

CHAPTER 26

Legal and Ethical Issues in Couple Therapy

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Individual therapists are subject to a variety of ethical and legal standards but, for the most part, the rules governing such treatment are relatively unambiguous, such as maintaining confidentiality and working for the welfare of one's client. When practitioners choose to work with couples, they encounter vexing ethical issues and legal challenges unique to this therapeutic modality. The introductory section of this chapter briefly provides some historical context, followed by a review of basic principles of biomedical ethics. We conclude that section with assumptions grounded in systems theory. The next section reviews unique ethical challenges faced by couple therapists, along with available alternatives and recommendations for practice. The final section concerns some of the legal issues that may arise in this practice niche and the available alternatives for coping with them.

BACKGROUND

Psychotherapy began as an individual matter. The early psychoanalysts were physicians who, basing their practice on a medical model, worked for the benefit of their patients. For example, in their ef-

forts to guard confidentiality zealously, it was not uncommon to exclude family members, who were often seen as obstacles to the therapeutic endeavor.

In the 1950s, practitioners from various disciplines began experimenting with a variety of relational therapies, such as the interdisciplinary group at the Mental Research Institute in Palo Alto, California (e.g., Broderick & Schrader, 1991; Gurman & Frankel, 2002). Although many considered such practices to be unique and groundbreaking, more traditional therapists viewed these activities as unethical, because they believed that therapists should not treat more than one member of a family.

Recalling this history now seems quaint. Relational therapy, in one form or another, is now practiced by a majority of mental health practitioners (Norcross, Hedges, & Castle, 2002), and a significant body of research has shown that various forms of marital and family therapy are both safe and effective (e.g., Pinsof, Wynne, & Hambright, 1996; Prince & Jacobson, 1995; Shadish, Ragsdale, Glaser, & Montgomery, 1995). Nevertheless, these treatment modalities present ethical and legal challenges that have received little attention in the literature.

PRINCIPLES OF BIOMEDICAL ETHICS

We base our ethical discussion on a system commonly referred to as principle-based or “prima facie” ethics. These terms refer to a system developed by English philosopher W. D. Ross (1877–1940), who tried to resolve the problems associated with both utilitarian and deontological theories of philosophy. According to Ross, the best ethical theory rests on certain basic moral principles he referred to as “prima facie duties.” By this he meant that an obligation would be maintained unless it was overridden by a superior one (Knapp & Vandecreek, 2006). There is now common agreement that there are five such principles: autonomy, non-maleficence, beneficence, justice, and fidelity (for a detailed discussion of these principles, see Beauchamp & Childress, 2001).

“Autonomy” refers to freedom of choice; that is, people are free to choose their own course of action so long as they are responsible for their own behavior. Autonomy includes both the right to act as a free agent and the idea that if we wish to be treated as autonomous persons, we should treat others in the same manner (Kitchener, 1984). From this principle, various ethical standards can be derived, such as respect for a client’s privacy and providing informed consent.

The concept of “nonmaleficence” is derived from the medical principle of *primum non nocere*, or “above all do no harm.” This obligation requires that one not cause intentional harm or act in a way that risks causing harm. Although marital therapy does not entail the same risks as thoracic surgery, our work is not benign and, as we will see, certain unavoidable iatrogenic risks inhere in this treatment format.

“Beneficence” refers to the fact that we should work for the betterment of others. In other words, we are required not only to avoid harm but also to contribute to the welfare of others (e.g., American Psychological Association, 2002, Principle A) and to work for social justice (e.g., ethical principles; National Association of Social Workers, 1996). As we see below, when therapists have couples as clients, working for the benefit of both partners can be very challenging.

Ethics scholars’ use of the term “justice” generally refers to the Aristotelian notion that we should treat others as equals and unequals unequally, but only in proportion to their relative differences (Kitchener, 1984, p. 49). For example, such issues arise in couple therapy when decisions

must be made regarding a disproportionate allocation of limited family resources.

The final principle, “fidelity,” or “professional–patient relationships,” includes elements such as the obligation of veracity, or truth telling (Beauchamp & Childress, 2001, p. 284). For example, fidelity is one of the bases for our obligation to provide informed consent. But what are we to do when certain therapeutic techniques require deception? Another aspect of fidelity is the notion that we must place the welfare of clients above that of our own and work for their benefit. In a legal sense, this creates a fiduciary duty between the therapist and the couple, but the goal of fidelity can be quite difficult to achieve when couples present with opposing interests that are not readily solvable.

SYSTEMS THEORY

Couple therapy can be performed with a variety of theoretical approaches, as this volume demonstrates. We choose to base our discussion on the principles of systems theory, because we believe the ethical challenges that couple therapists face are best understood from this perspective.

Systems theory is not a unitary concept; thinking in this area has evolved and expanded in a variety of directions, and has been applied to the understanding of biological, social, and cultural systems. Discussion of all of these notions is beyond the scope of this chapter. Here, we focus on the most basic and widely held systemic assumptions that directly impinge on marital therapy.

1. In its most basic formulation, systems theory holds that a group of interrelated parts functions as a larger unit of analysis (Becvar & Becvar, 2006). Systems theory maintains that families, like other systems, are greater than the sum of their parts, and that change in one part of the system can create changes elsewhere.

2. Systems theory emphasizes the contextually based nature of human behavior. Rather than maintaining a focus on individuals in a decontextualized manner, as do certain individual therapy approaches, systems theory focuses on interdependence and the notion that, based on the circumstances in which we find ourselves, our behavior varies. Because our primary relationships establish a basic relational context for our behavior, we assume that working with couples is a more eco-

logically valid and effective approach to relational problems.

3. Human behavior cannot be understood in a logical or linear fashion, such that we can explain C if we know how A caused B. Rather, systems theory emphasizes the circular and recurring nature of behavior, which makes the search for ultimate causes impossible. As a result, systems approaches to therapy entail interrupting dysfunctional behavioral patterns to provide an opportunity for healthier ones to emerge.

4. Systems theory does not explain how behavior changes. Rather, it teaches us how behavior remains the same; that is, presenting problems often represent a way couples have found to maintain problems rather than to solve them. Systems-oriented practitioners understand that the solution for the couple may lie in addressing issues of which they are unaware by disrupting dysfunctional interactional patterns rather than helping clients to understand them better.

5. "Triangulation" refers to the notion that when two persons are in conflict, each will try to align with a third person (or, at times, with a philosophical principle, value, or standard) to avoid or to gain assistance with the stressful dyad (Nichols & Schwartz, 1998; e.g., by increasing that person's influence in the dyad). For example, a husband might intensify his relationship with his son as an alternative to addressing a problematic relationship with his wife. Minuchin (1974) noted that this structure frequently places children in the uncomfortable position of being unable to satisfy both parents, because alignment with one is seen as an attack on the other. Systems-oriented practitioners remain mindful of this idea and work to maintain neutrality, because failing to do so may erode therapeutic effectiveness.

ETHICAL CHALLENGES

As we noted earlier, many psychotherapists viewed any type of multiperson therapy as unethical when it was first introduced. Now, over 50 years later, treating couples is considered common practice (Norcross et al., 2001), but it still presents us with unique ethical challenges that individual therapists do not encounter. To date, seven challenges have been identified that apply to couple, family, and group therapy. Below we describe these issues and the dilemmas they can create, list the alternatives that pertain to each, and provide recommen-

ations where possible (the first three issues were originally identified by Margolin [1982]).

Definition of the Client

The Problem

In any form of multiperson therapy, a practitioner's first and most important question is, "Who is the client?" Another way to ask this question is, "To whom am I primarily responsible?" Is the obligation to the couple, or to a more broadly defined "system," such as the members of a couple and a parent who lives in their home and provides care for the children? Or might it be the person for whom treatment is sought, such as the "identified patient?" Alternatively, should we consider treating the member who brings the couple into therapy even though he or she feels that the problem lies with the other?

The concern regarding defining the client is based on the systemic assumption that any intervention, even with an individual, may have an affect on one or another family members (Minuchin, 1974). Such a possibility can cause significant problems, because any intervention on behalf of one member may not be in the interest of another. Consider the following example:

John and Mary Smith present for marital therapy. Mary has decided to leave the relationship and agreed to marital therapy in response to John's request to give it "one last try." Although John is willing to do anything to keep her, Mary's motivation to pursue treatment is at best ambivalent.

This is an all-too-common scenario for couple therapists, and it creates a fundamental ethical dilemma. How is the practitioner to work on behalf of both parties when they have competing goals and actions that might benefit one but harm the other? To expand the problem only a bit further, what about the children? Whereas the therapist has no legal duty to nonclients, systems-oriented therapists cannot ignore the potential adverse impact that a divorce might have upon the children (see Lebow, Chapter 15, this volume).

A similar problem arises in the following example:

Susie and Bill Jones bring their son Bill Jr. for individual psychotherapy. Whereas Susie believes that Bill Jr. is distressed, Bill Sr. believes he is underdisciplined and blames Susie for the problem. After an initial assessment, the practitioner recommends couple therapy

for Bill and Susie, based on the assumption that Bill Jr. is the symptom bearer of the marital conflict. Bill Sr. responds, claiming that any problems in the family are Susie's fault, and he is unwilling to participate in any relational counseling.

In this example, the practitioner is left in a difficult situation. If he or she proceeds with treatment but does not include Bill Sr., treatment efficacy may be compromised, and Bill Jr. could deteriorate even further. On the other hand, if the therapist adheres to his or her initial recommendation, and Bill Sr. refuses to involve himself, the family might receive no services.

Alternatives

There are a number of alternatives available to the couple therapist that may resolve these questions. Following the first example, the potential for competing interests requires that the therapist make a thorough clinical assessment of the situation before agreeing to proceed. For example, he or she may determine that Mary's motivation is insufficient to proceed with marital therapy despite John's wishes. If so, agreeing to work with the couple, and being equally responsible to both, would be quite inadvisable, because the course of treatment is unlikely to be effective and is potentially harmful to one or both of them.

Alternatively, Mary might agree to a time-limited period of evaluation/exploration to determine whether she might find some hope for proceeding with a longer-term commitment to the treatment process. In this case, the therapist could accept the couple as the client for this limited purpose, so long as the agreement is reviewed at some predetermined point in the future.

What if Mary is unwilling to engage in either of these alternatives? Rather, she states that she is only leaving the marriage as a result of John's problems. She plans to move out and contends that were John to receive help, she might be willing to return after he has demonstrated progress in her eyes. In this situation, the therapist might agree to work with John individually, using Mary as a collateral resource assisting in the treatment, and if the treatment went well, Mary might agree to return for couple therapy later. (We address related situations in a later section on change of format.)

The second example presents similar conflicts. It would be inappropriate for the therapist to exert pressure on Bill Sr. to comply with treatment recommendations. Doing so would be coercive

and potentially harmful. Alternatively, accepting his terms may very well perpetuate the problems that brought the family for treatment in the first place. Finally, the therapist may determine that proceeding under any circumstances risks greater harm than doing nothing at all.

Recommendations

These examples present complex and vexing dilemmas regarding whether to proceed with the couple therapy, and if so, on what basis? Unfortunately, little guidance is available. The American Association of Marital and Family Therapy (AAMFT) code of ethics does not address this issue, and the *Ethical Principles and Code of Conduct* (American Psychological Association, 2002) devotes only one paragraph to it:

§10.02(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained.

This standard contains a number of issues that deserve closer explanation. First, the paragraph assumes that the practitioner has agreed to provide services. As a conservative matter, we must assume that this agreement was preceded by an initial evaluation. It is not advisable to initiate treatment without first making a professional assessment of the presenting problem and recommending a course of treatment. Second, after the plan is presented, a discussion should ensue regarding to whom the practitioner will be responsible. Treatment should not proceed until such agreements are made. To do otherwise creates unnecessary risk for therapists and clients alike. Third, after determining who is to be a client, there may remain a question about what relationship the practitioner will have with other family members. If for example, a family member agrees to serve as a collateral resource, the practitioner must make clear that he or she has no fiduciary obligation to that individual. Fourth, the practitioner must provide a thorough explanation of the advantages and disadvantages of the chosen course. Finally, the American Psychological Association code of conduct omits an important procedural detail.

Because making these agreements is a matter of informed consent, the practitioner must engage in this process as early as is feasible as a matter of respect for autonomy and to avoid harm [AAMFT, 2001, §1.2; American Psychological Association, 2002, §10.01(a)].

We recognize that it may be unappealing to some to engage in such procedures at the outset of a professional relationship. Although such feelings are understandable, we cannot overemphasize the importance of resolving these matters, and taking as much time as is needed to do so, before initiating treatment.

Confidentiality

The notion of confidentiality dates from the Hippocratic Oath (Beauchamp & Childress, 2001, p. 304). It is based on the assumption that clients will only reveal personal information if they have a reasonable expectation that it will remain private and under their control. As a result, confidentiality is a prerequisite to all mental health treatment, and most ethics codes are relatively clear regarding how, and under what circumstances, information may be disclosed to third parties. All 50 states have a statute providing for a psychotherapist–patient privilege, but it takes very different form from state to state. It ranges from stating that the privilege is the same as the attorney–client privilege (e.g., New York and Pennsylvania),¹ to creating a separate act with detailed provisions (e.g., Illinois). Other states (e.g., Maine, New Hampshire, North Carolina, and Virginia) have created a balancing test, making the privilege less reliable. One way or another, the privilege is always held by the patient and must be exercised by the therapist on the patient's behalf, and generally covers communications and records made in the course of treatment. Unfortunately, these ethical standards and laws have limited applicability in couple therapy.

The Problem

The expectation of confidentiality gradually expanded from the doctor–patient relationship to many other types of professional relationships, such as priest–penitent, attorney–client, and ultimately to mental health professionals and their clients. However, all of these protected relationships involved conversation between two persons. In fact, English Common Law held that anything said in the presence of a third party was, by definition, not confidential, and we know of no juris-

diction that has held otherwise. How, then, is a couple therapist to proceed when the couple cannot be ensured confidentiality?

Alternatives

The couple therapist has a choice between two basic alternatives. The first is to treat information provided by each member of the couple in individual sessions as confidential. If there are conjoint sessions, information provided to the therapist during individual sessions would remain confidential. This alternative solves the ethical–legal problem, because the therapist has two individual clients. This option may be more appealing for those who practice from a more traditional or psychodynamic perspective, but it presents two serious disadvantages. First, this alternative requires that the therapist keep information from the other member of the couple to whom he or she is equally responsible. The confidentiality obligation continues even in situations where the information would be vital to the unwitting partner, such as an extramarital affair or the existence of a sexually transmitted disease. By withholding such information, the practitioner risks harming the very person to whom he or she is primarily obligated. Second, treatment effectiveness may be reduced, because information obtained from one member of the couple cannot be used in conjoint sessions with the other. Hence, the therapist's inability to share and use information may reduce the effectiveness of the relational portion of the therapy.

The second alternative is to adopt the opposite position and refuse to keep any information confidential, even if the practitioner conducts individual treatment sessions. This “no secrets” policy is appealing because of its straightforwardness. Taking this position also has the advantage of supporting the couple's relationship, since the therapist reduces the risk of inadvertently aligning with one partner by withholding information from the other. While superficially appealing, this alternative also involves the significant disadvantage that potentially important information will be withheld. For example, little progress can be expected in a situation where the couple is working on “communications issues,” while one partner maintains an undisclosed extramarital affair. This is a serious problem, because the therapist, had he or she known of the affair, most certainly would have treated the family quite differently. Therefore, a “no secrets” policy risks compromising

treatment effectiveness and harming other family members when vital information is withheld.

In addition to the two alternatives noted earlier, two special circumstances deserve note. First, a therapist might have a “no secrets” policy but agree to keep certain information confidential. This is a common practice when treating children. For example, parents may be given information regarding their child but not necessarily be provided personal details that the child would prefer to remain private. Also, it is common to excuse children from family therapy discussions that involve purely adult matters, such as finances or the couple’s sexual relationship. Therefore, keeping certain information confidential is an appealing compromise, especially because it already occurs with some frequency. The dilemma however lies in the question of where to draw the line. How is a therapist to decide in advance which information will be held in confidence and which will not? What criteria would he or she employ in making such a decision? Furthermore, keeping certain information in confidence risks having the therapist become triangulated into the couple’s conflict by the member who knows that the information he or she disclosed will not be revealed.

Second, there may be times when a practitioner keeps certain information confidential on a temporary basis. Consider the following:

Helen and Robert Brown present for marital therapy complaining of long-term conflict regarding a number of basic issues. After a few sessions, the therapist meets with each partner individually. Despite the therapist’s “no secrets” policy, Robert reveals a previously undisclosed and ongoing extramarital affair. He wants to keep the secret from Helen long enough for the therapist to help him tell her.

This scenario places the practitioner in a very difficult situation. There is little question that he or she has an obligation to inform Helen of the affair. On the other hand, agreeing to keep the secret temporarily might facilitate the disclosure and contribute to a better outcome. However, this means that the therapist would withhold vital information from Helen, who is also a client and to whom he or she is equally obligated.

To make matters worse, what if Robert changes his mind and decides not to reveal the affair to Helen? The therapist can neither inform Helen without violating Robert’s confidentiality nor continue the therapy, knowing that Helen is being deceived. In this situation, a therapist might

contemplate withdrawing from the case, but he or she should not do so without first considering two issues. First, termination may prompt Helen to speculate about the therapist’s reason(s) and could lead to the secret being revealed against Robert’s wishes. Second, the therapist must terminate in a way that does not risk abandoning either member of the couple.

Recommendations

There is no ready solution to the problem of managing confidentiality in couple therapy. All available alternatives entail risks that cannot be avoided. One alternative is for the therapist to make decisions on a case-by-case basis using his or her clinical judgment. We contend that doing so is inadvisable, because the therapist will inevitably become confused regarding which rules apply to which couples, raising the possibility of inadvertent disclosures and potential harm.

Unfortunately, therapists are left to make judgments about such matters in the absence of any empirical data to provide guidance. Given the limitations inherent in each approach, we recommend that practitioners establish policy regarding confidentiality based on their theoretical orientation, the population served, and practice niche (for further information, see “Record Keeping”). Such a policy does not avoid all the problems we have mentioned, but we contend that establishing an ethics policy reduces adverse outcomes for two reasons. First, the practitioner who works from only one stance is more likely to be more consistent in his or her approach. Second, the practitioner is more alert to the inherent problems in adopting a particular policy, and more able to deal with them should they arise (for detailed recommendations, see Gottlieb, 1997).

Therapeutic Neutrality

Therapists who treat individuals are expected to be supportive, encouraging, and advocate for the benefit of their client. How does one do this when there are two clients?

The Problem

Systems theory teaches that when treating a couple, the therapist must remain neutral to avoid being triangulated into a dysfunctional family system (Epstein & Loos, 1989; Stancombe & White, 2005). If the therapist violates neutrality

and aligns with one family member at the expense of another, treatment effectiveness may be diminished or even lost. Despite this seemingly obvious recommendation, there is no consensus regarding how neutrality should be maintained.

Alternatives

First, the therapist may adopt the position that there will be no conflict of loyalties as long as he or she works for the good of the couple. This is an appealing alternative, in that it would seem to be the best way to avoid conflict. Unfortunately, things are seldom so simple. Consider the following:

Sandra McCall and Lisa Ellsworth come to treatment regarding a conflict over family resources. Sandra and Lisa have sacrificed themselves and their economic resources to no avail in an attempt to help their son Robert, who has a chronic, severe, disabling, and rare medical condition. They were recently informed that a new medical procedure might help Robert. Because it is still experimental, their insurance carrier will not cover the cost of treatment. The only available funds are those in their daughter Jill's college fund. Sandra wants to use the remaining funds to try and help their son, whereas Lisa feels that Jill has already sacrificed enough for her brother and should not be penalized further.

In this example, it is hard to imagine how the therapist could maintain neutrality and work for the good of family members with such deeply held and opposing values.

A second alternative is that the couple therapist may align him- or herself with one or another member of the couple at different times throughout the course of treatment. This approach, sometimes referred to as "multipartiality" (Stancombe & White, 2005), is exemplified by the work of Salvador Minuchin. Although this position is appealing, it is not without its disadvantages. First, one must frequently align with one member of the couple or another. Maintaining neutrality in this way requires much skill. It can be difficult for the therapist, because it requires great personal flexibility, intense concentration, and an ability to repair relational ruptures, so that neither member of the couple feels attacked or ignored for very long. For a therapist with a large number of couples in his or her practice, this approach can be quite tiring. A second problem is that multipartiality assumes that the couple will come to understand the continual shifting of allegiances as indicative of the therapist's neutrality. Such an assumption presumes a certain degree of insight and intellectual

sophistication that all couples may not possess. Finally, unless the therapist is careful, this approach risks premature termination. For example, as we noted in our assumptions, systems-oriented practitioners understand that the solution may lie in addressing issues of which the couple is unaware, and that doing so may disrupt interactional patterns. Such disruptions can be unpleasant. If such an intervention occurs at the end of a therapy session, the member of the couple who feels unsupported by the therapist may feel resentful and later work to sabotage the treatment.

Third, one may take the position of maintaining no alliances at all, declaring loyalty only to achieving the goals presented by the couple. Such "absolute neutrality" may help to maintain a focus on the presenting problem and enhance treatment effectiveness. On the other hand, accepting information provided by the couple at face value risks ignoring potentially critical clinical information. For example, many couples present with "communication problems," but experienced therapists know that such euphemisms can mask far more serious problems. If the therapist accepts the presenting problem at face value and makes no independent assessment, he or she might overlook serious but unvoiced problems, such as substance abuse, chemical dependency, and/or intimate partner violence (IPV). A second problem in having "no alliances" is its value-free assumption. This alternative may be appealing to social constructionist and narrative therapists, but we contend, as have others, that value-free practice is difficult, if not impossible, to achieve (Patterson, 1958; Vachon & Agresti, 1992; Wachtel, 1993; for an interesting discussion of this issue, see Tjeltveit, 2006).

Finally, there are at least two circumstances in which it may be necessary for even the most devoted systems therapist must abandon therapeutic neutrality. The most obvious example is that of child abuse or neglect. To qualify for funding under the Child Abuse Treatment and Prevention Act, all 50 states have passed some type of statute that mandates reporting of suspected maltreatment of a child to the authorities. If a therapist has reason to believe that one member of the couple may be mistreating a child, he or she can no longer remain neutral and must act to protect the child. Although taking such action clearly risks a rupture in the therapeutic relationship, some research has indicated that this outcome is not inevitable (Watson & Levine, 1989; Weinstein, Levine, & Kogan, 2000).

A second exception to maintaining neutrality arises in cases of IPV. There are a wide variety of views on whether therapists should even see couples under these circumstances, and if so, which criteria should be used in making the determination (e.g., Dutton & Corvo, 2006; Trute, 1998). Although a discussion of this issue is beyond the scope of this chapter, we note it here, because there are times when a member of the couple may be victimized, and the therapist must act to protect him or her. This issue is addressed in more detail by O'Leary (Chapter 16, this volume).

Recommendations

There is general agreement that neutrality is a prerequisite to therapeutic effectiveness, but there is no consensus on how it should be maintained, and we are unaware of any empirical data that support one position over another. Therefore, practitioners must find an approach that works, consistent with the population they serve, their theoretical orientation, and "practice niche." As we noted earlier, adhering to one position consistently remains the preferred choice for effective risk management (Gottlieb, 1997).

In addition to navigating the murky waters of neutrality, we must recognize that neutrality must at times be abandoned to protect vulnerable populations. Many data suggest that sizable percentages of practitioners resist making such reports (e.g., Flaherty et al., 2006). Although such decisions can be extremely difficult, there are times when following the law must supersede ethical guidelines, because failing to do so can incur criminal penalties (e.g., Florida, Oklahoma, and Texas; for further reading on conflicts between ethics and the law, see Knapp, Gottlieb, Berman, & Handelsman, 2007).

Iatrogenic Risk

As a matter of public policy, the work of mental health professionals is considered beneficial both to individuals and society (e.g., "the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance"; *Jaffee v. Redmond*, 1996). We consider ourselves to be healers, and for the most part we reward society's expectations of us with good work. On the other hand, counseling and psychotherapy are not always benign processes; discomfort and/or harm can result when practitioners are ignorant, incompetent, and/or distressed. But all forms of

psychotherapy entail some iatrogenic risk, that is, some discomfort may be unavoidable even when treatment is provided competently and is successful (e.g., Kitchener, 1984; for a detailed discussion, see Beauchamp & Childress, 2001). Hence, practitioners must weigh potential discomfort and harm against expected long-term benefits for each client they choose to treat.

The General Problem

When a therapist agrees to treat a couple, assessing potential iatrogenic risk becomes more complex; the therapist has two tasks. First, he or she must make a risk–benefit assessment for each member of the couple, as would an individual therapist. Second, if the outcome of the individual assessment for both parties is favorable, he or she must then perform a similar analysis based on interactional or relational factors. This problem was elegantly articulated by O'Shea and Jessee (1982), who defined "iatrogenic risk" as a situation in which "a previously asymptomatic family member may become symptomatic during or subsequent to therapy" (p. 15).

If we are to treat couples, this risk seems unavoidable in cases such as that of the Smiths. However, two considerations mitigate this problem. First, O'Shea and Jessee's definition was based on a theoretical assumption from systems theory; it is good advice, because it suggests a conservative course. However, recent data suggest that such an adverse impact is not always the case (Liddle, 2004). Although this is encouraging news, it does not preclude the need for the assessment we noted earlier.

Second, individual risk–benefit assessments may yield troubling findings. Consider the following:

Molly and Larry Short request couple therapy due to significant communications problems. Molly asserts that Larry does not understand her and is verbally abusive. Larry claims that Molly responds to him in ways that are incomprehensible to him. He denies ever mistreating Molly and is unable to understand what he did that so upset Molly, despite his ongoing efforts to comply with her wishes and understand her point of view.

Given the potential seriousness of this situation, the therapist decides to perform individual assessments. The assessments revealed that whereas Larry was generally functioning well, Molly had posttraumatic stress disorder due to severe child abuse, of which Larry was only vaguely aware.

What is a couple therapist to do in such a situation? A variety of treatment plans may be derived on the basis of one's theoretical orientation, but even the most devoted systems therapist must consider the possibility that therapy from an experienced and skilled individual therapist is the preferred course for Molly, and that any type of relational therapy may need to be postponed.

Specific Iatrogenic Risks

In addition to the general problem noted earlier, systems-oriented couple therapy also presents specific iatrogenic issues based on certain theoretical approaches. In this section we discuss some of the problems that can arise when using these treatment modalities.

UNWITTING COERCION

Couple therapists see themselves as helpers and healers, who intend to hurt no one and certainly do not view themselves as coercive agents. Unfortunately, there are circumstances in which clients may be coerced into therapy without the practitioner's knowledge. This problem can arise in a variety of clinical situations, but one of the greatest dangers may arise in cases of undisclosed IPV.

Ann and Jeff Carter presented for couple therapy. Both complained of chronic conflict. Ann complained that Jeff was easily angered over minor matters, and Jeff said that Ann was becoming too independent and less concerned with his needs. The therapist decided to help by improving communication between them, but after a number of weeks, they had made no progress. Only by virtue of an offhand remark did the therapist become suspicious that Jeff was physically abusing Ann, who had not disclosed the mistreatment in his presence.

This is a vexing situation in which the therapist may have unwittingly supported Jeff's coercion and abetted his abuse. However, couple therapists are not clairvoyant, and it is often very hard to identify IPV at the outset of treatment. Routinely screening for IPV is a prudent measure, and we recommend it, but even if Ann had been asked about such a problem, there is some likelihood that she might have denied it.

STRATEGIC AND PARADOXICAL STRATEGIES

One important way to reduce iatrogenic risk is by providing thorough informed consent prior to the initiation of treatment (e.g., AAMFT, 2001,

§1.2; American Psychological Association, 2002, §10.01), but this requirement presents a significant ethical challenge for strategic therapists and others who wish to use paradoxical strategies and other sorts of interventions that, at least to some in the field, may be considered to be deceptive.

Such techniques, firmly grounded in the systemic notion of the need to disrupt dysfunctional interactional patterns, have a long history and can be effective in many clinical situations (Beutler, Moleiro, & Talebi, 2002; Seltzer, 1986). They employ counterintuitive and/or seemingly contradictory instructions that often are intended to confuse clients. Seltzer defined "paradoxical strategies" as "a therapeutic directive or attitude that is perceived by the client, at least initially, as contrary to therapeutic goals, but which is yet rationally understandable and specifically devised by the therapist to achieve these goals" (p. 10). For strategic approaches to be effective, the therapist must play his or her cards close to the chest, not revealing the intention behind the instructions. Furthermore, these approaches are indicated and are most helpful only in situations in which symptoms are under voluntary control, and couples have a documented history of resistance to more direct instructions (Gurman, 1982; Rohrbaugh, Tennen, & Press, 1981). Hence, providing informed consent by explaining the therapist's intentions with such couples would likely reduce treatment effectiveness (Brown & Slee, 1996). For example, Hampton (1991) contended that "informed consent must be reasonably tempered when using paradoxical strategies in the interest of promoting client welfare, as full disclosure could result in premature termination and client harm" (p. 53).

A second problem involves harm that may arise from improper use of these techniques. We have seen inexperienced and/or frustrated therapists use these approaches to act out their own anger against an uncooperative couple. It is unclear to us why strategic approaches seem so vulnerable to misuse in such circumstances, but their use under these conditions is contraindicated and potentially dangerous. Out of an abundance of caution, those who are not thoroughly trained in these approaches should obtain consultation prior to using them (Huber & Barth, 1987).

NOT KNOWING

Narrative therapy is rooted in the postmodern and social constructivist traditions (e.g., Gergen,

1985, 2001). The unique contribution of this body of work is its emphasis on the cultural and political influences that form the ecosystemic context for individual and relational problems (Lyddon, 1995). Some who practice within this theoretical orientation employ a technique referred to as “not knowing,” in which the therapist eschews an expert position. Anderson and Goolishian (1992) defined it as means of maintaining neutrality, in which “the therapist’s actions and attitudes express a need to know more about what has been said, rather than convey preconceived opinions and expectations about the client, the problem, or what must be changed” (p. 29). This technique and attitude may be helpful in normalizing certain problems, but it also contains certain risks, at least in certain circumstances. For example, some cultures have strong traditions of collectivism, self-sacrifice, and respect for authority (e.g., Smith, 2004). When persons from such backgrounds seek couple therapy, they may be inclined to seek concrete advice from a practitioner. If told that they are the experts about their own situation, they may feel dismissed, confused, and leave treatment, concluding that couple therapy has nothing to offer them. We recommend that one’s theoretical orientation not take precedence over client welfare, and that when specific, treatment-relevant questions are asked, they should be answered as a matter of respect for a client’s autonomy (for further reading on diversity issues, see Sue & Sue, 2003).

Recommendations

There are iatrogenic risks inherent in all therapeutic approaches, and systems-oriented couple therapy is no exception. From this brief discussion, it should be clear that there is no way to avoid all of these pitfalls. Rather, one must be alert to the specific iatrogenic risks that exist within one’s practice niche and take appropriate steps to avoid or mitigate them when they arise or are suspected. Being alert for IPV, monitoring one’s resentful feelings toward a couple, and offering concrete recommendations, where indicated, are all prudent ways to minimize risk and enhance client welfare.

Change of Format

The term “change of format” was first used by Margolin (1982) as an example of frequently encountered problems of confidentiality in couple

therapy. She noted that ethical dilemmas can arise when a therapist who had been treating an individual changes the format to work conjointly with the individual and his or her spouse, or vice versa. Later, Gottlieb (1986) operationally defined this term as “a circumstance in which the formal definition of the client changes after the initiation of treatment such that the responsibility of the therapist is altered.” He then identified three specific ethical issues that arise in these circumstances (Gottlieb, 1995). Before reviewing these, consider the following example:

Jennifer Cooper called a couple therapist for assistance. Based on a telephone screening, an initial conjoint assessment session was recommended for Jennifer and her husband. Jennifer agreed and said that she and her husband Mike would be there. At the appointed hour Jennifer appeared by herself. She explained that Mike was suddenly called away on business, and she thought she could use the time for some of her own issues. The therapist agreed to see her, with the understanding that couple therapy remained the initial treatment plan. Another five individual sessions ensued before Mike arrived.

Confidentiality and Change of Format

Assuming that Mike is to be incorporated into the treatment process, how is the therapist to manage the information he or she has already obtained from Jennifer? Ideally, Jennifer would have agreed to a “no secrets” policy from the outset. If so, she would have no objection to the therapist sharing with Mike any information she had disclosed. However, after a number of treatment sessions, she may now be reluctant or even unwilling to share certain information with Mike.

This problem might have been resolved at the first session had Jennifer been asked to sign a release giving the therapist permission to share information with Mike. Had this been done, the therapist might feel free to proceed unencumbered. However, can the therapist safely presume that Jennifer will remember all the information she has revealed? Is it possible that she forgot about this agreement and shared with the therapist information she did not want Mike to know? Because the therapist cannot know Jennifer’s feelings about this issue, it would be prudent for him or her to review the agreement, as well as some of the information that had been revealed, to ensure that the “no secrets” policy, is still in force. If after this review, Jennifer remains comfortable

with the arrangement, it may be safe to proceed with couple therapy. But it is also possible that, after this discussion, Jennifer might assert her right to confidentiality. If so, the therapist would have little choice but to refuse to proceed with couple therapy, because he or she has good reason to believe that therapeutic neutrality cannot be maintained because of the need to keep secrets. The couple would need to be referred elsewhere, and Jennifer and the therapist would have to decide whether to proceed with individual therapy, in addition to couple therapy.

Professional Responsibility and Change of Format

As we noted earlier, the practitioner has an obligation to clarify the nature of the professional relationship with each person involved and to maintain equal professional responsibility for all clients (see the sections "Definition of the Client" and "Therapeutic Neutrality"). In the preceding example, how is the therapist to incorporate Mike into an ongoing individual therapy that he or she intends to change to conjoint treatment? For example, what risks are entailed in shifting from the previous position of exclusive responsibility to Jennifer to a new position of neutrality and equal responsibility for both partners? Is there a risk that Jennifer will feel betrayed by the therapist who used to be aligned with her? On the other hand, will Mike be apprehensive about entering a situation in which he fears that Jennifer and the therapist may already be aligned against him? How would the therapist persuade Mike of his or her neutrality? Finally, will the therapist risk alienating Jennifer when he or she spends a disproportionate amount of time at the outset establishing a relationship with Mike?

Iatrogenic Risk and Change of Format

As we noted earlier, when providing individual therapy to a married person, that person's spouse may deteriorate as he or she improves. In the case of Jennifer and Mike, the reverse must also be considered. For example, Jennifer may have made gains during the individual treatment sessions. If the therapist agrees to the change of format, he or she risks loss or deterioration of the progress Jennifer has made. In such a case, the therapist might unintentionally harm the person to whom he or she was primarily obligated.

Recommendations

Change of format is hardly new to mental health practitioners. As we noted earlier, children are often excused from family therapy when adult matters are discussed. When children are seen in individual therapy, one or both parents may often be incorporated into the process at the end of a session. Hence, changing format is commonplace and generally is considered helpful. Nevertheless, some guidelines may be useful in facilitating the process.

First, the therapist should make clear his or her systems perspective, even during an initial telephone call. Among other things, informing the prospective client of a "no secrets" policy should be a major consideration. Once treatment has begun, we recommend that the therapist maintain a focus on sharing rather than concealing information as a matter of respect for their relationship. Second, it is the responsibility of a couple therapist to be aware of the literature regarding the risks and benefits of individual versus couple therapy. Moving from an individual to a conjoint format is not risk-free, and the practitioner must remember that his or her primary obligation is to the existing client. Even if the client agrees to conjoint therapy, the wise therapist will ask how the client anticipates he or she will feel when the spouse joins them. Once conjoint treatment begins, it is highly advisable that the therapist ask the original client periodically how he or she feels about the change in format. Third, the couple therapist needs to remain mindful of potentially having additional responsibilities to the incoming spouse. We recommend that the therapist review the agreement with the original client and determine whether the incoming spouse understands it and wants to proceed. If so, the therapist should take as much time as is necessary to join with the new client before proceeding conjointly. Finally, making these decisions is not always a clear-cut matter. It is always advisable to provide clients with ample opportunity to discuss the risks and benefits of all treatment alternatives and time to think about them in advance.

Live Supervision

Live supervision, which has been an integral part of couple therapy since its inception, has many advantages, and it has now become a powerful teaching tool from which many benefit. Originally, live

supervision was practiced relatively unobtrusively. Soon, telephones were installed to allow supervisors to communicate with therapists only when necessary to minimize disruption (Haley, 1976). The next stage led to a wide variety of experiments in an effort to improve the quality of interventions (e.g., Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978; Minuchin & Montalvo, 1967). These experiments led Gottlieb (1995) to comment that “these developments have created a situation in which a method of training has become a form of therapy in which families are no longer treated by an individual but by a group” (p. 565). From an ethical perspective, he asked, “Who is the therapist? Or Who is professionally responsible for the family?” (Gottlieb, 1995, p. 565). He concluded that use of this treatment modality gave rise to three general ethical issues.

Professional Responsibility

The couple therapist has an obligation to clarify his or her own professional role, as well as that of the other members of the team (e.g., American Psychological Association, 2002, §10.02) as a matter of informed consent (e.g., AAMFT, 2001, §1.2; and American Psychological Association, 2002, §10.01). In “vertical models” (Gottlieb, 1995), lines of responsibility are clear-cut. For example, in training situations, a student therapist informs the couple about his or her status, and that the supervisor behind the one-way mirror is ultimately responsible for their care.

“Horizontal models” (e.g., Selvini-Palazzoli et al., 1978) create additional problems when no clear lines of authority are established. For example, who is to be contacted in case of emergency? How are decisions to be made if a team member disagrees with the others? How are lines of responsibility established? Who is ultimately responsible for the care of the couple?

Informed Consent

What is a couple told in advance about live supervision? For example, some couples may be reluctant to engage in this process out of legitimate concerns regarding privacy. If so, are alternative treatment options offered? If the service is offered for free or at low cost, would the partners feel some degree of pressure to remain if they could not obtain similar services elsewhere, without incurring additional cost or inconvenience? A second con-

cern surrounds interruptions from the team (e.g., Smith, Smith, & Saltz, 1991). How does the couple have confidence in a therapist who appears to need the supervision of so many others (Bullock & Kobayashi, 1978)?

Iatrogenic Risk

Social psychologists have known for many years that people make more extreme or riskier decisions in groups, especially when the group comprises like-minded individuals, than they would as individuals. This well-documented phenomenon is termed the “risky shift” (Hinsz & Davis, 1984). (More recently it has also been referred to as “choice shift” or “group polarization.”) The obvious implication of this effect is that a team may recommend more extreme measures than would an individual therapist. If so, they risk harming the couple (Gottlieb, 1995). Furthermore, the probability of the team making more risky decisions increases in ambiguous situations (Elmes & Gemmill, 1990). Risk is also increased in situations when social status plays a role in the process, because lower status and less experienced trainees are more likely to defer to senior colleagues (Schaller, 1992). Should this effect change the way live supervision is conducted? Is there a way to control the group’s influence?

Recommendations

Live supervision has been transformed from a teaching tool to a therapeutic technique. This change arose as a natural evolution of the field, but little research has been done to demonstrate its effectiveness (Kivlighan, Angelone, & Swafford, 1991), and little attention has been paid to the ethical issues it presents.

To some degree, the issues presented by live supervision are less worrisome today. The experimentation of the 1980s is over, and the advent of managed care has significantly restricted reimbursement for practitioners, making live supervision less practical due to its added expense. For example, two of use (Gottlieb and Simpson) live in an urban area of nearly 6 million people but are aware of only two locations in which live supervision is available to students. Furthermore, many of the problems noted here have been addressed and resolved by thoughtful trainers, who have taken these concerns into account (Personal communication, Dr. Shelly Riggs, May 12, 2007).

We feel that a useful way to think about the ethical issues involved in live supervision is to ask how we would like to be treated if it were offered to us. In that spirit we have the following recommendations.

Because live supervision is not something with which most clients are familiar, we recommend that, as a matter of informed consent, agency policies be explained fully. At a minimum, the couple should know the identities of the therapist and team members, their level of training and experience, who will be responsible for their care, and who is to be contacted in case of emergency. Finally, a couple that is uncomfortable with this format should be offered other treatment options with which the partners are more comfortable.

In our view, vertical models, in which lines of authority and decision making are unambiguous, are safer. If group members are to have an equal say in decision making, a senior practitioner should monitor the process and act to contain more risky recommendations. Finally, all these matters should be memorialized in a written agency policy that is provided to practicum students, interns, supervisors, and clients. Explaining these policies should be part of every annual trainee orientation and ongoing staff development.

Record Keeping

Record keeping is a necessary professional responsibility, because it improves the quality of care and provides for continuity of treatment (e.g., American Psychological Association, 2002, §6.01; AAMFT, 2001, §3.7). As with many other ethical principles, our record-keeping requirements come from the medical tradition, in which a physician has one patient and maintains an individual record.

The Problem

Unlike individual therapists, couple therapists have two clients, and interventions are generally relational in nature. But may a therapist keep one record for both clients (hereafter referred to as a comingled record), or should he or she keep two separate, individual records? A number of years ago, the Texas State Board of Examiners of Psychologists (TSBEP) published an opinion regarding record keeping in couple therapy, stating that "Separate patient files should be kept on each of the couple. Co-mingling of records should be

avoided" (TSBEP Newsletter, Spring 1992, p. 2). As one can imagine, this opinion was met with a firestorm of criticism from the marriage and family therapy community, and it was later rescinded. Even though this proposal was eventually withdrawn, ethical dilemmas surrounding comingled records continue.

Issue

A major problem with comingled records occurs when a couple therapist receives a request from a client to release information. For example, what if the partners have ended their relationship or divorced, and one of them requests individual therapy from another practitioner? In such a case, it is typical for the couple therapist to receive a release from one member of the couple to transmit information about him or her to the new therapist. But the couple therapist cannot release the entire record without first obtaining permission from the other member of the former couple. Releasing the entire record without permission would violate the couple therapist's obligation to maintain the confidentiality of the other member of the couple. This issue often arises when couples previously seen in treatment decide to divorce and litigate matters regarding child custody. In such cases, one or the other member of the former couple may seek the couple therapist's records to use to his or her advantage in the lawsuit. But what if the other member of the former couple refuses to allow the couple therapist to release the record? If so, he or she is now caught in the dilemma of trying to help one member of the former couple at the possible expense of the other.

Recommendations

There is no doubt that maintaining comingled records presents both ethical and legal difficulties that individual therapists do not encounter. Nevertheless, for those who choose to practice relational therapies, we contend that a comingled record is preferable to two individual ones. The more important reason is that a comingled record is the one place where interactional data can be preserved. Because relational therapies are based on interpersonal interventions, the comingled record is the only place where such clinical notes can be made, thereby providing the greatest benefit to the couple (Gottlieb, 1993).

As with the other ethical dilemmas we have discussed, there are no straightforward answers

to the problems presented by keeping comingled records, but many problems associated with them can be prevented by a thorough informed consent procedure at the outset of treatment. Specifically, it is necessary that the couple therapist inform the couple that the record cannot be released without the written permission of both parties, and that he or she take as much time as is needed to explain the process and requirements for releasing information to others.

In response to these dilemmas, one may ask why it is not simpler to avoid all these problems by redacting all references to the other member of the couple, then sending the record to the requesting party. In fact, at least one state requires it:

Licenses who release confidential record relating to a patient or client that also contain confidential information relating to a second patient or client that the licensee obtained through the provision of services to that second individual, and who lack consent or other legal authority to disclose the second individual's identity and/or records, must remove all identifying and confidential information relating to the second individual before releasing the records. [Texas State Board of Examiners of Psychologists, 2006, §465.12(f)]

We do not know how many other states have such provisions in their regulations, but we consider redacting a record undesirable. First, it is very difficult to protect the identity of the other party without redacting very large portions of the record; doing so may leave very little that would be of any use to another practitioner. Furthermore, the remaining information may be misleading, because it was obtained in a conjoint rather than an individual format. Because behavior is contextually based, it is not prudent for a new therapist to assume that his or her client will present in a manner similar to that reflected in the comingled record.

Finally, what if the other member of the couple cannot be located? This is less of a problem when married couples with children divorce, so long as they maintain family ties. But many therapists see couples who choose to not marry and/or are unable to do so. When these couples separate, there are fewer ties that would help the couple therapist locate the former partner. We are unaware of any law or regulation that specifically addresses this issue, but we recommend that the therapist always assert the privilege on behalf of the missing member of the couple and refuse to release their records without a court order. Because

this void leaves couple therapists in a very difficult position, we recommend that a local attorney be consulted before releasing the information.

With regard to custody litigation, laws vary widely. Some states (e.g., Texas and Alabama) specifically prevent the assertion of the privilege in custody matters and compel the disclosure of the records. Others (e.g., Indiana and Kentucky) hold that an affirmative request for custody places a party's mental health into question; therefore, the privilege is automatically waived. In still other states (e.g., New York and Kansas), courts have held that the children's paramount interests trump the parties' individual privilege. Finally, some states (e.g., Michigan, Mississippi, and Missouri), even in matters involving custody, uphold the privilege and prohibit disclosure of information. We would prefer to offer clear guidance on this matter, but given differing legal requirements across the states, the reader is well-advised to consult a knowledgeable attorney to be informed regarding the law in his or her jurisdiction before engaging in relational therapies.

If asked, most lawyers would advise practitioners to not keep comingled records as a matter of prudent risk management due to the complexities they create. This would especially be so when legal disputes arise (see the following section for a detailed discussion of how to manage these situations). Nevertheless, we contend that maintaining comingled records is ethically appropriate and clinically indicated, because it captures contextually based interactional data that are vital to successful relational counseling. Although it is not without its challenges, we contend that keeping individual records would lead to a loss of the very information that would be vital to helping a couple (Gottlieb, 1993).

In concluding this section, we would be remiss if we did not take a moment to discuss the importance of adequate record keeping. Many misguided practitioners continue to believe that *de minimus* record keeping somehow protects them from professional and legal liability. In our view, nothing could be further from the truth. We simply wish to remind the reader that couple therapists have fiduciary obligations to their clients. Keeping thorough records is both our ethical obligation and the best way to provide good care. Furthermore, in the event of an ethics complaint and/or civil law suit, a sound record can be the next best thing to a friendly witness (for further reading regarding the importance of record keeping, see Bennett et al., 2007).

LEGAL ISSUES

As licensed professionals, couple therapists function within the legal system. Yet many know little about how the system operates and are often frightened by it. In this section, we review some typical situations that may arise when treating couples and offer general suggestions for how they may be addressed to provide good care, protect clients' rights, and practice good risk management. Please note that our recommendations should not be construed as legal advice. Therapists should always consult an attorney familiar with the law in their jurisdiction whenever legal questions arise.

Dealing with Subpoenas

At one point or another, couple therapists are likely to receive subpoenas for comingled records. Practitioners who receive such subpoenas are well advised to remember that releasing information without a client's permission may expose them to both state regulatory board complaints and civil suit. In this section, we address how one should deal with such requests. We consider how to provide information to a client's attorney, then address how to protect information in adversarial situations. We conclude with how best to manage testifying about one's clients when it becomes necessary to do so.

Subpoenas

A "subpoena" is a writ that commands a person to appear before a court and subjects him or her to a penalty for failing to comply; if it includes a request for records, it is referred to as a *subpoena duces tecum* (for further reading, see Committee on Legal Issues, 1996). As we noted earlier, it is not unusual for a couple therapist to receive such a subpoena. Upon receipt of such an order, one should never assume that it should automatically be obeyed.

WHEN NO RELEASE IS INCLUDED FOR AN INDIVIDUAL CLIENT

It is often the case that subpoenas are sent with no release from the client or former client. To our knowledge, there is no jurisdiction that would allow the couple therapist to release information about a client without a release, because doing so would violate the client's right to keep the information confidential.

When no release is included, the couple therapist is well advised to call the sender of the subpoena, usually a lawyer, and respectfully decline to release the information, explaining that no release was included. Making a note of this conversation in the record is a must, and it is best to follow the telephone call with a letter to the requesting attorney, reminding him or her of the telephone conversation, and restating the reason the therapist is unable to release record. Absent a release, the therapist should provide no information to the attorney. For example, one might say:

"I'm sorry, but absent a competent waiver [the legal term for a release], I am unable to tell you whether the person named in the subpoena is or ever was a client of mine."

The attorney will generally understand and accept this explanation; often this omission is an oversight, and a release follows. If a release is not forthcoming, the couple therapist should do nothing further, other than to notify the client of the action taken.

WHEN A RELEASE IS INCLUDED FOR AN INDIVIDUAL CLIENT

It would seem that in this situation, one could send the record without further concern; typically, this may be the case, but we recommend an additional step. Even though a release has been enclosed, we suggest first calling the client to inform him or her of receipt of the subpoena and asking whether he or she knew about it, and to explain his or her understanding of what the release entails. Explain the general obligation to maintain confidentiality and determine the client's wishes, noting that the client still has the right to rescind the release if he or she so chooses. If the client agrees to releasing the information, explain to him or her the risks and benefits of doing so. One might go so far as to mention that previously disclosed, specific and/or sensitive information is contained in the record. Because the client may not remember giving the therapist this information when he or she signed the release, the reminder may prompt a change of mind. If the client chooses to rescind the release, the therapist must respond to the subpoena as discussed earlier, noting that the release has been withdrawn. The therapist should also encourage the client to call his or her lawyer to explain the reasons for the change.

Regardless of the outcome of this conversation, the therapist should follow the conversation with a letter to the client explaining his or her understanding of the client's position. We recommend including a place for the client to sign the letter indicating his or her acknowledgment of the therapist's understanding, that the therapist has discussed his or her concerns with the client, and that the client understands those concerns. After following this procedure, if the client still wishes the therapist to share information with his or her lawyer, then document the conversation in the record and proceed to the step below.

WHEN PERMISSION IS RECEIVED

Once these steps have been taken and permission is received, the therapist should call the attorney, identify him- or herself, explain the reason for the call, and offer his or her cooperation as the client has requested. It is always advisable, before sending the record, to determine what information the lawyer is seeking. For example, he or she may only want certain information that the therapist can provide verbally. In this situation, it may not be necessary to send the record, and the client's privacy can be preserved to the maximum degree possible. If the attorney wishes to have the entire file, then we recommend that he or she be made aware that the therapist's compliance with that wish may present certain risks and benefits to the client. For example, if the record contains personal and/or sensitive information that is not relevant to the legal matter, the attorney should be made aware of its existence in the hope that he or she may be able to protect it.

Finally, we would be remiss if we did not mention that lawyers often ask questions that therapists cannot answer. For example, "Well, Doctor, don't you think that my client would be the better parent of the two?" Unfortunately, some therapists, out of a boundless desire to help and/or ignorance, answer such a question, even though they should not. In this example, only a court-appointed custody evaluator can answer that question. For a therapist to do so exceeds the boundaries of his or her competence (e.g., American Psychological Association, 2002, §2.01) and is unethical (for a more detailed treatment of this issue, see Greenberg & Shuman, 1997; Committee on Ethical Guidelines for Forensic Psychologists, 1991). It is also likely that testifying to such a conclusion in court will lead to a blistering cross-examination and the likely exclusion of the testimony (see Federal Rule of

Evidence 702; *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 119 S. Ct. 1167 [1999]; and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786 [1993]). It is not rare for a state regulatory board complaint to follow. Therefore, therapists are well advised to provide information only to the extent that their data permit.

A RELEASE IS INCLUDED FOR ONE MEMBER BUT NOT ANOTHER

If the client was a couple and a subpoena is accompanied by a release from only one of them, the couple therapist should follow the recommendations given earlier, as if no release were obtained. The attorney should be informed that the records are comingling; therefore, the records cannot be provided without releases from all the persons who were clients. If the attorney asks who else was seen as a client, he or she must be reminded that the therapist is not free to disclose that information.

MAKING EFFORTS TO PROTECT THE RECORD

It is not unusual for a couple therapist to receive a subpoena when his or her former clients choose to separate or divorce and child custody is an issue. Unfortunately, the previously recommended steps are not always adequate if an attorney threatens to get a court order to obtain the records. If so ordered, the therapist is required to tender the records, but he or she may take certain steps to prevent having to provide them.

First, we recommend contacting the member of the couple whose release was not included in the subpoena and determining his or her wishes. In some cases, he or she will be unaware of the subpoena and instruct the therapist not to turn over the record. Because the couple therapist has some reason to believe that the requesting attorney will file a motion to compel the therapist to produce the record, he or she is well advised to have the client who has not signed the release contact his or her attorney. By doing so, the attorney for the client who did not sign the release has the opportunity to file a Motion to Quash the subpoena and/or a Motion for a Protective Order. If either of these motions is sustained, the record is protected.

If the client's attorney fails to file such motions, some lawyers recommend that the therapist retain his or her own attorney to file them. This alternative is seldom necessary, and it is expensive. On the other hand, doing so clearly indicates that

the therapist has done everything he or she can to protect the client's confidential information.

If such a motion is overruled, the attorney may ask for an *in camera* review of the records by the trial court. In this way, the judge has the opportunity to decide whether certain information can be protected.

By following these steps, the therapist has done everything he or she can to protect the client's record. But, if all the above efforts fail, and the court orders the records to be produced, then the therapist must surrender them. Therefore, the therapist should already have made a copy of the complete file to provide to the court, if the need arises. While failing to cooperate at this juncture means that the therapist risks being cited for contempt of court, cooperating, while perhaps undesirable from the therapist's perspective, assures the therapist that no complaint against him or her can be sustained. One can never be sanctioned for following a court order.

The importance of thorough documentation of all the actions taken cannot be overemphasized. Verbal communications with the client or an attorney should be followed up with a letter. In doing so, the therapist can avoid miscommunications or misunderstanding of his or her position and understanding of the client's position. Having an attorney review such letters is always a good idea.

Testimony

Couple therapists may be called to testify in court for a variety of reasons. In some cases, they do so willingly in an effort to help a client. In other cases, they are subpoenaed to testify despite their efforts to avoid it. We discuss these two possibilities below.

Voluntary Testimony

Most therapists are unfamiliar with their role in the legal process, appropriate courtroom demeanor, and legal procedures. As a result, they may feel apprehensive regarding their testimony, even when trying to help a client. In these cases, it is wise for the therapist to review with the lawyer the questions that will be asked and what to expect from cross-examination. Once the therapist understands what information will be requested, he or she should meet with the client before the trial to review the testimony that will be present-

ed. (This step should also be taken in the case of compelled testimony, discussed below.) This step is vital, because the therapist will often be asked to reveal information that he or she never gave, and did not intend to give, to the client. Therefore, providing this information beforehand helps the client to know what to expect at trial and works to preserve the therapeutic relationship. The client needs to understand that the therapist must answer the questions and is not allowed to refuse to answer. Some of this information may be very distressing to the client, and discussing it beforehand is the best the therapist can do to minimize harm.

Compelled Testimony

Sometimes therapists are called to testify with no release and against their will. If called in such a situation, the therapist may wish to retain counsel to make the necessary motions to protect both the therapist and the client. If the therapist chooses not to retain counsel, then after being sworn in and qualified, it will be necessary for the therapist to refuse respectfully to answer any questions about the client based on the fact that he or she has received no release and the requested information is privileged. At that point, the lawyer who is doing the questioning will ask the court to order the therapist to testify. If the court makes such a ruling, the therapist is released from his or her confidentiality obligation and may testify without fear of recrimination. If it is unclear whether the court has ordered the therapist to testify, it is appropriate for the therapist to ask the court specifically if that is what is being ordered. Once the judge has clarified the ruling, the therapist may testify safely. (For a general review of the process and requirements of expert testimony see Barsky & Gould [2002, pp. 147–187].)

After Testifying

We have every reason to believe that clients will be distressed after listening to their therapist testify about them in open court, even when it is done in the most supportive and caring manner. Therefore, we recommend that the therapist schedule a debriefing session as soon after the testimony as possible. Doing so sends a clear message that the therapist is doing whatever he or she can to preserve the therapeutic relationship in adverse circumstances.

Boundaries of Competence

As we noted earlier, therapists create great risks for themselves if they testify to matters for which they lack scientific support. Therapists are entitled to have opinions regarding a variety of matters, including signs and symptoms of mental and emotional disorders, diagnosis, prognosis, treatment choice, course, and anticipated expense. Going beyond these issues means sailing into treacherous waters. For example, therapists cannot have opinions regarding relative parenting capacity or whether a child has been sexually abused. Doing so hurts the parties involved, is disrespectful to the justice system, and is a formula for personal disaster. (For those unfamiliar with these issues, we recommend a detailed reading of Greenberg & Shuman [1997], who outline with great clarity the differences between therapeutic and forensic roles.)

CONCLUSION

After reading this chapter, some readers may feel deterred from practicing couple therapy because it presents unique legal and ethical challenges that individual therapists do not face. In our view, such a decision would be unfortunate. Our clients live within social and relational contexts that, when taken into account, can enhance treatment effectiveness and enrich their lives. We hope that by providing this information, we have assisted the reader in negotiating these issues, so that he or she can provide these services more safely and effectively.

NOTE

1. Full legal citations for all examples listed are available from the authors upon request.

SUGGESTIONS FOR FURTHER READING

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