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Exploring Ethical and Boundary Challenges in Outreach Psychotherapy: A Training Model

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Exploring Ethical and Boundary Challenges in Outreach Psychotherapy:
A Training Model

by

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology of
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Keene, New Hampshire



Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**EXPLORING ETHICAL AND BOUNDARY CHALLENGES IN OUTREACH
PSYCHOTHERAPY: A TRAINING MODEL**

presented on July 6, 2012

by

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Dedication

Working in the field of outreach psychotherapy, with clients who have survived unimaginable experiences, humbles me. These clients have struggled and survived. They are resilient, and use whatever means necessary to make it through another day. I am thankful to each and every one of them, for they have taught me lessons I could never have learned in an office.

Of all the preposterous assumptions of humanity, nothing exceeds the criticisms made of the habits of the poor by the well-housed, well-warmed, and well-fed.

~ Herman Melville

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My children, Joshua and Jesse, never lost confidence in their mother's ability to complete this task, and for that I thank them immensely. They are wonderful souls who light up my life.

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Last, but not least, I would like to thank Dr. Vic Pantesco, for often expressing *what is mentionable is manageable*. It has become my mantra. He says Mister Rogers was his inspiration.

Anything Mentionable is Manageable. ~ Mister Rogers

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Abstract

The need for outreach psychotherapists has increased considerably over the past few decades. Research suggests graduate training has not kept up with this phenomenon. Graduate students continue to be trained for in-clinic work, and are not prepared for the challenges of going into clients' homes and into the community. The literature supports the necessity for therapists who will be doing outreach psychotherapy to be trained in working in these atypical settings, as many innate challenges exist in this work. Challenging mental health issues, distracting environmental issues, safety concerns, lack of collegial support and supervision in the field, feelings of isolation, role confusion, and blurred boundaries are just some of these concerns. This research study reviewed the literature on home-based psychotherapy, and ethical and boundary challenges as they relate to working in atypical settings. A six-hour training to explore ethical and boundary challenges in outreach psychotherapy was created, and given to nine pre-doctoral psychology interns. Topics included: advantages and challenges of working in atypical setting, boundaries, confidentiality, self-disclosure, dual-relationships, safety, and self-care. Ethical decision-making models were reviewed and used to explore hypothetical vignettes of potential ethical challenges in the community. A post-training survey was given to participants to assess participants' perceived gained knowledge, gained skills in using ethical decision-making models, and to evaluate the training. Descriptive statistics revealed that the training was found to be useful to all participants, and that all participants would be able to use ethical decision-making models in their work. An open comment section is summarized and discussed. Future research is needed to explore the supervisory needs of outreach clinicians with the goal to create trainings for these supervisory staff.

Keywords: outreach training, ethics and outreach, boundaries and outreach

Chapter 1

In every man's memory there are things which he does not reveal to everyone, but only to his friends. There are also things which he does not reveal to his friends, but at best to himself and only under a pledge of secrecy. And finally there are things which man hesitates to reveal even to himself, and every decent person accumulates a considerable quantity of such things.

Fyodor Dostoevsky, 1864, *Notes from Underground*

The need for outreach psychotherapists has increased considerably over the past few decades (Adams & Maynard, 2000; Christensen, 1995; Zarski & Zygmund, 1989). This phenomenon has occurred as a consequence of a number of legislative acts, as well as many changes in the mental health care environment as a whole. Despite this shift, graduate programs continue to train psychotherapists in clinic-based skills, appearing to overlook changes that have been occurring in medically-approved standards of care for mental health clients.

Currently, there are neither formalized treatment manuals for mental health agencies providing outreach psychotherapy (OP) services, nor are there agreed-upon guidelines directing the formal training of clinicians within the outreach psychotherapy community. Nevertheless, research suggests that standards of care and reproducible, standardized training within clinics decreases therapist burnout, as well as addresses vital safety concerns inherent in community-based work (Boyd-Franklin & Bry, 2000). Engaging in OP services, which focuses on helping multi-problem clients who are often in acute distress, is particularly challenging clinical work (Lawson & Foster, 2005). Formal training for these outreach clinicians serves to familiarize them with common ethical challenges which may arise in the client's home or within the community, while encouraging critical thinking skills to resolve these dilemmas, and reducing feelings of isolation from colleague support and supervisor's reflections.

Nature of the Problem

Clinicians who have been trained to provide psychotherapy within an office setting find themselves in a foreign environment when conducting OP. Clinical psychology programs prepare psychologists-in-training for many aspects of clinical work (e.g., engagement, assessment, creation and application of therapeutic interventions intended to reach therapeutic goals, etc.). However, none of this training prepares the clinician to engage in the therapeutic process in a client's home, or other venues within the community (Adams & Maynard, 2000). Conducting OP can be a disorienting experience for the novice or experienced clinician. Absent are the four office walls which define the therapeutic role (Clark, Zalis, & Sacco, 1982), and offer the clinician a "holding environment" (Winnicott, 1956) to work within; where they can establish clinical power (Fernando, 2008) and implicitly affirm their social standing. Fernando opined, "The office and professional space of a clinic provides therapeutic legitimacy, not only to the individual who is the therapist but also to the process of psychotherapy" (p. 93). In contrast to the clinic, colleagues offering peer consultation and support are nowhere to be found after an exceptionally difficult therapeutic hour on the road. There are feelings of isolation and uncertainty (Lawson & Foster, 2005). Managing boundaries and ethical challenges in this new environment becomes a disorienting experience (Boyd-Franklin & Bry, 2000) due to the ambiguous roles and boundaries that are created when a clinician goes into the community (Knapp & Slattery, 2004). The clinician is left wondering how to regain the familiarity of the office setting in a context where the client normally maintains a more powerful and controlling influence—the home.

These issues are experienced first-hand, when pre-doctoral interns join the workforce as outreach psychotherapists. Without formalized training, colleagues have no venue, absent the

informality of the staff room, to discuss views on the proper way to provide outreach psychotherapy or how to manage boundaries and ethical challenges in these settings. Clinicians new to this experience are left with the impression that no clear answers exist when investigating how to confront challenges inherent in this perplexing occupation. These topics may not be brought up in supervision when new clinicians fear they are alone in their experiences.

A survey of the literature reveals few formal guidelines to help the outreach psychotherapist, and no specific degree-granting programs in OP. Although courses in ethics are required in advanced academic training, ethical codes do not speak to the unique dilemmas created while working in clients' homes, in schools, or in the back booth of a fast-food restaurant (American Psychological Association [APA], 2002). Interns struggle with the challenges of working therapeutically in such settings, not knowing what to expect, or how to manage the ethical and boundary challenges which may arise (K. McMahon, personal communication, September 10, 2010). What is needed is a way to help clinicians transition more smoothly from in-clinic work to the outreach environment. This dissertation offers a training program which was designed to orient pre-doctoral interns to the task of conducting outreach psychotherapy. The method of training creates a safe space which enables these newly practicing outreach psychotherapists to learn ways to reflect on the task at hand, be thoughtfully engaged in critical dialogue, and explore the ethical and boundary challenges inherent in this work.

Significance of the Study

Much of the literature concerning OP has focused on the efficacy of the intervention, not on the experience of the clinician (see, for example; Gordon, Arbuthnot, Gustafson, & McGreen, 1988; Kinney, Madsen, Fleming, & Haapala, 1977; Sheidow & Woodford, 2003). Some research studies look at the clinician's experience, but offer little insight into resolving such

struggles, except to acknowledge training would be useful. Nevertheless, the importance and necessity of good training to OP clinicians has been highlighted (Christensen, 1995; Lawson, 2005).

Therefore, this dissertation designed a training program enabling pre-doctoral interns, new to outreach psychotherapy, to explore their unspoken worries, beliefs, and concerns about boundary and ethical challenges, while offering them guidance using empirical literature, and providing hypothetical vignettes to explore, that highlight common ethical dilemmas in OP. The training had as its goal, the task of better preparing pre-doctoral interns to anticipate and effectively handle these ethical challenges while becoming more thoughtful, reflective, and effective outreach psychotherapists.

Objective of the Study

The objective of this study was to create a training program for pre-doctoral interns addressing the unique boundary and ethical challenges presented when doing outreach psychotherapy in clients' homes and beyond. This training was intended to create a safe environment which allowed trainees to "mention the unmentionable," and to become more adept at thoughtfully exploring boundary challenges and ethical dilemmas, while practicing the steps necessary to resolve them.

Evaluation of Training

The training was evaluated through a post-training survey created to allow participants to rate their perceived gained knowledge following the training experience. Some demographic data was gathered, followed by specific statements to be rated which explore, in more detail, the different topics of the training, as well as the style of presentation used to inform the participants.

There was also an open comment section at the end of the survey to allow participants to elaborate on any ratings, or to offer useful feedback to improve the training.

Training Topics

The training topics explored include: (a) the advantages and challenges of working in atypical settings (R. Peterson, personal communication, August 25, 2010); (b) issues of confidentiality, boundaries, and self-disclosure; (c) dual-relationships; (d) safety; and (e) self care. Ethical decision-making, risk-benefit analysis, and documentation were discussed as they related to these topics and to the trainees' understanding of the ethical and boundary challenges created in vignettes identifying potential outreach dilemmas.

Chapter 2: Literature Review

Researchers have discussed the benefits of home-based work (Berg, 1994; Boyd-Franklin & Bry, 2000; Lindblad-Goldberg, Dore, & Stern, 1998) and while some effort has been made to explore the experiences of home-based therapists (Adams & Maynard, 2000; Christensen, 1995; Lawson & Foster, 2005; Snyder & McCollum, 1999), the literature concerning ethical and boundary challenges posed by engaging in OP is sparse (Cottrell, 1994; Knapp & Slattery, 2004). For this reason, this literature review explores two main threads of research as they relate with this topic: (a) home-based family therapy, including a brief political history which explores the evolution of psychotherapy from the clinic to the community; and (b) ethics in clinical practice, including discussions of confidentiality, boundaries, and self-disclosure, dual relationships, safety, and self-care, and the particular dilemmas created in these areas while engaging in OP.

This chapter begins with a brief political history of the evolution of OP services, setting the backdrop for the movement toward increased need for, and availability of, OP services. It will mention legislative acts which directly influenced this evolution, and comment on changes in the mental health care milieu as a whole which led to this phenomenon.

This brief political history will be followed by a discussion of which populations are most often served by OP clinicians, as well as the advantages and challenges OP clinicians face while working in the client's home and in the community. There are beneficial characteristics of outreach clinicians which have been identified in the literature, and will be mentioned in this chapter. This is followed by a look at the current state of training for outreach therapists.

The second area of the literature to be explored in this chapter is six specific topics in the area of ethics in clinical practice. These topics are of particular concern to outreach clinicians due to the change in therapy dynamics once a psychotherapist leaves the four walls of the clinic

and enters the community. Ethical topics to be discussed include confidentiality and its critical and challenging role in the home, boundaries and the challenges to maintain them in the community, self-disclosure, dual-relationships, clinician safety, and self-care. Ethical decision making models will be reviewed, and risk-management, including informed-consent, documentation, and consultation will be discussed. The chapter will conclude with a summary of the literature, a statement of need for the training, and a summary of the training.

Home-based Family Therapy

Brief political history. The context in which psychotherapy has been carried out has evolved over the many years since its birth in Europe. Initially, it was an intensive endeavor, taking place in a doctor's office, reserved expressly for the elite. Upon its introduction to North America, although never intended to be something strictly performed by physicians, it became a medical intervention performed by psychiatrists (Plante, 2011). As its popularity grew, the middle class gained access to these services and the practice of psychotherapy advanced.

Insurance companies developed as a business and subscribers demanded that psychotherapy be included in the list of mandatory services covered by medical insurance (Brown & Minami, 2010). As this evolved, a cyclical, systemic pattern emerged in which greater demand for services required a broader range of providers (i.e., psychologists, counselors, and social workers), while simultaneously stretching the coffers of the insurance providers who sought to place ever greater limitations on financial reimbursement, while meeting the demands of their subscriber companies (Brown & Minami, 2010). In addition, the rise of psychopharmacological interventions was now narrowing the psychiatrist's role to one of psychotropic prescriber, leaving the delivery of psychotherapy services increasingly within the purview of allied mental health professionals (Plante, 2011).

The setting for these services was rapidly changing, along with all other aspects of psychotherapeutic services. What once was a service occurring weekly in an office setting was now being transferred to homes, schools, and other venues in the community. These clients are not the “worried well,” but often multi-problem, multi-stressed, multi-generational, low-income, high-risk clients demanding equality of mental health services be provided to them as it is to the more affluent sectors of the community.

This demand for mental health parity spurred a number of important legislative acts. The Early Periodic Screening, Diagnosis, and Treatment mandate (EPSDT), and the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) are just two of them. EPSDT offered parity of physical health, mental health, and developmental services to Medicaid recipients under the age of twenty-one. This act was established to offer needed healthcare to children who otherwise would not receive it (Health Resources & Services Administration, n.d.).

The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) was signed into law seeking to keep families together. The intent of this act was to shift federal funding from child placement in foster care, to prevention and reunification. This act stated that community agencies must provide services to families in need, to strengthen and maintain the family unit, while making a “reasonable effort” to prevent out-of-home placement of children (Adams & Maynard, 2000; Christensen, 1995; Zarski & Zygmund, 1989). This legislation paved the way for the availability of psychotherapy for all social classes, even those least likely to participate in clinic-based psychotherapy.

As the cost of in-patient hospitalization continued to climb, and the effectiveness of in-home psychotherapy in preventing such hospitalizations was increasingly shown to be effective, the era of OP had arrived (Brown & Minami, 2010). Best practices showed that cost savings

occurred for insurance companies when clients were able to be seen in their homes instead of needing to be hospitalized. Cottrell (1994) commented, “Given that most problems occur in the home and not in the clinic, it makes theoretical sense to consider home-based therapy” (p. 190). And so it had evolved; through time, financial constraints, legislative acts, and best practices: OP found its sizeable niche in the world of psychotherapy. However, the “how to” of effectively conducting OP has been rarely addressed in any formal venue, in any depth, or with much substance, as to provide a clinician new to this work much guidance. This critical work is not to be taken lightly, considering clinical burnout continues to be an ever-present threat to these clinicians (Boyd-Franklin & Bry, 2000).

Populations served. Philosophically, home-based therapy is designed for, and beneficial to, clients who are challenged to get to an office, particularly poor, multi-problem, multi-stressed families (Adams & Maynard, 2000; Brosman, 1990; Clark et al., 1982; Lawson & Foster, 2005; Madsen, 2007; Sacco, Twemlow, & Fonagy, 2011). Often, these families are unable to successfully utilize office-based services for any number of reasons, including: lack of transportation (Christensen, 1995); the inability to use public transportation due to social anxiety or lack of money (Woods, 1988), the need for childcare, the presence of chronic illness in a family member, physical limitations (Cottrell, 1994), or inexperience or irresponsibility in following through with scheduled appointments (F. Sacco, personal communication, August 26, 2010).

There clearly continues to be increased need for outreach psychotherapists. The client’s home has emerged as a common site in which therapy is delivered (Snyder & McCollum, 1999). Yet, little research has been done, and empirical literature is lacking, to aid these therapists in effectively offering these services to clients in their homes and in the community while creating

a supportive training environment which aids the mental health clinician in maintaining ethical behavior while monitoring and resolving boundary challenges in these atypical settings.

Advantages of the atypical setting. Researchers have found many benefits to seeing a client within the home (Berg, 1994). The home environment can aid in building a therapeutic relationship (Reiter, 2000). Woods (1988) explained that when a therapist shows up at the home, there is an implicit message that “they are willing to step into the family’s world” (p. 213). Therapy can be more flexible in the home, with more family members taking part, and more information being garnered simply through observation (Wood, Barton, & Schroeder, 1988). In-home therapy offers greater ecological validity (Slattery, 2005). What can only be talked about in the clinic setting can be experienced in the home. Important family members who may be unable to attend therapy in the clinic may find it easier to join the therapy in the home (Boyd-Franklin & Bry, 2000).

The family home provides much information that can be useful in therapy. Observing a family in its natural setting provides information never obtained through in-clinic work (Lawson & Foster, 2005) and these observations can help guide treatment (Woods, 1988). A clinician can respectfully observe what items a client or family hold dear. Treasured items are displayed in the home and can be a potential conversation starter which will aid in building rapport and moving the therapeutic relationship forward. Viewing the intimate details of their daily lives can only enhance a clinician’s understanding of the clients (Snyder & McCollum, 1999).

Challenges of the atypical setting. OP clinicians face numerous challenges working in an extraordinarily demanding environment. As Brosman (1990) pointed out, “home-based therapy is not merely office-based therapy transplanted to different soil” (p. 4). OP is an incredibly demanding intervention (Lawson & Foster, 2005) where therapists attempt to join

with the family, who may have no interest in engaging, while juggling multiple boundary challenges in the home, and being sidetracked by numerous concrete distractions (Christensen, 1995).

The initial meeting with the client can be a challenge simply due to the client not wanting outsiders in the home, making the therapist's presence feel intrusive (Berg, 1994; Cottrell, 1994). Many times, clients seen in-home have been referred by external sources, such as social welfare agencies or the court system. These clients have no interest in help and would not have a therapist in their home if it weren't mandated by an outside source (Boyd-Franklin & Bry, 2000; Brosman, 1990). These "involuntary" clients (Brosman, 1990; Clark et al., 1985) are suspicious, defensive, and angry that a therapist has been forced upon them (Adams & Maynard, 2000) and will show this through resistance to engagement (Boyd-Franklin & Bry, 2000). A client may not answer the door, be in the shower, have gone out, have visitors, or have the TV on to avoid building a relationship with an unwanted caller. This is a difficult way to start a therapeutic relationship.

In a qualitative study that looked at therapists' perspectives on home-based family therapy, Christensen (1995) reported that therapist participants found the home environment to be distracting. Some issues reported include the cleanliness or the temperature of the home, and frequent visitors interrupting. Other distractions included bugs, smoking, pets, loud music and the television. Kagan and Schlosberg (1989) suggested that clients use these environmental deterrents to keep OP clinicians out while maintaining stability in the family. All of these distractions take the attention away from therapeutic issues, and reduce the actual time able to be spent engaging therapeutically with the client.

The complex needs of the clients, combined with the unstructured setting of the home can create an environment that makes the possibility of therapy questionable (Cottrell, 1994; Lawson & Foster, 2005). New and seasoned OP clinicians alike can leave this situation wondering whether therapy took place or time just passed. Leaving this chaotic scene, it can be a relief to sit alone in one's car, while simultaneously being distressed by the feeling of isolation from peers and supervisors (Boyd-Franklin & Bry, 2000). Being without their supportive stance and guidance appears both disheartening and palpable. Feelings of isolation, from the clinic, colleagues, supervisor, structure, familiarity, and all things that say, "This is my profession; I have expertise in this field," create a much higher chance for burnout among OP clinicians than in-clinic therapists.

Being in a client's home opens a therapist up to many situations not experienced in an office setting. One of these dilemmas is a client offering the therapist food or drink. Reiter (2000) argued there are times when accepting an invitation for food or drink can help to build rapport and improve the therapeutic relationship. Boyd-Franklin and Bry (2000) added that the cultural background of clients play a role in food offering and its meaning. Clients have purported that the acceptance of such refreshments reduces the disparity felt between client and therapist (Reiter, 2000). Nevertheless, most outreach therapists don't eat meals or accept drinks at client's homes. Reasons for this decision range from cleanliness concerns and diet choice, to graduate training recommendations.

Beneficial characteristics of outreach therapists. Lawson and Foster's 2005 study found moderate levels of both ego development and conceptual level to be helpful to home-based therapists, noting "higher conceptual level scores are correlated with more desirable counseling behaviors" in the home (p. 158). Higher conceptual levels allow therapists to think more

abstractly and to make thoughtful decisions using complex information. Behaviors found particularly beneficial to home-based therapists included: clarity in thought and articulation, flexibility, high frustration tolerance, and being able to stay on task despite distractions. Clark et al. (1982) found useful characteristics in outreach therapists to include considerable patience and courage; a high tolerance for ambiguity, crisis, and stress; and solid and eclectic clinical understanding of the population served through outreach. Boyd-Franklin and Bry (2000) agreed important characteristics of these therapists to include both, the ability to tolerate ambiguity, and the ability to be flexible.

Current state of training for outreach therapists. Adams and Maynard (2000), in their study to explore training needs for home-based family therapists, found that training curricula has not kept up with the phenomenon of increased home-based psychotherapy, and therefore, graduate students are ill-prepared for this work. Christensen (1995) concluded that specialized training should be provided to therapists and supervisors in order to address the unique issues of home-based therapy. Lawson and Foster's (2005) study found that few home-based therapists have either graduate-level or clinic-based training in doing this work, and as an extension, most (74.2%) of the 120 outreach therapists surveyed felt under-supervised and under-supported considering the intensity of the work they do. Boyd-Franklin and Bry (2000) "view training and supervision as 'antidotes' to the burnout that so often occurs for front-line family workers, and as keys to empowerment of clinicians to do this work effectively" (p. 10). Lindblad-Goldberg, Dore, and Stern (1998) agree that burnout is a legitimate concern in this line of work, arguing that clinicians most likely to struggle with this will be those who feel "overworked, unappreciated, ineffective, and unsupported" (p. 211). Home-based therapists need specialized training and support to be effective in their work (Lawson, 2005).

Boyd-Franklin and Bry (2000) recommended that orientation of new clinicians include, not only an orientation to agency policies, but also training for these new outreach clinicians, including an overview of information useful to clinicians new to this field. Boyd-Franklin and Bry (2000) also suggested it was important for students and therapists new to OP work to join an agency “with a reputation for good support and training” in personal safety (p. 54), suggesting that an agency would do well to draft safety guidelines for their clinicians.

Ethics in Clinical Practice

No one would argue against the importance of ethical standards of practice and astute decision-making skills in mental health care. The American Psychological Association, (2002), along with a number of other professional organizations, has specific guidelines their members follow to help them navigate ethical challenges (see <http://www.kspope.com/ethcodes/index.php> for a comprehensive list). The preamble of the Ethical Principles of Psychologists and Code of Ethics (APA, 2002) clarified the APA’s intentions when creating their Ethics Code:

This ethics code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline. (p. 1062)

These guidelines are broad-based and dynamic, and are designed to be useful in a number of settings (Fisher, 2003). This is a key to their flexibility; however, this also makes it difficult for new outreach clinicians to feel confident when charged with ethical decision-making in the field. None of these ethical guidelines appear to take into account situations where therapists are, intentionally and therapeutically, meeting clients in the community or within the clients’ homes. Without clear ethical guidelines, therapists are left the difficult task of making complex ethical

decisions “in the moment.” This is a challenging task for therapists new to OP, who have not been exposed to these circumstances previously. Or, worse, these clinicians may disregard relevant ethical guidelines under the mistaken belief that they don’t apply when working in a client’s home (Fernando, 2008).

A course in ethics is a minimal requirement for licensure (APA, 2011). Ethics codes are studied, explored, dissected, and discussed (see, for example, Campbell, Vasquez, Behnke, & Kinscherff, 2010; Fisher, 2003; Johnson & Koocher, 2011; Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2007; Pope & Vasquez, 2011). Codes are necessarily open to allow for interpretation, and to fit with the moral and ethical values of the therapist (Pomerantz, Ross, Gfeller, & Hughes, 1998). Codes can also conflict with the law, and each other. Pope and Bajt’s (1988) sent out an anonymous survey on ethics to a group of esteemed psychologists. Of those surveyed, 77% believed that psychologists should sometimes violate formal legal or ethical obligations for the welfare of the client or due to their deeply held values. Of this group, only 18% believed that these issues were adequately addressed in training, education, or supervision. These highly regarded senior psychologists acknowledged the necessity of sometimes breaking the law or violating ethics code due to their own moral choices. Pope and Bajt (1988) argued:

How can psychologists who believe that the authority of the legal and ethical codes are not absolute ensure that their actions are based on sound professional judgment rather than on self-interest, prejudice, rationalization, and the sense that one is “above the law?” (p. 829)

Pope and Vetter (1992) looked at ethical dilemmas faced by APA members in their work. With 679 respondents noting 703 incidents in 23 categories, their findings revealed the top two

dilemmas faced by these professionals were confidentiality; followed by blurred, dual, or conflictual relationships. These professionals had the advantage of being in an office setting, where the four walls and door provide a sense of privacy and confidentiality with the client, and they still struggle with these issues. This dissertation argues that clinicians working in the community have a higher incidence of being challenged to maintain confidentiality and relationship boundaries with clients due to the less-structured nature of their work environment. For example, simply being in the community with other people around, presents challenges to maintaining confidentiality. Running into a client while walking on the street with another client can be a confidentiality dilemma. However, finding out these clients *know* each other compounds this conundrum.

Pope, Tabachnick, and Keith-Spiegel (1987), who surveyed psychologists about their ethical beliefs and behaviors as therapists found that these psychologists had engaged in unethical behaviors, even ones they ethically opposed. Unintentionally disclosing confidential data, and discussing a client with a friend, were two of the top four problem areas. Each of these ethical dilemmas is a potential problem in OP, particularly when the therapist is in the community. Being aware of one's surroundings is critical when doing therapeutic work in the community. There are many ears and eyes that are not acknowledged or even noticed, but nonetheless, bearing witness to the therapist—client interaction.

Despite their best intentions, psychologists in Pope et al.'s study (1987) went against their own ethical beliefs, making ethical breaches. If loose confidentiality standards appear to be a struggle with psychologists in an office setting, these problems are likely to cause even greater challenges for the outreach clinician.

Confidentiality. The fundamental rules of confidentiality apply no matter where a client is seen. However, therapist-client privilege must be understood as flexible and not absolute (Boyd-Franklin & Bry, 2000), which is why there are practical limits to confidentiality (Koocher, 2003). When engaging in outreach psychotherapy these limits must be clearly stated. When clients sign a contract acknowledging that therapy is a confidential endeavor, they must also understand that there are conditions where confidentiality will not be maintained or would need to be broken by nature of the circumstances. For example, an outsider entering the home disrupts the bounds of confidentiality.

Other reasons to make limits of confidentiality clear when doing OP have to do with in-family concerns, such as one member of the family learning a “secret” about another member, due to eavesdropping or unintentional disclosure (Boyd-Franklin & Bry, 2000); or a client allowing a neighbor or friend to be present while therapy is occurring, eliminating the context under which confidentiality can exist. Although the *therapist* will maintain the confidential relationship, there is no guarantee the neighbor or friend will. Nevertheless, confidentiality is a necessity for effective psychotherapy, and when clients understand and then sign informed-consent, many of the problems associated with understanding limits of confidentiality can be avoided (Younggren & Harris, 2008; see Clemens, 2002, for sample treatment consent form). Some psychotherapists suggest continuing to review the limits of informed-consent and confidentiality throughout the lifetime of the therapy (Pomerantz, 2005). This may be something to consider in OP as the therapeutic relationship evolves. Bennett, Bricklin, Harris, Knapp, VandeCreek, & Younggren (2006) argued informed-consent can help maximize client participation in the treatment process by having a meaningful conversation with the client concerning the therapy, therapy style, and therapist’s role. The conversation can encourage

client's to ask questions while discussing client concerns, feeling, and goals. Boundaries can be agreed upon, such as the understanding that therapy will stop if there is an outsider within earshot of the therapy session.

A therapist is also a mandated reporter whether in or out of the family's home. There seems to be greater possibility for a therapist to witness reportable behaviors occurring when having therapy sessions in a client's home and the family is engaging in daily routines and conflicts. By 1968, while all 50 states had passed laws requiring all health care professionals to report child abuse and neglect, it is estimated that only 1 in 5 suspected cases are reported (Lawrence & Robinson Kurpius, 2000). Appelbaum (1999) reported between 40% and 66% of psychologists surveyed indicated at least one suspected case of child abuse went unreported. Nicolai and Scott (1994) found, in their study of 204 psychologists, when presented with a vignette of child abuse, the more specific and frequent the information concerning confidentiality, given to a client, the more likely the clinician would be to report the abuse. Nevertheless, OP workers must make it clear, and family members must understand, that as a mandated reporter the therapist is required to report abuse or neglect toward a child. While it is less likely a therapist in a clinic setting will be witness to child abuse during session, the possibility of witnessing child abuse increases for OP clinicians in the home (J. Sacco, personal communication, January 11, 2011).

Clinicians new to OP may benefit from a review of information concerning abuse and mandated reporting. [See Black, Heyman, and Smith Slep (2001) concerning risk factors of child sexual abuse; Black, Smith Slep, and Heyman (2001) detailing risk factors for child psychological abuse; and Schumacher, Smith Slep, & Heyman's 2001 article pertaining to risk factors for child neglect.] Reviewing the literature offers new clinicians insight into the many

facets of child abuse, while the government has a comprehensive website on the Internet to help mandated reporters understand their duties in any of the fifty states (see <http://www.childwelfare.gov/responding.cfm>).

If a therapist is to contact a school, or other agency concerning a child or adult client, it is imperative that written permission be given. A release of information must be signed and in the client's file. Boyd-Frankin and Bry (2000) encouraged therapists to understand there is a difference between *getting* and *giving* information, "Although therapists should obtain from referral sources and other agencies as much information as they have available, therapists should be careful to give only information which benefits the client" (p. 122). Limited disclosure of client information is an integral part of clients feeling safe and open in this most personal relationship. As stated previously (Pope et al., 1987), unintentionally disclosing confidential data is an ethical breach that occurs with some frequency. Again, although this can occur within a clinic setting, OP clinicians are in the community, in the schools, and at meetings concerning clients, and in all these setting, they are more inclined to share information about their client beyond what is absolutely necessary.

Maintaining confidentiality during a session can be difficult, whether in-home or out in the community. Discussing personal matters in public places may be the only way to talk openly with a client; as when a spouse is at home and relationship issues are pressing. However, it also leaves the therapist and client vulnerable to eavesdropping and breaches in one of the basic tenets of psychotherapy—confidentiality. Some ways to reduce this vulnerability are: being cognizant of the environment, choosing a more private setting, and sitting away from other people when possible; not using names in the conversation, speaking softly and discreetly; and not having PHI (Protected Health Information) on paperwork exposed to bystanders. It serves the

therapeutic relationship well to explore these essential confidentiality issues with the client, and work to build the relationship through understanding of the client's basic rights.

Boundaries in clinical practice. Maintaining therapeutic boundaries in clinical practice is a form of self-care (Norcross & Guy, 2007). Boundaries allow therapists to define the separation of their work and private lives. Loose or inconsistent boundaries can cause the seepage of one life into the other. Clear boundaries create a therapeutic environment where safety and predictability allow the therapeutic engagement to prosper (Gutheil & Gabbard, 1998). Gutheil and Gabbard (1993) argued that while “boundary crossing” is a descriptive term, “neither laudatory nor pejorative” (p. 190), “boundary violation” represents a harmful crossing. According to Pope and Keith-Spiegel (2008) “[n]on-sexual boundary crossings can enrich therapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also, however, undermine the therapy, sever the therapist-patient alliance, and cause immediate or long-term harm to the client” (p. 651). Gutheil and Gabbard (1998) cautioned that context plays a critical role in determining boundary problems. They consider boundaries to be “flexible standards of good practice rather than lists of generically forbidden behavior” (p. 409). This point is important to explore with new interns who may anxiously treat all boundary crossings as ethical violations devoid of context.

Boundaries serve to maintain consistent and predictable therapeutic engagement with clients, particularly those who often lead chaotic lives. Although clients may test boundaries with therapists, they are consciously, or unconsciously relieved when a therapist holds boundaries and does not fulfill the client's fantasy for boundary violation (Fernando, 2008). This is particularly true in OP when the therapist is within the bounds of the client's home, and a sense of familiarity and friendship often pervades the client's conscious thought.

Fernando (2008) suggested therapist loss of boundaries, and difficulty maintaining the therapeutic role in a client's home, may be seen as "enactment of rescue fantasy" by providing extra or inappropriate help to the client or family (p. 95). OP clients often request extra services from their therapist, such as a ride to the store or pharmacy, a desperate plea to pick up their child from school, or asking the therapist to stay with one child while they run off to get the other. They may ask to borrow money, or request that you show your ID for a controlled substance at the pharmacy because they forgot theirs. There are so many versions of this need to be saved by the therapist, particularly while working OP, it may become appealing to some OP clinicians to lose sight of boundaries and become an integral player in the family dynamics. Pope and Keith-Spiegel (2008) argued "thoughtful consideration of boundaries must be solidly grounded in our basic approach to ethical decision-making" (p. 640). The decision an OP therapist makes with a client concerning boundary crossing must be imbedded in an understanding of the context of the therapy, the implications of crossing this particular boundary with this particular client, by a particular therapist, and thoughtful exploration of many other variables.

Norcross and Guy (2007) argued "The emotional exhaustion and intrapsychic depletion characteristic of burnout can result from over-responsible therapists who too readily assume responsibility for their clients' lives or feel they need to save or rescue them" (p. 100). Therapists must be attentive to need gratification and the role it plays in any therapy setting, but particularly when doing outreach work. OP clinicians appear more likely to cross these boundaries as lines blur in one's professional role. Clients who receive OP services are, by definition, clients with greater needs (Cottrell, 1994; Lawson & Foster, 2005), who require more services; case management, support, advocacy, letter writing, phone calls made, and the list goes on. Working with this population exposes the therapist to more critical incidents requiring

immediate attention, meetings to attend, etc. Without proper attention being paid, therapy sessions are extended, clients are being driven to the grocery store, and therapists are accepting phone calls at all hours of the day from clients “in crisis.” When boundaries are blurred, regaining a firm footing, grounded in professional practice, may be challenging. Two important resources are paramount: whether the clinician is willing to share and explore these crossings in supervision, and whether the clinician has considered consultation with a respected colleague who can provide honest feedback. Both of these outlets can be useful to help ground a clinician in this difficult work.

Self-disclosure. Therapist self-disclosure may be defined broadly as statements which reveal something personal about the therapist (Hill & Knox, 2001). It can be useful for immediate goals of the therapy process, such as normalizing client experience. However, self disclosure is avoided when it is motivated by the therapist’s own needs, or moves the focus of treatment away from the client and onto the therapist. Hanson’s (2005) study examined the views of eighteen psychotherapy clients regarding therapist self-disclosure and non-disclosure. Participants were two and a half times more likely to find disclosure helpful, and two times more likely to find non-disclosure as non-helpful. However, Pope and Keith-Spiegel (2008) argued “the idea that self-disclosure is always appropriate, always therapeutic, always wanted by the client, always free of risks or unintended consequences, or always the best option is the source of countless boundary mistakes” (p. 647).

Self-disclosure may be used for the client’s benefit, no doubt. However, OP workers who feel isolated or disconnected from peers and supervision may look to the therapist-client relationship as the place to find satisfaction that is missing in other areas of the therapist’s life. Therapist self-awareness is critical to preventing inappropriate self-disclosure to the client

(Goldstein, 1994). This is particularly pertinent with OP services, as the client already has the impression of a less structured, more personal relationship with the therapist entering the home. Some clients understandably view therapists as “friends” and pull for personal information from them to support this belief. It can be helpful to consider a few questions when choosing to self disclose information (Pope & Keith-Spiegel, 2008):

Is it consistent with the client’s clinical needs and the therapy goals? Is it consistent with the kind of therapy you are providing and your theoretical orientation? Does it mainly reflect or express your own personal needs (to talk about yourself, to bring the focus to yourself)? What is your purpose for self-disclosing at this particular time? (p. 648)

These questions can help an OP clinician remain cognizant of the frame of the therapy, the goals of the therapy, and the interventions chosen for the therapy of a particular client. When an OP therapist stops to consider how any statement made is useful to a client’s therapy, it opens up a critical self-dialogue as to how focused a clinician is on client goals and planned interventions.

Dual relationships. Once a therapeutic relationship has been established between clinician and client, they are not free to take on other relationships together outside the therapeutic relationship. The APA Ethics Code supports this notion by having standards which do not allow relationships which could cause the client to be taken advantage of, exploited, or harmed (APA, 2002). APA Ethics Code 3.05, Multiple Relationships, declared psychologists refrain from being in another role with a person when a professional relationship has already been established with that person or someone close to that person. Despite clinicians having this code to guide them, multiple relationships and their propriety continue to be argued (Kitchener, 1988). One survey of psychologists found that there remains wide disagreement as to whether nonsexual dual relationships are ethical (Borys & Pope, 1989). Psychotherapists continue to

place themselves, or find themselves placed, in these dual relationships. It can be a particularly slippery slope for OP clinicians due to their presence in the community and their inherently more flexible boundaries with clients' family members and acquaintances. Coyle (1999) argued that any intimate knowledge of a client creates a power differential and that once a therapeutic relationship has been established; a social relationship is no longer possible regardless of how the therapist OR the client feels about this.

Much of the literature concerning dual relationships is related to the challenges of providing psychotherapy services in rural and small communities (e.g., Campbell & Gordon, 2003; Helbok, 2003; Horst, 1989; Schank & Skovholt, 1997; Simon & Williams, 1999; Stockman, 1990), and while OP may often take place in more populated areas, some of the research concerning multiple relationships in rural communities can be applied to this type of work. OP clinicians are found in the community engaging with clients. Sometimes they have connections with the client's family members, or they have been introduced to neighbors or friends. Any of these relationships complicates this discrete and unique relationship, and although it may be easy to relax ethical standards in these situations, these are the exact times that ethical standards must be upheld (Helbok, 2003).

Younggren and Gottlieb (2004) suggested therapists considering entering into a dual relationship with a client should consider an ethically-based, risk-managed, decision-making model to guide them. There are a number of these, and they will be explored later in this writing. However, what is important to consider is that there are multiple ethical decision-making models available to OP clinicians (see Anderson & Kitchener, 1998; Gottlieb, 1993; Kitchener, 1988; Knapp & VandeCreek, 2006; Pope & Vasquez, 2011; Younggren & Gottlieb, 2004), and they should be used to help the clinician make sense of ethical dilemmas and how to resolve them.

Safety. Therapist safety is imperative no matter where a client is seen. Safety is discussed and explored during graduate school and the discussion continues through practica and internship. Without the concern and consideration of safety, therapists put themselves at risk to become complacent and careless when engaged with clients. They lose their innate ability to judge interactions and nuanced behaviors (De Becker, 1997) which occur during session, and to critically manage their perception that something “may not be right,” or that emotions are escalating beyond a safe point. Once out in the community, a whole new set of concerns may arise.

Participants in Christensen’s (1995) study reported safety as being a concern when going into a client’s home. Boyd-Franklin and Bry (2000) stressed the importance of therapist safety as well as creating safety guidelines for an agency. Clark et al. (1985) mentioned safety as a concern when clinicians leave clinic work to go into the community, and Adams and Maynard (2000) noted that staff safety is of concern to agencies who send workers into the home. Considering the consistency in the literature pertaining to safety concern issues when clinicians are doing OP, it seems surprising there is not a source containing an outline of recommendations for therapists to follow to help them be safe in clients’ homes, and comfortable in the community. An individualized safety plan may work best to meet the needs of each agency, as it will focus on guidelines appropriate for that particular city, town, or neighborhood (Boyd-Franklin & Bry, 2000). The following are safety guideline recommendations from a number of sources who have experience in outreach work. A “Sample Safety Guidelines” handout has been created (see Appendix A) from some of these resources, and can be adapted to fit a particular agency’s needs.

There are some who recommend new OP clinicians begin to learn the work by going out into the community with an experienced clinician for at least their first week prior to receiving

their own cases, and once the new clinicians are given their first cases, an experienced clinician can join them for those first sessions (Boyd-Franklin & Bry, 2000). This helps to build self-confidence and competency in the field for the new OP clinician. Once new clinicians are on their own, there are some steps that are useful for them to consider while out in the field.

Clients' physical addresses and phone numbers should be kept up-to-date and available to supervisory staff when needed. This is important because OP clients often have unstable housing and may move on a moment's notice (Boyd-Franklin & Bry, 2000). OP therapists' weekly schedules should also be available to supervisors so that there is a record of their appointment times and the neighborhoods they are visiting (Wasik & Bryant, 2001). Knowing where a clinician is in the community can help if trouble arises and assistance is needed.

Outreach appointments are best made for daylight hours. However, when this is not possible, it is suggested that the clinician make arrangements with the client to meet at the car when arriving for the appointment, and being walked back to the car when leaving (Boyd-Franklin & Bry, 2000; Wasik & Bryant, 2001). Cars should be parked in well-lit areas which are free of debris, and offer a clear view of the vehicle from the client's home. It is suggested that the car is not parked near dumpsters, trees, or shrubs, which may offer hiding places for potential attackers (Boyd-Franklin & Bry, 2000; Wasik & Bryant, 2001).

Boyd-Franklin and Bry (2000) noted the importance of OP clinicians keeping their arms free to enable them to use their cell phones, if necessary. Wasik and Bryant (2001) recommended clinicians limit carrying or wearing valuable possessions, only having a day's worth of money with them, and dressing so as not to stand out in the neighborhoods they enter, while still looking professional. Although appropriate dress has been explored in graduate school seminars, it appears this issue may be somewhat tricky with new therapists. Since everyone has their own

style of dress, it may be more challenging to get new clinicians to understand the importance of thoughtful attire worn out in the community.

When in a client's home, the OP clinician can feel uneasy, with concrete reasons or without. Any discomfort concerning a client needs to be discussed in supervision. Clinicians cannot be effective when distracted by anxiety and fear. Wasik and Bryant (2001) argued "perhaps the most important safety guideline is that [OP clinicians] should use common sense and follow their instincts," (p. 152). De Becker (1997) argued further that intuition is what will keep a person safe; adding that intuition is uncomfortable for many and most people prefer logic. He stated, "We much prefer logic, the grounded, explainable, unemotional thought process that ends in a supportable conclusion. In fact, Americans worship logic, even when it's wrong, and deny intuition, even when it's right" (p. 11). Wasik and Bryant (2001) suggested that if the OP clinician feels unsafe in a client's home, exiting the situation is the most sensible option. Berg (1994) concurred, "Do not feel compelled to stay in a potentially violent situation. Allow yourself easy access to an exit," (p. 26). Furthermore, de Becker (1997) observed, "The truth is that every thought is preceded by a perception, every impulse is preceded by a thought, every action is preceded by an impulse, and man is not so private a being that his behavior is unseen, his patterns undetectable" (p. 15). Clinicians sensing something not being right in a client's home may, in fact, be picking up on the unconscious processing that de Becker was describing.

Finally, if a clinician does leave a client's home in response to feeling unsafe, it is important to document personal safety concerns, and discuss the situation in supervision (Wasik & Bryant, 2001). An OP clinician cannot do good work when distracted by safety concerns. Both therapist and client lose under these circumstances.

Self-care. Ethical codes for mental health professionals often include a provision for therapist self-care. APA Ethics Code (2002) stated, “Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (p. 1062). Balance between work and self-care cannot be argued strongly enough. Norcross and Guy (2007) argued the need for psychotherapist self-care, stating what may appear obvious: psychotherapists often do not follow the recommendations for self-care they offer to clients. Restful sleep, a balanced diet, regular exercise, and meaningful relationships all create the balance necessary for psychotherapists to feel refreshed and invigorated to continue to do this challenging work.

Outreach clinicians have the daunting task of meeting clients in their homes. OP is an incredibly demanding intervention (Lawson & Foster, 2005) where therapists attempt to join with the family while juggling multiple boundary challenges in the home, and being sidetracked by numerous concrete distractions such as environmental concerns (e.g., bugs, noise, and neighbors; Christensen, 1995). Often, these clients have been referred by an outside source and have no interest in engaging with the OP clinician, seeing the clinician as a threat to the family. Environmental distractions can be the clients’ attempt to rid the family of this outsider and regain homeostasis within the family unit (Kagan & Schlosberg, 1989). Clearly, the OP clinician is charged with managing all of these extra distractions while attempting to help the client make changes which can make a difference in improved life functioning and satisfaction. All of this extra “management” makes the need for self-care even more critical to these clinicians.

In a 1997 study of psychotherapists’ personal problems, the most frequently reported problems clustered around emotional exhaustion and fatigue (Mahoney, 1997). This comes as no surprise considering the intensity of the work, and therapists’ inability to heed their own advice

(Norcross & Guy, 2007). Pope and Vasquez (2011) argued “[e]ffective self-care strategies take realistic account of both how stressful doing therapy can be and how distressed we can become” (p. 77). Feelings of isolation from colleagues (Christensen, 1995; Clark et al., 1985) due to the nature of the work, can lead to outreach therapists feeling disconnected from the very supports they require for staying grounded and feeling recognized as an integral part of this difficult work. In one study, Fernando (2008) suggested that a therapist who acknowledged feeling isolated from the clinic believed that “the normal rules don’t apply” when providing OP services, because those who work from the clinic “just don’t understand” (p. 95).

Burnout is certainly a concern in outreach psychotherapy. Clinicians report feeling overwhelmed by the clients’ emotional needs (Lindblad-Goldberg et al., 1998). Maslach (2003) described burnout as “a prolonged response to chronic emotional and interpersonal stressors on the job” (p. 189). Creating a multidimensional model of the burnout phenomena, Maslach, along with colleagues, described three key dimensions of this model: overwhelming exhaustion, feeling cynical and detached from the job, and feeling ineffective while lacking accomplishment in one’s work (2003). The literature supports this definition of burnout. In one study, a participant reported “I don’t have enough energy or resources to change the environment” (Christensen, 1995, p. 312). Working with multi-problem families, with complex needs, and an unstructured home environment is challenging to OP clinicians, leaving them feeling ineffective (Lawson & Foster, 2005; Lindblad-Goldberg et al., 1998), and inadequate (Fernando, 2008). These feelings can lead to a sense of being overwhelmed, leading to therapist burnout (Christensen, 1995). Pope and Vasquez (2011) noted when therapist self-care is neglected there can be a number of consequences including, disrespecting clients and the work, making more mistakes, lacking energy and interest, worrying more, feeling isolated and disconnected, and

neglecting health. None of these outcomes are what OP clinicians hope for when they start working in this challenging profession.

Mahoney (1997) found some beneficial self-care habits of psychologists included engaging in a hobby, reading for pleasure, taking trips for enjoyment, attending artistic events or movies, and engaging in physical exercise. Being able to feel distanced from work and immersed in recreation, family, and pleasure allowed clinicians to return to work invigorated and ready to be challenged by work-related events. However, important to note, Pope and Vasquez (2011) argued “[s]elf-care strategies that support, strengthen, deepen, replenish, and enliven may, less than a year later, become a senseless obligation, distraction, and waste of time” (p. 77), and therefore, should be re-examined from time to time to see if old strategies no longer fit and new ones need to be explored.

Finally, regularly scheduled supervision is essential to outreach therapists to feel supported in this difficult work, to increase clinical competence, and to reduce incidence of burnout (Boyd-Franklin & Bry, 2000). Therapists in Adams and Maynard’s (2000) study acknowledged reluctance to disclose information to supervisors due to feelings of demoralization and ineffectiveness. However, supervisors may help their supervisees by affirming the “universality” of the stressors that OP workers face, and they may explore the “overpersonalization” of these stressors by the therapist as a way of normalizing these feelings (Norcross & Guy, 2007). Supervision specifically targeted to OP clinicians is imperative to encourage and develop competence and confidence in the field.

Supervision, consultation, and continued training should all be considered critical for growth as a clinician, and as self-care strategies while working in this challenging occupation (Pope & Vasquez, 2011).

Risk management. The minimum standards of professional conduct come from external sources such as professional codes of ethics, laws, and regulations; however, the highest standards of professional conduct are those which come from within (Bennett et al., 2006). Clinicians must work from an internal sense of ethical behavior, a moral compass, and not be driven by external fears. This can be done by understanding risk-management strategies, where psychologists can minimize legal risks by maximizing a culture of safety with clients (Knapp & VandeCreek, 2006); or as Bennett and colleagues put it, the calculation of the probability of good or bad outcomes or consequences (Bennett et al., 2006). Knapp and VandeCreek (2006) argued psychologists who practiced virtue-based risk-management principals, such as being informed, competent, emotionally balanced, sensitive, and personally insightful, reflect good clinical practice, and therefore, good risk-management practices. Bennett et al. (2006) established that certain risk-management strategies are nearly universal, and the three key elements to risk management, they argued, are informed-consent, documentation, and consultation.

Informed-consent can help to maximize client participation in the treatment process by having a meaningful conversation with the client concerning the therapy, therapy style, and therapist. The conversation will encourage client questioning while discussing client concerns, feelings, and goals (Bennett et al., 2006). Some recommend a review of informed-consent throughout the therapeutic relationship (Pomerantz, 2005).

Documentation is critical to proficient clinical practice. Knapp and VandeCreek (2006) opined “adequate documentation can be considered part of competent practice” and acknowledged “courts give great deference to professional records” (p. 37). It is generally believed that if it isn’t in the client’s record, it did not occur. Bennett et al. (2006) stated that

psychologists can provide an adequate level of care, but it is the documentation that will show it. Furthermore, they argued, not only should documentation include what was done and the reasoning behind it, but also what was not done and the reasoning behind that as well.

Consultation, like documentation, is imperative to ensure the clinician is providing the client with an adequate level of care. If the relationship with the client is good, a therapist could receive feedback from the client directly concerning client progress toward goals (Bennett et al., 2006). Peer consultation may also be received through individual consultation with a trusted colleague, or through an on-going peer supervision group (Bennett et al, 2006; Kassan, 2010). Consultation has been recommended as a self-care strategy throughout this literature review (Lawson & Foster, 2005; Pope & Vasquez, 2011) and both new and seasoned OP clinicians should do well to explore the usefulness of consultation.

Ethical decision-making models. Ethical decision-making competence is critical to psychologists needing to make ethical and boundary decisions concerning their clients and others with whom they may have relations. Many models exist (i.e., Gottlieb, 1993; Kitchener, 1988; Knapp & VandeCreek, 2006; Pope & Vasquez, 2011; Younggren & Gottlieb, 2004) and can be useful to work through these ethical or boundary dilemmas, whether in a clinic or OP. Most ethical decision-making models follow a process through a number of steps to come to a decision (Zur, 2007). Ethical decision-making skills must be practiced to become useful to OP clinicians who are out in the community with clients making decisions on the spot. A few of these models will be discussed here.

Kitchener (1988) offered three variables for ethical decision-making which help to identify potentially harmful dual relationships: (a) incompatibility of expectations between roles, such as between a clinical role and a social role; (b) as the obligations required by different roles

diverge, the potential for divided loyalties and loss of objectivity increases; and (c) as the power and prestige differential between client and therapist increases, so does the potential for exploitation. There are a number of dual relationships or boundary challenges that can easily be defined as high risk using these criteria. For example, clinicians avoid engaging in financial or business practices with clients (Pope et al., 1987, 1988), and the unquestioned consensus of opinion in the field is that therapists do not engage in sexual relationships with clients (Pope et al., 1988). However, the challenge to identify harmful dual relationships and boundary challenges may be more nuanced in OP situations. If a therapist has been driving around for weeks with the “check engine” light on in the car, and the client is a mechanic, is it appropriate for the therapist to ask the client to look at the engine? Or when a therapist is at the client’s home and the parent is making an ethnic dish that smells delicious and she wants the therapist to try it, is that an ethical dilemma? What if the therapist then chooses to see the client at dinnertime every week, hoping to be fed; at what point does it become an ethical violation?

Gottlieb (1993) used three dimensions to assess the potential for harm from dual relationships: (a) power differential, (b) duration of treatment, and (c) termination and potential future clinical engagement. It certainly can be argued that there is always a power differential between therapist and client, both during and after therapeutic treatment. Duration of treatment often speaks to the severity of the symptoms where, for example, the length of therapy for a client with an adjustment disorder may be brief, while the client who is not stable on medication and continues to cycle through mania and depression may be longer. Again, termination and potential future clinical engagement can be judged by the client’s past therapy experiences and whether a client may be requiring services in the future.

Younggren and Gottlieb (2004) created five questions to help the clinician manage the risk associated with considering a dual-relationship with a client. Is entering into a relationship in addition to the professional one necessary, or should I avoid it? Can the dual relationship potentially cause harm to the client? If harm seems unlikely or avoidable, would the additional relationship prove beneficial? Is there a risk that the dual relationship could disrupt the therapeutic relationship? Can I evaluate this matter objectively? That final question is the pivotal one; will the clinician be able to thoughtfully and completely explore each prior question to be able to say, “I was able to evaluate the situation objectively.”

The five-step model proposed by Knapp and VandeCreek (2006) may be used during a crisis or an emergency because, they argued, it is easy to learn and overlearn, with the objective being to reach a “good decision” (p. 42). The five steps include identifying or scrutinizing the problem, developing alternatives or hypotheses, evaluating or analyzing options available, acting on or performing the best option, and looking back or evaluating the results.

The final ethical decision-making model explored here (Pope & Vasquez, 2011) has seventeen steps, although the authors argued that not every step is needed for every situation and some steps may need to be adapted. They progress as follows:

1. State the question, dilemma, or concern as clearly as possible.
2. Anticipate who will be affected by the decision.
3. Figure out whom, if anyone is the client.
4. Assess whether our areas of competence—and of missing knowledge, skills, experience, or expertise—are a good fit for this situation.
5. Review relevant formal ethical standards.
6. Review relevant legal standards.

7. Review the relevant research and theory.
8. Consider whether personal feelings, biases, or self-interest might affect our ethical judgment.
9. Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.
10. Consider consultation.
11. Develop alternative courses of action.
12. Think through the alternative courses of action.
13. Try to adopt the perspective of each person who will be affected.
14. Decide what to do, review or reconsider it, and take action.
15. Document the process and assess the results.
16. Assume personal responsibility for the consequences.
17. Consider implications for preparation, planning, and prevention.

It could be argued OP clinicians may not believe they have the time to explore seventeen steps while in the community, but the most thoroughly thought out answers do not come from rash decision-making.

Documentation. “If it is not documented, it did not happen.” Some form of this statement has been acknowledged by many authors in ethics literature in the field of psychology (e.g., Bennett et al., 2006; Knapp & VandeCreek, 2006; Monahan, 1993; Pope & Vasquez, 2007; Pope & Vasquez, 2011). “Documentation and consultation (supplemented by peer support and, where needed, supervision) are not only major pillars of liability prevention; they are also pillars of responsible clinical and ethical care” (Gutheil & Brodsky, 2008, p. 286). Good documentation is critical, to demonstrate a reasonable standard of care for the client (Bennett et al, 2006); to

help maintain clinical focus on treatment goals; to allow collateral agencies or future providers a fair understanding of the client; and to encourage self-reflection for what is written, and what is not, in the documentation (Gutheil & Brodsky, 2008). OP clinicians benefit from the time taken for thoughtful documentation.

Summary of Literature Review

As the need for psychotherapists to work in the client's home and community increases, it is critical that these workers are adequately trained to manage this challenging task.

Researchers recognize OP workers to be at a disadvantage when they enter the field because of this lack of training, making them more susceptible to ethical and boundary challenges, feelings of isolation in the field, and burnout (Adams & Maynard, 2000; Lawson & Foster, 2005).

If OP workers are not receiving specific training within their graduate degree programs to work competently and confidently in the community, it becomes essential that the agency in which they choose to work, provide them with the training and support they require (Boyd-Franklin & Bry, 2000). This training will show the agency's commitment to its employees, and be an impetus to further trainings and open discussions concerning this difficult, often isolating work.

This chapter reviewed the paucity of literature concerning outreach psychotherapy, and the need for specific training for outreach therapists. Literature was explored concerning ethical and boundary challenges of therapists as these dilemmas relate to OP work. Specifically, the literature concerning confidentiality, boundaries in clinical practice, self-disclosure, dual-relationships, safety, and self-care were considered through the lens of OP and its challenges. Also, risk-management, ethical decision-making, and documentation literature were explored as

an aid to OP therapists gaining skills which encourage boundary management and reduce the potential for ethical errors and boundary violation.

Statement of Need for Training

A review of the literature outlines the rationale for the development and presentation of a training to assist OP clinicians (for this research study, specifically, pre-doctoral interns) to work effectively and confidently in the community and within their clients' homes. While there is much these clinicians will need to learn to work with this challenging population, learning to manage ethical and boundary challenges as a foundation to other trainings will aid in building a firm underpinning on which other trainings may build upon.

Training Design Process

The training was designed to be given in three, two-hour sessions. Style of the training was mixed: including lecture, exercises, and discussion using a PowerPoint presentation as an aid (See Appendix B for PowerPoint; see Appendix C for Syllabus,). Stolovitch and Keeps (2002) argued people learn most effectively through active mental engagement, and using multiple styles of teaching is best for this. The goal of training is ultimately transformation of the participant, not transmission of information. Transformation occurs through meaningful interaction. Participation, engagement, response, and feedback are all pieces of effective learning experiences (Stolovitch & Keeps, 2002). Therefore, this training was created to engage the participants in multiple styles of engagement, participation, and activities with the goal of transforming their understanding and knowledge of working in the community effectively and ethically with their clients.

Psychological training programs have shifted their focus to a competency-based model to develop and assess education and training curricula for their students (Borden & McIlvried,

2010). The three areas of competency; knowledge, skills, and attitudes (KSAs), are essential for training competent professionals (Borden & McIlvried, 2010). Therefore, using this model as a guide, this training focused on the following objectives: (a) increase participant *knowledge* of the ethical and boundary challenges of working in the community, (b) enhance participant *skills* to use ethical decision-making models effectively when trying to resolve ethical dilemmas, and (c) heighten participant self-awareness and understanding of *attitudes* they carry toward ethical dilemmas through vignette exploration (See Appendix D for vignettes) and discussion.

Following the three weeks of training, a post-training evaluation was used to assess participants' perceived gained knowledge, gained skills in using ethical decision-making models, and to evaluate the training (See Appendix E for post-training evaluation). Questions in the survey explored whether the training objectives were met and if the participants felt the knowledge gained was useful and applicable in their work-setting. They also had the opportunity to rate each topic in the training as to whether the discussion was as thorough as they would have liked, and the second page of the survey offered the participants the opportunity to expand on their thoughts concerning the training through an open comment section at the end of the survey.

Training Rationale

A review of the literature indicated therapists engaging in OP have no formal training in this work (Boyd-Franklin & Bry, 2000). These clinicians do not know what to expect when going into clients' homes and the community to conduct therapeutic work that they were formally trained to do in a clinic setting. This training was created to bridge this gap and encourage these OP workers to be flexible, reflective, and effective psychotherapists who are confident in managing the ethical and boundary challenges which may arise in atypical settings. This training was created to encourage flexible critical thinking skills on the part of the

participants as they worked together to understand many perspectives of the same ethical dilemma. Learning to use a number of ethical decision-making models would likely offer the OP clinician a sense of competence in solving ethical challenges in the community. Therefore, using the survey results to explore participants' experiences, specific research questions and hypotheses are as follows:

Question One

Will the training increase participants' perceived knowledge of the ethical and boundary challenges of working in the community? It is hypothesized that a training exploring ethical and boundary challenges in OP will increase participants' perceived knowledge to do OP in clients' homes and the community.

Question Two

Will the training enhance participants' skills to use ethical decision-making models after learning them in the training? It is hypothesized that if participants are taught ethical decision-making models through multiple training methods (e.g., lecture, vignettes, discussion, and feedback) the participants' skills to use ethical decision-making models will be enhanced.

Training Summary

The material summarized in the literature review is also the information which was explored in the training that was implemented in a community mental health clinic to complete this research study. The following is a summary of the training. A more thorough exploration of the training follows in the Methods chapter.

The training was presented in two hour segments over a three week period, totaling six hours. Style of the training was mixed: including lecture, exercises, and discussion using a

PowerPoint presentation as an aid (See Appendix B for PowerPoint; see appendix C for Syllabus).

The first week's training explored what must be considered, in the area of ethics and boundary challenges, when doing outreach psychotherapy. Advantages and challenges of OP were explored, followed by discussions on confidentiality, informed-consent, boundaries, self-disclosure, and dual-relationships. Articles were handed out, pertaining to ethical decision-making models, to be read prior to the second week's training.

Week two's training explored "what we can do to better care for ourselves and, in turn, our clients." The training began with Sample Safety Guidelines for Outreach Therapists (see Appendix A), being handed out to the participants. Safety was discussed concerning clinicians going out in the community to see clients, and the steps they could take to keep themselves safe. Self-care was the next topic in the training, followed by a discussion of documentation, risk-management, and ethical decision-making skills. Finally, five ethical decision-making models were presented and explored.

After reviewing the five ethical decision-making models, participants were given a set of hypothetical vignettes (see Appendix D) and were asked to explore them over the week, and use one or more of the ethical decision-making models to resolve each dilemma to their satisfaction. The vignettes were divided between the two sets of interns so that each clinic's interns could choose to work together on specific vignettes if they desired.

Week three was a review of what had been learned in the training with much of the session spent discussing and exploring how participants were able to resolve the vignettes they were given at the end of session two. The training ended with participants filling out a post-training survey (see Appendix E).

Chapter 3: Methodology

This chapter explores the methodology used in this training created for, and given to, pre-doctoral interns engaging in outreach psychotherapy. It begins with a description of the participants and trainer. This is followed by a thorough discussion of the training. The post-training survey is then described.

Training Implementation

Prior to obtaining participants for this study, the principal investigator (PI) requested and received permission from the community mental health (CMH) clinic administrator, where the training would take place, to allow the training to be presented. A letter of approval from the clinic administrator was then submitted to the University Institutional Review Board (IRB) as proof of permission to present the training.

Participants. This training was implemented in a CMH clinic and was given to a group of nine pre-doctoral psychology interns. Four interns, two male and two female, were from a CMH satellite clinic in eastern Massachusetts. These interns commuted to the main clinic in western Massachusetts for the training. (It should be noted that these four interns commuted, each week, to the main office for their didactics and this was not a change from standard practice.) The five interns at the main clinic included four women and one man.

Trainer. The PI was the trainer. Discussion concerning who would be appropriate to facilitate this training in the future resulted in two clear criteria being critical: (a) the trainer must have experience in outreach psychotherapy (OP), and (b) the trainer must be credible and knowledgeable in the subject content. Someone with little outreach experience would not be able to take the training material and present it in a way that would come off as anything other than disingenuous (E. Campbell, personal communication, March 8, 2012).

Informed-consent. Prior to the training being initiated, the participants were introduced to the concept of the training which would be offered to them, by way of the informed consent. They were given a detailed informed consent which was explained to them (see Appendix G), and then given time, to consider the implications of participating and to sign the informed consent if willing to participate in the training series. All potential participants chose to participate in the training and therefore signed the informed consent. Each participant was given a copy of the document.

Informed consent is required to contain specific information for potential research participants to help them make the best choice for themselves. The document must state that research is being conducted, who is conducting it, the purpose of the study, what is entailed if the person chooses to participate in the research, foreseeable risks and perceived benefits to the participant being involved in the research, a note that participation is voluntary, and finally, who to contact with questions or concerns about the research. Each of these items can be found on the informed consent. Also, the form was approved by the University IRB before being given to the participants.

Training. The six hour training took place in three, two-hour sessions over a three-week period. The title of the training was, “What is Mentionable is Manageable: Exploring Ethical and Boundary Challenges in Outreach Psychotherapy.” The first session covered “what we must consider when doing outreach psychotherapy.” A syllabus of the training was handed out to the participants (see Appendix C). A trainer’s syllabus, which is much more detailed, was used by the trainer, and is attached as Appendix F. This syllabus breaks down each part of the training so that someone other than the PI could offer the training to clinicians learning OP. As stated previously, the trainer would need to have experience in OP and be credible and knowledgeable

in the subject content. A PowerPoint presentation was used during the training (see Appendix B), and methods used during this first module included lecture, group exercises, and discussion. Content areas covered during this session were: (a) advantages and challenges of working in atypical settings, (b) confidentiality, (c) boundaries, (d) self-disclosure, and (e) dual-relationships. Between the first and second sessions participants reviewed articles discussing boundaries and ethical decision-making to help prepare for discussions during the second session concerning risk-management and ethical decision-making (See Gottlieb, 1993; Kitchener, 1988; Pope & Keith-Spiegel, 2008).

The second session focused on “what we can do to better care for ourselves and, in turn, our clients.” Again, a PowerPoint presentation was used (Appendix B), and methods used during this module included lecture, exercises, group discussion, and vignettes. Content areas covered during this session were: (a) safety, (b) self-care, (c) risk-management, (d) ethical decision-making, and (e) documentation. During the safety discussion, there was a handout, “Sample Safety Guidelines for Outreach Psychotherapists” (see Appendix A), which had information on it integrated from multiple literature sources, and was created specifically for this training. At the end of the session, the participants took home a hand-out of vignettes (see Appendix D) to explore, individually or with other participants, using an ethical decision-making model of their choice, which they had learned about during session two. They were asked to be prepared to discuss these vignettes during session three. These vignettes were created to represent potential ethical dilemmas which the interns may be exposed to during their work in clients’ homes or in the community.

The third session focused on “exploring what we have learned: summary, review, and evaluation.” Methods used during this module included vignettes’ exploration, review discussion,

and post-training evaluation. The final session was used to explore the hypothetical vignettes, and allow the participants to share their thought processes, critical thinking skills, and ethical decision-making knowledge and flexibility. This group discussion allowed the participants to hear how each other thought through dilemmas to resolve ethical issues.

This time was also used to review any questions the participants had concerning any part of the training. And, lastly, a post-training evaluation (Appendix E) was given out to evaluate the training.

Training Evaluation

The training was evaluated through a post-training survey (see Appendix E) which rated participants' perceived gained knowledge from the six hours of training. The post-training survey sought demographic information including the following: (a) years experience working in the mental health profession; (b) years experience as an outreach therapist prior to this internship; (c) years experience working in community mental health prior to this internship; (d) in what field is highest degree; (e) this internship is consistent with my career goals—strongly disagree, disagree, neutral, agree, strongly agree; (f) theoretical orientation, and (g) gender.

Following demographic information collection, the survey asked for participants reactions to the training. There are sixteen statements requiring an answer from five choices on a Likert-type scale. The scale choices are strongly disagree, disagree, agree, strongly agree, and not applicable. The statements include: (a) the training objectives were clear; (b) overall, the knowledge I gained in this training will be useful in my work; (c) the order of the training topics and activities made sense to me; (d) the pace of the training was good—neither too fast nor too slow; (e) I can now use ethical decision-making skills in my work; (f) I am satisfied with what I gained from this training; (g) I would recommend this training to others; (h) this training is a

good addition to the internship program; (i) hand-outs and vignettes helped me understand the material; (j) the presentation on confidentiality was thorough; (k) the presentation on boundaries was thorough; (l) the presentation on self-disclosure was thorough; (m) the presentation on dual-relationships was thorough; (n) the presentation on safety was thorough; (o) the presentation on self-care was thorough; and (p) the presentation on documentation and risk-management was thorough. There is then a request for a global rating for the training: the overall rating I would give this training is: not useful, useful, very useful, or extremely useful. The final statement on the survey was a request for participants to add any further comments, clarifications, or thoughts: “Any further comments are appreciated to improve upon this training (e.g., elaborate on any of the ratings above; identify what was most or least useful in the training, what you might add to improve the training, any other thoughts)” with nearly a full page on which to write.

The goals of this training were, (a) to increase participant knowledge of the ethical and boundary challenges of working in the community, (b) enhance participant skills to use ethical decision-making models effectively when trying to resolve ethical dilemmas, and (c) to heighten participant understanding of the attitudes they carry toward ethical dilemmas. The survey was used as an attempt to explore participants’ subjective experience of knowledge gained.

The frequency of responses to each survey statement is displayed in tables found in the following chapter. A narrative explores more fully the implications of the results of the survey responses, and the open comments at the end of the survey are summarized. This resulted in a summary of the information collected in the survey. The effectiveness of this training was explored, using basic descriptive statistics, to create a better understanding of whether participants benefited from this training. Implications for improving future trainings are then considered.

Chapter 4: Results

This chapter will present the demographic information collected from the participants, along with the findings of the training survey. The open comment section of the survey will then be summarized.

Demographic Information

Tables 1—7 display demographic data collected concerning participants' work experience, educational experience, career goal consistency with internship, theoretical orientation, and gender. There were a total of nine participants in the training and the following information synthesizes the post-training survey responses.

The majority of the participants, six (67%), had between one and five years experience in the mental health profession, while two participants (22%) had six to ten years experience in the mental health field, and only one participant (11%) had more than ten years experience in the mental health profession.

None of the participants (0%) had ever worked as an outreach psychotherapist in their career, and four (44%) had never worked in CMH. Three participants (33%) had one year experience working in CMH, one participant (11%) had three years experience working in CMH, and one participant had five years experience working in CMH.

Seven participants (77%) had their highest degree in Psychology, and one participant each had their highest degree in Counseling (11%), and Education (11%).

More than half of the participants (67%) agreed or strongly agreed that the internship was consistent with their career goals; five participants acknowledged "agree" and one "strongly agree." Two participants (22%) responded "neutral," and one (11%) disagreed, meaning the internship was inconsistent with career goals.

Table 1

Participant years experience in the mental health profession

<u>Number of years</u>	<u>n</u>	<u>Percentage</u>
1-5 years	6	66.66%
6-10 years	2	22.22%
More than 10 years	1	11.11%

Table 2

Participant prior experience in outreach psychotherapy

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Yes	0	0%
No	9	100%

Table 3

Participant prior experience in community mental health

<u>Number of years</u>	<u>n</u>	<u>Percentage</u>
0	4	44.44%
1	3	33.33%
3	1	11.11%
5	1	11.11%

Table 4

Field in which participant has highest degree

<u>Field</u>	<u>n</u>	<u>Percentage</u>
Counseling	1	11.11%
Education	1	11.11%
Psychology	7	77.77%
Social work	0	0%

Table 5

Internship consistent with career goals

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly disagree	0	0%
Disagree	1	11.11%
Neutral	2	22.22%
Agree	5	55.55%
Strongly agree	1	11.11%

Theoretical orientation of participants varied, with four participants (44%) identifying as other (eclectic / integrative), three participants (33%) identified cognitive behavioral as their orientation, one participant (11%) reported psychodynamic, and one participant (11%) identified as interpersonal.

Two-thirds of the participants were female (66%) and, one-third male (33%).

Table 6

Participant theoretical orientation

<u>Theoretical orientation</u>	<u>n</u>	<u>Percentage</u>
Psychodynamic	1	11.11%
Cognitive Behavioral	3	33.33%
Humanistic	1	0%
Interpersonal	1	11.11%
Other/Integrated	3	44.44%

Table 7

Participant gender

<u>Gender</u>	<u>n</u>	<u>Percentage</u>
Female	6	66.66%
Male	3	33.33%
Transgendered	0	0%

Following the demographic questions on the survey, there were sixteen statements that participants were asked to rate concerning the training. Rating choices were “strongly disagree,” “disagree,” “agree,” “strongly agree,” and “not applicable.” No responses fell into the “strongly disagree” or the “not applicable” categories. Tables 8—24 display responses from the post-training survey. These responses relate to participants’ subjective experience of the training.

An overwhelming majority (89%) of the participants believed that the training objectives were made clear during the training. One participant (11%) did not agree. However, all participants affirmed that the knowledge gained in the training would be useful in their work: 56% agreed; and 44% strongly agreed.

One participant (11%) did not think that the order of the training topics and activities made sense, while 44% agreed they made sense, and 44% strongly agreed. Again, one participant disagreed that the pace of the training was good—neither too fast nor too slow. Six participants (67%) agreed, and two participants (22%) strongly agreed that the pace of the training was good. All participants agreed (67%), or strongly agreed (34%), that they could now use ethical decision-making skills in their work.

The majority of participants would recommend the training to others; seven participants (78%) strongly agreed, one participant (11%) agreed, and one participant (11%) would not recommend the training to others. All participants agreed that the training was a good addition to the internship program with 4 participants (44%) agreeing, and 5 participants (56%) strongly agreeing.

Table 8

The training objectives were clear

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	4	44.44%
Strongly Agree	4	44.44%
Not Applicable	0	0%

Table 9

Overall, the knowledge I gained in this training will be useful in my work

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	0	0%
Agree	5	55.55%
Strongly Agree	4	44.44%
Not Applicable	0	0%

Table 10

The order of the training topics and activities made sense to me

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	4	44.44%
Strongly Agree	4	44.44%
Not Applicable	0	0%

Table 11

The pace of this training was good-neither too fast nor too slow

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	6	66.66%
Strongly Agree	2	22.22%
Not Applicable	0	0%

Table 12

I can now use ethical decision-making skills in my work

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	0	0%
Agree	6	66.66%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 13

I am satisfied with what I gained from this training

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	5	55.55%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 14

I would recommend this training to others

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	1	11.11%
Strongly Agree	7	77.77%
Not Applicable	0	0%

Table 15

This training is a good addition to the intership program

Response	n	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Agree	4	44.44%
Strongly Agree	5	55.55%
Not Applicable	0	0%

All participants agreed that the handouts and vignettes helped them to understand the material presented in the training. Six participants agreed (67%), and three participants strongly agreed (33%), that these materials were useful.

Finally, the following responses pertain to each topic explored in the training. The same response options were used as previously stated: strongly disagree, disagree, agree, strongly agree, and not applicable. Each statement questions whether the topic presentation was thorough.

For the training presentation on confidentiality, two participants (22%) did not agree that it was thorough. Six participants (67%) agreed it was thorough, and one participant strongly agreed that it was thorough.

The presentation on boundaries had two participants (22%) responding they did not think it was thorough. Four participants (44%) thought the presentation was thorough, and three participants (33%) strongly agreed that the presentation on boundaries was thorough.

The presentation on self-disclosure had one participant (11%) disagreeing it was a thorough presentation, and eight participants (89%) agreeing that the presentation was thorough.

The training presentation on dual relationships resulted with one participant (11%) not agreeing it was thorough, seven participants (78%) agreeing it was thorough, and one participant (11%) strongly agreeing the presentation was thorough.

The presentation on safety was found to be thorough by all participants, with six participants (67%) agreeing, and three participants (33%) strongly agreeing.

The presentation on self-care had one participant (11%) disagree that it was thorough, five (56%) agree it was thorough, and three (33%) strongly agree the presentation was thorough.

The presentation on documentation and risk-management was found to be thorough by all participants; six participants (67%) agreed, and three participants (33%) strongly agreed.

Table 16

Hand-outs and vignettes helped me understand the material

Response	n	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Agree	6	66.66%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 17

The presentation on confidentiality was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	2	22.22%
Agree	6	66.66%
Strongly Agree	1	11.11%
Not Applicable	0	0%

Table 18

The presentation on boundaries was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	2	22.22%
Agree	4	44.44%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 19

The presentation on self-disclosure was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	8	88.88%
Strongly Agree	0	0%
Not Applicable	0	0%

Table 20

The presentation on dual-relationship was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	7	77.77%
Strongly Agree	1	11.11%
Not Applicable	0	0%

Table 21

The presentation on safety was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	0	0%
Agree	6	66.66%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 22

The presentation on self-care was thorough

<u>Response</u>	<u>n</u>	<u>Percentage</u>
Strongly Disagree	0	0%
Disagree	1	11.11%
Agree	5	55.55%
Strongly Agree	3	33.33%
Not Applicable	0	0%

Table 23

The presentation on documentaion and risk management was thorough

Response	n	Percentage
Strongly Disagree	0	0%
Disagree	0	0%
Agree	6	66.66%
Strongly Agree	3	33.33%
Not Applicable	0	0%

The final response on the post-training survey was to get a global rating to the training. The statement was “the overall rating I would give this training is,” followed by four choices: not useful, useful, very useful, or extremely useful. No participant responded “not useful.” Three participants (33%) found the training useful. Three participants (33%) found the training very useful, and the final three participants (33%) found the training extremely useful.

Table 24

Overall rating for the training

Response	n	Percentage
Not useful	0	0%
Useful	3	33.33%
Very Useful	3	33.33%
Extremely Useful	3	33.33%

At the end of the survey, there was an opportunity to share further participant feedback pertaining to the training. It was encouraged that participants add anything that might be useful to improve upon the training, including elaborating on any of the ratings given; identifying what was most or least useful in the training, or suggesting additions to improve the training. Three participants (33%) did not add comments to this section. Six participants (66%) added comments and these are summarized here:

- Appreciated the interactive components.
- Really appreciated your ability to personalize the training: own stories, using interns shared experiences to clarify points, humor with understanding of the population, and a depth and breadth of knowledge of outreach therapy.
- I would suggest using fewer examples from your own experience, or state that “another clinician shared...” All else was great.
- Would have benefited from the training earlier in the year (but was still beneficial).
- This training will be useful to new interns.
- Anecdotes were helpful and sparked useful conversation.

- The training stimulated lively dialogue among the participants.
- Some of the interactive parts took up too much time and may have detracted from the training.
- Possibly actively doing the vignettes together in the group (instead of between sessions).
- You have a real talent to facilitate trainings.
- You did an excellent job as far as making the training cohesive, relevant, and interesting.

This chapter explored the results obtained from the post-training survey. There were two research questions posed: (a) will the training increase participants' perceived knowledge of the ethical and boundary challenges of working in the community, and (b) will the training enhance participants' skills to use ethical decision-making models after learning them in the training? It appears that both of these questions have been answered in the affirmative, since the survey responses most closely related to these questions were both unanimously agreed upon. The responses to whether the knowledge gained in the training would be useful in the participants' work were 66% agreed, and 33% strongly agreed. The responses to "I can now use ethical decision-making skills in my work" were 66% agreed, and 33% strongly agreed. In general, the training appears to have been successful at enhancing participant knowledge and understanding through meaningful interaction, and transformation of participants, using multiple training styles.

The following chapter will discuss the findings from presenting the training, implication of these findings, limitations of the training, and recommendations for future research.

Chapter 5: Discussion

The purpose of this research study was to create and offer training to pre-doctoral interns who had chosen an internship doing outreach psychotherapy. There was a consensus in the literature that outreach psychotherapy is challenging work (Lawson & Foster, 2005), and that clinicians are not prepared for this difficult task upon completing graduate studies (Adams & Maynard, 2000). Therefore, this training was created with the following objectives in mind: (a) to increase participant knowledge of the ethical and boundary challenges of working in the community, (b) to enhance participant skills to use ethical decision-making models effectively when trying to resolve ethical dilemmas, and (c) to heighten participant self-awareness and understanding of attitudes they carry toward ethical dilemmas. This chapter presents a discussion of the most significant findings from the post-training survey, implications of the training survey results, limitations of the training, and recommendations for future research. Closing thoughts complete this chapter.

Conclusions: Participant Feedback

Results from the post-training survey support the hypothesis that the training would be useful to the participants; however, feedback suggested there would be increased benefit for the participants to have had the training earlier in the internship year. Two of the participants acknowledged this, stating that new interns would benefit from the training, and also that although there was benefit from having this training later in the internship year, it would have been more helpful earlier in the year.

Throughout the training, and acknowledged in the comment section, participants reported that this training, in particular, engaged the interns more with each other than any past training. Specifically, participants reported that the training “stimulated lively dialogue among the

participants,” and that the “anecdotes were helpful and sparked useful conversation.” Something which may have helped encourage this interaction was that the training space was intentionally made a non-evaluative space for participant reflection and expression. Only the trainer and participants were present during the training. Other persons of an evaluative nature were not present, and understood and respected the intent of the training to be a non-evaluative space where the participants could explore their thoughts and beliefs about the nature and challenges of outreach psychotherapy.

While one participant appreciated the interactive component, another suggested that it sometimes took up too much time and may have detracted from the training. This feedback is helpful to balance future trainings.

Another participant appreciated that the trainer personalized the training by using anecdotal and engaging therapy stories, and encouraging participants to reflect upon the challenges they had faced with their own clients doing this work. Making the information feel personal helps the participants hold onto the lesson and transform their understanding of a topic.

On the other hand, when the trainer tells of events, starting with “one time [this happened],” it can sound as though all of the experiences were personal to the trainer. This was made clear when a participant suggested “using fewer examples from your own experience.” It is useful to get feedback that lets the trainer know what the participants are hearing, whether intentional or not.

Finally, one participant suggested actively exploring the vignettes together, during the training time, in the group. The ethical decision-making models were reviewed during the second session, and then the participants were assigned vignettes to explore during the week. They were to come back for session three and be able to discuss how they worked through the challenges. It

would make sense to go through a vignette during the training time, before sending the rest of the vignettes home to explore. If this training continues to be used, vignettes may be explored after reviewing the ethical decision-making models toward the end of session two.

More generally, the surveys were reviewed for any data which seemed notable. The outliers appeared to be that one participant had over ten years experience in the mental health field and five years, specifically, in CMH; and, contrasting this, only one participant reported that the internship was not consistent with the participant's career goals, while the other participants were neutral or found the internship consistent with career goals.

Interestingly, the results of exploring these two participants' surveys seemed quite surprising. Contrasting findings from these two participants appears somewhat remarkable. However, what first appears counter-intuitive developmentally may make sense.

The one participant with over ten years experience in the mental health profession, and also over five years experience in CMH found the training to be "extremely useful." The participant had an eclectic theoretical perspective, "agreed" that the internship was consistent with career goals, and rated all parts of the training with either "agree" (n = 7), or "strongly agree" (n = 9). The participant also gave critical feedback in the summary section which was reflective and useful.

The one participant to report that the internship was not consistent with career goals (marking "disagree"), had one to five years experience in the mental health profession, one year experience in CMH, and reported an integrated theoretical perspective, found the training "useful." Moreover, the participant rated the training more critically; "agree" (n = 6), "strongly agree" (n = 2), and "disagree" (n = 8). The participant gave no feedback in the summary section, which clearly would have helped to understand the ratings more completely.

The two points which seem to stand out in this comparison are as follows. Although first thoughts might be that a clinician with over ten years experience in the mental health profession, and more than five in CMH may have found the training somewhat elementary following this much experience, it appears that the training was “extremely useful.” One explanation may be that the participant could synthesize the information on a more complex conceptual level than a participant with many years less experience. Also, because the internship was not consistent with the other participant’s career goals, it may not have been as interesting or valuable to that participant, and therefore, was rated lower.

Finally, concerning the survey itself, it was suggested that instead of a “not applicable” choice on the survey, that a new rating of “neutral” be added to the survey for when a participant does not have an opinion one way or the other concerning a statement (K. McMahon, personal communication, March 8, 2012). Although, this was not changed on this survey, it could be considered in the future, and may be a more useful response for rating. Also, it would be useful for each participant to make comments at the end of the survey to help improve on the training.

Implications. The implications of this training are that it was useful to the participants, and would benefit other clinicians if given to them earlier in their outreach career. This training can be revised to be used with other workers who go into the home (e.g., therapeutic mentors, early intervention workers, paraprofessionals, and other wraparound program caseworkers). The training has direct clinical application and can also be used in future research to create new trainings for outreach clinicians.

Limitations of the training. Some limitations of this training must be noted. First, with only nine participants in this study, the results are limited and not generalizable across the field of outreach work. However, the information gained from the survey can help to refine the

training, which can then be given to larger groups of outreach clinicians. The results from the survey given in future trainings will then help to continually refine the information most useful to outreach clinicians.

Second, the participants were all pre-doctoral interns, a very homogeneous group, suggesting a higher level of conceptual thinking and experiences. This training may not be understood by less experienced clinicians at the same conceptual level due to a more rigid thinking style concerning ethical behaviors. Nevertheless, trainings are understood at the intellectual capacity of the individual participant. Therefore, each participant may be getting different benefits from the training.

Third, as suggested, the training may have offered greater benefits to the participants had it been offered to them earlier on in the training year (instead of nine months into their internship). This unfortunately was impossible due to the timeframe of the researching and writing of this work. However, with this information in mind, if this training continues to be offered to new interns, it will most likely benefit them most to be given to them four to six weeks into their training year, when they have established some outreach clients, but are still managing the therapeutic engagement process.

Recommendations for Future Research

The current training lays a foundation for outreach clinicians to feel empowered and create confidence in their work through exploration of potential boundary and ethical challenges they may face in this unfamiliar environment. Each topic has the potential to be explored further, in depth and breadth, which could then be developed into future trainings. For example, clinicians would benefit from a specific training on informed-consent, learning to manage early sessions to create the most fertile environment for therapy to be explained, boundaries to be

established, and a healthy therapeutic relationship to form, where goals are co-created and clients feel empowered to work efficiently toward them.

Paraprofessionals who go into the home to serve families could also benefit from trainings created to explore boundaries and role confusion. These workers generally have less academic experience, and may never have participated in any ethics training.

Also, it is clear from the paucity of literature, that the supervisory needs of outreach clinicians have not been fully explored, or met. Christensen (1995) argued specialized training needed to be provided to outreach supervisors in order to address the unique issues of clinicians working in client's homes and the community. Much of the literature on supervision of outreach workers is outdated (Zarski, Greenbank, Sand-Pringle, & Cibik, 1991; Zarski & Zygmund, 1989). The most recent literature found on supervision of outreach therapists (Lawson, 2005) acknowledged that the literature-base is sparse. Little research has examined the important skill sets and interpersonal qualities necessary to be an effective and inspiring outreach supervisor; one who not only works with these clinicians to hone their clinical skills, but instills in them a sense of achievement in, and dedication to, their work.

Closing Thoughts

This has been a long, and sometimes painfully slow, process. However, as the light from the end of the tunnel beckons, it appears the academic process has won out. Knowledge has been honed, new findings have been established, and the literature concerning the ethical and boundary challenges of engaging in outreach psychotherapy has been expanded upon.

People take different roads seeking fulfillment and happiness. Just because they're not on your road doesn't mean they've gotten lost.

~Dalai Lama

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Appendix A: Sample Safety Guidelines for Outreach Therapists

“The truth is that every thought is preceded by a perception, every impulse is preceded by a thought, every action is preceded by an impulse, and man is not so private a being that his behavior is unseen, his patterns undetectable,” de Becker (1997, p.15).

- It is important to perceive what is actually happening in the environment, as opposed to imaginings of what is possible. Perception enhances safety; imagining potential dangers drowns out perception’s subtle signals by creating the distracting noise of panic.
- “Real fear occurs in the presence of danger and will always easily be linked to pain or death” (p. 300). The fear signal is NOT voluntary! Worrying is voluntary AND a choice.
- “Precautions are constructive, whereas remaining in a state of fear is destructive,” (p.294).

Precautions for safety while doing Outreach Psychotherapy:

- Physical addresses of clients should be updated regularly and available to supervisor.
- A copy of your outreach schedule should be available each week.
- Appointments are best made for daylight hours.
- Cars are parked in areas that are well-lit & free of clutter (e.g., shrubs, trees, or dumpster).
- Do not carry so much that you could not free a hand to use your cell phone.
- Limit carrying/ wearing valuable possessions, have just enough \$\$ to get through the day.
- Any discomfort concerning a client needs to be discussed in supervision. Clinicians cannot be effective if distracted by anxiety or fear.
- If clinician is fearful during session: Assess gravity of the situation and leave if situation is perceived as dangerous. For example, intoxicated individuals, drug use or dealing, violence in the home, or evidence of a weapon.
- Document personal safety concerns after leaving the session. If it is not documented, it did not happen.

Ideas adapted from: Berg, 1994; Boyd-Franklin & Bry, 2000; De Becker, 1997; and Wasik & Bryant, 2001.

Appendix B: PowerPoint Training

What is Mentionable is Manageable:
Exploring Ethical and Boundary Challenges in Outreach Psychotherapy

Training Objectives

- Increase participant knowledge of the ethical and boundary challenges of working in the community.
- Enhance participant skills to use ethical decision-making models effectively when trying to resolve ethical dilemmas.
- Heighten participant self-awareness and understanding of attitudes they carry toward ethical dilemmas.

Session One
What We Must Consider When Doing Outreach Psychotherapy

Content Areas:

- advantages and challenges of atypical settings
- confidentiality
- boundaries
- self-disclosure
- dual relationships

“A simple gesture of removing one’s shoes [...] can begin a therapeutic process on a note of respect” (Reiter, 2000, p.33).

- *What is your initial reaction to this statement?*
- *Did you ever consider a situation where you would take off your shoes doing therapy?*
- *How would you respond to the following?*



What might be involved in this client request?

- Culture?
- Boundaries?
- Engagement?
- Respect of being in client’s home?
- Power struggle?
- Test?

Advantages and Challenges of the Atypical Setting

Exercise:

- Break up into dyads
- List Advantages of Atypical Settings (5 min)
- List Challenges of Atypical Settings (5 min)
- Share lists with the group
- Discuss findings
- Implications?

Advantages

- A:
- B:
- C:
- D:
- E:
- F:
- G:

Challenges

- A:
- B:
- C:
- D:
- E:
- F:
- G:

Ethical Issues and Boundary Considerations

- What must we consider when doing outreach psychotherapy?

- How do we manage these topics with the added distractions in outreach that are not present in-clinic?

Confidentiality

It is critical to effective psychotherapy

- Therapist-client privilege is flexible and not absolute, and there are limits to confidentiality.
- If a child is in danger of being hurt by self or other, or court request., but...
- What about all the incidental confidentiality breaches?

Informed-Consent

Informed-consent can help to maximize client participation in the treatment process by having a meaningful conversation with the client concerning the therapy, therapy style, and therapist. The conversation will encourage client questioning while discussing client concerns, feelings, and goals (Bennett et al., 2006).

This is the point where boundaries can be agreed upon.

Taken-for-Granted Practices

Assumptions:

- Client knows how “to do” therapy
- Client knows how to maintain boundaries
- Client knows “the right to confidentiality”
- Client knows how to respond to empathy
- Client should feel safe around you
- Client should trust you

Mandated- Reporting

- **Child-abuse: What is the threshold?**
- 'Abuse' means the nonaccidental commission of any act by a caregiver upon a child under age 18 that causes or creates a substantial risk of physical or emotional injury, or constitutes a sexual offense under the laws, or any sexual contact between a caregiver and a child under the care of that individual.
- http://www.childwelfare.gov/systemwide/laws_policies/state/index.cfm?event=stateStatutesProcessSearch
- **Tarasoff: What is this?**
- Mental health professionals have a “duty to protect” an intended victim of bodily harm by a patient.
- http://en.wikipedia.org/wiki/Tarasoff_v_Regents_of_the_University_of_California

Boundaries

- What are they?
They are flexible standards of good practice, not lists of generically forbidden behaviors. (Guthrie & Gabbard, 1998)
- What do we do with them?
We use them to keep our clients and ourselves safe (both physically and psychologically)
- Use of the therapy hour:
 - How is it managed?
 - Who is it for?
- Need Gratification:
 - Therapist problems in other areas of life?
 - Self-awareness is critical.

Self-Disclosure

- Therapist self-disclosure may be defined broadly as statements which reveal something personal about the therapist (Hill & Knox, 2001).
- Therapist self-awareness is key to preventing therapists from having their own needs met through self-disclosure to the client (Goldstein, 1994).

Considering Self-Disclosure?

- Is it consistent with the client's clinical needs and the therapy goals?
- Is it consistent with the kind of therapy you are providing and your theoretical orientation?
- Does it mainly reflect or express your own personal needs (to talk about yourself, to bring the focus to yourself)?
- What is your purpose for self-disclosing at this particular time?
Pope & Keith-Spiegel (2008)

Dual Relationships

Once a therapeutic relationship has been established between clinician and client, they are not free to take on other relationships outside of the therapeutic relationship.

Ethics Code 3.05, Multiple Relationships, declares psychologists refrain from being in another role with a person when a professional relationship has already been established with that person or someone close to that person.

Dual-Relationships
(Multiple Relationships)

- How do you manage in the same town as your clients, particularly when you are already out in the community with them?
- Clients: I consider you my friend.
- Parents: We have a lot in common...
- Collaterals: Managing relationships
- Community Resources: Knowing your clients

References: Session One

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http://en.wikipedia.org/wiki/Tarasoff_v_Regents_of_the_University_of_California

Sample Safety Guidelines for Outreach Therapists

- It is important to perceive what is actually happening in the environment, as opposed to imaginings of what is possible. Perception enhances safety; imagining potential dangers drowns out perception's subtle signals by creating the distracting noise of panic.
- "Real fear occurs in the presence of danger and will always easily be linked to pain or death" (p. 300). The fear signal is NOT voluntary! Worrying is voluntary AND a choice.
- "Precautions are constructive, whereas remaining in a state of fear is destructive," (p.294).

Safety Guidelines continued
Precautions for Safety While Doing Outreach Psychotherapy:

- Physical addresses of clients should be updated regularly and available to supervisor.
- A copy of your outreach schedule should be available each week.
- Appointments are best made for daylight hours.
- Cars are parked in areas that are well-lit & free of clutter (e.g., shrubs, trees, or dumpster).
- Do not carry so much that you could not free a hand to use your cell phone.
- Limit carrying/wearing valuable possessions, have just enough \$\$ to get through the day

Safety Guidelines continued

- Any discomfort concerning a client needs to be discussed in supervision. Clinicians cannot be effective if distracted by anxiety or fear.
- If clinician is fearful during session: Assess gravity of the situation and leave if situation is perceived as dangerous. For example, intoxicated individuals, drug use or dealing, violence in the home, or evidence of a weapon.
- Document personal safety concerns after leaving the session. If it is not documented, it did not happen.

Ideas adapted from: Berg, 1994; Boyd-Franklin & Bry, 2000; De Becker, 1997; and Wasik & Bryant, 2001.

Are there clients you just don't see in the home?

Self-Care

- There is a Universality to what we do and the experiences involved in our work.
- We can feel similar emotions and have similar thoughts.
- What we each do with these experiences, however, is based on our own stories, our own history, our own reality.

Affirming Universality

- "When recognizing the stresses you encounter as a psychotherapist, keep in mind that similar kinds of pressure are experienced by virtually all of your colleagues. Confidentiality, isolation, shame, and a host of additional considerations lead us to overpersonalize our own sources of stress when in reality they are part and parcel of the 'common world' of psychotherapy. Disconfirming our individual feelings of unique wretchedness and affirming the universality of stresses are in and of themselves therapeutic" (Norcross & Guy, 2007, p. 57).

Vicarious Traumatization

- “[T]he transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients’ trauma experiences and their sequelae .”

- “[I]mplics changes in the therapist’s enduring ways of experiencing self, others, and the world.”

Pearlman & Mac Ian (1995), p. 558.

Characteristics of Outreach Population

- Possibly any or all of the following:
 - Multi-problem
 - Multi-generational
 - Severe trauma history
 - Lacking hope or vision for change
 - Low SES
 - Few resources
 - Dysfunctional ways of trying to get their needs met

Let’s Look at Ways to Reduce This Stress

- Recognizing commonality of experience.
- Realizing you are not alone.
- A thought is only a thought, no matter how _____ (fill in the blank) We all have them.
- Understanding and practicing safety and self-care could equate to feelings of confidence and competence in our work and our lives.

More Self-Care

Eat well-balanced, nutritious meals; get sunshine and fresh air; regular exercise; and quality sleep.

Wait, does this sound familiar?
Why can't we follow our own advice?

And a Few More

Mahoney (1997) found the beneficial self-care habits of psychologists to include:

- engaging in a hobby
- reading for pleasure
- taking trips for enjoyment
- attending artistic events or movies
- engaging in physical exercise

What is your favorite self-care strategy?

Critical Judgment and Decision-Making Skills

Thinking on your feet
by using
risk-management and
ethical
decision-making

Why Smart People Do Stupid Things

At some point, people make mistakes when:

- they fail to recognize the limits of their own knowledge, or
- they fail to consider the interests of other people.

Sternberg, 2003

Risk-Management

- **What is it?** The calculation of the probability of good or bad outcomes or consequences.
- **Why do we need it?** External forces may cause us to prioritize elsewhere and we end up taking shortcuts.
- **Why is it so important in our outreach work?** Outreach psychotherapy can feel overwhelming at times; external stressors can distract us from our full attention to the task at hand.
- **What does risk-management look like?**

Risk-Management

- **Informed-consent:** Maximize patient participation in the treatment process, encourage questioning, and discussing concerns, feelings, and goals.
- **Documentation:** What was done and the reasoning behind it. What was not done and the reasoning behind that.
- **Consultation:** When in doubt, get high-quality consultative services in the necessary area. Someone who will be honest, not someone who will be nice.

Bennett, Bricklin, Harris, Knapp, VandeCreek & Younggren, 2006

Younggren & Gottlieb, 2004

Managing risk associated with dual-relationships involves five questions:

- a) Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
- b) Can the dual relationship potentially cause harm to the client?
- c) If harm seems unlikely or avoidable, would the additional relationship prove beneficial?
- d) Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- e) Can I evaluate this matter objectively?

Knapp & VandeCreek, 2006

- May be used during periods of crisis or an emergency because this 5-step model is easy to learn and overlearn.

- a) Identify or scrutinize the problem.
- b) Develop alternatives or hypotheses.
- c) Evaluate or analyze options.
- d) Act on, or perform the best option.
- e) Look back or evaluate the results.

IDEAL

Pope & Vasquez, 2011

Seventeen steps: Not every step is needed for every situation. Some steps may need to be adapted.

- 1) State the question, dilemma, or concern as clearly as possible.
- 2) Anticipate who will be affected by the decision.
- 3) Figure out who, if anyone, is the client.
- 4) Assess whether our areas of competence—and of missing knowledge, skills, experience, or expertise—are a good fit for this situation.
- 5) Review relevant formal ethical standards.
- 6) Review relevant legal standards.
- 7) Review the relevant research and theory.
- 8) Consider whether personal feelings, Biases, or self-interest might affect our ethical judgment.

Pope & Vasquez, (2011), p.117-121 (continued)

- 9) Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.
- 10) Consider consultation.
- 11) Develop alternative courses of action.
- 12) Think through the alternative courses of action.
- 13) Try to adopt the perspective of each person who will be affected.
- 14) Decide what to do, review or reconsider it, and take action.
- 15) Document the process and assess the results.
- 16) Assume personal responsibility for the consequences.
- 17) Consider implications for preparation, planning, and prevention.

Protecting Self and Agency
 If it isn't documented, it didn't happen.

"Good documentation demonstrates that you used a reasonable standard of care in conceptualizing, planning, and implementing treatment." *Bennett et al. (2006)*

It also offers collaterals useful information to aid in helping the client in other areas, and encourages the therapist to be thoughtful and thorough in documentation.

Examples?

- Specific statement made by client that caused you concern.
- Behavior that made you uncomfortable.
- Something about surroundings out of place.
- Extra person "monitoring session."
- Client high or potentially using.

Mindful Interventions

Mindful interventions come through:

- Training (graduate school and beyond)
- Supervision
- Time
- Familiarity
- Confidence
- Growth

...And these together create clinical acuity

**Last But Not Least
Concerning Documentation**

Collateral Contacts (reminder) :

- Cannot *acknowledge* client without signed release of information.
- Cannot *discuss* client without signed release.
- If it is DCF, and they are the guardian, there should be a release in the file which they signed.
- Just because someone calls and says it is on the behalf of your client does not make it so.

Vignettes

We have explored :

- Confidentiality, boundaries, self-disclosure, multiple relationships, safety, and self-care.

We have discussed:

- Risk-management, ethical decision-making, and documentation.

Vignettes

Now you can:

- See how your views have transformed, if at all, through exploring vignettes and using ethical decision-making models to come to a thoughtful conclusion.
- Pick a model we discussed.
- Work alone or with others.
- Next week we will explore these vignettes and your responses to them.

Plan?

West Roxbury Interns:

Springfield Interns:

Let's Try One Before You Go

Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something...and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two.

How would you respond?

References: Session Two

Gottlieb, M. C. (1993). Avoiding exploitative dual relationships: A decision-making model. *Psychotherapy, 30*, 41-48.

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Younggren J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice, 38*(3), 255-260.

What is Mentionable is Manageable:

Exploring Ethical and Boundary Challenges in Outreach Psychotherapy Session Three

Horizontal lines for writing notes.

Session Three Exploring what we have learned; summary, review, evaluation

Content areas: Confidentiality, boundaries, self-disclosure, dual-relationships, safety, self-care, ethical decision-making, risk-management.

- Vignettes
• Discussion
• Evaluation

Horizontal lines for writing notes.

Vignette 1

You have been seeing a 9-year-old boy in his home since he was 7. Therapeutic alliance is strong. Work has focused on reducing his anxiety concerning family safety, which elevated after his home was broken into while his mother, his older sister, and he were away visiting his aunt and uncle. After you began working with this boy, his family got a puppy to protect their home. You have been there and have watched her grow into a beautiful dog. Conversation, at times during session, has involved commenting on how much you like his dog and how you wish you had one like her. The dog is going to have puppies and your client and his family, knowing how much you care for the dog, want you to have one of her puppies. What do you do? How do you come to this decision? What are the implications of saying yes? What are the implications of saying no?

Horizontal lines for writing notes.

Vignette 2

You are a female therapist. You are seeing a young father of 3 small children, ages 9 months to 4 years. He is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. He tells you that his girlfriend (the mother of his children) is very aggressive and has been in jail a number of times for assault. You learn that the girlfriend has recently been released from jail and has gone to your client's apartment and told him if she sees any female go near him, she will "seriously f--- her up!" You know she has this reputation. What do you do? How do you come to this decision?

Vignette 3

You get a new client. She is a 40-year-old single mother of two school-aged children. When you get to the house it is dark inside (all shades are drawn), the client is smoking (you do not smoke), and there are beer bottles strewn across the kitchen counter and the living room floor (client does not smell of alcohol). You feel like you can barely breathe. It is winter and all windows are closed. Intake reports reason client requests services is for symptoms of depression. What do you do? How do you come to this decision?

Vignette 4

You do therapy with a family consisting of a soft-spoken mother, a domineering father, a 12-year-old pubescent girl (who would spend all her time in her room talking to friends on the phone if she could), and twin 6-year-old boys (one loves to read and tell stories, and the other prefers building things to knock them down). The therapeutic alliance is still being established 6 weeks into therapy. Due to the father's work schedule, and his insistence to be there during therapy, the therapeutic hour has necessarily seeped into the dinner hour. You are often hungry while you are there, and smelling supper cooking only distracts you more from focusing on the therapy. The mother has invited you for dinner a couple of times and you have said, "No, thank you." Tonight, the father insists the mother set a place for you, while you graciously decline. The father is not taking "no" for an answer. What do you do? How do you come to this decision?

Vignette 5

You have been seeing a 15-year-old adolescent male since he was 12. His mother has severe, persistent mental illness, including PTSD, MDD, and DID. His father can be outright hurtful and unreliable with your client. Sometimes you see your client at his mother's apartment, sometimes at his father's house, and sometimes at his grown brother's or sister's homes. He has a brother two years younger who is always "hanging around" during session; floating in and out of the room, making comments, asking questions, being annoying or charming, but always nearby. Your client will ask his brother to leave, with mixed results depending on which day it is. Confidentiality is certainly in question, although your client seems not very concerned. The mother, who has physical and legal custody, approaches you one day and states the younger brother needs therapy also and "only wants to see you." She tells you that she asked your client if he would mind and that he said he would be fine with his brother seeing you. What do you do? How do you come to this decision?

Vignette 6a

Your client, a 38-year-old male who is in partial remission from Opioid Dependency and struggles with MDD and bouts of suicidal ideation has told you, while you are in his home, that he has run out of medication and needs to get to the pharmacy to pick the prescriptions up. The pharmacy is two miles from your client's home, it is near the end of the month, and he doesn't have bus fare. It is over 90 degrees outside. You know your client will not walk there and does not have social connections to help him. You know these medications help your client stay stable and clean. What do you do? How do you come to this decision?

Vignette 6b

Your decision, in the prior example, is to take your client to the pharmacy. He goes inside and soon pops his head out the door, calling you, asking you to come inside. You have a bad feeling in your stomach but go inside to see what is going on. Your client tells you he doesn't have the co-pay for his medication but, in the past they had always let him have it without paying. Your client wants to borrow two dollars for his medication co-pay and promises to pay you if you'll just take him to his mother's apartment after this. What do you do? How do you come to this decision?

Vignette 9

You are a male therapist. You are seeing a young mother of 3 small children, ages 9 months to 4 years. She is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. She tells you that her boyfriend previously pistol-whipped her into the hospital. You learn that the boyfriend has recently been released from jail and has gone to your client's apartment and told her if he sees any man go near her, he will kill him. You know he has a gun. What do you do? How do come to this decision?

Vignette 10a

You are sitting at the kitchen table of a client who is nearly your same age, opposite sex. A neighbor knocks on the door, is let in, and you are introduced. The neighbor states "so you're the faithful one, you show up every week and do what you promise, that certainly is a nice change from the usual. Are you married?" How would you respond? How do you come to that decision?

Vignette 10b

Same scenario, but you and your spouse had recently gone through a painful divorce. The neighbor sees sadness in your eyes and comments, continuing to question you. How would you respond?

Vignette 11

You have been working with a 16-year-old female, for the past 8 months, living in foster care. You have therapy in her bedroom since that is the only place for privacy. You have been working on reuniting client with mother and learned that client has received a birthday card from mother and is excited. Client states, "I'll go get it. I'll be right back." and runs off. When she leaves, the foster mother steps in and says "You know, I have a degree in counseling and I have been listening to you for the past 8 months and you aren't doing a thing for this girl. You are going about this all wrong and I can't see her improving whatsoever." After you get past the point of being mortified, how do you respond? How do you come to that decision?

Vignette 12

You and your spouse have been trying to have a baby. There appears to be infertility issues and you are seeking medical help. You are seeing a client with a 3-year-old child. The child has been to the emergency room and old tibia fractures have been discovered. Although not proved, it is clear that the client's boyfriend has caused these. You gently try to explore the client's relationship with the boyfriend and the potential danger for the child. The client states "I can always have another child but a good man is hard to find." How would you respond? How do you come to that decision?

Vignette 13

Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something... and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two. How would you respond?

Change your mind at all during the week?

Appendix C: Syllabus

What is Mentionable is Manageable:

Exploring Ethical and Boundary Challenges in Outreach Psychotherapy

Training Objectives

- Increase participant knowledge of the ethical and boundary challenges of working in the community.
- Enhance participant skills to use ethical decision-making models effectively when trying to resolve ethical dilemmas.
- Heighten participant self-awareness and understanding of attitudes they carry toward ethical dilemmas.

Session One (2 hours)

Style: Lecture, Exercises, and Discussion

Content Areas: What we must consider when doing outreach psychotherapy

- Overview of Outreach Psychotherapy

Outreach psychotherapy is different from in-clinic psychotherapy in a number of ways

Exercise:

Advantages of the Atypical Setting (5 minutes)

Challenges of the Atypical Setting (5 minutes)

Discussion:

A) Ethical Issues and Boundary Challenges (what must we consider? How do you decide?)

- 1) Confidentiality
 - a. Informed-consent
 - b. Taken-for granted practices
 - c. Mandated reporting
 - i. Child abuse
 - ii. Tarasoff
- 2) Boundaries
 - a. Use of the therapy hour
 - b. Need gratification
- 3) Self-disclosure
- 4) Dual relationships/ multiple relationships
 - a. Clients

- b. Parents
- c. Collaterals
- d. Community Resources

Articles to read:

Gottlieb, M. C., (1993). Avoiding exploitative dual relationships: A decision-making model.

Psychotherapy, 30, 41-48.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal*

of Counseling and Development, 67, 217-221.

Pope, K. S. & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy:

Making decisions, bypassing blunders, and mending fences. *Journal of Clinical*

Psychology: In Session, 64(5), 638-652).

Younggren J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple

relationships. *Professional Psychology: Research and Practice, 35*(3), 255-260.

Session Two (2 hours)

Style: Lecture, Exercises, and Discussion

Content Areas: What can we do to better care for ourselves and, in turn, our clients?

A) Safety

- a. Sample safety guidelines (appendix A)
- b. Being aware of your surrounding and the inherent dangers present
- c. Understanding challenges of particular diagnoses
- d. Are there clients you just DON'T see in the home?

B) Self-Care

- a. Affirming the Universality of the work we do
- b. Impact of Vicarious Trauma and the overwhelming needs of this population
- c. You are not alone; getting your needs met
- d. Neglected self-care
- e. Need for Supervision (what would the ultimate supervision look like? What do you hope for in supervision?)
- f. Other options: peer supervision, consultation with respected colleague
- g. Training and Skills Development (Competence = Confidence?) What topics would you like to know more about? Of which topics do you feel competent?
- h. Value of Balance
 - i. Balance between professional and personal lives
 - ii. Balance between “empathic connection with, and self-preserving distance from, clients”
 - iii. Balance between “others’ needs and your own limits”
 - iv. Balance between “isolation from, and connection with, colleagues”
 - v. Coach John Wooden: “You are neither God, nor the devil.”
- i. More self-care: Eat well-balanced, nutritious meals; get sunshine and fresh air; get regular exercise; and quality sleep (following our own advice)

C) Documentation and Risk Management

- a. Critical Judgment and Decision-making Skills (thinking on your feet by using risk-management and ethical decision-making)
 - i. Risk-management
 - ii. Ethical decision-making models
 - 1. Kitchener, 1988
 - 2. Gottlieb, 1993
 - 3. Younggren & Gottlieb, 2004
 - 4. Knapp & VandeCreek, 2006
 - 5. Pope & Vasquez, 2011

- b. Protecting Self and Agency (if it is not documented, it didn't happen)
- c. Mindful Interventions (using supervision and trainings, for growth and clinical acuity)
- d. Collateral Contacts (signed release-of-information in file)

Vignettes to explore using ethical decision-making models

Let's try one now, using Knapp & VandeCreek's IDEAL model:

Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something...and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two. How would you respond?

Homework: Divide up vignettes (handout: Appendix D) to work on during the week and discuss during session three.

Session Three (2 hours)

Style: Vignettes, Discussion, and Post-training Evaluation

Content: Exploring what we have learned; explore some of the vignettes and participants' thought process in evaluating ethical concerns, summary, questions, and evaluation.

- Confidentiality
- Boundaries
- Self-Disclosure
- Dual Relationships
- Safety
- Self-Care

Experiential Exercise: Vignettes to Explore (Topics above)

Participants will engage in discussing vignettes, the challenges of ethical decision-making, the blurring of what may have initially appeared as clearly defined boundaries, and the struggles faced when using new lenses to understand these challenges.

Evaluation and Feedback from Participants

Appendix D: Vignettes

- 1) You have been seeing a 9-year-old boy in his home since he was 7. Therapeutic alliance is strong. Work has focused on reducing his anxiety concerning family safety, which elevated after his home was broken into while his mother, his older sister, and he were away visiting his aunt and uncle. After you began working with this boy, his family got a puppy to protect their home. You have been there and have watched her grow into a beautiful dog. Conversation, at times during session, has involved commenting on how much you like his dog and how you wish you had one like her. The dog is going to have puppies and your client and his family, knowing how much you care for the dog, want you to have one of her puppies. What do you do? How do you come to this decision? What are the implications of saying yes? What are the implications of saying no?

- What to consider?

2) You are a female therapist. You are seeing a young father of 3 small children, ages 9 months to 4 years. He is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. He tells you that his girlfriend (the mother of his children) is very aggressive and has been in jail a number of times for assault. You learn that the girlfriend has recently been released from jail and has gone to your client's apartment and told him if she sees any female go near him, she will "seriously f--- her up!" You know she has this reputation. What do you do? How do come to this decision?

- What to consider?

3) You get a new client. She is a 40-year-old single mother of two school-aged children. When you get to the house it is dark inside (all shades are drawn), the client is smoking (you do not smoke), and there are beer bottles strewn across the kitchen counter and the living room floor (client does not smell of alcohol). You feel like you can barely breathe. It is winter and all windows are closed. Intake reports reason client requests services is for symptoms of depression. What do you do? How do you come to this decision?

➤ What to consider?

➤ 4) You do therapy with a family consisting of a soft-spoken mother, a domineering father, a 12-year-old pubescent girl (who would spend all her time in her room talking to friends on the phone if she could), and twin 6-year-old boys (one loves to read and tell stories, and the other prefers building things to knock them down). The therapeutic alliance is still being established 6 weeks into therapy. Due to the father's work schedule, and his insistence to be there during therapy, the therapeutic hour has necessarily seeped into the dinner hour. You are often hungry while you are there, and smelling supper cooking only distracts you more from focusing on the therapy. The mother has invited you for dinner a couple of times and you have said, "No, thank you." Tonight, the father insists the mother set a place for you, while you graciously decline. The father is not taking "no" for an answer. What do you do? How do you come to this decision?

➤ What to consider?

➤ 5) You have been seeing a 15-year-old adolescent male since he was 12. His mother has severe, persistent mental illness, including PTSD, MDD, and DID. His father can be outright hurtful and unreliable with your client. Sometimes you see your client at his mother's apartment, sometimes at his father's house, and sometimes at his grown brother's or sister's homes. He has a brother two years younger who is always "hanging around" during session; floating in and out of the room, making comments, asking questions, being annoying or charming, but always nearby. Your client will ask his brother to leave, with mixed results depending on which day it is. Confidentiality is certainly in question, although your client seems not very concerned. The mother, who has physical and legal custody, approaches you one day and states the younger brother needs therapy also and "only wants to see you." She tells you that she asked your client if he would mind and that he said he would be fine with his brother seeing you. What do you do? How do you come to this decision?

➤ What to consider?

➤ 6a) Your client, a 38-year-old male who is in partial remission from Opioid Dependency and struggles with MDD and bouts of suicidal ideation has told you, while you are in his home, that he has run out of medication and needs to get to the pharmacy to pick the prescriptions up. The pharmacy is two miles from your client's home, it is near the end of the month, and he doesn't have bus fare. It is over 90 degrees outside. You know your client will not walk there and does not have social connections to help him. You know these medications help your client stay stable and clean. What do you do? How do you come to this decision?

➤ What to consider?

➤ 6b) Your decision, in the prior example, is to take your client to the pharmacy. He goes inside and soon pops his head out the door, calling you, asking you to come inside. You have a bad feeling in your stomach but go inside to see what is going on. Your client tells you he doesn't have the co-pay for his medication but, in the past they had always let him have it without paying. Your client wants to borrow two dollars for his medication co-pay and promises to pay you if you'll just take him to his mother's apartment after this. What do you do? How do you come to this decision?

➤ What to consider?

➤ 6c) Your decision, in the prior example, is to take your client to the pharmacy. He goes inside and soon pops his head out the door, calling you, asking you to come inside. You have a bad feeling in your stomach but go inside to see what is going on. The pharmacist tells you that one of the medications is a controlled substance and someone must show identification to be able to pick it up. Your client states he has no ID on him and needs you to show yours so he can get his medication. What do you do? How do you come to this decision?

➤ What to consider?

➤ 7) You go into a home to meet with a ten-year-old girl who acts out by being mean to her five-year-old sister (e.g., pushing her, yelling at her, teasing her). Client reports it is unfair HER father is in jail and has never been there for her, while her younger sister's "father AND grandmother sends her gifts and money for her birthday and holidays, and calls her on the phone all the time." The home is chaotic, with the TV playing loudly in

one room and a radio playing loudly in another. Grandmother is in the kitchen preparing dinner and mom is busy talking on the phone. You are forced to go into the client's bedroom, with no place to sit but on the bed. However, there is a strong, persistent smell of urine in the room from your client's nighttime struggles with enuresis. What do you do? How do you come to this decision?

➤ What to consider?

➤ 8) You are in the office and receive a phone call from the adult sister of your 17-year-old male client, Brandon, who you see as angry and aggressive. The caller states she was speaking to her mother and told her mother it was important for Brandon's therapist to know that he has pushed and hit his mother. The mother told the daughter to call you and gave her your number. With this information, you think about the times you have been in Brandon's house and the interactions you have witnessed between mother and son. You are headed to Brandon's house later in the day. What do you do? How do you come to this decision?

➤ What to consider?

9) You are a male therapist. You are seeing a young mother of 3 small children, ages 9 months to 4 years. She is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. She tells you that her boyfriend previously pistol-whipped her into the hospital. You learn that the boyfriend has recently been released from jail and has gone to your client's apartment and told her if he sees any man go near her, he will kill him. You know he has a gun. What do you do? How do you come to this decision?

What to consider?

10a) You are sitting at the kitchen table of a client who is nearly your same age, opposite sex. A neighbor knocks on the door, is let in, and you are introduced. The neighbor states “so you're the faithful one, you show up every week and do what you promise, that certainly is a nice change from the usual. Are you married?” How would you respond? How do you come to that decision?

What to consider?

10b) Same scenario, but you and your spouse had recently gone through a painful divorce. The neighbor sees sadness in your eyes and comments, continuing to question you. How would you respond?

What to consider?

11) You have been working with a 16-year-old female, for the past 8 months, living in foster care. You have therapy in her bedroom since that is the only place for privacy. You have been working on reuniting client with mother and learned that client has received a birthday card from mother and is excited. Client states, “I’ll go get it. I’ll be right back,” and runs off. When she leaves, the foster mother steps in and says “You know, I have a degree in counseling and I have been listening to you for the past 8 months and you aren’t doing a thing for this girl. You are going about this all wrong and I can’t see her improving whatsoever.” After you get past the point of being mortified, how do you respond? How do you come to that decision?

➤ What to consider?

12) You and your spouse have been trying to have a baby. There appears to be infertility issues and you are seeking medical help. You are seeing a client with a 3-year-old child. The child has been to the emergency room and old tibia fractures have been discovered. Although not proved, it is clear that the client's boyfriend has caused these. You gently try to explore the client's relationship with the boyfriend and the potential danger for the child. The client states "I can always have another child but a good man is hard to find." How would you respond? How do you come to that decision?

What to consider?

13) Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something...and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two. How would you respond?

What to consider?

Appendix E: Post-Training Course Evaluation

**WHAT IS MENTIONABLE IS MANAGEABLE:
EXPLORING ETHICAL AND BOUNDARY CHALLENGES IN OUTREACH PSYCHOTHERAPY**

PART I: DEMOGRAPHIC INFORMATION

Circle or fill in the appropriate answer.

1. How many years experience do you have working in the mental health profession? (a) 1-5 (b) 6-10 (c) more than 10
2. Have you ever worked as an outreach therapist prior to this internship? (a) no (b) yes If yes, how many years experience? _____
3. How many years experience do you have working in community mental health prior to this internship? _____
4. In what field is your highest degree? __ Counseling __ Education __ Psychology __ Social Work __ Other _____
5. This internship is consistent with my career goals? ___ Strongly Disagree ___ Disagree ___ Neutral ___ Agree ___ Strongly Agree
6. My theoretical orientation is: __ Psychodynamic __ Cognitive Behavioral __ Humanistic __ Interpersonal __ Other _____
7. Gender: __ Female __ Male __ Transgendered

PART II: YOUR REACTION TO THIS TRAINING

Circle one rating number for each item.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Applicable
8. The training objectives were clear.	1	2	3	4	n/a
9. Overall, the knowledge I gained in this training will be useful in my work.	1	2	3	4	n/a
10. The order of the training topics and activities made sense to me.	1	2	3	4	n/a
11. The pace of this training was good—neither too fast nor too slow.	1	2	3	4	n/a
12. I can now use ethical decision-making skills in my work.	1	2	3	4	n/a
13. I am satisfied with what I gained from this training.	1	2	3	4	n/a
14. I would recommend this training to others.	1	2	3	4	n/a
15. This training is a good addition to the internship program.	1	2	3	4	n/a
16. Hand-outs and vignettes helped me understand the material.	1	2	3	4	n/a
17. The presentation on confidentiality was thorough.	1	2	3	4	n/a
18. The presentation on boundaries was thorough.	1	2	3	4	n/a
19. The presentation on self-disclosure was thorough.	1	2	3	4	n/a
20. The presentation on dual-relationships was thorough.	1	2	3	4	n/a
21. The presentation on safety was thorough.	1	2	3	4	n/a
22. The presentation on self-care was thorough.	1	2	3	4	n/a
23. The presentation on documentation and risk management was thorough.	1	2	3	4	n/a

The overall rating I would give this training is:

not useful

useful

very useful

extremely useful

Any further comments are appreciated to improve upon this training (e.g., elaborate on any of the ratings above; identify what was most or least useful in the training, what you might add to improve the training, any other thoughts):

Appendix F: Trainer Syllabus/ PowerPoint

Slide 1

What is Mentionable is Manageable:
 Exploring Ethical and Boundary Challenges in Outreach Psychotherapy

Welcome. This is the 1st of 3, two hour training sessions where we will explore, through active engagement, ethical and boundary challenges which may present as you learn to engage in outreach psychotherapy with, what is often considered, a challenging population.

Slide 2

Training Objectives

- Increase participant knowledge of the ethical and boundary challenges of working in the community.
- Enhance participant skills to use ethical decision-making models effectively when trying to resolve ethical dilemmas.
- Heighten participant self-awareness and understanding of attitudes they carry toward ethical dilemmas.

Psychological training programs have shifted their focus to a competency-based model to develop and assess education and training curricula for their students (Borden & McIlvried, 2010). The three areas of competency; knowledge, skills, and attitudes (KSAs), are essential for training competent professionals (Borden & McIlvried, 2010).

Slide 3

Session One
What We Must Consider When Doing Outreach Psychotherapy

Content Areas:

- advantages and challenges of atypical settings
- confidentiality
- boundaries
- self-disclosure
- dual relationships

Lecture
Exercises
Discussion

Slide 4

“A simple gesture of removing one’s shoes [...] can begin a therapeutic process on a note of respect” (Reiter, 2000, p.33).

- *What is your initial reaction to this statement?*
- *Did you ever consider a situation where you would take off your shoes doing therapy?*
- *How would you respond to the following?*

Explore reactions, discussion

Slide 5

Sign at a client’s home



When you thought about what outreach psychotherapy would entail, did you ever think about managing whether your shoes stayed on or were taken off?

Slide 6

What might be involved in this client request?

- Culture?
- Boundaries?
- Engagement?
- Respect of being in client’s home?
- Power struggle?
- Test?

Outreach psychotherapy is different from in-clinic psychotherapy in a number of ways. Next slide→

Slide 7

Advantages and Challenges of the Atypical Setting

Exercise:

- Break up into dyads
- List Advantages of Atypical Settings (5 min)
- List Challenges of Atypical Settings (5 min)
- Share lists with the group
- Discuss findings
- Implications?

(Pass out paper, if necessary) “Break up into dyads. You have 10 minutes. 5 minutes to list advantages of atypical settings, and 5 minutes to list challenges of atypical settings. When you are through, we will share these lists with the group.” (Use easel and paper in front of room and list.)

Slide 8

Advantages

- A:
- B:
- C:
- D:
- E:
- F:
- G:

Get services to families and individuals who otherwise would be unable to receive them.

Meet important family members/ extended family who would be unable to get to clinic.

Experience directly the stressors and risk factors client faces.

Find/ explore protective factors and opportunities in the making for client.

Create greater understanding of the social context in which client lives.

Seek community resources and supports within neighbors and neighborhood.

Be exposed to culture of client/family to better understand.

Observe family interactions and social relationships in natural setting.

Experience family’s home through their eyes (not through hearsay).

Slide 9

Challenges

- A:
- B:
- C:
- D:
- E:
- F:
- G:

Impatience and frustration concerning the “slow progress” of these clients. Doing more “case management” than therapy.

Therapist demoralization: overwhelmed by the magnitude of interventions and support services required.

Less confrontation in-home due to safety and boundary concerns.

Distractions: visitors, phone calls, noise (people, TV, music, neighborhood), smoking, pets, bugs, cleanliness of home, temperature in home.

Home risk factors: bugs, pets, cleanliness, smoking, violence, safety (including neighbors and neighborhood) Do you ask about weapons?

Community risk factors: physical safety, drugs, gangs, weapons, darkness, randomness

Delicate matters discussed in public places

Custodial confusion: living with extended family, CHINS, foster care, permanent placement, change of placement (who is legal/ who is physical guardian?)

Use of vehicle: to get there, to do therapy in, to take client somewhere? Safety of parking area?

Individual risk factors: Clinician self-care, balance, does supervision meet clinician’s needs, peer support, feelings of: isolation, ineffectiveness, inadequacy, confusion.

Slide 10

Ethical Issues and Boundary Considerations

- What must we consider when doing outreach psychotherapy?
- How do we manage these topics with the added distractions in outreach that are not present in-clinic?

Until we are “in it,” we can’t even imagine what might be. The topics we will explore this week include: confidentiality, informed-consent/ mandated-reporting, boundaries, self-disclosure, and dual-relationships. All of these topics have been discussed in graduate courses; however, each of these topics takes on a new perspective when pertaining to outreach psychotherapy.

Slide 11

Confidentiality

It is critical to effective psychotherapy

- Therapist-client privilege is flexible and not absolute, and there are limits to confidentiality.
- If a child is in danger of being hurt by self or other, or court request., but...
- What about all the incidental confidentiality breaches?

Neighbors in and out, family members joining without being asked, going into the community, seeing other clients while with one. What have you found to be challenging?

Slide 12

Informed-Consent

Informed-consent can help to maximize client participation in the treatment process by having a meaningful conversation with the client concerning the therapy, therapy style, and therapist. The conversation will encourage client questioning while discussing client concerns, feelings, and goals (Bennett et al., 2006).

This is the point where boundaries can be agreed upon.

Slide 13

Taken-for-Granted Practices

Assumptions:

- Client knows how “to do” therapy
- Client knows how to maintain boundaries
- Client knows “the right to confidentiality”
- Client knows how to respond to empathy
- Client should feel safe around you
- Client should trust you

This is your opportunity to tell the client how YOU do therapy, what they can expect from you, how you operate, how your boundaries work, why they can feel safe with you, . . . and ask them what has worked and what hasn’t (if they have had therapy before).

Slide 14

Mandated- Reporting

- **Child-abuse: What is the threshold?**
- 'Abuse' means the nonaccidental commission of any act by a caregiver upon a child under age 18 that causes or creates a substantial risk of physical or emotional injury, or constitutes a sexual offense under the laws, or any sexual contact between a caregiver and a child under the care of that individual.
- http://www.childwelfare.gov/systemwide/laws_policies/state/index.cfm?event=stateStates.processSearch
- **Tarasoff: What is this?**
- Mental health professionals have a “duty to protect” an intended victim of bodily harm by a patient.
- http://en.wikipedia.org/wiki/Tarasoff_v._Regents_of_the_University_of_California

Child-abuse: If a child is being harmed or neglected you file and they can screen it in or out. For more information concerning reporting child abuse or neglect,
<http://www.childwelfare.gov/responding.cfm>

Tarasoff:
http://en.wikipedia.org/wiki/Tarasoff_v._Regents_of_the_University_of_California

Slide 15

Boundaries

- What are they?
 They are flexible standards of good practice, not lists of generically forbidden behaviors. (Gutheil & Gabbard, 1998)
- What do we do with them?
 We use them to keep our clients and ourselves safe (both physically and psychologically)
- Use of the therapy hour:
 - How is it managed?
 - Who is it for?
- Need Gratification:
 - Therapist problems in other areas of life?
 - Self-awareness is critical.

Define: They are flexible standards of good practice, not lists of generically forbidden behaviors. (Gutheil & Gabbard, 1998)

Importance: We use them to keep our clients and ourselves safe (both physically and psychologically)

Modeling appropriate behaviors

Use of therapy hour: How is it managed? Use the informed-consent process to decide this. Who is it for? Always for the client.

Need gratification: Therapist struggling in other areas of life? Self-awareness is critical.

Slide 16

Self-Disclosure

- Therapist self-disclosure may be defined broadly as statements which reveal something personal about the therapist (Hill & Knox, 2001).
- Therapist self-awareness is key to preventing therapists from having their own needs met through self-disclosure to the client (Goldstein, 1994).

Define: Statements which reveal something personal about the therapist.

Need gratification

Slide 17

Considering Self-Disclosure?

- Is it consistent with the client’s clinical needs and the therapy goals?
- Is it consistent with the kind of therapy you are providing and your theoretical orientation?
- Does it mainly reflect or express your own personal needs (to talk about yourself, to bring the focus to yourself)?
- What is your purpose for self-disclosing at this particular time?
Pope & Keith-Spiegel (2008)

What are the client’s clinical needs? Are you modeling engagement and reciprocity with a client who lacks affect and engagement?

What are the therapy goals?

A professor once said “How is what you are about to say going to be useful to the client?” It slows down the therapy but really gets you to self-reflect.

Slide 18

Dual Relationships

Once a therapeutic relationship has been established between clinician and client, they are not free to take on other relationships outside of the therapeutic relationship.

Ethics Code 3.05, Multiple Relationships, declares psychologists refrain from being in another role with a person when a professional relationship has already been established with that person or someone close to that person.

Pretty clear, right?

Why do so many therapists have problems with this?

Slide 19

Dual-Relationships
(Multiple Relationships)

- How do you manage in the same town as your clients, particularly when you are already out in the community with them?
- Clients: I consider you my friend.
- Parents: We have a lot in common...
- Collaterals: Managing relationships
- Community Resources: Knowing your clients

Clients: How do you clarify your relationship with the clients?

Parents: You are trying to help their child. You are in their home. It is a less formal environment than the clinic. “I consider you my friend.” What would you say?

Collaterals: Some collaterals are trying to help your client, others are monitoring.

Community Resources: If you take multiple clients to the same community resources, people begin to know who you are and the relationships you have.

Slide 20

References: Session One

Bennett, B. E., Bricklin, P. M., Harris, E., Knapp, S., VandeCreek, L., & Younggren, J. N. (2006). *Assessing and managing risk in psychological practice: An individualized approach*. Rockville, MD: The Trust.

Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22(4), 417-433.

Hill, C. E., & Knox, S. (2001, Winter). Self-disclosure. *Psychotherapy*, 38(4), 413-417.

Monahan, J. (1993, March). Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment. *American Psychologist*, 48(3), 242-250.

Give articles to read over the week:

Slide 21

References, continued

Pope, K. S. & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology: In Session*, 64(5), 638-652.

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Slide 22

What is Mentionable is Manageable:
 Exploring Ethical and Boundary Challenges in Outreach
 Psychotherapy
 Session Two

Welcome back!

Slide 23

Session Two
 What we can do to better care for ourselves and, in turn, our clients

Content Areas:

- safety
- self-care
- risk-management
- ethical decision-making
- documentation

Last week we explored: Confidentiality, informed-consent, mandated reporting (child abuse and Tarasoff), boundaries (use of the therapy hour and need gratification), self-disclosure, and dual (or multiple) relationships. This week we will explore safety, self-care, documentation and risk-management, as they relate to clinician care.

Lecture
 Exercises
 Discussion
 Vignettes

Slide 24

Safety

- Awareness is KEY for clinicians
- Being aware of your surroundings and the inherent dangers present helps to keep you safe.
- *“The truth is that every thought is preceded by a perception, every impulse is preceded by a thought, every action is preceded by an impulse, and man is not so private a being that his behavior is unseen, his patterns undetectable.”*
De Becker (1997, p.15).

Let’s begin by concretely looking at YOUR safety going out into the community on a regular basis.
 Perception enhances safety.
 Pass out Appendix A: Sample Safety Guidelines
 Show de Becker book: The Gift of Fear

Slide 25

Sample Safety Guidelines for Outreach Therapists

- It is important to perceive what is actually happening in the environment, as opposed to imaginings of what is possible. Perception enhances safety; imagining potential dangers drowns out perception's subtle signals by creating the distracting noise of panic.
- "Real fear occurs in the presence of danger and will always easily be linked to pain or death" (p. 300). The fear signal is NOT voluntary! Worrying is voluntary AND a choice.
- "Precautions are constructive, whereas remaining in a state of fear is destructive," (p.294).

The world should not become a scary place because of this discussion, but I hope that this conversation will help to increase your awareness of your surroundings, which in turn, might actually increase your confidence out in the world.

Slide 26

Safety Guidelines continued
Precautions for Safety While Doing Outreach Psychotherapy:

- Physical addresses of clients should be updated regularly and available to supervisor.
- A copy of your outreach schedule should be available each week.
- Appointments are best made for daylight hours.
- Cars are parked in areas that are well-lit & free of clutter (e.g., shrubs, trees, or dumpster).
- Do not carry so much that you could not free a hand to use your cell phone.
- Limit carrying/wearing valuable possessions, have just enough \$\$ to get through the day

Slide 27

Safety Guidelines continued

- Any discomfort concerning a client needs to be discussed in supervision. Clinicians cannot be effective if distracted by anxiety or fear.
- If clinician is fearful during session: Assess gravity of the situation and leave if situation is perceived as dangerous. For example, intoxicated individuals, drug use or dealing, violence in the home, or evidence of a weapon.
- Document personal safety concerns after leaving the session. If it is not documented, it did not happen.

Ideas adapted from: Berg, 1994; Boyd-Franklin & Bry, 2000; De Becker, 1997; and Wasik & Bryant, 2001.

Slide 28

Are there clients you just don't see in the home?

People who are psychotic? Clients with active delusions? DID?

Slide 29

Self-Care

- There is a Universality to what we do and the experiences involved in our work.
- We can feel similar emotions and have similar thoughts.
- What we each do with these experiences, however, is based on our own stories, our own history, our own reality.

Slide 30

Affirming Universality

- “When recognizing the stresses you encounter as a psychotherapist, keep in mind that similar kinds of pressure are experienced by virtually all of your colleagues. Confidentiality, isolation, shame, and a host of additional considerations lead us to overpersonalize our own sources of stress when in reality they are part and parcel of the ‘common world’ of psychotherapy. Disconfirming our individual feelings of unique wretchedness and affirming the universality of stresses are in and of themselves therapeutic” (Norcross & Guy, 2007, p. 57).

Affirming universality: Does it help?
 What is mentionable is manageable.
 (THIS is my belief.)
 What we do is hard, and we don't need to make it harder by attacking ourselves for what we perceive as personal shortcomings.

Slide 31

Vicarious Traumatization

- “[T]he transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients’ trauma experiences and their sequelae .”
- “[I]mplics changes in the therapist’s enduring ways of experiencing self, others, and the world.”

Pearlman & Mac Ian (1995), p. 558.

We don’t want this, and self-care is one way we can help with this. Let’s look at some characteristics of the population we serve.

Slide 32

Characteristics of Outreach Population

- Possibly any or all of the following:
 - Multi-problem
 - Multi-generational
 - Severe trauma history
 - Lacking hope or vision for change
 - Low SES
 - Few resources
 - Dysfunctional ways of trying to get their needs met

Working with this population can be exhausting. This is a real concern due to the overwhelming needs of the population we work with: multi-problem, multi-generational struggles, often severe trauma history, lacking hope or vision for change, low SES, few resources, and dysfunctional ways of trying to get their needs met, etc.

Self-care and a well-balanced life are imperative to inoculating yourself from the stresses of this work.

Slide 33

Let’s Look at Ways to Reduce This Stress

- Recognizing commonality of experience.
- Realizing you are not alone.
- A thought is only a thought, no matter how _____(fill in the blank) We all have them.
- Understanding and practicing safety and self-care could equate to feelings of confidence and competence in our work and our lives.

These types of conversations offer the opportunity to realize our experiences are not as rare as we believe. We are not alone. Thoughts come and go. We all have them and they can be kind or wretched, but they are only thoughts. They can be explored or discarded, but they do not define you.

Slide 34

You are NOT Alone in Your Experience

When I feel alone, isolated, confused, or frustrated _____

is what I wish I could have.

Fill in the blank, if you wish. Think about it, take some time.

Slide 35

When I Feel Alone in My Experience

This: _____

is what I have gotten.

Is there a disconnection between what you want and what you have gotten? How could you get your needs met? This is about not feeling isolated and alone, and knowing you can have connection and support when necessary.

Slide 36

Neglected Self-Care

- When therapist self-care is neglected there can be a number of consequences, including:
 - ❖ disrespecting clients and the work
 - ❖ making more mistakes
 - ❖ lacking energy and interest
 - ❖ worrying more
 - ❖ feelings of isolation and disconnection
 - ❖ neglected health

Slide 37

**Self-Care
Options to Consider at Work**

- Supervision:
 - What would the ultimate supervision look like?
 - What are your hopes for supervision?
 - Do you get your needs met in supervision?
- Peer supervision groups?
- Consultation with a colleague you respect?
- What else would be helpful?

Supervision as a form of self-care?
Style? Content? Process? Skills
development? Modeling? Time?
Frequency?

Please take advantage of your
supervision time and interactions with
colleagues.

There are a number of options when
you feel isolated: supervision, peer
supervision groups, consultation... what
else have you used or thought of using?

Slide 38

Training and Skills Development

- Does competence equate to confidence?
- We learn best by sharing our information,
knowledge and enthusiasm.
- What topics would you like to know more
about?
- Of which topics do you feel competent?
- Have you been to a training that really stood
out to you, for any reason?

Competence equals confidence. We
learn best by sharing our information
and knowledge. Case conference?
Reviewing training that you enjoyed?
Talk about a theory, theorist, or concept
that excites you?

Slide 39

Value of Balance

- ...between professional and personal lives.
- ... between empathic connection with, and self-
preserving distance from, clients.
- ...between others' needs and your own limits.
- ...between isolation from, and connection
with, colleagues.

Coach John Wooden: "You are neither God, nor
the devil." (there is balance there as well.)

"You are neither God, nor the devil."
This quote helps to balance the
perspective that we are not our clients'
saviors nor can we create their demise.
They were around and functioning (no
matter how dysfunctionally) before we
met them, and they will continue on
after we are gone.

Slide 40

More Self-Care

Eat well-balanced, nutritious meals;
get sunshine and fresh air; regular
exercise; and quality sleep.

Wait, does this sound familiar?
Why can't we follow our own advice?

Someone write list

Slide 41

And a Few More

Mahoney (1997) found the beneficial self-care habits of psychologists to include:

- engaging in a hobby
- reading for pleasure
- taking trips for enjoyment
- attending artistic events or movies
- engaging in physical exercise

What is your favorite self-care strategy?

Slide 42

**Critical Judgment and
Decision-Making Skills**

Thinking on your feet
by using
risk-management and
ethical
decision-making

When you're ethical boundaries are being tested, do you have a plan for how to resolve these dilemmas?

Slide 43

Why Smart People Do Stupid Things

At some point, people make mistakes when:

- they fail to recognize the limits of their own knowledge, or
- they fail to consider the interests of other people.

Sternberg, 2003

Competence?... arrogance?...
supervision?... consultation?...

Slide 44

Risk-Management

- **What is it?** The calculation of the probability of good or bad outcomes or consequences.
- **Why do we need it?** External forces may cause us to prioritize elsewhere and we end up taking shortcuts.
- **Why is it so important in our outreach work?** Outreach psychotherapy can feel overwhelming at times; external stressors can distract us from our full attention to the task at hand.
- **What does risk-management look like?**

Risk-management: The calculation of the probability of good or bad outcomes or consequences.
External forces may cause us to prioritize; take shortcuts.
OP can feel overwhelming at times, and external stressors can distract you from your full attention to the task at hand.
It looks like informed-consent, documentation, and consultation (Bennett et al., 2006).

Slide 45

Risk-Management

- **Informed-consent:** Maximize patient participation in the treatment process, encourage questioning, and discussing concerns, feelings, and goals.
- **Documentation:** What was done and the reasoning behind it. What was not done and the reasoning behind that.
- **Consultation:** When in doubt, get high-quality consultative services in the necessary area. Someone who will be honest, not someone who will be nice.

Bennett, Bricklin, Harris, Knapp, VandeCreek & Younggren, 2006

What it looks like... client as active participant; thorough documentation showing an adequate level of care; and knowing when to consult.

Slide 46

Ethical Decision-Making Models

Let's look at a few:

- Kitchner, 1988
- Gottlieb, 1993
- Younggren & Gottlieb, 2004
- Knapp & VandeCreek, 2006
- Pope and Vasquez, 2011

Did you practice ethical decision-making in graduate school?
 With a particular model?
 Do you use one now?
 Have you had reason to use one in your clinical experience?
 All participants have the articles?

Slide 47

Kitchener, 1988

- Based on role theory and centered on the role conflicts created in dual relationships.

- 1) Incompatibility of role expectations, such as between clinical and social.
- 2) As obligation of different roles diverge, the potential for divided loyalties and loss of objectivity increases.
- 3) As the power and prestige differential increases, so does the potential for exploitation.

Example

Slide 48

Gottlieb, 1993

- Uses three dimensions to assess the potential for harm from dual relationships.
- Power differential.
- Duration of treatment.
- Termination and potential future clinical engagement.

Assess the current relationship, its nature and intensity, and evaluate the incompatibility and role conflict of the potential dual relationship.

Slide 49

Younggren & Gottlieb, 2004

Managing risk associated with dual-relationships involves five questions:

- a) Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
- b) Can the dual relationship potentially cause harm to the client?
- c) If harm seems unlikely or avoidable, would the additional relationship prove beneficial?
- d) Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- e) Can I evaluate this matter objectively?

Example

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Knapp & VandeCreek, 2006

- May be used during periods of crisis or an emergency because this 5-step model is easy to learn and overlearn.

- a) Identify or scrutinize the problem.
- b) Develop alternatives or hypotheses.
- c) Evaluate or analyze options.
- d) Act on, or perform the best option.
- e) Look back or evaluate the results.

IDEAL

Principle-based model: The goal is to reach a “good decision.” P. 42

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Pope & Vasquez, 2011

Seventeen steps: Not every step is needed for every situation. Some steps may need to be adapted.

- 1) State the question, dilemma, or concern as clearly as possible.
- 2) Anticipate who will be affected by the decision.
- 3) Figure out who, if anyone, is the client.
- 4) Assess whether our areas of competence—and of missing knowledge, skills, experience, or expertise—are a good fit for this situation.
- 5) Review relevant formal ethical standards.
- 6) Review relevant legal standards.
- 7) Review the relevant research and theory.
- 8) Consider whether personal feelings, Biases, or self-interest might affect our ethical judgment.

1. Coming up with the best approach requires this step to be thought through and accurate, not rushed and vague. 2. No one lives in a vacuum. 3. Any conflict or confusion? 4. Can someone else step in and do a better job? 5. Do ethical standards speak directly to the situation or are they ambiguous? 6. Does legislation or case law speak to this situation? 7. We often lose touch with the theory emerging outside our own theoretical orientation. 8. Does the situation make us angry, sad, or afraid? Do we want to please someone?

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Pope & Vasquez, (2011), p.117-121 (continued)

- 9) Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.
- 10) Consider consultation.
- 11) Develop alternative courses of action.
- 12) Think through the alternative courses of action.
- 13) Try to adopt the perspective of each person who will be affected.
- 14) Decide what to do, review or reconsider it, and take action.
- 15) Document the process and assess the results.
- 16) Assume personal responsibility for the consequences.
- 17) Consider implications for preparation, planning, and prevention.

9. Does our own social identity in relation to the client's enter into the process? 10. Is there someone whose judgment we trust? 11. Keep searching for best possible alternatives. 12. What impact is each action likely to have? 13. Put yourself in each person's shoes. 14. Once we have decided on a course of action, review it one more time for flaws, and then act. 15. Keep track of the process through documentation. 16. If in hindsight things went wrong, do we need to address the consequences? 17. Are there practical steps that would head off future problems?

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Protecting Self and Agency

If it isn't documented, it didn't happen.

"Good documentation demonstrates that you used a reasonable standard of care in conceptualizing, planning, and implementing treatment." Bennett et al. (2006)

It also offers collaterals useful information to aid in helping the client in other areas, and encourages the therapist to be thoughtful and thorough in documentation.

Examples?

- Specific statement made by client that caused you concern.
- Behavior that made you uncomfortable.
- Something about surroundings out of place.
- Extra person "monitoring session."
- Client high or potentially using.

What else would you document precisely?

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Mindful Interventions

Mindful interventions come through:

- Training (graduate school and beyond)
- Supervision
- Time
- Familiarity
- Confidence
- Growth

...And these together create clinical acuity

There are so many things to think about and try to remember, but it all comes in time and through experiences.

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**Last But Not Least
Concerning Documentation**

Collateral Contacts (reminder) :

- Cannot *acknowledge* client without signed release of information.
- Cannot *discuss* client without signed release.
- If it is DCF, and they are the guardian, there should be a release in the file which they signed.
- Just because someone calls and says it is on the behalf of your client does not make it so.

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Vignettes

We have explored :

- Confidentiality, boundaries, self-disclosure, multiple relationships, safety, and self-care.

We have discussed:

- Risk-management, ethical decision-making, and documentation.

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Vignettes

Now you can:

- See how your views have transformed, if at all, through exploring vignettes and using ethical decision-making models to come to a thoughtful conclusion.
- Pick a model we discussed.
- Work alone or with others.
- Next week we will explore these vignettes and your responses to them.

Let's decide now how you will do this. I really want this exercise to be useful for you. And if you each engage fully in this exercise, next week's conversations will be lively, thoughtful, and engaging.

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Plan?

West Roxbury Interns:

Springfield Interns:

Slide 59

Let's Try One Before You Go

Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something...and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two.

How would you respond?

Let's use Knapp & VandeCreek, since it may be used during periods of crisis or an emergency. This may be seen as one.

- Identify or scrutinize the problem.
- Develop alternatives or hypotheses.
- Evaluate or analyze options.
- Act on, or perform the best option.
- Look back or evaluate the results.

IDEAL

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References: Session Two

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What is Mentionable is Manageable:

 Exploring Ethical and Boundary Challenges in Outreach
 Psychotherapy
 Session Three

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Session Three
 Exploring what we have learned; summary, review, evaluation

 Content areas: Confidentiality, boundaries, self-disclosure, dual-relationships, safety, self-care, ethical decision-making, risk-management.

- Vignettes
- Discussion
- Evaluation

How did it go? Who wants to start?
 Pass out paper?
 Use Easel to make notes?

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Vignette 1

You have been seeing a 9-year-old boy in his home since he was 7. Therapeutic alliance is strong. Work has focused on reducing his anxiety concerning family safety, which elevated after his home was broken into while his mother, his older sister, and he were away visiting his aunt and uncle. After you began working with this boy, his family got a puppy to protect their home. You have been there and have watched her grow into a beautiful dog. Conversation, at times during session, has involved commenting on how much you like his dog and how you wish you had one like her. The dog is going to have puppies and your client and his family, knowing how much you care for the dog, want you to have one of her puppies. What do you do? How do you come to this decision? What are the implications of saying yes? What are the implications of saying no?

What to consider:

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Vignette 2

You are a female therapist. You are seeing a young father of 3 small children, ages 9 months to 4 years. He is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. He tells you that his girlfriend (the mother of his children) is very aggressive and has been in jail a number of times for assault. You learn that the girlfriend has recently been released from jail and has gone to your client's apartment and told him if she sees any female go near him, she will "seriously f--- her up!" You know she has this reputation. What do you do? How do you come to this decision?

What to consider:

Slide 65

Vignette 3

You get a new client. She is a 40-year-old single mother of two school-aged children. When you get to the house it is dark inside (all shades are drawn), the client is smoking (you do not smoke), and there are beer bottles strewn across the kitchen counter and the living room floor (client does not smell of alcohol). You feel like you can barely breathe. It is winter and all windows are closed. Intake reports reason client requests services is for symptoms of depression. What do you do? How do you come to this decision?

What to consider:

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Vignette 4

You do therapy with a family consisting of a soft-spoken mother, a domineering father, a 12-year-old pubescent girl (who would spend all her time in her room talking to friends on the phone if she could), and twin 6-year-old boys (one loves to read and tell stories, and the other prefers building things to knock them down). The therapeutic alliance is still being established 6 weeks into therapy. Due to the father's work schedule, and his insistence to be there during therapy, the therapeutic hour has necessarily seeped into the dinner hour. You are often hungry while you are there, and smelling supper cooking only distracts you more from focusing on the therapy. The mother has invited you for dinner a couple of times and you have said, "No, thank you." Tonight, the father insists the mother set a place for you, while you graciously decline. The father is not taking "no" for an answer. What do you do? How do you come to this decision?

What to consider:

Slide 67

Vignette 5

You have been seeing a 15-year-old adolescent male since he was 12. His mother has severe, persistent mental illness, including PTSD, MDD, and DID. His father can be outright hurtful and unreliable with your client. Sometimes you see your client at his mother's apartment, sometimes at his father's house, and sometimes at his grown brother's or sister's homes. He has a brother two years younger who is always "hanging around" during session; floating in and out of the room, making comments, asking questions, being annoying or charming, but always nearby. Your client will ask his brother to leave, with mixed results depending on which day it is. Confidentiality is certainly in question, although your client seems not very concerned. The mother, who has physical and legal custody, approaches you one day and states the younger brother needs therapy also and "only wants to see you." She tells you that she asked your client if he would mind and that he said he would be fine with his brother seeing you. What do you do? How do you come to this decision?

What to consider:

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Vignette 6a

Your client, a 38-year-old male who is in partial remission from Opioid Dependency and struggles with MDD and bouts of suicidal ideation has told you, while you are in his home, that he has run out of medication and needs to get to the pharmacy to pick the prescriptions up. The pharmacy is two miles from your client's home, it is near the end of the month, and he doesn't have bus fare. It is over 90 degrees outside. You know your client will not walk there and does not have social connections to help him. You know these medications help your client stay stable and clean. What do you do? How do you come to this decision?

What to consider:

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Vignette 6b

Your decision, in the prior example, is to take your client to the pharmacy. He goes inside and soon pops his head out the door, calling you, asking you to come inside. You have a bad feeling in your stomach but go inside to see what is going on. Your client tells you he doesn't have the co-pay for his medication but, in the past they had always let him have it without paying. Your client wants to borrow two dollars for his medication co-pay and promises to pay you if you'll just take him to his mother's apartment after this. What do you do? How do you come to this decision?

What to consider:

Slide 70

Vignette 6c

Your decision, in the prior example, is to take your client to the pharmacy. He goes inside and soon pops his head out the door, calling you, asking you to come inside. You have a bad feeling in your stomach but go inside to see what is going on. The pharmacist tells you that one of the medications is a controlled substance and someone must show identification to be able to pick it up. Your client states he has no ID on him and needs you to show yours so he can get his medication. What do you do? How do you come to this decision?

What to consider:

Slide 71

Vignette 7

You go into a home to meet with a ten-year-old girl who acts out by being mean to her five-year-old sister (e.g., pushing her, yelling at her, teasing her). Client reports it is unfair HER father is in jail and has never been there for her, while her younger sister's "father AND grandmother sends her gifts and money for her birthday and holidays, and calls her on the phone all the time." The home is chaotic, with the TV playing loudly in one room and a radio playing loudly in another. Grandmother is in the kitchen preparing dinner and mom is busy talking on the phone. You are forced to go into the client's bedroom, with no place to sit but on the bed. However, there is a strong, persistent smell of urine in the room from your client's nighttime struggles with enuresis. What do you do? How do you come to this decision?

What to consider:

Slide 72

Vignette 8

You are in the office and receive a phone call from the adult sister of your 17-year-old male client, Brandon, who you see as angry and aggressive. The caller states she was speaking to her mother and told her mother it was important for Brandon's therapist to know that he has pushed and hit his mother. The mother told the daughter to call you and gave her your number. With this information, you think about the times you have been in Brandon's house and the interactions you have witnessed between mother and son. You are headed to Brandon's house later in the day. What do you do? How do you come to this decision?

What to consider:

Slide 73

Vignette 9

You are a male therapist. You are seeing a young mother of 3 small children, ages 9 months to 4 years. She is unable to come into the clinic due to the children, lack of a babysitter, and financial struggles. She tells you that her boyfriend previously pistol-whipped her into the hospital. You learn that the boyfriend has recently been released from jail and has gone to your client's apartment and told her if he sees any man go near her, he will kill him. You know he has a gun. What do you do? How do come to this decision?

What to consider:

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Vignette 10a

You are sitting at the kitchen table of a client who is nearly your same age, opposite sex. A neighbor knocks on the door, is let in, and you are introduced. The neighbor states "so you're the faithful one, you show up every week and do what you promise, that certainly is a nice change from the usual. Are you married?" How would you respond? How do you come to that decision?

What to consider:

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Vignette 10b

Same scenario, but you and your spouse had recently gone through a painful divorce. The neighbor sees sadness in your eyes and comments, continuing to question you. How would you respond?

What to consider

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Vignette 11

You have been working with a 16-year-old female, for the past 8 months, living in foster care. You have therapy in her bedroom since that is the only place for privacy. You have been working on reuniting client with mother and learned that client has received a birthday card from mother and is excited. Client states, "I'll go get it. I'll be right back," and runs off. When she leaves, the foster mother steps in and says "You know, I have a degree in counseling and I have been listening to you for the past 8 months and you aren't doing a thing for this girl. You are going about this all wrong and I can't see her improving whatsoever." After you get past the point of being mortified, how do you respond? How do you come to that decision?

What to consider:

Slide 77

Vignette 12

You and your spouse have been trying to have a baby. There appears to be infertility issues and you are seeking medical help. You are seeing a client with a 3-year-old child. The child has been to the emergency room and old tibia fractures have been discovered. Although not proved, it is clear that the client's boyfriend has caused these. You gently try to explore the client's relationship with the boyfriend and the potential danger for the child. The client states "I can always have another child but a good man is hard to find." How would you respond? How do you come to that decision?

What to consider:

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Vignette 13

Pre-doctoral internship requires long hours, hard work, and focused effort to complete all required tasks during the year. You are seeing 20 clients, doing assessments, writing meaningful psychological reports, presenting at case conference, and attending trainings. You have noticed that, by the end of the week, client sessions are getting shorter (you are arriving late and leaving a few minutes early to try to catch up on time with the next client). Your memory of the session is fuzzy and notes are becoming vague. You are at your 3:00 appointment. The grandmother goes into the kitchen to help your 5 year old client get something...and when you open your eyes, your client is staring you in the face. You are sure you only closed your eyes for a second...or two. How would you respond?

What to consider:

(Yes, this is a repeat, but put here in case it is not explored during the 2nd session or if there are new thoughts.)

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Training Evaluation

- Please fill out the training evaluation
- Add any comments which would be useful

Thank you

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Pope and Bajt (1988) argued:

How can psychologists who believe that the authority of the legal and ethical codes are not absolute ensure that their actions are based on sound professional judgment rather than on self-interest, prejudice, rationalization, and the sense that one is “above the law?” (p. 829)

And this is why I hope you will consider ethical decision-making models your friends... 😊

Slide 81

In every man’s memory there are things which he does not reveal to everyone, but only to his friends. There are also things which he does not reveal to his friends, but at best to himself and only under a pledge of secrecy. And finally there are things which man hesitates to reveal even to himself, and every decent person accumulates a considerable quantity of such things.

Fyodor Dostoevsky, 1864, Notes from Underground

When I read this quote, I thought “This acknowledges the isolation and the overpersonalization that takes place when we believe we are alone in our thoughts and our feelings. We are not alone.”

Appendix G: Participant Informed Consent

Please read this consent form carefully before you decide to participate in this training.

My name is Susan Rogers and I am a doctoral candidate in the Clinical Psychology department at Antioch University New England. **I am conducting research** for a doctoral dissertation entitled, *Exploring Ethical and Boundary Challenges in Outreach Psychotherapy: A Training Model*, and I am requesting that you consider participating in this study.

The purpose of this study is to teach clinical psychology pre-doctoral interns about the fundamental differences between in-clinic and outreach psychotherapy, encourage thoughtful exploration about the ethical and boundary challenges inherent in outreach psychotherapy, and then to measure the effectiveness of this training program.

If you choose to participate, you will be asked to attend three 2-hour trainings over a three week period, during your regularly scheduled didactic time. At the end of the training, you will be asked to fill out a post-training survey concerning demographics and your experience of the training. This information will be published as findings from this study with the understanding that all information provided will remain anonymous and your identity confidential.

Foreseeable risk to you is minimal; however, topics discussed during the training may cause discomfort to you, and you are encouraged to discuss this with the trainer. You may also leave the training to relieve your discomfort, and you are encouraged to discuss your feelings with your supervisor, who is prepared to explore with you any discomfort or confusion you may experience.

Perceived benefits of participation in this training include your increased understanding of the ethical and boundary challenges of engaging in outreach psychotherapy, and improved future trainings through your critical feedback on the survey.

Participation in this study is voluntary and you may withdraw at any time without penalty.

You do not have to answer any questions or statements on the survey that may cause discomfort or that you do not want to answer for any reason, please feel free to skip over these. I hope that you will respond honestly to all of the items, as this will give the most accurate results. The survey should take approximately 10-15 minutes to complete.

If you have any questions about the study, you may contact Susan Rogers at (413) 739-5572 x 41 or via email at srogers2@antioch.edu. This research is being conducted under the supervision of Roger L. Peterson, Ph.D., ABPP. He may be reached via email at rpeterson@antioch.edu.

If you have any questions about your rights as a research participant, you may contact Kevin P. Lyness, Chair of the Antioch University New England Human Research Committee, (603) 283-2149, or Stephen Neun, AUNE Vice President for Academic Affairs, (603) 283-2150.

Your signature below indicates that you agree to participate in this study. You will receive a copy of this signed document.

Participant Signature

Date