

Part V
Training and Practice

Ethical and Legal Issues Unique to Systemic Family Therapy

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All forms of therapy should consider ethics as a foundational part of practice. This statement in itself may be common sense, yet how we attend to and enact ethics when balancing the needs of two or more family members can be extremely challenging, with multiple potential paths forward. As practitioners, we have much to consider when contemplating those paths beyond theory: ethical principles, our profession's Code of Ethics, applicable laws, the context in which therapy takes place, and the agency of involved stakeholders, especially clients themselves (Hecker & Murphy, 2015).

Ethical principles that guide our work are taught in ethics courses required of all clinicians, so they are discussed briefly here (Beauchamp & Childress, 2013). First, *autonomy* refers to the individual's ability to make decisions for themselves, which includes being fully informed about the benefits and risks of therapy prior to engaging in the therapeutic relationship. Second, *beneficence* indicates that the practitioner will practice to the best of their ability to benefit the client; from this comes the edict to do good. Third, *nonmaleficence* is the idea that the clinician will do no harm to the client in the course of providing services. Fourth, *veracity* refers to the clinician being truthful to the clients and providing a level of honesty in their work with others. Fifth, *justice* refers to fairness in therapy and providing services without discrimination. Sixth, *fidelity* refers to honoring commitments and promoting trust. These basic principles are seen as integral to ethical work across professional disciplines and therefore applicable to therapeutic practice in any country and culture around the world.

Moreover, these ethical principles are enshrined in every counseling profession's Code of Ethics. For example, the American Association for Marriage and Family Therapy (AAMFT, 2015) Code of Ethics reflects *autonomy* in Standard 1.2, Informed Consent, in that clients need to be informed of risks and benefits to treatment in order to make an informed decision about engaging in therapy. *Justice* can be found in Standard 1.1, Nondiscrimination, in that all clients need to be treated fairly in therapy. In the United States, other counseling professions' Codes of Ethics reflect these principles, although they may be worded differently (e.g., American Counseling

Association, 2014; American Psychological Association, 2017). These ethical principles are found in Codes of Ethics around the world as well; for example, the UK Council for Psychotherapy (2009) addresses *autonomy* with a clear statement that “The psychotherapist undertakes to respect their client’s autonomy” (1.7). The Turkish Psychological Association’s Ethics Code (2004) has an entire standard on beneficence and maleficence (Standard 2). Ethics also becomes entwined with the law, which is reflected in numerous cautions in the Code to adhere to “applicable laws, ethics, and professional standards” (AAMFT, 2015). Practitioners need to stay abreast of laws at multiple levels, including but not limited to local, state, province, and federal laws that impact therapy and are ever changing.

Common ethical decision-making models walk practitioners through the steps of factors to consider when faced with ethical dilemmas. Oftentimes, these steps include having an awareness that an ethical dilemma is present, identifying facts related to the dilemma, consideration of relevant ethical principles and the profession’s code of ethics, consideration of applicable laws, consultation with peers, consideration of culture and context, decision making, and follow-up evaluation of the process (e.g., Kitchener, 1986). Embedded in traditional decision-making models are cultural assumptions reflective of linear decision making and ethical dilemmas that appear to develop independent of the typical therapeutic relationship (Shaw, 2017). As it is, current ethical decision-making models can be helpful to some extent, especially when applied to work with an individual in therapy. The drawback to most decision-making models such as those proposed by Kitchener (1986) and Keith-Spiegel and Koocher (1998) is that they assume clinicians will have time to think through the multistep decision-making process, when in reality ethical decisions need to be made in the moment. These models also separate actions and decisions from relationships; the concern is that if a situation is not seen in terms of ethics, then the entire ethical decision-making process will not happen. If, instead, we frame ethics as inherent in all relationships, then we may be more likely to be aware of and enacting ethics in our relationships (Shaw, 2017).

The complexity of working ethically increases exponentially when working with two or more members of a system, such as a couple or family. Systemic family therapy necessitates a shift from focusing on the individual to focusing on the system; it involves a paradigm shift from the individual to the relational. This change in focus has implications for ethical practice. The difficulty in using common ethical decision-making models is further highlighted when considering two or more people involved in a relationship with each other, as these two (or more) people reflect different cultures, customs, and values, not to mention those the therapist brings to the relationship (Hendricks, Bradley, & Robertson, 2015). Ethical decision making from a systemic perspective should include a recursive process reflective of systems theory itself. A systemic model of ethical decision making proposed by Scott (2009) utilizing the acronym “SLEEP” was developed specifically to include a systems approach to clinical professional decision making (see Figure 23.1). The emphasis on this model is the feedback loop, in which the practitioner must continually reevaluate, at each step, feedback received from clients. “S” refers to *sociocultural considerations*, including gender, race, sexual preference, class, religion, and ability to the problem, issue, or dilemma. “L” refers to *legal implications* of the ethical issue. “E” refers to *ethical imperatives*, including professional codes of ethics, ethical principles, and the practitioner’s personal morals and values. The second “E” refers to the *economic impact* of

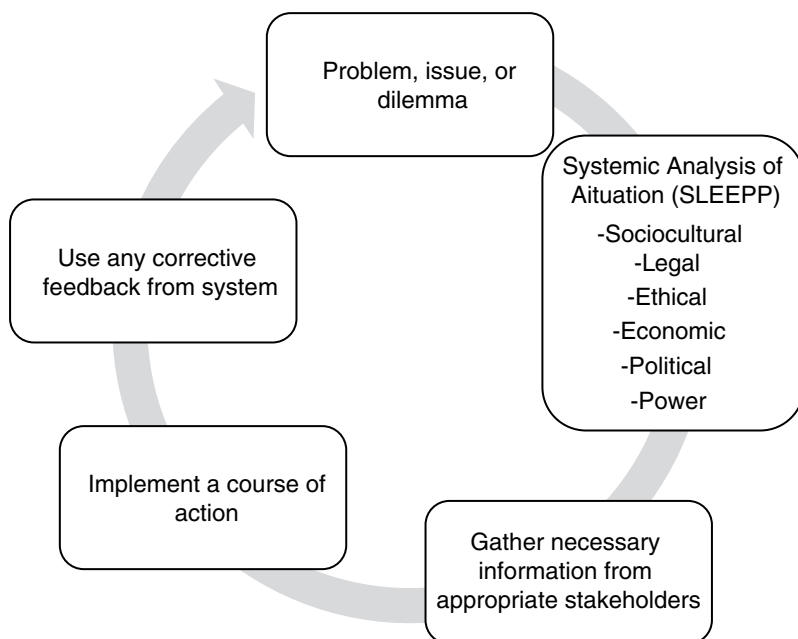


Figure 23.1 SLEEPP model of systemic ethical decision making. Adapted from Scott (2009, p. 41). Copyright 2009 by Elsevier.

the dilemma or issue. “P” refers to *political ramifications* of the ethical decision or broader impact or consequences for relationships. We like the consideration of socio-cultural factors in this model, as well as the economic and political ramifications. Therapists using this model are to apply the principle of symmetry, meaning that they examine the decision from opposing points of view to ensure that multiple perspectives are considered. We would add a second “P” to this model to include *analysis of power*—both the power the therapist has by virtue of their personhood and identity (including privileged identities), the power by virtue of their role as therapists, and power within the system with which they are working. This systemic model attends to both the individual and the relational, thereby addressing the complexities therapists working with couples and families inevitably face. The critiques made of the Kitchener (1986) and the Keith-Spiegel and Koocher (1998) models can be applied to the SLEEPP model in that, even though the SLEEPP model is more systemic, it relies on recognition of an ethical dilemma separate from relationships and assumes time to think through decisions logical order.

A common criticism of systems theory is that gender and power inequities are overlooked (Goldner, 1989). Some exciting developments in *relational ethics* (distinct from relational ethics as used in contextual family therapy) have been written by Gergen (2015), Haslebo and Haslebo (2012), McNamee (2015), and Shaw (2017), which give systemic family therapists (SFTs) a different way to address ethical decision making. Relational ethics suggests a move from a focus on self and other to a focus on the “we” of a relationship (Gergen, 2015). Gergen discusses a second-order morality, replacing individual responsibility with relational responsibility. Indeed, how we determine what is “good” or “bad” is co-constructed and is relationally and contextually

situated. A focus on relational ethics involves a move from the therapist thinking “I am an ethical therapist” to “What am I doing to be relationally ethical?” McNamee (2015) suggests that we all think of ourselves as ethical therapists, yet this does not help us act ethically; being ethical is a state of *being*, not a fixed identity (which itself is individually focused). We have to be in continuous dialogue with others in constructing the “good” and the “bad” and know that these definitions are ever changing and contextually dependent. Relational ethics involves asking questions about who decides what is ethical and exploring how our actions impact others. McNamee states, “We must focus on the process of constructing worldviews (moral orders) as opposed to searching for universal techniques, answers, and ethics” (2015, p. 424). Being ethical becomes a process instead of a fixed identity. For some, *not* having clear answers to ethical dilemmas is frightening; it is our hope instead that relational ethics opens up doors, conversations, and possibilities that considers all members of the involved therapeutic system ... and beyond to include the community and larger culture in which we are embedded.

With these considerations in mind, we discuss ethical situations that may present themselves in the course of work with family systems—specifically couples and families. All of us live in ever-shifting times. We discuss ethical situations that are common to clinical work with couples and families, including working with triangles, considering who is the client, safety concerns, managing boundaries, therapist positionality, and confidentiality, which includes Health Insurance Portability and Accountability Act (HIPAA) elements of privacy and security. We provide brief vignettes that may be common in practice with couples and families and apply, where appropriate, elements of relational ethics and the SLEPP model.

Working with Triangles

The systemic concept of triangulation distinguishes systemic therapy from other forms of therapy in that therapy is focused around triangular relationships (Dallos & Vetere, 2011). Indeed, the genesis of couple’s therapy itself is that it is a process of triangulation when a couple draws a third person into their relationship hoping to right instability in the system. This conceptual shift includes understanding how dyads will involve the most vulnerable other person to become a triangle when anxiety increases (Bowen, 1976). Working with triangles allows the therapist to open powerful sources of influence into relationships; triangles can be used to stabilize or destabilize relationships. Working with the power of triangles must be done while managing the therapeutic alliance, including (a) engagement in the therapeutic process, (b) emotional connection with the SFT, (c) safety within the therapeutic system, and (d) a shared sense of purpose within the couple or family (Friedlander, Escudero, & Heatherington, 2006).

Consider the following scenario:

Lee and Jan¹ are seeing Tammy, an SFT who is a seasoned therapist. The couple are career professionals who have been married for seven years and present to therapy with communication issues. Tammy soon noticed a pattern that while Lee and Jan would come to compromises in therapy, neither would follow through on what they agreed to do to change the relationship

dynamics. Further, Tammy suspected Jan was having an affair. She asked them about external relationships, but they denied engaging in any affairs. Tammy was left with the uneasy feeling that neither partner was being candid in therapy.

Triangles in marital and other long-term relationships are extremely common, and as stated, therapy itself is a triangle and hopefully one that intervenes in relationships in a positive way. But what should Tammy do about her feelings about undercurrents of triangles and deception in this relationship? How can she maintain her alliance with Lee and Jan while exploring the unstated aspects of their relational presentation? We need a bit more information; there are many potential sociocultural factors at play in Lee and Jan's relationship. We have yet to understand much about Lee and Jan's cultural background, which may impact the directness of their communication (or lack thereof). We also don't know how gender roles play out in their relationship; both work outside the home, but Lee appears to be the primary breadwinner with more economic power than Jan, though both are established professionals. In therapy, the process of triangulation can occur if ground rules are not set. Tammy must have in place a "secrets policy" of how she will handle confidential information she receives from the partners (Kuo, 2009). However, the AAMFT Code of Ethics (2015) defines confidentiality from an individual basis. Unless Tammy has a written agreement to the contrary, she must honor individual confidentiality. If she does obtain individual information that a partner does not want shared with the other, then she is now in alliance with the revealing partner, with possibly the start of a coalition. She must then work to "de-triangle" from the unstable triangling process. Likewise, if she sets a strict secrets policy, she may not have all the relational dynamics on the table, potentially truncating her understanding of the marital relationship. The decision to see the couple separately brings with it the ethical issue of confidentiality. The AAMFT Code of Ethics (2015) notes that "When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual." Thus, Tammy must either have had to address this in her informed consent with the couple, or she will need to address this issue prior to seeing the couple individually. If she does not, and an affair is revealed, she must keep that secret and the therapeutic dynamics will then include an unproductive alliance at best and a potential coalition at worst. Additionally, potential secrets bring with it ethical issues of justice (fairness), beneficence (doing good), nonmaleficence (not doing harm), and fidelity (trust). As with all couple's therapy, Tammy must decide how to handle secrets within the relationship should she decide to separate the couple to gain more clarity on relational dynamics, but this must be done considering each individual's legal right to confidentiality.

Tammy appears to hold the belief that an affair is detrimental for this couple's relationship, and she wants to address her feeling that there is something more going on for Lee and Jan. Her expert power as the therapist allows her to take this stance, but she may at some point need to consider whether an affair triangle is a viable option for relationships, rather than allow her personal values to dictate therapy. The couple can make this decision for their relationship.

Who Is the Client?

When children are brought to therapy, issues of power burst into the therapy room along with them. Are they in therapy of their own free will, or are they mandated clients? Have they given informed consent? Can they decide to not attend therapy despite parental wishes for them to participate? Consider the following scenario:

Roberta and Alex Johnson bring their 12-year-old daughter Emma to therapy concerned that she has been acting out at school. She gets into minor scrapes but claims that she has been defending herself against bullies. However, she has had several detentions because of these scrapes. Alex is also concerned that Emma has been falling away from the teachings of their fundamentalist church and is concerned about Emma's lack of respect for authority. The therapist, Mike, notes that Emma is extremely quiet and that both parents seem to talk for Emma in the absence of her own speech. Emma seems very uncomfortable being in the therapy office.

The Johnson family provides interesting ethical and legal issues for examination. There are many sociocultural factors in this family's presentation to therapy. There are potential gender issues within the context of the family's culture (unknown at this time) as well as gender issues brought forward by the relational context of a fundamentalist religious embeddedness. There are hints of traditional gender roles that may put Emma at odds with her parents if, as part of her development, she is learning about alternatives to a constrained role of what it means to be female. Her school and religion may be teaching her conflicting messages. There may or may not be sexual orientation issues at hand, and Mike may be unsure of how to support Emma's developmental independence on this issue while also supporting the parents' right to raise their daughter according to their cultural and religious values.

Legally speaking, depending upon the state or province, Emma may or may not need to give her legal consent to be part of the therapy process. What happens if she does not want to be part of therapy? In some states, Emma must go along with what her parents dictate; in others she will have legal options about whether or not she consents to therapy. Her parents have the right to bring her to therapy, but do they have the right to force her to attend against her will? This legal issue will bring forward ethical issues that follow. Would it be ethical for Mike to see Emma against her will?

Whenever a minor presents to therapy, there is always the ethical issue of autonomy (Hecker & Sori, 2017). Have they made an informed decision to consent to therapy, or are they "mandated clients?" Emma appears uncomfortable with therapy, but we are unsure whether it is due to her mandated status, discomfort with her parent(s), or discomfort with the therapist. Should Mike see her separately to gain her confidence, and if so, how should her confidentiality be handled?

With minors there are also economic and political factors. The parents are paying Mike for therapy, targeting Emma's behavior. There is an economic contract with the parents that could impact how Mike treats Emma; he will need to remain cognizant of this inherent unequal status in the therapeutic relationship.

There are power issues playing out in the therapy room by the nature of therapy itself (bringing a minor to therapy) and the parents talking for Emma. While they may actually be attempting to help Emma express herself, their efforts may thwart her own development. The therapist's expert role on understanding adolescent human

development may collide with the parent's authority in raising their daughter. Additionally, based on his training, Mike may hold a different view on sexual orientation development than what Emma's parents may have. His scholarly training in this area may bump up against the parents' religious teachings, putting Emma potentially sitting on an uncomfortable point in that triangle!

Therapists have to decide how they are going to act based on ethical principles. In this case, principles of autonomy, nonmaleficence, veracity, and justice seem to be the primary principles in conflict. Even in ranking these principles, values come into play. Therapists may consider prioritizing justice and veracity first by having a conversation with the family about their values and the therapist's values so that family members can exercise autonomy in making treatment decisions (i.e., whether to stay in therapy or to seek therapy elsewhere). If there are safety issues, then nonmaleficence may be prioritized by the therapist above cultural values expressed by the family. If immediate safety issues are not present, then the therapist may have more time to engage in conversation about values, including the importance of psychoeducation on adolescents' sexual and identity development. As with any ethical situation, it is difficult to point to a clear pathway forward, because many other factors may be at play (state laws guiding minors' autonomy and confidentiality, for example).

Safety

Therapist concern for client safety is essential in clinical work. One could argue that it is easier to explore client safety when working with an individual; the picture gets complicated quickly when the therapist works with two or more people, especially when they are in different places when it comes to safety. This type of situation arises most commonly in reference to relationships in which there is risk to physical or emotional safety to one or both members of a couple. Ideally, therapists conduct successful screening for abuse prior to seeing members of a couple together. Research suggests that conjoint couples therapy can be effective with couples who demonstrate a mild level of violence and who can cease dangerous behaviors while in therapy (Stith, McCollum, Amanor-Boadu, & Smith, 2012). The possibility of domestic violence (which includes physical and emotional abuse) occurring in the clinical population is quite high, leading to the likelihood that even the most diligent of therapists will not catch couples in which violence is actively occurring or in which one or both members of a couple is not safe (Harway & Hansen, 1993). Some level of safety must be assured prior to the start of couple's therapy so that couples can explore difficult emotional issues and interactions. Inevitably, in working with couples, therapists will encounter—after a course of several sessions—that abuse is currently occurring or has recommenced, posing ethical dilemmas for the therapist. It is now considered ethical practice to routinely screen couples for domestic violence early in the treatment process (Bograd & Mederos, 1999).

A common yet extreme example occurs when a client (typically the victim) makes a therapist aware that abuse has happened and does not want the partner to know that they have expressed a fear for their safety, out of concern that they will experience further abuse and harm. Assuming that the ethical principle of nonmaleficence is applied, the therapist would not want to see either partner harmed or placed at risk

for further abuse. The dilemma for the therapist may start with sociocultural considerations; the couple unit may, for example, cite religious reasons for one partner to harm another. The therapist then must decide whether to uphold this belief or challenge it. The therapist—at all times—must be aware of their power to make decisions that impact the couple and whether the therapist supports the adherence to or challenging of cultural discourses.

The therapist must be aware of any laws that mandate reporting of harm to others; laws vary widely state to state and country to country. Even if it is decided that a report needs to be made, the therapist must consider how to (or whether to) share that information with clients, as well as what happens to the future course of therapy. Yet before the therapist makes these decisions, they must decide whether to act on the client's report of the incident or whether to explore further while keeping in mind that it is not the therapist's job to investigate. Believing (or not believing) a client will have an impact not only on the therapeutic relationship but on the relationship between partners as well.

If the victim does not want their partner to know that they have reported abuse to the therapist, the therapist needs to decide whether nonmaleficence in relation to the victim outweighs the autonomy of the perpetrator in deciding the course of therapy. The therapist may decide to split the couple for safety concerns but will need to decide what to tell both clients about this decision. This may include being clear about treatment goals in seeing the couple individually before deciding to bring them back together as a couple, presumably after safety of both parties has been established.

Luisa and Ramone have been together for 8 years. Luisa's parents immigrated to the United States from Mexico before she was born; she is a housekeeper at a local hotel. Ramone is an undocumented immigrant from Mexico who works at a meatpacking plant. They have two children together, who are 2 and 5 years old. They have been in couple's therapy for 4 weeks. Two days before the 5th session, Luisa calls the therapist to cancel the session, saying that Ramone beat her severely over the weekend and she is too bruised, sore, and embarrassed to come to therapy.

The therapist faces an immediate dilemma: whether to reschedule the session and decide later who to see and how (i.e., to continue to see the couple together or to split them up to talk with them individually). The therapist, of course, has other options available, including calling the police, calling for a wellness check, or providing a referral.

Let us assume the therapist has an opportunity to talk with Luisa, either over the phone or in an individual session. Luisa tearfully admits that Ramone has beat her throughout her relationship, that she doesn't know what to do, and that she fears for the safety of herself and her children. She says that she doesn't want to call the police because she is fearful that Ramone will be deported and that she wants him to stop harming her but does not want him to be punished to the extent that he is deported. She also worries about being able to support herself and her children on her meager earnings as a housekeeper.

Given the SLEPP model, the therapist at this point needs to weigh several considerations, including safety of the children and possible legal requirements to report suspected child abuse. Laws vary in relation to reporting—whether the children are

present or not during the beatings is relevant, as well as whether the children themselves have been physically abused by Ramone. The therapist must consider the political climate of the area in which the family lives and therapy takes place, which may be such that Luisa is valid in her fears that Ramone will be deported if he comes to the attention of the authorities. If Luisa is isolated from family and friends, she may indeed not have a home to live in, which may lead to (further) involvement by the state if child protective services is called. Unfortunately, the therapist cannot reassure Luisa that Ramone will not be deported. Ultimately, it is possible that the family will experience further harm in ways generated by the system upon report of abuse by the therapist.

Managing Boundaries

Therapists working with more than one person have always had to manage boundaries. Any therapist who works with couples knows that a lot of important information can be communicated to the therapist by one partner on the phone or in the waiting room while waiting for the other partner to arrive. The quick communication methods offered by texting or email speeds up the pace at which information is delivered and opens doors to positive as well as negative communication with members of a family system (Bradley & Hendricks, 2009). As prepared as therapists may try to be via having comprehensive and thorough informed consent documents, it is impossible to anticipate all situations in which boundaries may be challenged by clients.

Maria and Gina are coming to therapy to work on conflict and communication in their marriage. Between sessions, the therapist receives an email from Maria saying that she is furious that she found a dating profile on <http://Match.com> that Gina had set up. According to Maria's email, Gina has been dating two other people off and on for the past 3 years. Maria says she is no longer coming to therapy and plans to file for divorce.

The therapist had been proactive by saying that email was not an acceptable form of communication and that both Maria and Gina agreed to this statement when they signed the Informed Consent for Treatment. Still, the therapist now must decide how to respond to the email—Is it better to contact Maria to ask for clarification? Is it the therapist's responsibility to contact Gina to cancel the session? Does she call them both and offer individual therapy? The therapist does not know what communications have occurred between Maria and Gina about this issue. Ethical dilemmas may continue in this case, if the therapist is unable to reach Gina about canceling or rescheduling the appointment; indeed, Gina may show up for the next session as scheduled, unaware of Maria's email and communications with the therapist.

Use of cell phones in therapy can pose other sets of ethical dilemmas for the therapist. Clients can and do get out their phones to show the therapist "proof" of a partner's indiscretions, or they may show the therapist texts of their underage child "sexting" another student in their high school. Likewise, clients can feel compelled to check their phone, text in session, or otherwise be protective of their phone in relation to their partner or a parent. In these situations, as with others in therapy, therapists need to decide which boundaries to enforce when in session; sometimes enforcing

“no cell phone” boundaries may result in damage to or loss of the therapeutic relationship. In regard to cell phones, ethical principles of autonomy and veracity may be in conflict. Partners in a couple relationship may disagree, with one favoring autonomy, or the ability to decide what to share, and the other partner favoring veracity, or truth in the relationship. The therapist must seek justice or fairness in helping the couple decide what to share with each other, as well as what can and cannot be shared in therapy. The therapist can decide that, in keeping with the ethical principles of veracity and justice in therapy, that the therapist believes she should facilitate a conversation about what each partner’s values are in relation to sharing and truth telling in their relationship and explore the implications of these values for each partner as well as for their relationship.

Social media such as Facebook or LinkedIn accounts can also pose boundary challenges for therapists (Wilcoxon, 2015).

Sharon has worked with Vanessa, a 15-year-old girl, and her parents for nearly a year in therapy. Vanessa’s parents initially brought her in due to concerns about her depression. After working to alleviate Vanessa’s depressive symptoms, family therapy turned to focus on Vanessa’s live-in grandmother’s sudden death due to a stroke. The family and Sharon agreed to end therapy after working through these issues. Six weeks after therapy ended, Sharon received a Facebook message from Vanessa, in which Vanessa said she was cutting herself and thinking of running away with her friend Becky (who Sharon remembers had not been a positive person in Vanessa’s life).

The therapist faces legal and ethical dilemmas in how to react: whether she responds to Vanessa via Facebook, whether to contact the parents, and if so, when (how immediate is the concern)? Also, another option may be to call the police. Local, state, and federal laws may play a role in the extent to which confidentiality is assured in this situation. Questions arise about Sharon’s privacy settings on Facebook—Is the therapist expected to have strict privacy settings on Facebook? Must the therapist include Facebook privacy issues in her informed consent (Jordan et al., 2014)?

The proliferation and use of Facebook and LinkedIn allows for connections with friends, as well as friends of friends. Depending on others’ privacy settings, a therapist may be able to see a client’s activities indirectly through their own network of friends.

Less than a week before Vanessa messaged her, Sharon discovered that Vanessa was hanging out with the “wrong crowd” in high school, through her friend’s daughter’s (Evelyn) Facebook posts, which showed pictures of Vanessa, Becky, and Evelyn at what appeared to be a party with a beer keg.

Whether looking for information about clients or not, therapists can more easily come across information about clients through social media sites (Kellen, Schoenherr, Turns, Madhusudan, & Hecker, 2014). The therapist needs to consider how to respond, based on ethics, laws, and sociocultural context, as well as other considerations. Oftentimes, therapists may be put in a position to “hold” information—that is, not share information they may have come across while living their lives (on social media sites). Or the therapist may decide that it may be of most benefit for the client to share information with them or with the parents, as in this case with Vanessa, particularly in relation to receiving a message about running away and self-harm.

The therapist risks damaging the therapeutic relationship depending upon the avenue she chooses. In this case, safety is paramount, so the therapist needs to determine the possible level of risk experienced by Vanessa in order to maximize benefit for the client (beneficence) and minimize harm (nonmaleficence). The therapist may decide that she has a commitment (fidelity) to ensure the safety of this former client that outweighs the minor client's right to decide (autonomy) what information should be shared with her parents. Therapists can always consider connecting with colleagues—if they have the luxury of time and an immediate response is not needed—to inquire about ethical decision making. In this case, Sharon may need to consult with colleagues to learn how to change her Facebook privacy settings.

Electronic Therapy

Over the past decade, there has been an increase in and demand for electronic therapy (e-therapy), which raises legal and ethical issues for SFTs. Foremost are confidentiality and privacy concerns. Best practices suggest that therapists inform clients of the risk to confidentiality and privacy concerns in their informed consent document (Twist & Hertlein, 2017). Therapists need to take steps to ensure that information transmitted electronically is secure. Practicing e-therapy raises the obvious potential of practicing across state lines, bringing with it concerns about practicing in another state without a license (Twist & Hertlein, 2017). Yet it is possible to practice across national lines as well, raising a more complicated set of ethical and legal issues. Lustgarten and Colbow (2017) discuss risks of governmental surveillance, citing the National Security Agency's attempts to intercept protected data worldwide, including emails and video conferences. Ethically, it is the therapist's responsibility to ensure that client information is kept secure, private, and confidential.

The benefit (beneficence) to clients is apparent in the provision of e-therapy. It may be more affordable, more accessible, and convenient for clients, particularly those in rural locales. However, boundaries are another concern with e-therapy. SFTs must clearly describe when they are available and clarify expectations for their availability to clients via electronic means in the informed consent document. Twist and Hertlein (2017) describe challenges in assessing for risk issues in e-therapy, including client self-harm and suicidal ideation. Child abuse reporting requirements vary widely from state to state, necessitating therapist's knowledge of the laws of the state in which the client resides. These types of emergency situations are further complicated when practicing e-therapy across national lines. As a field, we are in our infancy in sorting out these important legal and ethical issues as related to provision of e-therapy.

Therapist Positionality

The therapist is always in relationship with the clients who are being seen in therapy. In systemic practice, this means that there is a relationship between the therapist and each member of the couple or each member of the family. Therefore, the therapist is a crucial member of these relationships; in many ways, the therapist has the most

power in the system by virtue of their role as therapist and expert on relationships. Therapist positionality is a concept drawn from feminism, intersectionality, and social constructionist thought; it suggests (a) that we are inherently in relationship with others; (b) that our identities are shaped by the relationships we are a part of, and therefore our identities are ever shifting; and (c) that our identities carry power via privileges we have connected to our identities in relation to others (Gergen, 2015; Murphy & Hecker, 2017; Watts-Jones, 2010). The concept of therapist positionality inherently challenges previous writings on the desirability of neutrality by the therapist in systemic therapy with more than one client. Therapist neutrality has been widely critiqued in the family therapy field by feminists (Knudson-Martin, 1997). Yet true neutrality is not possible, nor is it desirable for the therapy in relation to clients. Some therapists suggest taking a stance of curiosity or multidirected partiality; both concepts have also been recently critiqued for their lack of attention to larger sociocultural issues (Stancombe & White, 2005). According to the SLEPP model, one has to consider sociocultural factors that are present in ethical dilemmas; there are inherent cultural differences in all relationships therapists have with clients (and that clients have with each other). Therapists need to consider power differences that will result from these sociocultural differences between people in relationships and act ethically in relation to them.

In relational ethics, therapist positionality involves transparency, engaging in ongoing conversations with clients, and the therapist being aware of the power they hold by virtue of the helper role, as well as power connected to privileged identities in relation to clients (Murphy & Hecker, 2017). From a relational ethics frame, therapists continually work to listen to the narratives generated in the therapy room and listen for what is made possible by such narratives and what is made less possible. There is a value in balance, fluidity, and collaboration with clients that exists within the narrative constructed by society that therapists have an ability to shape reality. Ethics, then, become a part of the conversations therapists have with clients, instead of a separate entity to consider when a clear ethical violation has occurred.

In the United States—and perhaps to an extent—worldwide, there is increased polarization between political groups or parties, which of course impact families and couples and the relationships they have with each other. Therapists are not immune to or separate from these ideological divisions. Indeed, they cannot be neutral. Consider the following scenario:

Gene and Lily have been married for 5 years. They both report that their relationship has been plagued with conflict. However, since the most recent elections, their differences seemed to have become even starker. Lily's experiences of sexual abuse were triggered by one candidate's statements about abusing women. Lily cannot understand how Gene could have voted for this candidate, given his knowledge of Lily's history of abuse. Gene says that he voted for who he thought was the best candidate. The therapist, Monique, also has experienced a wide range of emotions after the election, feeling shocked that a person who has made disparaging statements about women was elected to be the nation's leader.

Therapists are not neutral people; they have values, morals, and biases that are shaped by their lived experiences and that they bring with them into the therapy room. This is true in regard to this scenario and *all* other relationships therapists have with clients. Given that it is inhuman to be neutral, therapists can embrace transparency as

a way of providing clients with autonomy to decide whether to continue in the therapeutic relationship. Watts-Jones (2010) suggests that therapists situate themselves and their identities in relation to clients, thereby opening up conversations about how similarities and differences may impact therapy and the relationships within the therapy room. Therapists and clients together can decide what will benefit the couple in therapy, what goals they want to work toward, and how they will know when therapy is completed. Considerations of power are crucial in this scenario—for the key question may come down to justice and what is fair for each member of the couple. It could be argued that the therapist has the power—by virtue of her role—to raise issues of justice and fairness in therapy and to help the couple to be in conversation about justice in relation to their values and political views.

Confidentiality in Systemic Therapy

There are three distinct issues that affect confidentiality in the therapeutic relationship: confidentiality, privacy, and security. *Confidentiality* is the foundation of all types of counseling and therapy (Kaplan & Culkin, 1995). Confidentiality is about the relationship between the SFT and their clients; there is an expectation that SFTs will hold the confidences of their clients. Confidentiality is our ethical obligation to keep client information private, which builds the foundation of the relationship between the SFT and their client(s). This expectation is typically codified into state professional statutes and is also reflected in the Code of Ethics (AAMFT, 2015). *Privacy* relates to an individual's right to control their personal information (Siegel, 1979). Before we reveal confidential information, we respect the client's privacy and obtain the necessary authorizations. Privacy in the United States has also evolved into privacy regulations and laws, such as the HIPAA Privacy Rule, and state statutes that proscribe privacy practices. *Security* is the newest partner to confidentiality. With the advent of electronic health records, and private information kept digitally in other methods, security of electronic health information has become a third prong to confidentiality (Sabin, 1997). Like privacy, security of electronic health information is now in the purview of federal law, specifically the HIPAA Security Rule. Other countries have global privacy and security laws as well, and most have now passed security breach notification laws (Hecker, 2016). The United States also has a federal breach notification requirement, and states also have breach notification statutes for various types of personal information. Privacy and security concerns affect the trust inherent in the confidential relationship between the therapist and client. In this section, confidentiality issues are explored from these three important lenses (see Figure 23.2). First, however, the shifting nature of professional confidentiality is explored.

Confidentiality

Keeping confidentiality in the therapist–client relationship has fundamentally changed with the advent of digital technology and our use of it in therapy. From electronic health records and other electronic storage of client data to online therapy modalities to texting and social media, the avenues for potential breaches of confidentiality have multiplied exponentially. What does this mean for the average SFT? How we think

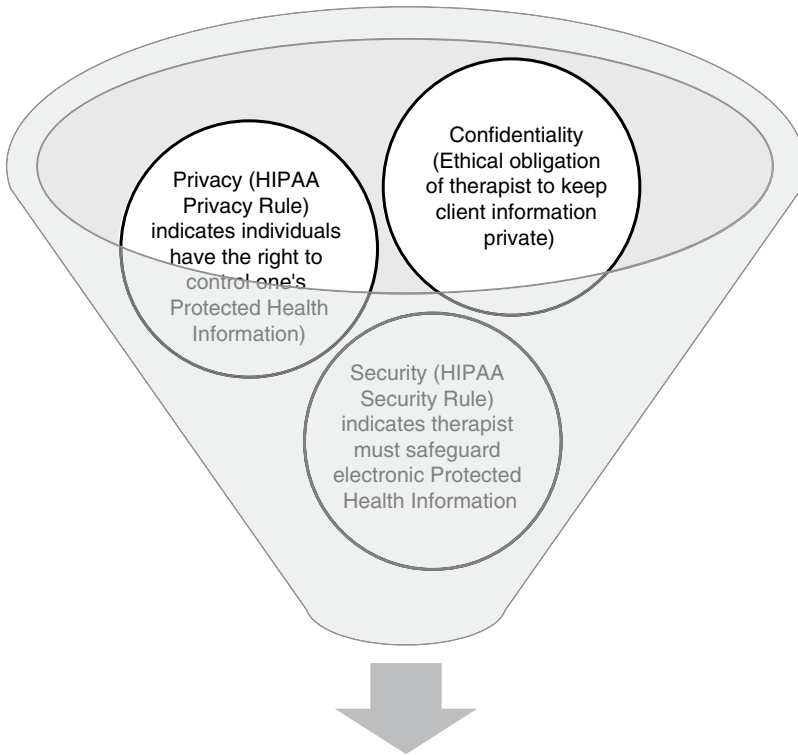


Figure 23.2 Confidentiality considerations in systemic therapy.

about protecting confidentiality must change; it is no longer about the “trusted relationship,” but has moved to include the integral areas of consumer privacy and security. What is at stake has changed: within our fiduciary relationship with clients, we now must think about risks to them such as identity theft, medical identity theft, and a potential loss of trust in the SFT. Practitioners must also think about the ramifications to their practices for poor security practices, such as state and federal fines and penalties, civil liabilities, and loss of business due to reputational damage (Hecker, 2016). We have previously discussed many ways confidentiality considerations occur in all forms of relational therapy; in this section we will discuss privacy and security considerations as we expand our notion of confidentiality.

Privacy considerations

Privacy revolves around the client’s right to control their personal information. Within the therapeutic relationship, what is considered private? The HIPAA Privacy Rule helps us understand what health information should be kept private, by both defining Protected Health Information and describing specific identifiers that make individually identifiable information Protected Health Information. Protected Health Information is:

Individually identifiable health information, including demographic data, that relates to: 1) the individual’s past, present or future physical or mental health or condition; 2) the provision of health care to the individual; or 3) the past, present, or future payment for

the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. (45 C.F.R. §160.103)

There are 18 Protected Health Information identifiers identified by the Privacy Rule that give us guidance to understand what information we should be guarding, including but not limited to names, certain geographic units such as zip codes, elements of dates, telephone numbers, electronic mail addresses, social security numbers, account numbers, Internet protocol (IP) address numbers, and full-face photographic images and any comparable images. If these 18 identifiers are stripped from client data, it is considered “de-identified” and is no longer information that needs protection. This information by itself (the 18 identifiers) is not enough to be considered Protected Health Information; it must be paired with health data (for example, diagnosis, treatment plan, prognosis, and so forth; Hecker, 2016). More information about de-identifying data can be found in Hecker (2016).

Notice of privacy practices A father brought his minor daughter for an evaluation to a family-focused agency when the daughter had been heard making suicidal threats at school. The teenage daughter read the Notice of Privacy Practices and started to shout that there was “no way” she would ever share anything with the therapist, citing the multiple items in the Notice that indicated the therapist was free to share information with outside entities. Frightened that her personal information might be shared with others without her consent, she stood up to leave; the father was unsure what to do.

This young client was rightfully scared that her therapy information might be shared with others. What happened was that the agency had adopted a Notice of Privacy Practices template from a professional association but failed to integrate more strict state mental health law into the Notice. And while most persons may not mind having their X-rays freely shared with another provider, sharing more sensitive information would probably give most people pause.

How a therapist intends to share Protected Health Information must be detailed in the HIPAA required Notice of Privacy Practices (45 C.F.R. §164.520). This document is given to clients at service delivery, and the therapist is required to put forth a “good faith effort” to get written acknowledgement that the client has received the Notice of Privacy Practices (and document client refusal if they do not wish to sign the acknowledgement). However, services may not be denied if the client refuses to sign the acknowledgement; the law is the law and how therapists may share Protected Health Information does not change even if clients do not sign that they have received this notice of how their information may be legally used or disclosed. Each family member should receive the Notice of Privacy Practices, including minors (although whether a parent or guardian should sign for the child is often a matter of state law); it is to be written in “plain language” for ease of understanding, though the laws themselves make this task challenging. Further making the Notice of Privacy Practices a challenge, clients should be informed of stricter state law that protects their Protected Health Information. Often therapists copy template Notice of Privacy Practices and shortchange clients by not informing them of these additional protections to their data. This can affect the confidential relationship between a therapist and client if the client believes that their private therapeutic information may be freely shared in the

same way as their physical information. Most information protected under HIPAA can be freely shared for Treatment, Payment, and Health Care Operations (TPO) without an authorization. State law typically curtails this about mental health information, and clients should be correctly informed of their rights. It is the ethical obligation of the SFT to get a clear picture of how patient Protected Health Information is protected within their state and adequately communicate that to their clients so that clients can understand their specific privacy rights when it comes to the information they divulge in therapy. Note that the Notice of Privacy Practices requirements changed in 2013 with the passage of the HIPAA Omnibus Final Rule, adding additional requirements such as breach notification. It is up to the SFT to stay abreast of regulatory changes; clinicians should sign up for updates.² More information about Notice of Privacy Practices and Protected Health Information can be found in Hecker (2016).

Personal representatives A family therapy agency located in Illinois was seeing 12-year-old Christopher unbeknownst to his mother, Emily. When his mother found out that he was attending therapy behind her back, she contacted the therapist asking for access to his treatment information. Emily has legal custody of Christopher.

When seeing clients, generally a therapist must allow a client's "personal representative" to inspect and receive a copy of Protected Health Information. The personal representative may be a health-care power of attorney. For children, the personal representative is usually the child's parent or legal guardian; state laws may be more proscriptive regarding who has access to Protected Health Information of a minor. In cases where a custody decree exists, the personal representative is the parent(s) who can make health-care decision under the custody decree. Because Christopher is being seen in Illinois, minors are afforded considerable rights to privacy, which must be evaluated as well. In Christopher's case, Emily's request for records brings forward ethical issues of autonomy (Christopher's) and beneficence (Emily's rights as his mother to protect him), as well as the interplay of state and federal laws and our professional code of ethics.

Minimum necessary standard Mary is a receptionist at a small family therapy practice. Mary has access to the electronic records system both to help with billing and to schedule clients. Mary notices that her neighbor is bringing her daughter in for treatment. Concerned due to a spate of suicides at the local school, Mary looks at the intake assessment for the daughter to ensure herself the girl is OK.

While SFTs are typically cognizant of minimizing sharing of Protected Health Information, federal HIPAA law expounds upon this notion in what is referred to as the minimum necessary standard (45 C.F.R. §164.502(b), 45 C.F.R. §164.514(d)). The minimum necessary standard dictates that Protected Health Information may not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. This means that each SFT must evaluate their practice and enhance safeguards to limit unnecessary or inappropriate access to and disclosure of Protected Health Information. The minimum necessary standard does not apply when uses or disclosures are for treatment purposes, to the individual client themselves, information pursuant to an authorization, or required by HIPAA or other law, or for enforcement purposes by the Department of Health and Human Services. In this case scenario, Mary has overstepped her boundaries to the point that her situation is a

reportable HIPAA breach for the practice. The practice must act to limit Protected Health Information available to those who do not need access to it.

Security considerations

Confidentiality considerations have changed with the explosion of the digital era. Electronic security goes hand in hand with our ethical and legal obligation to keep our clients' information confidential. With the advent of electronic health records and private information kept digitally by other methods, security of electronic health information has become an important confidentiality consideration. Security of electronic health information is now in the purview of US federal law, specifically the HIPAA Security Rule, as well as data protection laws in other countries such as the much more encompassing General Data Protection Regulation (GDPR) of the European Union (EU). The HIPAA Security Rule aims to ensure the confidentiality, integrity, and availability of Protected Health Information. The United States also has a federal breach notification requirement, and within the United States all states now have some form of breach notification. The GDPR also requires breach notification. Consider how confidentiality concerns have changed in the following scenario:

A therapist wished to be able to see when her clients arrive in her lobby, so she put a security camera in her waiting room, which broadcasts only to her office for her convenience. Unbeknownst to the therapist, the installer did not change the default password, allowing a Russian website access to her video feed and broadcasting her therapy office to a website called <http://insecam.org>.

Fact or fiction? Thus far, fiction, but this did happen to a dentist in Toronto who had their office broadcast on this site; they had their entire office broadcast for all to see until someone tipped them off about this intrusion (Russell, 2017).

In a study of patient concerns about their private information, Software Advice (2015) found that 45% of patients were "significantly concerned" about a data breach involving their Protected Health Information; furthermore, 21% said they actually withhold information from providers out of their concern for data security. What they withheld is of import to SFTs: they said they withhold personal health information including their own (or their family's) prescription information, mental illness, and substance abuse history! SFTs need to be thinking about these concerns that trouble our clients.

HIPAA Compliance Process

Creating a robust privacy and security program can be a daunting task. The HIPAA Security Rule gives baseline guidance for how to establish this process. This includes completing a security risk analysis, producing a remediation plan, assigning a chief privacy officer and chief security officer, developing policies and procedures to adequately protect client Protected Health Information and meet regulatory requirements, training workforce on policies and procedures needed to do their job,

and auditing and monitoring compliance with the therapist's HIPAA privacy and security program. Additionally, with the advent of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2013, therapists must also consider their business associate relationships (Hecker, 2016). What follows is a cursory look at HIPAA security requirements; this is a compliance overview—there are additional requirements to consider that are outside of the purview of this chapter.

Security risk analysis

The cornerstone of HIPAA compliance lies in the security risk analysis and is a requirement under the HIPAA Security Rule (HIPAA, §164.308(a)(1)(ii)(A)). The security risk analysis is a comprehensive analysis of all of the threats and vulnerabilities to client Protected Health Information. The results inform an organization's HIPAA policies and procedures. The industry standard (in the United States) is to use the NIST 800-30 protocol (NIST is a US organization called the National Institute of Standards and Technology). The risk analysis is a required component of HIPAA; for each vulnerability to a practitioner's electronic Protected Health Information, the threat that can exploit that vulnerability is examined, along with the likelihood that threat will occur and the impact it would have on one's practice and one's clients should the threat come to pass. A "vulnerability" is a cybersecurity term that refers to a flaw in a system that can leave it open to attack (Techopedia, n.d.). A "threat" is a potential danger that might exploit a vulnerability to breach security and therefore cause possible harm. A threat can be either "intentional" or "accidental" (e.g., the possibility of a computer malfunctioning or the possibility of a natural disaster such as an earthquake, a fire, or a tornado; Wikipedia, n.d.). Unencrypted laptops and other unencrypted mobile devices are a very common source of loss or theft; the lack of encryption would be the vulnerability, and the potential for loss or theft is the threat. Within the security risk analysis, a risk score gets assigned to each vulnerability, and a practitioner can learn what the strongest risks are to their practice, so an action plan is in place to address those vulnerabilities.

Remediation plan

Once the security risk analysis is in place, the practitioner is required by HIPAA regulation to generate a remediation plan (risk management) (HIPAA, §164.308(a)(1)(ii)(B)). The remediation plan is a time-stamped plan whereby each vulnerability is addressed with a plan to decrease the vulnerability to within an acceptable level of risk. The plan details how the practitioner will do this, who will do the assigned tasks, and by when they are to be accomplished. In the event of an audit or complaint, SFTs can show that they are making strides to become compliant with the regulations and protect client data.

Chief privacy officer and chief security officer

Each entity must designate a chief privacy officer and chief security officer (Hecker, 2016). In smaller organizations this may be the same person, but need not be. These individuals are in charge of development, implementation, and dissemination of privacy and security policies, respectively, along with monitoring compliance with the policies.

Policies and procedures

HIPAA policies and procedures are put in place to protect client data. HIPAA requires both privacy and security policies and procedures. The security policies and procedures specifically address the issues in the remediation plan and are broken into safeguards of data: administrative, physical, and technical safeguards. While the policies and procedures requirements are too expansive to discuss here, there are 54 security regulations that must be addressed within the therapist's policies and procedures, which specifically target safeguarding client data (Hecker, 2016).

Training of workforce

A compliance program is only as good as the people involved with client data. Workforce must be adequately trained on the therapist's HIPAA privacy policies and procedures (HIPAA, 45 C.F.R. §164.530), as well as the therapist's HIPAA security policies and procedures (HIPAA, 45 C.F.R. §164.308(a)(5)(i)) for them to be able to do their job.

Audit and monitoring of the HIPAA compliance program

The security regulations have a requirement designated "evaluation" whereby the practitioner is required to audit and monitor their HIPAA compliance program to be sure that the practitioner is doing what their policies and procedures dictate (HIPAA, §164.308(a)(8)). An overall audit is typically done on a yearly basis or if there is a significant security incident. Audits of program components, such as training compliance, can be run on a quarterly basis to be sure workforce are complying with this aspect of the regulations.

Due diligence on business associates

Business associates are those entities that a practitioner subcontracts for services who have access to client Protected Health Information. This may be the practitioner's attorney, shredding service, electronic records vendor, billing service, and so forth, if they have access to Protected Health Information. If a practitioner who is a covered entity

knows of a material breach or violation by the business associate of the contract or agreement, the covered entity is required to take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, to terminate the contract or arrangement. If termination of the contract or agreement is not feasible. (HIPAA, §164.504(e))

Thus, it is not enough to be HIPAA compliant oneself; if client data is entrusted to others, the therapist must ensure that they are compliant with the regulations and enter into a "business associate agreement" with that entity. The contents of these agreements are set by regulation and ensure that the therapist's business associate will guard the clients' Protected Health Information, as well as notify the therapist if there is a breach of client Protected Health Information.

Conclusion

As SFTs, ethics moves past linear decision making and includes the challenge to consider the recursive process when evaluating ethical decisions. We presented the SLEPP model of ethical decision making adapted from Scott (2009) as one way to conceptualize how to move forward in making ethical decision consistent with systems theory. Additionally, we invite readers to learn more about relational ethics as a way to bridge gaps posed in systemic ethical decision making. Systemic therapy ethical issues include managing triangles constructively, reflecting upon who the client is when seeing multiple members in therapy, especially those with less power such as minors, and addressing the therapist's positionality in relation to clients and what this means for treating clients ethically.

We also noted that confidentiality considerations have shifted considerably with the advent of digital technology. Although confidentiality has long been the foundation of therapy, with the trust of the SFT as a paramount consideration, confidentiality considerations have shifted to include both privacy considerations (client's rights to share or not to share their Protected Health Information) and digital security considerations. Digital security means SFTs must consider the technology we are using in our daily practice and how we need to guard this electronic information as we would any information clients reveal to us. We suggested that HIPAA privacy and security regulations provide a baseline for tackling this challenge; all SFTs must engage in HIPAA (or similar data protection laws such as the EU GDPR) in order to best maintain client confidentiality in this modern era.

Notes

- 1 We have protected the confidentiality of those described in the vignette by disguising material, limiting specific descriptions, and using composites. This holds true for all vignettes in this chapter.
- 2 Sign up for the Office for Civil Rights Privacy and Security Listservs at <https://www.hhs.gov/hipaa/for-professionals/list-serve/index.html>

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