When a Supervisee is in Need of Ethics

Marriage and family therapists are tasked with making decisions that are congruent with legal and ethical standards. The American Association for Marriage and Family Therapy (AAMFT) provides a set of ethical guidelines containing several standards and codes that support ethical decision making (AAMFT, 2015). In the following paper, we will apply the AAMFT Code of Ethics to a hypothetical scenario involving therapist Monique, her supervisor, and the family she is seeing.

Responsibility to Clients

Regarding Standard I, Responsibility to Clients, several violations are evident in the hypothetical. First, Monique violated code 1.2 Informed Consent when she invited Elsa Hope House (HH) for treatment without enough attention to informed consent (AAMFT, 2015). Even though Elsa verbally agreed to receive support from HH, Monique did not assess Elsa in person to determine whether Elsa had the capacity to consent and did not obtain signed informed consent. It is preferable to discuss informed consent in person with clients to ensure their full capacity to consent. Second, Monique engaged in dual relationships with Elsa (1.3 Multiple Relationships), acting as both therapist and caregiver for her children, additionally purchasing ice cream for them (AAMFT, 2015). It is the responsibility of couple and family therapists to avoid the development of dual relationships and to use their best judgement to navigate the relationship if it is unavoidable (Gonyea, Wright, & Earl-Kulkosky, 2014). Monique must maintain a clear therapeutic relationship to minimize problems with boundaries. She may accomplish this through staying with Elsa during her intake process and linking the children with another caregiver such as a family support. Third, Monique violated code 1.7 Abuse of the Therapeutic Relationship (AAMFT, 2015). Monique needed relational hours, which may have prevented her from prioritizing client care. We recommend for Monique to consider all systemic issues in this case, seek supervision, and support safety of all parties involved within the constructs of her agencies. Fourth, Monique acted in a way that did not respect the client’s own preferences and
did not empower Elsa to make her own decisions, which violates code 1.8 Client Autonomy in Decision Making (AAMFT, 2015). Monique may have undermined the family’s freedom of choice such as stressing to Barry that therapy is “the only thing that will save his marriage” and threatened to persuade Elsa toward divorce. A better course of action would be to empower client choice. Fifth, Monique and Dory failed to provide adequate referrals (1.10 Referrals) because it is clear that neither of them had significant knowledge or experience in domestic violence or managing significant power imbalances in couples and families. Neither Monique nor Dory them facilitated referral to a need-congruent resource (AAMFT, 2015). Monique ill-informed referral of Elsa to HH may have increased risk of harm to Elsa given Elsa’s methadone treatment (Deering et al., 2017; Roux et al., 2016).

Monique engaged in courses of action that jeopardized the safety of both clients and others. Monique abandoned a client who was in crisis at South Newport Addiction Recovery Center (SNARC) without evidence of linkage to another clinician or emergency services, which violated code 1.11 Non-Abandonment. We recommend for Monique to make every effort to ensure a client’s well-being prior to terminating a crisis session and possibly leaving the client at risk. It may be helpful for Monique to obtain more information on the nature of her client’s crisis to support more effective decision-making. Last, Monique violated ethical code 1.13 Relationships with Third Parties (AAMFT, 2015). Monique disclosed details of Elsa’s participation in services at HH to Barry. Although the hypothetical provided no evidence of violence in Barry’s history, Monique’s disclosure of Elsa’s whereabouts may have put Elsa and others at risk for harm. We recommend for Monique to clarify each family member’s role in treatment.

Confidentiality

The hypothetical did not provide information on whether Monique disclosed to Elsa the limits of confidentiality during the initial phase of treatment, which is congruent with code 2.1 Disclosing Limits of Confidentiality (AAMFT, 2015). Monique informed her coworkers at HH
about Elsa coming into the facility prior to her arriving, therefore disclosing that Elsa was currently her client at another facility and possibly breaching confidentiality. To avoid breaching confidentiality, Monique could have refrained from informing the front desk of Elsa’s arrival or informed them without mentioning that she was a current client of hers.

In addition, Monique violated code 2.2 Written Authorization to Release Client Information (AAMFT, 2015) when she spoke on the phone with Elsa’s husband, Barry, and provided information that confirmed Elsa was in fact her client. Monique also provided information to Barry without written consent from Elsa. While speaking to Barry, we recommend for Monique to have stated limits of confidentiality without acknowledging that Elsa was her client and provided a referral for a therapist if he was interested in having a session. Monique then could have spoken to Elsa about her options and the possibility of inviting Barry in for a conjoint session if it was determined that there was no violence within the relationship.

Monique did maintain Elsa’s confidentiality while consulting with her supervisor when she excluded identifying information, which adheres to code 2.7 Confidentiality in Consultation (AAMFT, 2015). Monique was responsible for maintaining confidentiality in her consultation with Dory because Dory was not the supervisor at either of Monique’s practice sites.

**Professional Competence and Integrity**

Regarding Standard III, Professional Competence and Integrity, Monique may have improved her decision making on several points. She violated code 3.1 Maintenance of Competency when she operated outside her scope of knowledge (AAMFT, 2015). She treated the case as if domestic violence was involved without clear evidence of such and without effort to learn more about domestic violence or power dynamics in couples and families. Moreover, Dory also operated outside her limits of competency, providing a diagnosis for Elsa and course of action for Monique without adequate training in domestic violence and without having assessed the family herself. It may be helpful to have more information on what factors influenced Monique’s decision making. Her actions may stem from information not provided in
the hypothetical or from countertransference. Both Monique and Dory neglected code 3.2 Knowledge of Regulatory Standards when they neither demonstrated appropriate knowledge of regulatory standards, nor consulted ethical codes, laws, or other professional standards. We recommend learning and adhering to the ethical standards congruent with their professional locations. Monique adhered to code 3.3 Seek Assistance when she sought consultation with Dory, but only after having made a multitude of decisions without support (AAMFT, 2015). We strongly recommend trainees to seek consultation at the earliest opportunity. Monique violated code 3.4 Conflicts of Interest when engaged in a conflict of interest with the family when she assumed caregiving responsibilities for Elsa’s children and purchased them ice cream (AAMFT, 2015). These blurred boundaries may confuse the clients and pose potential harm to them. Acting as a caregiver for Elsa’s children may cloud Monique’s clinical judgement in working with the family as a whole. Monique may have violated code 3.8 Exploitation when her decisions possibly created or exacerbated family problems and allowed her access to the family to obtain relational hours as a trainee (AAMFT, 2015). Monique was seeking relational experience, and there is no evidence of her isolating this goal against her actions in the case.

**Responsibility to Student and Supervisees**

Dory did not have experience with domestic violence and therefore her advice to not allow Elsa to leave the clinic and her suggested diagnosis of “Battered Woman’s Syndrome” were a violation of code 4.4 Oversight of Supervisee Competence (AAMFT, 2015). In addition, Dory’s lack of experience and training with domestic violence prohibited her from providing supervision on Monique’s cases at the domestic violence shelter. Dory should have referred Monique to her supervisor from the domestic violence shelter for help on this case rather than providing uninformed suggestions.

Again, the hypothetical did not evidence violence within the relationship or household; it is unclear why Monique referred Elsa to the domestic violence shelter. If Monique’s referral to HH stemmed from countertransference, then Monique failed to maintain professionalism, which
violates code 4.5 Oversight of Supervisee Professionalism (AAMFT, 2015). It may be highly beneficial for Monique to process her feelings of countertransference with a supervisor and discuss the next steps to minimize risk of harming the client and to avoid unnecessary and unethical action. Seeking supervision sooner may have allowed Monique to following a course of action with less risk and more favorable outcomes without compromising ethics.

**Technology-Assisted Professional Services**

Monique used FaceTime to communicate with Elsa, which is a major violation of Standard VI, Technology-Assisted Professional Services. She did not make efforts to determine if FaceTime is an appropriate mode of communication, evaluate its capacity for confidentiality, did not discuss risks or benefits, and there was no information on whether this mode of communication was included in a consent to treat. Monique may avoid violation of these standards if she had simply redirected Elsa to a traditional phone line.

**Conclusion**

The purpose of the code of ethics is to protect clients, students, and research participants within the field of marriage and family therapy from maltreatment and exploitation (AAMFT, 2015). We applied these standards, identified several concerns, and discussed the codes Monique and her supervisor Dory either violated or adhered to. We shared other courses of action that may have positively influenced the course of treatment, better protected the client, and more directly aligned with the code of ethics. A final recommendation for Monique and her supervisor would be to use the Koocher and Keith-Spiegel (2007) ethical decision-making model, which involves eight steps: Outline the parameters, explore all potential issues, consult ethical and legal guidelines, assess rights and responsibilities for all parties involved, consider alternate decisions, weigh consequences of each decision, estimate outcomes, and choose a decision. Steps in the Koocher and Keith-Spiegel model are congruent with AAMFT Code of Ethics and provide a structure for ethical decision making that may minimize risk and maximize favorable outcomes.
References


