Setting Ethical Limits: For Caring and Competent Professionals

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Lisa Hutchison, LMHC, has more than 20 years of experience providing individual and group counseling with adults. She specifically focuses on teaching assertiveness, stress management, and boundary setting for empathic helpers. Ms. Hutchison graduated from the University of Massachusetts, Boston, with a Master's degree in education for mental health counseling.

Faculty Disclosure

Contributing faculty, Lisa Hutchison, LMHC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

Alice Yick Flanagan, PhD, MSW
Margaret Donohue, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, counselors, and marriage and family therapists in all practice settings.

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A complete Works Cited list begins on page 31.

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Designations of Credit

Social workers completing this intermediate-to-advanced course receive 6 Social Work Ethics continuing education credits.

NetCE designates this continuing education activity for 2.5 NBCC clock hours.

NetCE designates this continuing education activity for 6 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

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Course Objective

The purpose of this course is to educate helping professionals on how to provide compassionate care ethically to those they serve without causing burnout.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define professional competence.
2. Describe the importance of cultural competence.
3. Outline components of the therapeutic relationship.
4. Define empathy and describe the difference between empathy and sympathy.
5. Identify compassion fatigue, vicarious trauma, and burnout and describe their impact on mental health professionals.
6. Define transference and countertransference and discuss their implications for the mental health professional.
7. Identify the functions of professional boundaries in the therapeutic relationship and multiple relationships.
8. Discuss the guidance on giving and receiving gifts provided by professional ethics codes.
9. Discuss the legal and ethical considerations of providing distance therapy.

INTRODUCTION

Counselors can make a significant, positive impact in the lives of those with whom they work, and the practice of therapy can be highly rewarding and gratifying. However, it can also be emotionally demanding, challenging, and stressful. Counselors are at risk for occupational stress from a variety of sources, including [1]:

- The demands of clinical and professional responsibility
- The challenges of managing the client/counselor relationship
- The role characteristics that make counselors prone to burnout (e.g., high level of involvement)
- Vulnerability to vicarious traumatization
- The changing standards and business demands of the profession (e.g., increased documentation requirements, increased intrusion of legal/business concerns into therapeutic practice)
- The intersection of personal and professional demands

Healthy boundaries are a critical component of self-care. Setting boundaries can help counselors manage occupational stressors and maintain the delicate balance between their personal and professional lives. Boundaries also demonstrate competency in clinical practice and help counselors avoid ethical conflicts [2].

Please note, throughout this course the term "counselor" is used to refer to any professional providing mental health and/or social services to clients, unless otherwise noted.

COMPETENCE

Professional associations representing the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect both the mental health professional and the individuals with whom they work. For example, the American Psychological Association (APA), the American Counseling Association (ACA), the National Association of Social Workers (NASW), the National Board of Certified Counselors (NBCC), and the National Certification Commission for Addiction Professionals (NCCAP) each has an ethics code created to identify core values, inform ethical practice, support professional responsibility and accountability, and ensure competency among its members [3; 4; 5; 6; 7].

Competency is defined as "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" [8]. It is the scope of the professional's practice. According to the ethics codes of the APA, the ACA, and the NASW, members are to practice only within their boundaries of competence [3; 4; 5].

APA'S ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2014 ACA CODE OF ETHICS

C.1. Knowledge of and Compliance with Standards

Counselors have a responsibility to read, understand, and follow the ACA Code of Ethics and adhere to applicable laws and regulations.

C.2. Professional Competence

C.2.a. Boundaries of Competence

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

C.2.b. New Specialty Areas of Practice

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.

C.2.c. Qualified for Employment

Counselors accept employment only for positions for which they are qualified given their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

C.2.d. Monitor Effectiveness

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors.

C.2.e. Consultations on Ethical Obligations

Counselors take reasonable steps to consult with other counselors, the ACA Ethics and Professional Standards Department, or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education

Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations.

C.4. Professional Qualifications

C.4.a. Accurate Representation

Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training.

C.4.b. Credentials

Counselors claim only licenses or certifications that are current and in good standing.

C.4.c. Educational Degrees

Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence

Counselors clearly state their highest earned degree in counseling or a closely related field. Counselors do not imply doctoral-level competence when possessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counseling or a related field. Counselors do not use "ABD" (all but dissertation) or other such terms to imply competency.

C.4.e. Accreditation Status

Counselors accurately represent the accreditation status of their degree program and college/university.

C.4.f. Professional Membership

Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of ACA must clearly differentiate between professional membership, which implies the possession of at least a master's degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

CODE OF ETHICS OF THE NASW

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

(d) Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges.

(e) Social workers who use technology in providing social work services should comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located.

CULTURAL COMPETENCE

A general (aspirational) principle articulated in the APA's ethics code addresses respect for people's rights and dignity. The principle states, in part, that [3]:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

CODE OF ETHICS OF THE NASW

1.05 Cultural Competence

(a) Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.

(c) Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own culture, committing to lifelong learning, and holding institutions accountable for advancing cultural humility.

(d) Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(e) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients' use of and access to electronic technology and seek to prevent such potential barriers. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

Although counselors are not expected to know about every nuance of each culture they serve, it is important to be open to learning about diverse cultural backgrounds in order to provide empathic, competent care. It is also important to be aware of culture-specific religious or spiritual practices that are regarded as healing forces in the client's world.

Achieving this awareness may involve researching the client's culture and inquiring about their culture-specific healing practices in a manner that respects the client's dignity and privacy [3]. It is always the professional's goal to do no harm. As previously stated, professionals must "try to eliminate the effect on their work of [their] biases" and address them outside the therapeutic time with a trusted colleague or supervisor [3].

CHARACTERISTICS OF A CULTURALLY COMPETENT COUNSELOR

Three characteristics of a culturally competent counselor have been described. First, a culturally competent counselor is actively engaged in the process of becoming aware of his or her assumptions about human behavior, values, biases, preconceived notions, and personal limitations [9]. This is an ongoing process of self-discovery that requires the willingness to address any issues that may arise. For example, because the concept of boundaries varies across cultures, therapeutic elements related to boundaries should be modified to adapt to this variance. The expectation of confidentiality also varies, so the counselor should not assume that confidentiality is implicitly restricted to the counselor and client. In many cultures, confidentiality is neither expected nor therapeutic [10]. Being culturally competent also requires vigilance and an understanding that referral to another counselor might be necessary in some circumstances (i.e., when working with a particular client is beyond the counselor's boundaries of competence) [9].

Next, a culturally competent counselor actively attempts to understand the worldview of a culturally different client by employing empathy and avoiding negative judgments [9]. This involves becoming familiar with the culture, subculture, and political history of the client when these differ from those of the counselor. This yields valuable rewards and is useful in avoiding the common therapeutic blunder of overgeneralization [10]. For example, knowing the client's ethnicity, political affiliation in their country of origin, religious beliefs, and expectations of gender roles all contribute to providing the counselor a more precise framework from which therapy can be applied. Clients usually recognize and appreciate the counselor's attempts to learn about their culture, which can enhance the therapeutic alliance [10]. It is also important to recognize that the client is part of a larger cultural system that may include family members, societal elders, or others of significance to the client. These others can impact the client's therapy, with positive or negative outcomes, depending on whether they are enlisted as therapeutic allies or alienated [10].

Last, a culturally competent counselor actively develops and practices appropriate, relevant, and sensitive intervention strategies and skills when working with culturally different clients. In order to keep abreast of new interventions and strategies, the counselor may need to acquire additional education, training, and supervised experience **(*Resources*)** [9].

Common issues in the therapeutic relationship (e.g., gifts, touch, eye contact, medication compliance, choice of vocabulary) are all influenced by culture. Rather than adhere to a rigid theoretical approach to dealing with these issues, it is best to seek out their cultural meaning on a case-by-case basis. Enlist the expertise of a "cultural informant" if one is available. This person is generally from the same culture as the client, is not an active participant in the therapy, and functions as a consultant to the professional by interpreting or identifying culture-specific issues. The therapeutic paradigm should be flexible. The degree of active intervention by the mental health professional, definition of therapeutic goals, techniques used, and outcome measures should all be modified to reflect cultural differences in the therapy. Also, transference and countertransference interactions influenced by culture will occur and require that professionals become familiar with the types of culturally influenced reactions that can occur in therapy. Phenomena such as cultural stereotyping often occur even when the counselor and client share the same ethno-cultural background [10].

THE THERAPEUTIC RELATIONSHIP

Many situations that occur in the counseling office are not written about in text books or taught in a classroom setting. Counselors learn through hands-on experience, intuition, ongoing supervision, and continuing education. One constant is the therapeutic relationship. Every therapeutic relationship is built on trust and rapport. Counselors teach their clients what a healthy relationship is through the compassionate care and limit setting that occurs within the therapeutic context. Counselors model acceptable behavior in the office so their clients are equipped to emulate and apply that behavior in the outside world. In many cases, counselors are teaching self-regulation to clients who are learning how to control impulses or regulate behavior in order to improve their connection to other people.

Bandura has described self-regulation as a self-governing system that is divided into three major subfunctions [11]:

- Self-observation: We monitor our performance and observe ourselves and our behavior. This provides us with the information we need to set performance standards and evaluate our progress toward them.
- Judgment: We evaluate our performance against our standards, situational circumstances, and valuation of our activities. In the therapeutic setting, the counselor sets the standard of how to interact by setting limits and upholding professional ethics. The client then compares the counselor's (i.e., "the expert's") modeled behavior with what they already have learned about relationship patterns and dynamics (i.e., referential comparisons).
- Self-response: If the client perceives that he or she has done well in comparison to the counselor's standard, the client gives him- or herself a rewarding self-response. The counselor should reinforce this response by delivering positive reinforcement and affirmation for the newly learned behavior. For example, if the client arrives to therapy habitually late and then makes an effort to arrive on time, the counselor can remark, "I notice that you are working hard to arrive on time for session. That is great." The counselor's positive reinforcement and acknowledgment can have a positive impact on the client's self-satisfaction and self-esteem.

According to Rogers, "individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior" [12]. To facilitate a growth-promoting climate for the client, the counselor should accept, care for, and prize the client. This is what Rogers refers to as "unconditional positive regard," and it allows the client to experience whatever immediate feeling is going on (e.g., confusion, resentment, fear, anger, courage) knowing that the professional accepts it unconditionally [12]. In addition to unconditional positive regard, a growth-promoting therapeutic relationship also includes congruence and empathy.

CONGRUENCE

Trust is built and sustained over time through consistent limits that are maintained within the sacred space of each therapeutic hour. When a counselor is observed as consistent and congruent, the client notices. Being authentic is part of being compassionate and empathic. Clients know when a counselor's words and actions do not match. These actions can be overt, such as cutting short the therapeutic time or going over the time allotted. They also can be subtle, as when leaked out and expressed through a stressed vocal tone, facial expression, or other body language indicator (e.g., arms folded across the chest). To the highly aware client, these actions can result in a loss of trust.

Nevertheless, counselors are not perfect and can err from time to time. This is why it is important for counselors to be self-aware, acknowledge when their words and actions do not match, and discuss that within the therapeutic relationship. If a client notices one of these cues of incongruence and expresses it to the counselor, it is essential that the counselor listen openly and validate the client's experience. Any defensiveness on the part of the counselor will decrease relationship trust. Conversely, this admission of human failure can actually build a stronger bond of trust. Clients see that counselors are, like themselves, human and imperfect. This presents an opportunity for clients to learn and then model this type of integrity in their own relationships. "Congruence for the therapist means that he (or she) need not always appear in a good light, always understanding, wise, or strong" [12]. It means that the therapist is his or her actual self during encounters with clients. Without façade, he or she openly has the feelings and attitudes that are flowing at the moment [12]. The counselor's being oneself and expressing oneself openly frees him or her of many encumbrances and artificialities and makes it possible for the client to come in touch with another human being as directly as possible [12]. As discussed, this involves self-observation and self-awareness on the counselor's part.

This does not mean that counselors burden clients with overt expression of all their feelings. Nor does it mean that counselors disclose their total self to clients. It means that the counselor is transparent to the client so that the client can see him or her within the context of the therapeutic relationship [13]. It also means avoiding the temptation to present a façade or hide behind a mask of professionalism, or to assume a confessional-professional attitude. It is not easy to achieve such a reality, as it involves "the difficult task of being acquainted with the flow of experiencing going on within oneself, a flow marked especially by complexity and continuous change" [12].

EMPATHY

There is great power in empathy. It breaks down resistance and allows clients to feel safe and able to explore their feelings and thoughts. It is a potent and positive force for change [12]. Empathy serves our basic desire for connection and emotional joining [14]. Empathy may be defined as the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another. It is a deeper kind of listening in which the counselor senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client [12]. Empathy is not parroting back the client's words or reflecting only the content of those words. It entails capturing the nuances and implications of what the client is saying, and reflecting this back to the client for their consideration using clear, simply connotative language in as few words as possible [15]. Counselors also can show empathy in nonverbal ways to their clients by, for example, looking concerned, being attentive, leaning forward, and maintaining eye contact [15].

Empathy is a multi-level process of relating to others. It encompasses both an emotive experience and a cognitive one. It includes an intellectual component (namely, understanding the cognitive basis for the client's feelings), and it implies the ability to detach oneself from the client's feelings in order to maintain objectivity [16]. While engaged in empathic listening, mental health professionals should remain responsive to feedback and alter their perspective or understanding of the client as they acquire more information [16]. Empathy may be summarized by the ability to [17]:

- See the world as others see it.
- Be nonjudgmental.
- Understand another person's feelings.
- Communicate your understanding of that person's feelings.

Empathy should not be confused with sympathy, which may be defined as an affinity, association, or relationship between persons wherein whatever affects one similarly affects the other. Compared with empathy, sympathy is a superficial demonstration of care. With sympathy, you feel sorry for the client; with empathy, you feel the client's pain. Although a counselor can get caught up in the client's feelings, he or she should always strive to empathically understand what the client is experiencing while maintaining emotional detachment. This potentially provides a broader perspective that extends beyond the client's situational distress. Mental health professionals want to employ the best tools in order to affect change in their clients without causing harm, and empathy surpasses sympathy in terms of effectiveness. Research has validated the importance of empathy, unconditional positive regard, and congruence for achieving an effective therapeutic relationship [18].

Compassion-focused therapy is a rapidly growing, evidence-based form of psychotherapy that pursues the alleviation of human suffering through psychological science and engaged action [19]. According to Gilbert, the following are attributes of compassion-focused therapy [20]:

- Sensitivity: Responsive to distress and needs; able to recognize and distinguish the feelings and needs of the client.
- Sympathy: Being emotionally moved by the feelings and distress of the client. In the therapeutic relationship, the client experiences the counselor as being emotionally engaged with their story as opposed to being emotionally passive or distant.
- Distress tolerance: Able to contain, stay with, and tolerate complex and high levels of emotion, rather than avoid, fearfully divert from, close down, contradict, invalidate, or deny them. The client experiences the counselor as able to contain her/his own emotions and the client's emotions.
- Empathy: Working to understand the meanings, functions, and origins of another person's inner world so that one can see it from her/his point of view. Empathy takes effort in a way that sympathy does not.
- Nonjudgment: Not condemning, criticizing, shaming, or rejecting. It does not mean nonpreference. For example, nonjudgment is important in Buddhist psychology, which emphasizes experiencing the moment "as it is." This does not mean an absence of preferences.

Empathic Boundaries

Counselors strive to achieve empathy with their clients while maintaining boundaries that protect their own energies. Professionals should ''sense the client's private world as if it were [their] own, without ever losing the 'as if' quality,'' and while not becoming entangled with their perception of the client [12; 21]. It takes work to maintain a healthy distance emotionally while feeling and intuiting what the client is saying.

Too much sympathy, or working with empathy without proper boundaries in the therapeutic relationship, drains the counselor of energy and leads to burnout. In a study of 216 hospice care nurses from 22 hospice facilities across Florida, it was found that trauma, anxiety, life demands, and excessive empathy (leading to blurred professional boundaries) were key determinants of compassion fatigue risk [22]. In other words, there can be too much of a good thing. In order to motivate client change, there should be a limit to the use of empathy in therapy. Empathy is but one tool that a compassionate mental health professional can use to ensure client growth.

THE COSTS OF CARING

Humans need humans and heal best with compassionate care. However, mental health professionals must guard against caring too much. While hearing about and sharing the joyous parts of a client's life is wonderful, most therapeutic work involves listening to a client's emotional pain, which can take its toll on even the most seasoned professional.

STRESS

Stress is a warning sign that indicates that self-care needs to be increased. Stress tells you that something is not right. It is like the "check engine" light on your car's dashboard, which, if ignored, can lead to major engine malfunction. Stress that is left unchecked or poorly managed is known to contribute to high blood pressure, heart disease, obesity, diabetes, and suicide [23]. Stress reminds us that we are human and that we have limits. The symptoms of stress include [23]:

- Headaches, muscle tension, neck or back pain
- Upset stomach
- Dry mouth
- Chest pains, rapid heartbeat
- Difficulty falling or staying asleep
- Fatigue
- Loss of appetite or overeating "comfort foods"
- Increased frequency of colds
- Lack of concentration or focus
- Memory problems or forgetfulness
- Jitters, irritability, short temper
- Anxiety

Other warning signs that more self-care is needed include outbursts, depression, anxiety, and lowered tolerance to frustration. Fatigue, whether physical, emotional, mental, or spiritual, can lead to reactivity and poor judgment. Little or no self-care can contribute to burnout, illness, and even addiction. It can also leave the professional vulnerable to crossing or violating boundaries.

A counselor's job is stressful for many reasons, including working in isolation; shouldering the burden of a client's depression, anxiety, apathy, and suicidality; witnessing slow, gradual progress in the therapeutic process; and managing increasing administrative demands (e.g., insurance claims, documentation). These demands can often lead to increased stress and frustration for the counselor.

Self-care includes stress management and vice versa. Self-care should be part of your preventative wellness routine, not instituted only when signs of illness or breakdown are already occurring. Activities that one recommends to clients to decrease their stress will also work for professionals. This includes healthy eating, time management, relaxation techniques, adequate sleep, and maintaining hobbies and outside interests.

COMPASSION FATIGUE, VICARIOUS TRAUMA, AND BURNOUT

When work-related stress is combined with a lack of self-care and support, more serious stress reactions can occur. Compassion fatigue can develop when a mental health professional cares too much or carries too much material [24]. Chronic day-to-day exposure to clients and their distress (e.g., sexual and physical abuse, military combat, community disaster) can be emotionally taxing for the helping professional and can result in compassion fatigue, vicarious trauma, or, ultimately, professional burnout [24; 25]. Vicarious trauma describes a profound shift in worldview that occurs in helping professionals when they work with clients who have experienced trauma; the professional's fundamental beliefs about the world are altered by repeated exposure to traumatic material. Burnout describes the physical and emotional exhaustion that helping professionals can experience when they have low job satisfaction and feel powerless and overwhelmed at work. It is not the same as being depressed or overworked. It is a subtle process in which an individual is gradually caught in a state of mental fatigue and is completely drained of all energy. However, burnout does not necessarily indicate a change in worldview or a loss of the ability to feel compassion for others [26; 27; 28].

The chronic use of empathy combined with day-to-day bureaucratic hurdles (e.g., agency stress, billing difficulties, balancing clinical work with administrative work) can generate the experience of compassion fatigue [29; 30]. This type of listening and exposure can take its toll on mental health professionals, particularly when combined with the need to maintain strong limits and boundaries both inside and outside the office. Yet, no matter how well-defined the boundaries are, there will be times when the professional will be affected by listening to what the client has lived through in order to survive; it can be very difficult to hear. This is why peer supervision is necessary. The professional benefits from having a place to offload and receive support following an intense client session in order to mitigate the risk of negative consequences, such as post-traumatic stress disorder, which can be an indirect response to clients' suffering. Compassion fatigue can also cause professionals to lose touch with their own empathy. Strong emotions, as evoked by traumatic material, may strain the empathic ability of the therapist [31]. Symptoms of compassion fatigue result in a loss of interest toward holding empathic response to others due to feeling overwhelmed and burdened by the client's trauma and illnesses. Caregivers with compassion fatigue may develop a preoccupation with re-experiencing clients' trauma; they can develop signs of persistent arousal and anxiety as a result of this secondary trauma. Examples of this arousal can include difficulty falling or staying asleep, irritability or outbursts of anger, and/or exaggerated startle responses. Most importantly, these caregivers ultimately experience a reduced capacity for or interest in being empathic toward the suffering of others [32]. Overlap can occur between compassion fatigue, vicarious trauma, and burnout, with the mental health professional experiencing more than one emotional state.

Some causes of burnout and compassion fatigue can result in part from the personality characteristics of the professional (e.g., perfectionism, overinvolvement with clients) [33]. Because burnout is largely identified in young, highly educated, ambitious professionals, many consider the conflict between an individual's expectations and reality as one of the main characteristics of burnout [27]. Additionally, the professional's attitudes, beliefs, and assumptions can have an impact on performance (e.g., "I must get all my clients better") and may lead to irritation, a sense of failure, or burnout. Some attitudinal issues are specific to particular client groups (e.g., people who get hostile or perpetrators of sexual assault) or to particular elements of the therapy process (e.g., "I must be available for all of my clients all the time") [34]. In order to prevent or decrease cases of burnout, compassion fatigue, and vicarious traumatization among professionals, it is important that they receive education on the signs and symptoms of each and that they have access to an open and supportive environment in which to discuss them.

MITIGATING THE COSTS OF CARING

Disengage

As noted, counselors are at increased risk for compassion fatigue, burnout, and/or vicarious trauma when the majority of their caseload involves trauma cases; when there is a lack of balance between work, rest, and play; and when there is a lack of attention to spiritual needs. To reduce their risk, counselors should learn to let go and leave work at work—they should learn to disengage. Disengagement can lower or prevent compassion stress by allowing counselors to distance themselves from the ongoing misery of clients between sessions. The ability to disengage demands a conscious, rational effort to recognize that one must "let go" of the thoughts, feelings, and sensations associated with client sessions in order to live one's own life. Disengagement is the recognition of the importance of self-care and of the need to carry out a deliberate program of self-care [30].

When counselors employ self-care, they model for their clients what mental health looks like. When clients know that counselors have done their own therapeutic or healing work, it instills in them a sense of hope. They see results that indicate the process can work for them, too.

Seek Support

Research indicates that encouraging peer support groups, providing education on the impact of client traumas on mental health professionals, diversifying caseloads, encouraging respite and relaxation, and encouraging a sense of spirituality and wellness are several means of providing support for at-risk professionals [35]. Counselors can be more resilient, accomplish more, and feel more worthwhile when they have close, supportive relationships. Support acts as a buffer against the effects of stress and burnout [36]. Counselors with a larger sense of meaning and connection who practice self-care and work in collaboration with others are less likely to experience vicarious traumatization [37; 38].

Set Self-Care Boundaries

In addition to setting and maintaining boundaries with clients, counselors also should set and maintain self-care boundaries to avoid burnout. When setting self-care boundaries, counselors may consider some of the following habits [24; 39]:

- Leave work at the office. Avoid conducting research, making telephone calls, and catching up on record keeping at home. Set office hours, publish them on your answering machine, and adhere to those hours.
- Have a procedure for after-hours emergency calls. For example, many counselors instruct clients to call the nearest hospital or go to the local emergency room. Other offices may have an on-call clinician dedicated to responding to emergency calls. The important thing is that there be a clear policy in place for after-hours calls and that clients are aware of and understand the policy.
- Do not skip meals to see an extra client. Include regularly scheduled breaks as part of each work day.
- Schedule and take vacations. Do not check your messages while on vacation. Ask another counselor to see clients in cases of emergency. Most clients can tolerate their counselor's absence for a week or two.
- Live a well-rounded life beyond the office. Make time for friends and family and engage in interests that renew you.
- Educate yourself about trauma and its effects. If you are a supervisor, consider using instruments that measure stress with supervisees. The Maslach Burnout Inventory (MBI) and the Professional Quality of Life (ProQOL) scale should be administered on a regular basis to assess both organizational and individual risk of burnout and trauma-related conditions in high-risk settings.
- Increase your capacity for awareness, containment, presence, and integration. Awareness can be encouraged through meditation, visualization, yoga, journal keeping, art, other creative activities, and personal psychotherapy. Containment abilities can be built through self-care efforts and a balanced life that includes time spent in activities unrelated to work.

Mental health professionals should strive to maintain a balance between giving and getting, between stress and calm, and between work and home. These stand in clear contrast to the overload, understaffing, over-commitment, and other imbalances of burnout. To give and give until there is nothing left to give means that the professional has failed to replenish his or her resources [28].

Practice Mindfulness

Helping professionals often feel like they have to fix others or have all the answers. This is a faulty cognition. Oftentimes, the most healing and powerful act a counselor can do is being in the moment with the client, holding the space for his or her feelings and thoughts. Mindfulness practice can facilitate this. The practice of mindfulness (i.e., present-focused attending to ongoing shifts in mind, body, and the surrounding world), integrated into daily life, can help counselors to develop enhanced patience, presence, and compassion [38]. It can help counselors to stay calmly focused and grounded, which allows them to be less reactive and engage with greater equanimity [38].

One study investigated how the use of dialectical behavioral therapy (DBT) in working with young, self-harming women with borderline personality disorder affected the occupational stress and levels of burnout among psychiatric professionals [40]. DBT was stressful in terms of learning demands, but it decreased the experience of stress in actual treatment of clients. Participants felt that mindfulness training, which was one aspect of DBT, improved their handling of work stressors not related to DBT [40]. Counselors were better able to accept feelings of frustration, cope with stress, and be more patient and relaxed [40]. Mindfulness has been found to decrease stress, increase concentration, and increase the counselor's ability to detach from the client's material. It also assists a counselor's empathy and boundary setting [41]. Mindfulness, attention, empathy, and counseling self-efficacy have been found to be significantly related to one another [41].

One study explored the impact of Buddhist mindfulness (meditation) practice on the attitude, work, and lived experience of counselors and their self-reported experiences of working with clients [42]. Findings suggest that a long-term mindfulness meditation practice can positively impact counselors' ability to distinguish their own experiences from their clients' experiences, can enrich clarity in their work with clients and may help them develop self-insight [42]. Mindfulness may also help to increase patience, intentionality, gratitude, and body awareness [43]. It is an excellent tool for caring, compassionate professionals to use to maintain their own energies and support their clients' growth.

Expand Your Professional World

Symptoms of burnout or compassion fatigue can be signs of a need to grow professionally. This might mean branching out from individual therapy sessions to include group therapy, teaching at local colleges, supervising other professionals, developing continuing education units, or providing consultations. In some instances, it might mean changing careers or exploring other ways to use your licensure and experience.

TRANSFERENCE AND COUNTERTRANSFERENCE

The term transference was coined by Freud to describe the way that clients "transfer" feelings about important persons in their lives onto their counselor. As Freud said, "a whole series of psychological experiences are revived, not as belonging to the past but applying to the person of the physician at the present moment" [44]. The client's formative dynamics are recreated in the therapeutic relationship, allowing clients to discover unfounded or outmoded assumptions about others that do not serve them well, potentially leading to lasting positive change [45]. Part of the counselor's work is to "take" or "accept" the transferences that unfold in the service of understanding the client's experience and, eventually, offer interpretations that link the here-and-now experience in session to events in the client's past [46]. The intense, seemingly irrational emotional reaction a client may have toward the counselor should be recognized as resulting from projective identification of the client's own conflicts and issues. It is important to guard against taking these reactions too personally or acting on the emotions in inappropriate ways [47]. Therapists' emotional reactions to their patients (countertransference) impact both the treatment process and the outcome of psychotherapy.

REFLECTION

It also is important to be reflective rather than reactive in words and actions. Use of the mindfulness technique can help counselors to become reflective rather than reactive and can help counselors unhook from any triggering material and maintain appropriate limits and boundaries. Reflection demands a reasonable level of awareness of one's thoughts and feelings and a sound grasp of whether they deviate from good professional behavior. Reflection includes [48]:

- A questioning attitude towards one's own feelings and motives
- The recognition that we all have blind spots
- An understanding that staff are affected by clients
- An understanding that clients are affected by staff behavior
- A recognition that clients often have strong feelings toward staff

Clients are more accepting of transference interpretations in an environment of empathy. Transference interpretation is most effective when the road has been paved with a series of empathic, validating, and supportive interventions that create a holding environment for the client [50].

Freud believed transference to be universal, with the possibility of occurring in the counselor as well as the client. He described this "countertransference" as "the unconscious counter reaction to the client's transference, indicative of the therapist's own unresolved intrapsychic conflicts" [51]. Freud felt that countertransference could interfere with successful treatment [45]. Since the 1950s, the view of countertransference has evolved. It is no longer believed to be an impediment to treatment. Instead, it is viewed as providing important information that the professional can use in helping the client [45].

Empathy allows the counselor to experience and thus know what the client is experiencing. Countertransference emerges when the client's transference reactions touch the counselor in an unresolved area, resulting in conflictual and irrational internal reactions [52]. Good indicators of countertransference are feelings of irritability, anger, or sadness that seem to arise from nowhere. Countertransference frequently originates in counselors' unresolved conflicts related to family issues, needs, and values; therapy-specific areas (e.g., termination, performance issues); and cultural issues [53]. When feelings have intensity or when they persist, this is an indicator for future work and healing.

The counselor's work is to bear the client's transferences and interpret them. When the counselor refuses the transference, there is often a mutual projective identification going on, in which both counselor and client project part of themselves onto the other. Refusal may also mean that one of the counselor's own blind spots has been engaged. As Shapiro explains, "a rough edge of our character has been 'hooked' by a bit of what the patient is struggling with, and we act out a bit of countertransference evoked in us by the transference" [54]. In a group therapy setting, family dynamic re-enactments can emerge as transferences. Managing these complex dynamics can raise the counselor's anxiety and mobilize his or her defenses, compromising a usually thoughtful stance. When counselors experience intense reactions in trauma groups that pull them out of the present moment, they should investigate whether they are responding to traumatic content, personal unresolved issues, or individual or collective transference [55]. Counselors who find themselves ruminating about a previous session's content, a client's welfare, or their own issues should talk with a trusted, objective colleague. Countertransference issues for the mental health professional should be resolved apart from the therapeutic environment to avoid burdening and potentially harming clients [51]. One study of countertransference found that therapists' self-reported disengaged feelings over a treatment period adversely impacted the effect of transference work for all patients, but especially for patients with a history of poor, nonmutual, complicated relationships [48].

SELF-AWARENESS

Problems arise when the professional lacks awareness or refuses to devote the necessary time to process the personal emotions and thoughts that arise within the therapeutic relationship. Feelings of anger, grief, jealousy, shame, injustice, trauma, and even attraction can, when they touch a wound from the past, trigger reactions within even experienced professionals. Clients' experiences can replicate the professional's past relationships and trigger emotions that have not been worked on or addressed. If this occurs, the professional can, without disrupting the client's session, make a mental note of the feelings. This allows the professional to attend to the present moment. After the client's session has ended, the professional can arrange to talk to a colleague or supervisor for processing. If the countertransference continues, it may be necessary for the professional to seek counseling. Self-awareness helps the professional to reflect back to the client's true emotions. It also is an important component of training, development, and effectiveness [56]. Mental health professionals need to possess certain values, qualities, and sensitivities, and should be open-minded and have an awareness of their comfort levels, values, biases, and prejudices [57].

As stated in the ethics codes of the ACA [4]:

> Therapists are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. They respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when their values are inconsistent with the client's goals. They refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner. When they become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend, or terminate their work-related duties.

BOUNDARIES AND LIMITS

Generally speaking, a boundary indicates where one area ends and another begins. It indicates what is "out of bounds" and acts to constrain, constrict, and limit. In the therapeutic relationship, a boundary delineates the "edge" of appropriate behaviors and helps to rule in and out what is acceptable, although the same behaviors might be acceptable or even desirable in other relationships [58; 59]. Boundaries have important functions in the therapeutic relationship, helping to build trust, empower and protect clients, and protect the professional.

BUILDING TRUST

An inherent power differential exists in the therapeutic relationship between the client, who is placed in a position of vulnerability as she or he seeks help, and the practitioner, who is placed in a position of power because of her or his professional status and expertise [59]. When the client sees the counselor sitting in a chair, with a diploma or licensure on the wall, it can be intimidating. To help mitigate these feelings with the client, it is important to maintain a sense of professionalism while working to build trust and rapport. Part of that professionalism includes setting limits and explaining what they are in the context of therapy.

The familiarity, trust, and intensity of the therapeutic relationship create a powerful potential for abuse that underscores the need for careful attention to the ethical aspects of professional care [59]. Trust is the cornerstone of the therapeutic relationship, and counselors have the responsibility to respect and safeguard the client's right to privacy and confidentiality [4]. Clients have expressed what they believe to be essential conditions for the development of trust in the therapeutic relationship. These include that the clinician [60]:

- Is perceived as available and accessible
- Tries to understand by listening and caring
- Behaves in a professional manner (evidenced by attributes such as honesty in all interactions)
- Maintains confidentiality
- Relates to the client as another adult person rather than as an "expert"
- Remains calm and does not over-react to the issue under discussion

Only when satisfied that the clinician is sufficiently experienced, professional, flexible, and empathic can a foundation for therapy be laid. Clients acknowledge that this takes time and that the trustworthiness of the therapeutic relationship may be tested. If the relationship is perceived to be wanting, clients indicate that they would have difficulty continuing it [60].

THE VALUE OF FLEXIBILITY

Rigid boundaries can negatively reinforce the power differential that exists between the client and the counselor. Rigid boundaries may serve the fears and needs of counselors who are new to the profession and/or concerned with the implications of boundary violations. However, rigid boundaries can lead to harm for the client who perceives that the "rules" are more important than his or her welfare. While rigidity and remoteness on the counselor's part may help ensure that boundaries are intact, they do not accurately reflect the intended role of boundaries in clinical practice. Boundaries should never imply coldness or aloofness. As stated, clients value flexibility, caring, and understanding. Within conditions that create a climate of safety, flexible boundaries can accommodate individual differences among clients and counselors and allow them to interact with warmth, empathy, and spontaneity [61]. Firm, intractable boundaries may be a comfort to the helping professional; however, fixed rules cannot capture the complex reality of the therapeutic relationship [59].

EMPOWERING AND PROTECTING THE CLIENT

Boundaries and effective limit setting in sessions help to empower and protect clients by teaching and reinforcing the skills they need to become healthy. Boundaries set the parameters and expectations of therapy, so it is important to articulate them in such a way that each client's understanding of them is clear. Counselors should constantly and actively make judgements about where to draw lines that are in the client's best interests [62].

Boundaries begin the moment a client enters the room. Indicate which chair is yours and where it is acceptable for the client to sit. Take note of where your seat is in relation to the door should an emergency arise. Be sure to maintain an appropriate amount of space between yourself and the client. Too much space can feel impersonal and too little can feel invasive. Consider the décor of the setting. Clients may become distracted by the counselor's personal artifacts and family photographs and may place their focus on the counselor rather than on their own therapeutic work. Some clients with poor boundaries may become preoccupied with the counselor's family, which can become a source of transference.

Clients often enter therapy with a history of prior boundary violations (e.g., childhood sexual abuse, domestic violence, inappropriate boundary crossings with another professional) that leave them with persisting feelings and confusion regarding roles and boundaries in subsequent intimate relationships [63]. Consequently, they may test the boundaries as children do. The counselor should recognize these boundary dilemmas and manage them by reiterating the boundaries calmly and clearly [62]. The counselor must also set and maintain boundaries even if the client threatens self-harm or flight from therapy. This can be extremely challenging when faced with a client's primitively motivated, intense demands. However, counselors should recall that one description of the tasks with clients with primitive tendencies is to resist reinforcing primitive strivings and to foster and encourage adult strivings [64]. Winnicott refers to this as a "holding relationship," wherein the counselor acts as a "container" for the strong emotional storms of the client. The act of holding helps reassure the client that the clinician is there to help the client retain control and, if necessary, assume control on his or her behalf [65].

Due to the potential issues and challenges that the client brings to therapy (e.g., cognitive deficits, substance abuse/addictions, memory issues, personality disordered manipulations), it is important to maintain a record of instances when the articulated boundaries and limits have been ignored or violated. For example, a client is habitually late, despite knowing that it is unacceptable to arrive more than 10 minutes late to session. The first instance of a late arrival might simply warrant a reminder of the 10-minute limit, whereas repeated instances would require that the limit be enforced. The clinician who overidentifies with a client might experience a need to do things for the client rather than help the client learn to do things for him- or herself. While this behavior may appear relatively harmless, it suggests overinvolvement with a client and potential boundary problems [66]. Such behavior inhibits the client's ability to learn personal responsibility and how to resolve conflict [67]. It also may impede the reflective and investigative character of an effective helping process [39]. Mental health professionals should take reasonable steps to minimize harm to clients where it is foreseeable and unavoidable [3; 4]. They also should facilitate client growth and development in ways that foster the interest and welfare of the client and promote the formation of healthy relationships [4].

PROTECTING THE PROFESSIONAL

As stated, professional associations that represent the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect the professional and the individuals with whom they work [3; 4; 5; 6; 7]. Client welfare and trust in the helping professions depend on a high level of professional conduct [3; 4]. Professional values, such as managing and maintaining appropriate boundaries, are an important way of living out an ethical commitment [4].

Some situations in therapy are clear with regard to boundaries (e.g., no sexual relationships with clients). Other situations may be not as clear or may be ambiguous (e.g., receiving gifts from clients). When faced with such situations, professionals should engage in an ethical decision-making process that includes an evaluation of the context of the situation and collaboration with the client to make decisions that promote the client's growth and development [4]. Supervision and colleague support also may be necessary to reach the best decision. Such a process helps clinicians maintain justice and equity and avoid implications of favoritism in dealing with all of their clients [68].

Professionals who deliver services in nontraditional settings, such as those who have home-based practices, face unique challenges related to boundaries and limit setting. As with office-based therapy, some situations cannot be prepared for and will need to be addressed in the moment. While delivering services in nontraditional settings may benefit some clients, when working in homes or residences, the professional is advised to emphasize informed consent, particularly with regard to therapeutic boundaries.

Whenever possible, the impact of crossing boundaries on therapy and on the therapeutic relationship should be considered ahead of time [69].

BOUNDARY CROSSINGS AND VIOLATIONS

A boundary crossing is a departure from commonly accepted practices that could potentially benefit clients; a boundary violation is a serious breach that results in harm to clients and is therefore unethical [70]. Professional risk factors for boundary violations include [71]:

- The professional's own life crises or illness
- A tendency to idealize a "special" client, make exceptions for the client, or an inability to set limits with the client
- Engaging in early boundary incursions and crossings or feeling provoked to do so
- Feeling solely responsible for the client's life
- Feeling unable to discuss the case with anyone due to guilt, shame, or the fear of having one's failings acknowledged
- Realization that the client has assumed management of his or her own case

Denial about the possibility of boundary problems (i.e., "This couldn't happen to me") also plays a significant role in the persistence of the problem [71]. Lack of self-care and self-awareness also can leave the mental health professional vulnerable to boundary crossings and/or violations.

Whatever the reason the professional has to cross a boundary, it is of utmost importance to ensure that it will not harm the client. Each boundary crossing should be taken seriously, weighed carefully in consultation with a supervisor or trusted colleague, well-documented, and evaluated on a case-by-case basis. Intentional crossings should be implemented with two things in mind: the welfare of the client and therapeutic effectiveness. Boundary crossing, like any other intervention, should be part of a well-constructed and clearly articulated treatment plan that takes into consideration the client's problem, personality, situation, history, and culture as well as the therapeutic setting and context [72]. Boundary crossings with certain clients (e.g., those with borderline personality disorder or acute paranoia) are not usually recommended. Effective therapy with such clients often requires well-defined boundaries of time and space and a clearly structured therapeutic environment. Dual or multiple relationships, which always entail boundary crossing, impose the same criteria on the professional. Even when such relationships are unplanned and unavoidable, the welfare of the client and clinical effectiveness will always be the paramount concerns [72].

Some counselors may consider a boundary crossing when it provides a better firsthand sense of the broader clinical context of their client, such as visiting the home of a client that is ailing, bedridden, or dying; accompanying a client to a medically critical but dreaded procedure; joining a client/architect on a tour of her latest construction; escorting a client to visit the gravesite of a deceased loved one; or attending a client's wedding [72]. Many mental health professionals will not cross these boundaries and will insist that therapy occur only in the office. Each professional should operate according to the parameters with which he or she is comfortable. As stated, the best interests of the client, including client confidentiality, and the impact to therapy should be of paramount importance when considering whether to cross a boundary.

To be in the best position to make sound decisions regarding boundary crossings, mental health professionals should develop an approach that is grounded in ethics; stay abreast of evolving legislation, case law, ethical standards, research, theory, and practice guidelines; consider the relevant contexts for each client; engage in critical thinking and personal responsibility; and, when a mistake is made or a boundary decision has led to trouble, use all available resources to determine the best course of action to respond to the problem [73].

The risk management strategy also should include discussions with supervisors, colleagues, and the client. Each step should be documented and should include supervisory recommendations and client discussion regarding the benefits versus the risks of such actions. Although minor boundary violations may initially appear innocuous, they may represent the foundation for eventual exploitation of the client. If basic treatment boundaries are violated and the client is harmed, the professional may be sued, charged with ethical violations, and lose his/her license [74].

MULTIPLE RELATIONSHIPS

Examples of multiple relationships include being both a client's counselor and friend; entering into a teacher/student relationship; becoming sexually involved with a current or former client; bartering services with a client; or being a client's supervisor. Even when entering into a multiple relationship seems to offer the possibility of a better connection to a client, it is not recommended. Multiple relationships can cause confusion and a blurring of boundaries and risk exploitation of the client.

The issue of multiple relationships is addressed by the codes of ethics of mental health professions. According to the APA's ethics code [3]:

> A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. A psychologist refrains from entering into a multiple relationship if the multiple relationships could reasonably be expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

The ethics code of the NASW defines dual or multiple relationships as occurring "when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively." [5]. It also states that "social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries" [5]. The code further states that it is the professional's responsibility to "be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment" and that counselors should "inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible" [5]. In some instances, this may require "termination of the professional relationship with proper referral of the client" [5].

The ACA ethics code states that [4]:

> Counselors are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective. . .They also are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media). . .When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately.

Mental health professionals who practice in small, rural communities face special problems in maintaining neutrality, fostering client separateness, protecting confidentiality, and managing past, current, or future personal relationships with clients [75]. Whether the practice is located in a small town or a big city, there will be times when counselors and clients will encounter one another outside the office. To ignore a client who is reaching out in a social setting may cause the client harm. However, it also is important to avoid violating the client's privacy. The best way to minimize the potential awkwardness of such an encounter is to prepare ahead of time. For example, a counselor might incorporate a conversation about such an encounter into the initial evaluation process by telling the client: "If I happen to be at a store or a restaurant and see you, I won't say hello because I respect your confidentiality and want to protect your privacy. However, if you want to smile or say hello to me, I will respond in kind." Explain to the client that the conversation or acknowledgment must be brief to prevent any violation of the client's privacy. After an encounter in public, address the event in your next session, discuss any feelings the client had about the encounter, and note the discussion in the client record. Such an encounter would not fall under the category of dual/multiple relationships unless, for example, the counselor and client went grocery shopping at the same time every week and interacted each time. In this instance, the counselor is advised to change his or her shopping day and/or time in order to avoid risking loss of client confidentiality.

BOUNDARY VIOLATIONS WITHIN MULTIPLE RELATIONSHIPS

Mental health professionals are forbidden to exploit any person over whom they have supervisory, evaluative, or other similar authority. This includes clients/patients, students, supervisees, research participants, and employees [3; 4]. Professional ethics codes outline specific instances of behaviors and actions (some that are expressly prohibited) that have exploitative potential, including [3; 4; 5]:

- Bartering with clients
- Sexual relationships with students or supervisees
- Sexual intimacies with current or former clients
- Sexual intimacies with relatives/ significant others of current therapy clients
- Therapy with former sexual partners or partners of a romantic relationship
- Romantic interactions or relationships with current clients, their romantic partners, or their family members, including electronic interactions or relationships
- Physical contact with clients (e.g., cradling or caressing)

There are times when a client has an emotional session and hugs the counselor unexpectedly before leaving the office. This physical contact should be noted in the client's record along with what precipitated it. It should be revisited with the client at the next session, with this discussion recorded in the client's record. While you may prefer no physical contact, you can try to respond positively to the desire for closeness. For example, make personal contact with your hand as you hold the client at a distance, make eye contact, and tell the client that while physical reaching out is positive and welcome, you cannot allow it [12].

The ACA ethics code prohibits sexual and/or romantic counselor/client interactions or relationships with former clients, their romantic partners, or their family members for a period of five years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships [4]. The APA ethics code indicates that this period should be "at least two years after cessation or termination of therapy," and that "psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances" [3]. Mental health professionals who choose to engage in relationships with former clients have the burden of demonstrating that there has been no exploitation, in light of all relevant factors [3]. Factors to consider include the amount of time passed since termination of therapy; the client's personal history and mental status; the likelihood of an adverse impact on the client; and statements or actions made by the counselor during therapy suggesting or inviting a possible sexual or romantic relationship with the client [3].

Standards regarding sexual relationships and physical contact also are addressed by the NASW ethics code [5]:

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

The safest course of action is to continue to maintain established boundaries and limits indefinitely after therapy ends. In addition to the noted relevant factors, counselors should keep in mind that the client may return for further treatment. If the counselor has become involved in a business or social relationship with a former client, he or she deprives the client of the opportunity to return for additional treatment. It is vital to be mindful of the potential to exploit the client's vulnerability in a post-termination relationship [76].

Mental health professionals who find themselves attracted to a client should seek supervision around this issue. It is normal for feelings to develop in any type of relational context. It is not the feelings of attraction that are the problem, but rather actions taken. Mental health professionals should never act on these feelings, but instead discuss them with a trusted supervisor or colleague, exploring the possibility of countertransference as well as the potential trigger for the attraction. If the attraction causes intense feelings, it is advisable to seek personal therapy. If the feelings interfere with one's ability to treat a client, the client should be transferred to another professional, and work with the client terminated.

GIFTS

It is not unusual during the course of therapy for a client to present a counselor with a token of appreciation or a holiday gift, and receiving gifts from clients is not strictly prohibited by professional ethics codes. Instead, the ethics codes advise professionals to consider a variety of factors when deciding whether to accept a client's gift.

Section A.10.f (Receiving Gifts) of the 2014 ACA Code of Ethics states that [4]:

> Counselors understand the challenges of accepting gifts from clients and recognize that, in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

The National Board for Certified Counselors Code of Ethics: Directive #21 provides similar guidance to its members [6]:

> Counselors shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant. Counselors shall consider the value of the gift and the effect on the therapeutic relationship before accepting. Acceptance of a gift shall be documented in the client's record.

In the code of ethics of the Association for Addiction Professionals, Principle I-40: The Counseling Relationship states that [7]:

> Addiction professionals recognize that clients may wish to show appreciation for services by offering gifts. Providers shall take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

As noted in these excerpts, the effect on the therapeutic relationship should be a primary consideration when considering whether to accept a gift. Gifts can mean many things and also can fulfill social functions. The counselor's task is to identify the contextual meaning of the gift and determine when the gift is not merely a gift. To do so, the counselor must draw out from the client information to discern the possibility of a metaphorical or culturally significant meaning for the gift giving [77]. Counselors should consider the client's motivation for gift-giving as well as the status of the therapeutic relationship. Gifts that may seem intended to manipulate the counselor are probably best refused, whereas rejection of a gift intended to convey a client's appreciation may harm the relationship [78].

If the counselor is most comfortable with a "no-gift policy," it is best that the policy be discussed at the beginning of therapy. To wait until a client is presenting a gift to state that it is your policy to decline gifts may harm the client and damage the therapeutic relationship. Clear communication, both written and spoken, of the policy with clients as they enter therapy may help avert difficult later interactions around gifts. If clients have an understanding as they begin therapy what the counselor's approach will be, misunderstandings may be avoided [79]. While restrictive guidelines might be unhelpful, confusion surrounding gifts seems to be exacerbated by a lack of professional discussion about the topic [80].

Many professionals try to keep gifts "alive" throughout client sessions. This often involves putting the gift "on hold" (including decisions about acceptance and rejection) until the best moment for exploration with the client occurs. This allows that gifts given during therapy (where possible) remain part of therapy (i.e., they stay in the room and are available for future sessions) [80]. When considering whether to discuss the gift as part of therapy, the counselor should evaluate pertinent factors, such as the client's time in therapy, the context and frequency of gifts, and client dynamics. While not all gifts warrant full discussion (e.g., those given to show appreciation or of modest financial value), some, such as repeated or expensive gifts, do. Although counselors should be careful not to make too much of a gift, especially those that clients at least initially see as being given simply as a way to say thank you, such conversations may enable both members of the dyad to attain greater insight into the gift's intention and meaning and thereby prove helpful to the continued therapy work [81].

Gifts can range from physical objects, to symbols or gestures. As stated, consider the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift [4; 5; 7]. If there are concerns about any of these factors, it may be best to explore the intent of the gift in session. If a gift is deemed inappropriate, the counselor is advised to decline to accept it. In these cases, counselors should express appreciation for the thought and gesture, explain why they are unable to accept the gift, return it with kindness, and note the encounter in the client's record.

Professionals who work with children have unique challenges regarding gifts. Rejecting a child's gift or trying to explain a "no-gift policy" can cause the child to feel confused or rejected; children do not have the same levels of cognition and understanding that adults have. For play counselors, potential compromises include incorporating the gift into the

other materials and toys in the playroom or directly sharing the gift with the child [81]. An important factor affecting the decision to accept a gift is the kind of gift presented by the child. Artwork or something created by the child is an extension of the child and therefore can be viewed as an extension of emotional giving. Accepting non-purchased items (e.g., a flower picked by a child or a child's drawing) would be acceptable in most cases [82].

Clients with personality disorders present unique challenges regarding the issue of gifts. Generally, these clients exhibit manipulation, poor boundaries, and fixed or rigid patterns of relating, and gift giving can be a feature of the clinical picture for such clients. Accepting a gift from such a client may reinforce patterns of manipulative or self-debasing behaviors that are symptomatic of the problematic levels of functioning. In such instances, counselors should discern which course of action is truly in the client's best interests [77].

Often, a small token may be given or received at the termination of therapy for a long-term client. A touchstone that has meaning for the client, such as a meditation CD, book, or greeting card, is appropriate. As with all gifts, the gift and the context in which the gift was given or received should be noted in the client's record, along with your own intent and how you think the client perceived the gift.

THE GIFT OF SELF-DISCLOSURE

Self-disclosure can be considered another type of gift; however, it is best saved for a special occasion, shared deliberately, and always with the client's welfare first and foremost in mind. Self-disclosure is useful when it benefits the client, not the counselor. Although self-disclosure may cause no problems in therapy, it may intrude on the client's psychic space or replace a client's rich and clinically useful fantasy with dry fact, stripped of meaningful affect [71].

Humanistic theorists openly embrace counselor self-disclosure, asserting that such interventions demonstrate counselors' genuineness and positive regard for clients [83]. It is not surprising that professionals with behavioral and cognitive orientations view professional self-disclosures positively, especially when these interventions are intended to serve as a model for client self-disclosure [84]. And there will be times that self-disclosure is helpful in therapy. For example, it may serve as a vehicle for transmitting feminist values, equalizing power in the therapy relationship, facilitating client growth, fostering a sense of solidarity between counselor and client, helping clients view their own situations with less shame, encouraging clients' feelings of liberation, and acknowledging the importance of the real relationship between counselor and client. It also may enable clients to make informed decisions about whether or not they choose to work with a counselor [84].

According to one study, the content areas clinical social workers felt most comfortable self-disclosing about were loneliness, relationship status, aging, and other developmental issues of adulthood. Many talked freely about their marital status, the composition of their families, their parenting, their education, and their work. The most significant content area for sharing was grief work around significant losses either through separation, divorce, or death [85]. In these cases, counselor self-disclosure can help clients feel less alone and can normalize an emotional experience. It can give a client hope to learn that a trusted counselor has gone through the same situation.

Cautions Regarding Self-Disclosure

The power differential in the therapeutic relationship gives the professional access to a great deal of information about the client, which is transmitted in a one-way direction from client to counselor.

Occasionally, a client will ask personal questions of the counselor. The questions may arise simply out of curiosity, but they also may arise when a client is attempting to gain a feeling of control, as seen in individuals with personality disorders. Personal questions also may signal a client's wish to avoid feeling uncomfortable with emerging feelings/thoughts. Acknowledging and showing compassion for the client's curiosity while maintaining professional boundaries will satisfy most clients. While it is normal for clients to be curious, it is important to remind them that they are the focus of session. Gently redirect the conversation with comments such as, "Let's get back to you," or "What were you thinking or feeling before you asked me about myself?" It is important that professionals keep their sharing limited, even when the client asks for them to self-disclose.

No matter how on guard one is, there will be times when personal information makes its way to clients. Accidental self-disclosures may include extra-therapeutic encounters, slips of the tongue, or public notices of events or lectures. Personal aspects of the counselor's life may come to light if he or she calls a client by another client's name, a newspaper prints an obituary of the counselor's spouse, or the counselor is seen entering a place of worship [86]. Most clients who learn a bit of personal information about their counselor will mention it only to express care or concern, as when they learn of a death. Clients are generally satisfied with a brief acknowledgement of the disclosure and an appreciation for the client's expressed feelings about it.

As stated, mental health professionals' primary concern is to avoid burdening or overwhelming clients. Professionals should generally avoid using disclosures that are for their own needs, that remove the focus from the client, that interfere with the flow of the session, that burden or confuse the client, that are intrusive, that blur the boundaries between the professional and client, or that contaminate transference [84].

TECHNOLOGY AND DISTANCE THERAPY

We live in a rapidly changing world, especially where technology is concerned. In the past, therapy was offered only through in-person interaction in an office setting. Then, gradually, some professionals began to offer telephone sessions. Today, counseling is offered through video conferencing and other forms of telepsychology, and paper client records are being replaced with electronic records. Competent counseling includes maintaining the knowledge and skills required to understand and properly use treatment tools, including technology, while adhering to the ethical code of one's profession.

The APA has created guidelines to address the developing area of psychologic service provision commonly known as telepsychology [87]. The APA defines telepsychology as the "delivery of psychological services using telecommunication technologies... Telecommunication technologies include, but are not limited to synchronous (i.e., live and real-time interaction, e.g., videoconferencing, audio-only telephone) and asynchronous (i.e., store-and forward, non-live; e.g., text, email, messaging program, data-tracking smartphone applications) methods of healthcare-related communication and transmission of healthcare-related information. Transmitted information may include text, image, audio, interactive videoconferencing, remote patient monitoring, or other data related to patient care" [89]. The APA guidelines are informed by its ethics code and record-keeping guidelines as well as its guidelines on multicultural training, research, and practice.

The guidelines allow that telecommunication technologies may either augment traditional in-person services or be used as stand-alone services. However, the guidelines are intended to "help psychologists apply best professional practices when using telecommunication technologies" and not to "contravene any limitations set on psychologists' activities based on ethical standards; federal, state, provincial, and

territorial laws; and other organizational regulations" [87]. When one set of considerations may suggest a different course of action than another, the professional should balance them appropriately, with the aid of the guidelines, while holding to all current legal and ethical standards of practice [87]. The complete guidelines are available online at https://www.apa.org/about/policy/telepsychology-revisions.

The 2014 ACA Code of Ethics also addresses distance counseling, technology, and social media. It states [4]:

> Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

The ACA code also addresses legal considerations, informed consent and disclosure, confidentiality, security, and multicultural and disability considerations as they relate to technology.

The NBCC recognizes that distance counseling presents unique ethical challenges to professional counselors; related technology continues to advance and be used by more professionals; and that the use of technology by professionals continues to evolve. In light of this information, the NBCC Code of Ethics includes an updated and expanded section on telemental health, social media, and technology. The revised policy advises in detail about privacy concerns, legal considerations, obtaining the necessary information and consent from the client, and social media best practices [6].

According to the NASW ethics code, "Social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages" [5]. Professionals are advised to "comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located" [5]. In general, the NASW Code of Ethics advises that "Social workers should develop and inform clients about their policies, consistent with prevailing social work ethical standards, on the use of electronic technology" [5]. Professionals who are involved in discoverable (by the client) "electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients" [5].

Professionals interested in providing online interventions also should consider the potential for boundary confusion, inappropriate dual relationships, or harm to clients [5]. For example, instant message systems can alert clients each time the professional is online, allowing the client to send chat requests. Clients might access a professional's personal webpage or sign onto online discussion groups to which the professional also belongs. Some may continue to send the professional emails after the termination of the relationship. E-counselors should consider their response to such ongoing contact. Potentially more seriously, clients may use the Internet to harass or stalk current or former counselors [88]. The best way to prevent potential problems is to discuss the boundaries with clients during the initial assessment. Being up front and clear with clients about limits and policies regarding the use of technology and social networking is recommended [89].

Miscommunication is a commonplace occurrence in the online world. Even the simplest things (e.g., punctuation marks) can be misinterpreted. Studies reveal that 7% of any message is conveyed through words, 38% through certain vocal elements, and 55% through nonverbal elements (e.g., facial expressions, gestures, posture) [90]. Some technology-based forms of communication can result in the loss of important nonverbal and vocal cues, leading to an increased risk for miscommunication between client and counselor. Interactive communication, such as texting and email, involves the loss of nonverbal social cues that provide valuable contextual information and interpretation of meaning. Loss of these physical social cues may also increase the client's tendency to project personal psychologic material onto the blankness of the communication. While this may be helpful in some forms of psychotherapeutic interventions and it may offer advantages over in-person communication, it also presents a potential risk for increased miscommunication [88].

The compassionate professional strives to communicate nonverbally to clients that he or she is listening to and in the moment with the client. Physical cues, such as nodding and eye contact, have been shown to be positively associated with the degree that clients feel the counselor is respectful and genuine [91; 92]. Much attention also is paid to the voice, as it carries the verbal message and people often believe the voice to be a more reliable indicator of one's true feelings [93]. Because research exploring how empathy is experienced in an online environment is minimal, counselors should check with their clients to determine if the empathy is being transmitted in their text-based communications [12].

No matter what type of counseling is offered, a thorough initial evaluation should be completed to assess whether a client is appropriate for distance counseling. Practicing within recommended guidelines does not release counselors from the personal responsibility to be aware of, and to independently evaluate, the variety of ethical issues involved in the practice of online therapy [88]. Certain clients (e.g., those with suicidal, homicidal, or substance abuse history, clients with personality disorders) would not be suited to online therapy.

LEGAL AND ETHICAL CONSIDERATIONS

The challenges of online therapy lead to legal and ethical concerns associated with the delivery of mental health services via the Internet. Those opposed to online or distance therapy worry about licensure issues related to doing therapy across jurisdictional boundaries, legal responsibility in the event of a crisis, and the appropriateness of client anonymity [94].

Providing services across state lines is one of the biggest unresolved issues. Although communication technologies allow counselors to reach clients anywhere, state licensing laws generally do not permit out-of-state counselors to provide services via these methods. Some states offer guest licensure provisions, but most states require that the counselor hold a license in his or her own state and in the client's state. Providing distance therapy within one's own state is simpler, and it allows mental health professionals to reach people who would not otherwise have access to services (e.g., rural residents, people with certain disabilities) as well as those who want to receive services from home. To confidently provide distance services [95]:

- Abide by all applicable licensing requirements and professional standards of care.
- Understand the technology being used.
- Periodically check your state legislature's website for the latest telehealth laws and regulations.
- Check for a board policy statement that provides guidance on telepractice.
- Check whether your state licensing board has issued policies related to telepractice.
- Confirm that telehealth services (both in-state and across jurisdictional lines) are covered under your malpractice policy.

The COVID-19 public health emergency increased demand for mental and behavioral health services while driving most of those services to telehealth platforms. In response to this, in 2020, the APA led a campaign to maximize the availability of telepsychology services [96]. In March 2020, the federal government designated psychologists as critical, essential workers, and the Centers for Medicare and Medicaid Services (CMS) improved access to care for Medicare beneficiaries. CMS issued further guidance to waive key telehealth requirements. Because the new legislation cannot supersede state licensing laws (e.g., those that prohibit psychologists from using telehealth to provide services across state lines), the APA drafted letters to governors in all 50 states urging them to temporarily suspend state licensing laws and regulations regarding telepsychology services to ensure continuity of care. Within weeks of receiving the APA letter [96]:

- 12 states issued executive orders calling for expansion of telehealth service rates.
- 14 states issued executive orders allowing patients to receive telehealth services in their own homes.
- 16 states temporarily lifted licensing requirements.
- 22 states either expanded their policies for out-of-state providers to temporarily practice in their states or instituted emergency expedited registration for out-of-state providers.

However, the COVID-19 public health emergency ended in August 2023, and professionals offering telehealth services must use fully HIPAA-compliant software. Some options include Skype for Business, Updox, VSee, Zoom for Healthcare, and others [97]. More information can be found at https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html [98]. The APA also advises professionals to review individual payer's policies to confirm what telehealth services are covered and to determine the requirements for coding and billing telehealth services. Depending on the state, telehealth services may be limited to videoconferencing or include asynchronous communications or audio-only phone. It is also important to determine if there are originating site restrictions for where the patient may receive services or if coverage of telehealth services is limited to in-network providers or telehealth-only providers [97]. Emergency licensing provisions enacted during the COVID-19 pandemic have also ended.

SOCIAL MEDIA

With the advent of social media, clients can now search for and find the Facebook or Twitter page of their counselor, if one exists. Counselors who accept a client's "friend request" are in essence agreeing that the counselor and client are now friends, creating a multiple relationship. As discussed, when clients have access to their counselor's social media sites, both intentional and unintentional self-disclosures can occur. Modern social networking systems (e.g., Facebook, Instagram) exemplify intentional self-disclosure without a particular client focus. In contrast, Internet search engines (e.g., Google, LexisNexis) may allow unintended disclosure of personal details of the professional's life. Professionals should be aware and cognizant of social media involvement, including what information is public. Many sites offer ways to post minimal information if a connection to other professionals is desired. Avoid posting a profile photo that includes your family or other personal details, as these are public [86].

CONCLUSION

Competent counselors are well-educated and well-versed in the ethics of their profession. They understand that trust is built over time in the therapeutic relationship, with the help of limits and boundaries, and that it is reinforced by empathic response. Competent, compassionate professionals are both self- and other-aware and able to seek appropriate supervision and consultation when necessary. They establish self-care boundaries in order to protect their own compassionate, empathic response as well as their physical, emotional, and spiritual well-being. This enables counselors to most effectively help their clients.

RESOURCES

Administration for Community Living
Diversity and Cultural Competency
https://www.acl.gov/programs/strengthening-aging-and-disability-networks/diversity-and-cultural-competency

Office of Minority Health
Cultural and Linguistic Competency
https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Health Resources and Services Administration
Culture, Language and Health Literacy
https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

APA Ethical Principles of
Psychologists and Code of Conduct
https://www.apa.org/ethics/code

ACA Code of Ethics
https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf

NAADAC Code of Ethics
https://www.naadac.org/code-of-ethics

NBCC Code of Ethics
https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

NASW Code of Ethics
https://www.socialworkers.org/About/Ethics/Code-of-Ethics

Substance Abuse and Mental Health Services
Administration Cultural Competence
https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

HelpGuide: Benefits of Mindfulness
https://www.helpguide.org/harvard/benefits-of-mindfulness.htm

Mindfulnet.org
http://www.mindfulnet.org

Plum Village Mindfulness Practice Center
https://plumvillage.org/mindfulness-practice

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