The Six Most Significant Points on Family Law and Ethics

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I find this course about family law and ethics very informative, from which I summarized six most significant points that I have learned and will be applied in my future practice.

First, I have learned that although confidentiality is a fundamental principle in therapeutic treatment and also an ethical obligation of the therapist toward clients, there are some exceptions in addition to the authorized release of information by the clients. The exceptions may include mandatory reporting of child and elder abuse, permissive disclosures when there is reasonable cause to believe the clients may have serious danger to self or to others, a court order issued by a judge that requests the release of information. Under HIPAA regulations, the therapist may also be permitted to disclose certain information without client's authorization for the purposes of the provider's treatment, payment and health care operations, with the principle of minimum necessary information (AAMFT, 2016; Murphy & Hecker, 2017).

Before taking this ethics course, I did not have a comprehensive knowledge about the limitations to the general rule of confidentiality in therapy. Now I know that under specific circumstances, I am not only allowed but also obliged to release client's information without being worried about breaching confidentiality. It is for the purpose of both compliance with code of ethics and the ultimate benefit of the client and people involved. I will be mindful about these exceptions during therapy.

It is also important to include the limitations to confidentiality in the informed consent and review these circumstances with the client prior to the outset of therapy to avoid future disputes or negative impact to the therapeutic relationship. While releasing the confidential information, I will only release the minimum amount of information necessary for the purpose of maximizing the client's confidentiality. And if in doubt, I shall rather preserve confidentiality than releasing it unless exception is triggered (AAMFT, 2016).

Second, I have learned that marriage and family therapists are legally required to report child abuse, elder abuse or abuse of other dependents to the proper authorities with merely reasonable cause to suspect such abuse, which is called “duty to report” or “mandated reporting”. Failure to do so may lead to legal charges, criminal penalties, and/or civil liabilities (Murphy & Hecker, 2017).

I never knew that my future profession is assigned the legal liability to protect those who cannot protect themselves from abuse or neglect and the therapist’s inaction may have legal consequences. This makes me a bit nervous as I have never worked in a job position that may face legal challenges. While it brings me a new perspective on my role as MFT and my responsibility for the welfare of those in-need, I also feel the pressure of staying vigilant during therapy for evidences that may trigger duty to report. Moreover, I also have concerns about the possible negative effect on therapeutic relationship after the reporting.

However I feel a bit relieved to know that it only requires a merely reasonable cause to suspect abuse or neglect, therefore as long as I act the reporting in good faith, I don’t have to worry about breaching confidentiality even if the reporting is not backed up with solid evidence. Additionally, New York State offers free mandated reporter training that equips therapists with necessary knowledge and information such as the common indicators of abuse or maltreatment to enable a more accurate assessment. The specialist who receives the report will also help determine if the information I provide can be registered as a report (NYSOCFS, n.d.). That really minimizes the chance of inappropriate reporting. In order to act for the benefit of client while preserving the therapeutic relationship, I may remind client of my duty to report which should have been indicated clearly in the informed consent prior to the start of therapy and discuss the

possibility of client's self-reporting with therapist's presence. Pros and cons of self-reporting can be openly reviewed with the client (Murphy & Hecker, 2017).

Third, I have got to know that although AAMFT Code of Ethics does not expressively prohibit dual relationship or multiple relationship, it suggests MFTs to "make every effort to avoid" such situation as it may impair professional judgement of the therapist or increase the risk of exploitation (AAMFT, 2015).

It is with much dismay that I have learned about this ethical rule regarding dual relationship. Ever since I was called by God to pursue the path of marriage and family therapy, I have been thinking of serving my church and the Chinese community in my neighborhood someday with what I learn. As both circles are comparatively small in scale, the chances to have dual relationships with either church members or community friends are pretty high, if I practice MFT in the neighborhood. I never thought about the complexity that dual relationships may bring to the therapy room.

Now that I know about its potential risk and challenge, I will be mindful to avoid dual relationships as much as I can. I may hold some educational lectures in my church and community to contribute the knowledge that I have learned about couple and family relationships. I may also give friends and family members casual advice on relationships, not as therapist but friend or family, without worrying about being unethical. I am also glad to know even if dual relationships are unavoidable in a small church and community setting like mine, I can navigate its complexity by evaluating the potential risk of harm from various dimensions of perspectives such as the ethical guidelines, theories that I apply in my practice, and contexts of the specific relationship to help me and client draw and maintain a clear boundary throughout the therapy (Hill & Malakakis, 2001). Every precautionary action that I take during therapy will be

documented properly (AAMFT, 2015). If the potential harm of dual relationship outweighs the benefits I can bring to the client, I can always provide a suitable referral.

Fourth, I have learned that when having individual sessions with minors, even though state law or HIPAA may allow parents or guardians to have access to the minor's treatment record, it is unethical for the therapist to promise the minor with confidentiality but subsequently release the record to others. The therapist should ethically advocate for the minor's privacy if parents/guardians would like to access the minor's therapy records though they have prior agreed to provide the minor with a safe and neutral ground to talk about some issues and feelings (Murphy & Hecker, 2017).

I never thought that the confidentiality of minors could be a conflict of law and ethics in therapy where the state law or HIPAA grants parents with access to the minor's treatment record while a good and ethical clinical practice may require the privacy of the minor. I learned that such paradox is not uncommon when treating minors especially when divorce or custody battle is involved (Murphy & Hecker, 2017). Therefore, it's important for me, as a therapist, to be mindful of this complex issue and get prepared both for the best interest of the minor and compliance with legal regulations.

I am glad to know that some actions can be taken in order to ease the tension between law and clinical practice. If a minor is brought to individual therapy by the parents, I can discuss the minor's confidentiality and its limitations with the parents prior to the outset of therapy and facilitate an open conversation between the minor and the parents as to what kind of information can or cannot be disclosed to the parents. The terms of confidentiality should also be explained to the minor in an understandable way. Hopefully a compromised agreement in written can be achieved to avoid future dispute. If necessary, a separate informed consent regarding

confidentiality issues can be prepared for those who may require therapist in legal proceedings (Murphy & Hecker, 2017).

Fifth, I have learned that therapists are ethically obliged to respect client's autonomy for decision making despite any value differences between them. It's considered unethical for a therapist to direct clients into making their life decisions or project the therapist's own values onto the client (AAMFT, 2015; Murphy & Hecker, 2017).

This is a significant point for me to be mindful of because in real life I am used to giving advice to people. My friends often come to me for advice when they get into trouble and I am always glad to do so by suggesting what I believe is the best solution to their problems. I am a bit worried that I may feel natural to bring the same mindset and practice to the therapy room with my clients which may lead to unethical approach that finally interferes the therapeutic process. Now I know that the two settings are totally different and it is important, as a therapist, to allow clients to make their own decisions on their presenting issues, which empowers them for the positive changes in their lives.

Although I should not make life decisions for the clients, I can facilitate them to come to an outcome they prefer. Some theories like Narrative therapy may help handle the value differences. For example, it asks the therapist to explore the values that the client holds without being judgmental, analyze the origin of those values, identify any potential obstacles of the values and help the client go down the path they would like to choose based on their own beliefs and values (Murphy & Hecker, 2017). It is not possible for therapists to completely distance themselves from value issues, however, it is always helpful if they can be more conscientious about value issues during the therapeutic process. As long as I stay sensitive about value issues without ignoring it or avoiding it, meet the clients at where they are, respect their right of making

life decisions, I will be ethically supporting the client to get benefits from the therapy. I could also state clearly to the client at the beginning of therapy that they, not the therapist, are responsible for their life decisions such as marriage, divorce, cohabitation, custody, visitation, etc. (AAMFT, 2015).

Last but not least, I have learned that the person of the therapist, as an indispensable component of the outcome of therapy, is ethically required to maintain high standards of professional competence through continuing education and supervisions throughout one's career. The therapist in New York State is mandated to complete at least 36 hours of continued education during each triennial registration period, that is, a registration period of three years (Murphy & Hecker, 2017; NYSOP, 2010).

My previous jobs, although require high level of professional competency and skills, never mandate continued education. I felt a little overwhelmed when I got to know the minimum requirement in New York state, which means the education does not end on the day of my graduation or obtaining of the license but shall last till the end of my career life. However, I realize it makes sense that the therapist, as an instrument through which the various therapeutic interventions are provided to the clients, must be constantly tuned for high quality service rendered. The high standards of maintaining professional competence actually make me feel quite proud of my future profession.

Just as an old Chinese saying puts, "Sharpening your axe will not delay your job of wood chopping". In order to maintain a high standard of competence and skill, I shall allocate time to keep abreast of the latest developments in the field by attending various training programs and conferences, connecting with peers for information exchange, reading literature journals to learn about evidence-based approaches with proved effectiveness, etc.. I shall also seek supervision

when using a new therapeutic approach or treating an unfamiliar population of clients (Murphy & Hecker, 2017).

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