliding scale is a very common and acceptable form of fee arrangement. This allows clients to pay what they can afford in a flexible, individually tailored way. As with any fee arrangement, therapists should try to clearly articulate, preferably in writing, and agree upon the arrangement. The concern with the sliding scale is that it can put therapists and clients in a conflict of interest, where clients may have an investment in presenting a scaled down financial picture in order to obtain a lower rate. If this negotiation takes place at the beginning of therapy, it can contaminate the therapeutic relationship. Some factors, such as retirement investments, upcoming inheritance, etc., cannot be easily factored into the equation of the sliding scale.
- Therapists should take into account the ethical considerations of fees. For a summary of the Codes of Ethics on fees and payment issues, http://www.drzur.com/ethnicsoffee.html
- The therapist should try to come to a fee agreement as soon as possible after the
There is a view among therapists that clients who pay more for therapy value it more and are likely to benefit more from clinical work. Some go further and suggest that the higher the financial and other sacrifices clients make for therapy, the more likely the client is to gain from therapy. These (most probably) self-serving beliefs are not conclusively supported by research. Some research has shown that those patients who are engaged in no-fee therapy neither value it less nor gain less than those who pay.

Sometimes patients' financial situations change in the course of therapy. Sometimes patients lose their jobs, homes or health insurance, get sick or are faced with unexpected new financial burdens. Therapists should be open to and flexible about changing the fee arrangements to accommodate changes in clients' lives.

Therapists should not engage in misdiagnosis in billing.

Therapists should report procedure codes accurately, i.e., use individual code only for individual sessions.

The fee is also a clinical issue. Therapists should try to be flexible and sensitive about money issues. Different fee arrangements have different meanings for different clients. Therapists should explore these meanings when and if appropriate.

Therapists should allow for free or very low fee sessions in their practices.

Therapists should document all fee arrangements and if or when they change.

Different theoretical orientations sometimes guide the type and extent of discussion regarding fees. Psychodynamic psychotherapists are more likely to focus on unconscious, transferential and counter-transferential dynamics regarding fees. Feminist therapists may focus on justice issues and reducing the power differential between therapists and clients by reducing the fee.

Different settings may require different approaches to fee setting. Agricultural and rural communities are likely to be more accepting of bartering of goods.

Therapists should consult with an expert colleague whenever concerns arise, and of course, document the consultation.

When appropriate, therapists should educate their clients about the benefits of private pay and the risks of managed care in regard to confidentiality, privacy, continuity, control of care, etc.

Therapists should be flexible with missed sessions and late cancellations due to illness, transportation problems, etc.

Therapists should be careful with bartering arrangements. Bartering for goods, especially when one can assess their fair market value, is often less complicated and less complex than bartering for services. Unlike bartering for goods,
bartering for services is always a dual relationship. Therapists should try to consult in complex cases. (For extensive article on bartering, http://www.drzur.com/bartertherapy.html)

- Billing methods have changed drastically since the introduction of HIPAA in 2003. Most experts agree that even if you do not submit electronic billing it is important to be HIPAA compliant. This is because HIPAA is most likely to become the standard of care. (For HIPAA general info, http://www.drzur.com/hipaa.html. For HIPAA related billing information, http://www.drzur.com/billing.html)

- Therapists should be careful of the accumulation of debt by clients. Large debts by clients tend to be clinically very tricky and burdensome. If the therapist does let a client accumulate debt, s/he should try to document the reasons (i.e., patient's house is on the market) and should try to consult in complex cases.

- Therapists should collect debts with caution. Therapists should think twice before using a collection agency, because you increase the likelihood of a complaint being filed against you with your licensing board. Therapists should make sure debt collection is mentioned in the office policies. Before therapists inform their clients that they are about to submit the debt to collection, they should send a couple of letters inviting the client to develop an affordable payment plan.

- Fee splitting, or what is better known as a "kickback", is a practice where a referral source gets a fee for their services. While common in medicine, business and law, it is more complex in mental health. This is both an ethical and legal concern as it indirectly draws a third party into the therapeutic relationship and can also create a conflict of interest. The APA Code of Ethics (2002) is very clear on the issue of referral fees. In section 6.07 Referrals and Fees it states: "When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself." While some fee splitting is legal and regulated by the Federal Trade Commission (FTC), it may still present a boundary and ethical issue for psychotherapists.

- It is important that therapists should explore their own personal thoughts, feelings and issues in regard to money. Many clinical and ethical complications stem from therapists' mishandling of money due to their ambivalence about money issues and lack of training and education in how to handle it.

Online Course on Fees in Therapy: http://www.drzur.com/feesintherapycourse.html

Guidelines, Zur, P. 15
6. GIFTS

Generally, there is not one right way to deal with gift-giving in therapy. How therapists, ethically and clinically, appropriately handle gift-giving is determined by their culture, theoretical orientation, training, history, clientele (i.e., clients' factors, such as culture, history, Dx) and setting and context of therapy. Keeping this in mind, following are some general guidelines for gift-giving in psychotherapy and counseling:

- Explore your own attitudes, thoughts and feelings towards gift-giving in general and, more specifically, gift-giving in psychotherapy by clients and by therapists.
- Be aware that appropriate gift-giving is neither boundary violation nor unethical nor below the standard of care.
- Do not uncritically reject clients' appropriate gifts out of fear of ethics committees, licensing boards or courts. You are being paid to help your clients, not to practice risk management. The good news is that thoughtful and competent therapists can simultaneously serve their clients well and protect themselves.
- Do not indiscriminately reject all clients' gifts. This is likely to lead to clients feeling rejected and insulted and, in turn, harm the therapeutic alliance and clinical progress.
- Having pre-existing "No-Gifts" policies does not prevent a client's sense of rejection or insult when their gift is rejected. Such policies can also eliminate the potential therapeutic benefits of gift giving and receiving.
- Remember that while traditional analytically oriented therapies frown on gift-giving, most other therapeutic orientations, such as humanistic, behavioral, feminist, family, child and adolescent or group therapies, view appropriate gift-giving as a potentially valuable way to enhance therapeutic alliance and therapeutic outcome. Get clarity on what your relationships are to gift-giving in the context of your primary theoretical orientation.
- It is very important that, whenever it is appropriate, you express gratitude and thank the client for the present.
- When given a present by a client, if you are inclined to, try first to assess its meaning, symbolism and appropriateness. Besides the actual present, take into consideration the timing of the gift-giving, client's culture, history, presenting problem and Dx, the therapeutic relationships, the setting and the context of therapy.
- Evaluate and appraise the meaning, symbolism and appropriateness of the
gift in regard to its content. Evaluate the content also by considering the client's individual and unique experience relative to the symbolic meaning of the gift.

- While it is important to note whether the content of the gift is sexual, offensive or illegal, even in situations where you may not accept the gift, it is still as important to understand the meaning and intent of the gift from the client's perspective.

- It is very important not to initiate a discussion prematurely or compulsively on the meaning or symbolism of the gifts. Such discussion should be carried out with thoughtfulness and clinical sensitivity. Some situations may call on the therapists to simply express gratitude and nothing more. For some clients in certain situations a basic "Thank you, how thoughtful of you!" may be all that is clinically necessary.

- If you feel strongly that a non-critical acceptance of the gift is counter-clinical or unethical, it is less offensive to most clients if you discuss the process of gift-giving and their experience of it rather than the meaning of the present itself.

- If necessary, you can tell clients that you would "hold" the present in your office. This would be an option with a gift that is given at the end of a session or one that presents a clinically or ethically complex or uncertain situation. This is a way to neither accept nor reject the gift, which can be discussed and dealt with at a later time, if necessary.

- Determine if the gift may affect other people related to the client, especially when it comes to gifts that are bequests.

- If you choose to give a present to a client, treat it as any other clinical intervention or boundary crossing (i.e., self disclosure, touch) and make sure it is always done with the client's welfare in mind.

- Document all gift exchanges in therapy. Articulate who gave the gift, exactly what the gift was, what the response to the gift was and any related discussions with the client. When appropriate, add a clinical note in regard to your thoughts and interpretation of the meaning of the gift.

- Whenever possible add the gift itself into the record. This is mostly done with greeting cards or small paintings.

- Consult, in complex cases, and document the consultation in the clinical notes.

**Online Course on Gifts in Therapy:**
7. RECORD KEEPING

- Good records are the primary proof of quality of care.
- Keeping psychotherapy records is part of the standard of care.
- Assume that no records are immune from disclosure.
- Follow state, federal and professional organization guidelines for record keeping.
- Never alter records.
- The main reasons to keep records are:
  o It helps therapists provide quality care by providing therapists with continuity where they do not need to rely on their memory to recall details of their patients' lives and the treatment provided.
  o Not keeping any records is below the standard of care, is unethical and, in many states, illegal.
  o In case of civil, criminal or administrative litigation, it is often not the therapist's word against the client's, but the client's word against the psychotherapy records. Many boards make the decision of whether to pursue a case based on experts who develop their opinion from reading the clients' complaints and the therapists' records but not necessarily interviewing the therapists themselves.
  o In case the treating therapist becomes disabled, dies or cannot continue to provide care, records can help the next treating therapist with information and the clients with continuity.
- Store hard copy records in a safe, locked place that is reasonably protected from theft, intrusion, fire, earthquake, water damage and unauthorized access.
- Protect your computer records by use of password, virus protection, firewall and access log. Backup regularly, and store your backup disks off site in a secure location. Print hard copies of very important documents and use access log if necessary.
- Enter relevant information in the clinical records for each session and each meaningful contact, including important phone calls. Include date and type of service and fees, payments and copies of third party billing.
- Make sure that the records include basic demographic information, mental status exam and diagnosis or presenting problem (does not need to be DSM diagnosis, can be familial, developmental, etc.), fee agreement and treatment plan. If relevant, include risk factors, medical and other issues relevant to treatment, collateral information and request for information.
- Before treatment starts present clients with *Office Policies and Informed Consent* forms, which include information on limitation of confidentiality, fees, third party billing, client's rights, cancellation policies, etc.

- **The Office Policies and Informed Consent, may include the following:**
  - Therapist's identifying information and license #
  - Statement of confidentiality
  - When Disclosure Is Required By Law
  - When Disclosure May Be Required
  - Health Insurance & confidentiality of records
  - Litigation Limitation
  - Consultation disclosure
  - E - Mails, Cell phones, Computers and Faxes
  - Medical Records and Your Right to Review Them
  - Telephone and Emergency Procedures
  - Payment and Insurance Reimbursement
  - Mediation and Arbitration
  - Process of Therapy
  - Scope of Practice
  - Discussion of Treatment Plan
  - Termination
  - Cancellation Policies
  - Agreement & Signature

- Update your treatment plans and report on progress or lack there of, as necessary. Treatment plans usually include: Presenting problem, Dx or what you are treating, goals of treatment, interventions or means to achieve these goals, the theoretical, rational or research base for your interventions, referrals, if applicable. (For a complete Treatment Planning Manual, [http://www.drzur.com/catalog.html#7](http://www.drzur.com/catalog.html#7)).

- Records should reflect your competence, thoughtfulness, decision-making ability, capacity to weigh available options, rational for treatment selection and knowledge of clinically, ethically and legally relevant matters.

- Appropriately document special occurrences, important telephone calls, emergency, dangerousness, mandated and other reporting, consultations, testing, referrals, contact with family members, etc.

- Make sure that your records include the following forms:
  - Office Policies and Agreement for Treatment
  - Clients' demographic information, which includes how to reach them in emergencies
  - Treatment Plan
- HIPAA forms, as applicable. For HIPAA information, http://www.drzur.com/hipaa.html.
- When applicable, Consent to release information and Consent to treat a minor, test data, medical or educational reports and any relevant collateral data.
- Informed consent in forensic and custody evaluations or any other situation that requires such consent.
- Summary of termination, who initiated it, for what reason, what was achieved, any follow-up information, and referrals may be necessary. Include copies of follow-up letters, especially when clients terminate prematurely or when managed care inappropriately stops authorizing additional sessions.

- Because no records are immune from disclosure, be careful in your documentation and do not include clinically superfluous details that can cause unnecessary harm for clients or others if they are disclosed or become public.

- Document, as applicable, give the clinical rational and, when appropriate, ethical considerations for:
  - Gifts from clients, therapists or from third party to therapists, loans of books or CDs and bartering arrangement
  - Extensive use of touch or self-disclosure
  - Recording or videotaping of sessions
  - Out-of-office experiences, such as home visits, attending weddings or funerals, going on hikes, taking a client to a medical appointment, adventure therapy and clinically meaningful incidental/chance encounters
  - E-therapy, phone therapy or any other telehealth practices, including a special disclosure if these practices are the basic mode of therapy.
  - Dual relationship: The nature, extent, etc.

**Online course on Record Keeping:**
http://www.drzur.com/recordkeepingcourse.html
8. SUBPOENA

- When receiving a subpoena neither ignore nor send records. A therapist does not need to automatically response to the subpoena and uncritically send the records.
- Therapists should not release confidential and/or privileged information or surrender any documents or records to the person serving the subpoena no matter how aggressive the request is. The subpoena document should be accepted, and the psychologist should then evaluate the situation and, when necessary, obtain legal counsel regarding applicable law and resulting obligations.
- When being served with a subpoena, therapists should neither acknowledge that they know or treated the person whose records are being subpoenaed. They can simply say: "I am not allowed and cannot disclose whether or not the person noted in the subpoena is known to me or has been under my care. If the person has been my client, I could not provide any information without a signed release from that individual or a valid court order."
- Do not attempt to avoid being served a subpoena. It is unrealistic and probably unprofessional.
- After receiving a subpoena therapists should carefully determine its validity, who initiated it and whether it is in fact a court order.
- Obtaining an authorization to release information from clients is one of the better and simpler ways to deal with subpoenas.
- Contacting the clients, when appropriate, is very important. Sometimes clients are willing to sign an authorization to release information and want the therapist to respond fully to the subpoena.
- Before responding to a subpoena consider the source of the subpoena, client's welfare, other people's welfare, state and federal laws (i.e., HIPAA, Patriot Act, copyright laws), codes of ethics, and, where applicable, your contractual relationships to test publishers.
- Sometimes providing only a summary of the treatment rather than the entire file may be acceptable to clients, attorneys and courts.
- Provide the minimum information necessary. However, some situations may demand that you release the entire file.
- If a signed authorization to release form is included, but the therapist believes that the material may be clinically or legally damaging, he/she should discuss these issues with the client before releasing the records. If the client still insists on such a release, the therapist should note in their records their concerns and
should document the discussion with the client. As always, seek consultations in complex situations.

- When the subpoena request includes tests' protocols, record forms, raw data or entire test kits, be aware and cautious of copyright laws, your contract with the publisher as well as federal and state laws. Consult with expert counsel and/or explain to the judge, if and when necessary, about the potential conflict between the subpoenas, professional codes of ethics and copyrights laws.

- Do not release the Psychotherapy Notes (if you have any) unless specifically ordered by the court or have received a written authorization to release this part of the records.

- Consult with knowledgeable experts, attorneys or the attorney of your malpractice insurance.

Online Course on subpoena:
http://www.drzur.com/subpoenacourse.html
9. TERMINATION

- Clarify expectations and obligations from the outset. The Office Policies are the best way to articulate and discuss such expectations and obligations.
- Be familiar with the relevant guidelines and standards in your professions' Codes of Ethics with regards to termination and abandonment issues. Summaries of the different Codes of Ethics on Termination of Psychotherapy and Counseling, available at www.drzur.com/ethicsoftermination.html.
- Some terminations are short and swift, while others may be long and protracted. Then termination can have different meanings and be just an end of a phase in intermittent-long-term therapy. The form and type of termination depends on the client, setting of therapy, therapeutic orientation, quality and type of therapist-client relationship and the therapist.
- If necessary, review with patients their insurance coverage, limits to managed care contracts, and how utilization review may impact on termination. Set up arrangements for addressing patient treatment needs if continued authorization is denied.
- Make adequate arrangements for coverage during any periods of planned or unplanned absences.
- Provide patients with referrals to other treatment sources, if needed, and work to assist them in their transition to other health care providers.
- Do not terminate patients who are in crisis, regardless of payment issues. Provide needed treatment or help them find it elsewhere.
- Do not tacitly condone patients dropping out of treatment when your clinical judgment indicates continued care is needed. When clinically and otherwise appropriate, notify the patient of your assessment and recommendations. There is no ethical, clinical or legal mandate to send a registered letter to client. Different clients and situations may require different actions and, at times, lack of action.
- When appropriate, offer referrals and other recommendations and, when relevant, offer to help with the transition to other professionals. If clients give you written authorizations to disclose information, you can help with the transition to other care givers by providing written or verbal summaries and recommendations.
- Termination of treatment is not always a permanent ending of the professional relationship. Termination is often not relevant during, or an end of phase in, intermittent-long-term psychotherapy. These forms of therapy may continue throughout the life span of individuals and families.

- Termination is a phase of each patient's treatment. Plan for it, prepare for it, and process it. Additionally, each clinician should consider termination in light of their theoretical orientation and treatment approach, each patient's/client's diagnosis and treatment needs, and any relevant diversity factors that might impact the process.

Online Course on Termination:
http://www.drzur.com/terminationcourse.html
10. TOUCH

ETHICAL CONSIDERATION OF NON-SEXUAL TOUCH IN THERAPY

- Touch in therapy is not inherently unethical.
- None of the professional organizations codes of ethics (i.e., APA, ApA, ACA, NASW, CAMFT) view touch as unethical.
- Touch should be employed in therapy when it is likely to have positive therapeutic effect.
- Practicing risk management by rigidly avoiding touch is unethical. Therapists are not paid to protect themselves, they are hired to help, heal, support, etc.
- Avoiding touch in therapy on account of fear of boards or attorneys is unethical.
- Rigidly withholding touch from children and other clients who can benefit from it, such as those who are anxious, dissociative, grieving or terminally ill, can be harming and therefore unethical.
- Sexual, erotic or violent touch in therapy is always unethical.
- Stopping therapy in order to engage in sexual touch or sexual relationships is unethical and often illegal.
- Ethical touch is the touch that is employed with consideration to the context of the therapeutic relationship and with sensitivity to clients' variables, such as gender, culture, history, diagnosis, etc.
- Seeking ethical consultation is important in complex and sensitive cases.
- Ethical therapists should thoroughly process their feelings, attitudes and thoughts regarding touch in general and the often-unavoidable attraction to particular clients.
- Critical thinking and thorough ethical decision-making are most important processes preceding the ethical use of touch in therapy.
- Documentation of type, frequency and rationale of extensive touch is an important aspect of ethical practice.

CLINICAL CONSIDERATIONS FOR TOUCH IN PSYCHOTHERAPY

- The meaning of touch can only be understood within the context of who the patient is, the therapeutic relationship, and the therapeutic setting.
- Touch, like any other therapists' behavior and interventions, should be employed if it is likely to help clients.
- Touch increases therapeutic alliance, the factor found to be the best predictor of therapeutic outcome.
- Touch can help therapists to provide real or symbolic contact and
nurturance, to facilitate access to, exploration of, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships.

- Clinically appropriate touch must be employed with sensitivity to clients' variables, such as history, gender, culture, diagnosis, etc.
- Sensitive, attuned touch gets etched into our developing neural pathways enabling us to feel of value, and to connect emotionally with others. As such, touch can be a powerful method of healing.
- Language never completely supersedes the more primitive form of communication, physical touch. As such it can have a significant therapeutic value.
- The unduly restrictive and analytic risk management or defensive medicine’s emphasis on rigid and inflexible boundaries along with the mandate to avoid touch interferes with human relatedness and sound clinical judgment.
- Due to the absence of attention to touch in most training programs, clinical supervision, research and testing, the majority of therapists tend not to incorporate the use of touch in therapy.
- Fear, misguided beliefs and lack of training often lead to therapists employing an approach of "touch but don't talk."
- Touch that is inappropriate, sexual, cold or abusive can be harmful.
- Traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and images, while the linguistic encoding of memory is suppressed. Therefore, appropriate touch can have a significant therapeutic value.
- Disturbances in non-verbal communication are more severe and often longer lasting than disturbances in verbal language. Using touch in therapy may be the only way to heal some of these disturbances.
- To disregard all physical contact between therapist and client may deter or limit psychological growth.

GUIDELINES FOR CLINICAL AND ETHICAL TOUCH IN THERAPY.

- Touch should be employed in therapy if it is likely to be helpful and clinically effective.
- Avoiding touch due to fear of boards and attorneys is unethical and a betrayal of our clinical commitment to aid clients.
- Touch in therapy must always be employed with full consideration to the context of therapy and clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, the clients level of ability to assertively identify and protect his or her
boundaries, as well as the gender and cultural influences of both the client and the therapist.

- Touch should be used according to the therapist’s training and competence.
- Extensive touch should be incorporated into the written treatment planning.
- The decision to touch should include a thorough deliberation of the clients' potential perception and interpretation of touch.
- Therapists must be particularly careful to structure a foundation of client safety and empowerment before using touch.
- Factors that are associated with congruence are: clarity regarding boundaries, patients' perception of being in control of the physical contact, the patient's perception that the touch is for his/her benefit rather than for the therapist.
- The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.
- Permission to touch should be obtained from clients if the form involves more than a handshake. Extensive use of touch, as utilized in some forms of body psychotherapy, is likely to require a written consent.
- Touch is usually contraindicated for clients who are highly paranoid, actively hostile or aggressive, highly sexualized or who implicitly or explicitly demand touch.
- Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.
- Therapists should not avoid touch out of fear of boards, attorneys or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.
- Consultation is recommended in complex cases.
- Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.

Online Courses on Touch in Psychotherapy:
http://www.drzur.com/touchcourse.html
http://www.drzur.com/touchadvcourse.html

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