

*Chapter Eleven*

**Working with Couples and Families**

*Simon Nuttgens and Jeff Chang*

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## Working with Couples and Families

### Chapter Objectives

This chapter addresses ethical issues that arise when counselling couples and families. The specific objectives are to:

- Summarize ethical issues germane to couple and family counselling
- Explain the relationship between counsellor education and competency in the provision of couple and family counselling
- Identify gender issues specific to couple and family counselling and show how these can lead to compromised ethical care of female clients
- Discuss the importance of counsellor self-awareness when engaging in couple and family counselling
- Describe and explicate parameters of confidentiality and informed consent specific to couple and family counselling
- Identify ethical issues that arise when working with families affected by separation or divorce

### Self-Assessment

*Directions:* Before reading this chapter, please use the following scale to reflect upon your beliefs and attitudes toward issues of working with couples and families. For each statement, identify the response rating that most closely aligns with your beliefs and attitudes.

5 = Strong agreement with this item

4 = Moderate agreement with this item

3 = Undecided about this item

2 = Moderate disagreement with this item

1 = Strong disagreement with this item

- \_\_\_\_ 1. When counselling couples and one partner privately discloses to the counsellor infidelity, the counsellor should share this information with the other partner.
- \_\_\_\_ 2. Family members have a right to know what is said in counselling sessions that they did not attend.
- \_\_\_\_ 3. Once you begin working with an individual, it is unethical to subsequently provide couple counselling.
- \_\_\_\_ 4. Family and couple counselling theories and models reflect a patriarchal worldview, and hence, should be used with caution.
- \_\_\_\_ 5. A family counsellor should not agree to see a youth if it appears that he or she has been coerced into attending.
- \_\_\_\_ 6. If a counsellor learns that one member of a couple has had an affair, this information should not be shared with the other member of the couple.

7. Couple and family counsellors must have received personal counselling during their training in order to provide ethically sound services.
8. Divorcing parents can be treated pretty much like "intact" couples when one is seeking informed consent to counsel a child.

## Introduction

There are significant differences in ethical practice when counselling couples and families compared to counselling individuals. Moreover, issues that may prove challenging in individual counselling can be compounded when working with multiple clients who often have competing interests. The therapeutic utility of involving multiple clients in counselling is evident given that many client problems involve or affect another family member. General systems theory, originally conceived by von Bertalanffy in the mid-twentieth century (Nichols, 2013), serves the foundational premise for most current family therapy models. This theory holds that families can be viewed as systems consisting of interdependent parts that interact in patterned ways to maintain a bounded state of equilibrium, or homeostasis. While it is problematic to adhere to the systemic metaphor too literally (lest complex relationships be reduced to mechanistic cogs), the idea of interdependence and relational reciprocity does bear upon the ethics of working with multiple clients, either as families or couples.

### An Overview of Ethical Issues When Counselling Families and Couples

The type of ethical challenges that can arise when working with multiple, emotionally involved, clients is highlighted by a typical scenario in couple counselling where one party believes that his or her best interest is served in the preservation of the union, while the other believes just the opposite. The issue becomes one of extending beneficence (an action that benefits another) to one party when doing so is experienced as maleficence (harm) by the other. A similar situation can arise when counselling adolescents, where the youth views leniency and increased freedom as essential to his or her wellbeing, while the parents believe the reverse to be true.

Another ethical concern that seems intrinsic to couple and family counselling involves the principle of autonomy. Held as a fundamental human right in many cultures, autonomy refers to the freedom to choose and direct one's affairs without interference or coercion from others. In counselling ethics, autonomy holds that individuals have the right to freely choose whether or not they wish to participate. In individual counselling, this right is sometimes brought to question when services are mandated

**Beneficence** – being proactive in promoting the client's best interests.

**Nonmaleficence** – not willfully harming clients and refraining from actions that risk harm.

**Autonomy** – refers to respecting the rights of clients to self-determination.

by a third party (e.g., as part of a probation order). Here the mandated client knows in advance that certain repercussions will follow if he or she fails to comply with the order. While in couples and family counselling (CFC) individuals may not be formally mandated to attend counselling, they may nonetheless experience varying degrees of pressure. It is often clear to the counsellor upon the first CFC meeting that enthusiasm for counselling is not shared by all. Research by Hawley and Weisz (2003) indicates that parents and children agree upon the nature of the presenting concern less than 25% of the time. In some cases, potential participants may directly refuse to partake. The counsellor must decide how to proceed when it appears that one or more family members are being coerced to attend.

Managing confidentiality also has its challenges in CFC. What in individual counselling is often a relatively straightforward undertaking, becomes increasingly complex when the focus of intervention is the family or couple unit. For example, a significant body of literature addresses what is commonly referred to as "keeping secrets" in couple counselling. Of ethical concern is how counsellors should proceed when one member of a couple shares something in confidence that the other member may benefit from knowing. Does the counsellor deem what was shared as confidential, thus upholding that individual's right for confidentiality? Or does beneficence extended to one party trump the other's right to confidentiality? Similar predicaments arise when couples are divorced or separated and children are involved in counselling. If a child discloses something about parent A and you, as the counsellor, thinks parent B would benefit from knowing this information, do you disclose regardless of how the child or other parent might feel?

The aforementioned ethical considerations confirm the need for a tailored approach to ethics when counselling couples and families. It is not uncommon for counsellors to come to family and couple work through serendipitous means. A counsellor seeing a woman for depression quickly hypothesizes that her client's distress is rooted in the oppressive actions of her husband. The husband is invited in and couple work begins. While this decision may be clinically sound, if ethical considerations have not been attended to beforehand, the counsellor may soon find herself or himself backpedaling with haste and hoping for a way out.

The ethics of working with couples and families are best not addressed as an afterthought. Systemic counselling requires systemic ethics, and "good" systemic ethics is unequivocally preemptive in nature.

Competent practice in CFC is an ethical requirement intended to ensure safe and effective service. The Canadian Counselling and Psychotherapy (CCPA, 2007) *Code of Ethics* details this requirement in Standard A3. Standards for gaining and maintaining competence in the field of counselling are the purview of provincial regulatory bodies in tandem with professional associations (e.g., CCPA) whose role is to ensure the welfare of those who use counselling services. Currently, however, the regulation of CFC is limited to Québec (McLuckie, Allan, & Ungar, 2013), with no protection of the title "Marriage and Family Therapist" outside of this province.

Regulatory issues aside, the CCPA (2007) *Code of Ethics* clearly indicates that those who practice CFC must have training and experience in this area. This ethical imperative is constrained by the existence of only two dedicated family therapy programs at the postgraduate level currently operating in Canada. For the most part, training in couple and family therapy occurs through graduate-level coursework offered through other health disciplines such as nursing, social work, and counselling, buttressed by postgraduate supervised experience (McLuckie et al., 2013). Conferences, continuing education, workshops, and similar educational offerings afford additional opportunities for training in CFC; however, such offerings can be expensive (McLuckie et al., 2013).

**Defining competence in CFC.** The American Association for Marriage and Family Therapy (AAMFT) recognizes entry-level competence in CFC by granting the Clinical Fellow designation. In addition to courses typically found in a master's level counselling curriculum, to become a Clinical Fellow, applicants must have taken three courses in family studies, that present "fundamental introduction to systems theory," enabling the applicant "... to think in systems terms across a wide variety of family structures and a diverse range of presenting issues." This would include "systems theory, family development, subsystems, blended families, gender issues in families, cultural issues in families, etc." (AAMFT, 2012, p. 1). Also required are three courses in family therapy, which "focus on advanced family

### A3. Education, Training, and Competence

Counsellors limit their counselling services and practices to those which are within their professional competence by virtue of their education and professional experience, and consistent with any requirements for provincial and national credentials. They refer to other professionals, when the counselling needs of clients exceed their level of competence.

systems theories and systemic therapeutic interventions... intended to provide a substantive understanding of the major theories of systems change and the applied practices evolving from each theoretical orientation..." (AAMFT, 2012). Finally, 1000 hours of direct client contact and 200 hours of supervision (100 of which must be individual) are required (AAMFT, 2012).

**The need for specialized training.** Specialized training in CFC is necessary for two principal reasons. First, although many theoretical models of family functioning are adaptations of individually-based theories (e.g., object relations [Stiefel, Harris, & Rohan, 1998]; cognitive behavioural therapy [Dattilio, 2011]; behaviour therapy [Jacobson & Margolin, 1979]), many others originate from models of social organization that focus more on what goes on *between people*, as opposed to what goes on *within people* (e.g., Beavers & Hampson, 2000; Bowen, 1978; Haley & Richeport-Haley, 2003; Minuchin, 1974; Olson, 2008; Skinner, Steinhauer, & Sitarenios, 2000; Tomm, 1987a, 1987b, 1988; Wilkinson, 2000). Thus, the theoretical models for conceptualizing family functioning and intervention are very different than in individual counselling.

Second, managing the working alliance in CFC is qualitatively different than in individual counselling. Friedlander, Escudero, and their colleagues (Beck, Friedlander, & Escudero, 2006; Escudero, Friedlander, Varela, & Abascal, 2008; Friedlander, Escudero, Heatherington, & Diamond, 2011; Friedlander, et al, 2006; Friedlander, Lambert, & de la Pena, 2008), in an international research program over the last decade found that a shared sense of purpose, or as Symonds and Horvath (2004) put it, allegiance with one another, is more predictive of outcome than the alliance with any given individual. Managing the working alliance with a couple or family requires different "micromoves" than in individual therapy. For example, providing an empathic response to one family member might invite another to think that you are siding with the first, or taking their factual position at face value, undermining your alliance with others in the family. Defining problems or setting goals in a mutual way is more complicated than doing so with an individual. For example, parents' desire that their adolescent comply with their rules, although reasonable, may not translate into a desired goal for the youth.

## Gender in CFC

While a detailed discussion of culture and ethics within CFC is beyond the scope of this chapter, there is reason to address the specific instance of gender within an ethical framework for CFC. This need is born from critical events throughout the history of family therapy, the likes of which still resonate today.

For the first half of the 20<sup>th</sup> century, counselling and psychotherapy were dominated by theories and models that encircled the individual as the locus of assessment and intervention. While families and intimate relationships were viewed as instrumental to personality development by these early models, such theories did not translate to a relationally oriented therapy. The median number of therapy participants remained two until the 1950s when family therapy took shape as a field of practice through the efforts of forerunners such as Gregory Bateson, Jay Haley, Nathan Ackerman, Murray Bowen, Virginia Satir, and Salvador Minuchin. Notable among these names is the presence of only one woman (Virginia Satir) who, interestingly, did not align herself with the feminist movement underway in the 1960s (Silverstein, 2003). Not surprisingly, the early years of family therapy were dominated by organizing ideas that reflected larger patriarchal values and practices. These ideas went unchallenged until the 1980s, at which time feminist-oriented family therapists began exposing the many ways that traditional family therapy theories could disadvantage, pathologize, or otherwise marginalize women. Three primary critiques emerged.

The first critique challenged the notion that families could be viewed as hierarchies based on age, with the parents sharing equal power atop the order. This view failed to recognize that unequal power enjoyed by men outside the home, reproduced itself within the home. Thus, while family therapy models viewed and acted upon members of the parental dyad as equal partners, in many instances the delimiting effects of a patriarchal society meant less power for women within and outside the family.

A second critique took issue with early models' over-subscription to gender stereotypes. For example, a popular, if not exclusive, therapeutic hypothesis that populated many family counselling sessions, held that the root cause

## A10. Sensitivity to Diversity

Counsellors strive to understand and respect the diversity of their clients, including differences related to age, ethnicity, culture, gender, disability, religion, sexual orientation and socioeconomic status.

of a family's trouble was an over-involved mother set in opposition to a withdrawn father; the father would then be encouraged to assume disciplinary responsibilities to counter the mother's inadequacy (Silverstein, 2003). This solution, as Silverstein (2003) noted, served "to devalue the mother as 'inadequate' and to idealize the father as he was brought in to manage the acting-out child" (p. 19). Doing so amounted to a shortsighted acceptance of traditional gender roles, without consideration of how such roles were socially constructed within a patriarchal society. A second example of gender stereotyping involved the work of Murray Bowen and his theory of "differentiation", wherein the desired attainment of this state closely aligned with traits traditionally identified as masculine (e.g., autonomous, intellectual), while traits that reflected the socialization of women (e.g., supporting others, relatedness) described a poorly differentiated individual (Hare-Mustin, 1978).

A third, and perhaps most serious criticism, was directed toward the seminal idea within CFC that families operate as self-correcting systems that function through circular and reciprocal patterns of interaction. Central to this model, as originally conceived, is the view that family members are equally responsible for the initiation and maintenance of problems. While many family problems can be viewed through such a lens with innocuous or even helpful results, when it comes to concerns such as family violence, the belief in equal power and reciprocal influence can speciously implicate women as provocateurs of their own abuse (Wilcoxon, Remley, & Gladding, 2012).

The aforementioned criticisms of some formative ideas within family therapy should alert family and couple counsellors to the need to carefully and continually assess how theories and models invite one to conceptualize women within the family or couple unit.

### **Counsellors Values/Counsellor Self-Awareness**

As counsellors, we come to this profession with a patchwork collection of values, biases, predilections, and vulnerabilities earned through the sum of life experience. As contextually situated beings, we must be aware of, and responsive to, the personal factors that influence our work with clients. This is so for all counselling work, though arguably, more so when working with couples and families;

the universality of the familial experience means that we will have existing beliefs regarding emotionally charged topics such as infidelity, divorce, corporal punishment, gender roles, traditional versus nontraditional lifestyles, and so forth (Corey, Corey, & Callanan, 2011). Our family experience will inevitably colour how we think about and intervene with families. As an ethical responsibility, we need to manage our personhood such that it does not compromise ethical and effective CFC practice; this requires continual vigilance and acute sensitivity to our beliefs, values, and emotional triggers.

The spectrum of self-awareness, in service to ethical propriety, takes many forms. As counsellors, we must be aware of culture issues broadly defined, including our racial identity and accompanying privilege. We must be aware that we are socialized beings who are continually shaped and reshaped through multiple socializing forces that operate at all levels of society. Certainly, we must be aware of our personal psychology including the developmental and relational experiences that contribute to who we are as counsellors, all of which can adversely affect the counselling relationship if unheeded.

The theoretical constructs of *transference* and *countertransference* (borrowed from psychoanalytic theory) are important to both ethical and effective family counselling (Corey et al., 2011). Transference refers to the influence of the client's past relationships on the present relationship with the counsellor; countertransference is simply the same, but in reverse. In both cases, the reaction, which often lies outside conscious awareness, resembles a reenactment of a past relational pattern (Cormier, Nurius, & Osborn, 2013). The elicitation of a countertransference reaction will inevitably, if not routinely, occur in our work as counsellors, sometimes due to a transference projection from our clients, and sometimes simply through the topic at hand. In either case, the reaction must be managed therapeutically and ethically. A recent meta-analysis of countertransference research came to the broad conclusion that negative countertransference responses in counselling can be harmful to the counselling relationship, while managing such responses effectively can contribute to a positive outcome (Hayes, Gelso, & Hummel, 2011). Managing countertransference begins with our professional training

### **A1. General Responsibility**

Counsellors maintain high standards of professional competence and ethical behaviour, and recognize the need for continuing education and personal care in order to meet this responsibility.

through opportunities afforded to examine how our personal histories converge with our role and identity as a counsellor. Many counsellor education programs formalize this personal reflection through requiring or strongly encouraging personal therapy. A thorough examination of transferential material during one's education does not, however, eliminate the need for ongoing self-reflective activities, such as supervision, consultation, personal counselling, and other related self-care activities.

### Confidentiality

While the general ethical standard of confidentiality requires little explanation, the specific parameters of confidentiality applied to CFC are rife with complexity. As noted earlier, this complexity arises from the broader application of beneficence, which holds that we must promote the best interests of client. In the case of confidentiality, however, CFC participants may have sharply diverging views regarding just what constitutes "best interest" (Wilcoxon, et al, 2012). Where one family member believes withholding information is in his or her best interest, another family member may believe just the opposite. There are many variations to this theme; common to all is the counsellor's need to decide what, and how much, information to share.

Given the necessary brevity of the CCPAs (2007, 2008) *Code of Ethics* and *Standards of Practice*, a more indepth discussion of confidentiality is warranted. Three common situations will be addressed: (a) secrecy in couple therapy; (b) confidentiality when working with family members individually; and, (c) later in the chapter, confidentiality in cases of separation and divorce.

### Secrets in Couple Therapy

Much is at stake when considering secrets in couple counselling. What begins as a simple commission to help two people address their relationship can quickly devolve into an ethical vortex of competing ethical, clinical, and personal posturing. Ethically, we must advance the best interest of each party while adhering to standards of confidentiality; therapeutically, we strive to help couples in the face of past and present hurts, commitment ambiguity, strained or ineffective communication, and in some cases, infidelity. Personally, we inevitably bump up against our

#### A4. Supervision and Consultation

Counsellors take reasonable steps to obtain supervision and/or consultation with respect to their counselling practices and, particularly, with respect to doubts or uncertainties which may arise during their professional work.

#### B2. Confidentiality

Counselling relationships and information resulting therefrom are kept confidential.

#### B13. Multiple Clients

When counsellors agree to provide counselling to two or more persons who have a relationship (such as husband and wife, or parents and children), counsellors clarify at the outset which person or persons are clients and the nature of the relationship they will have with each person. If conflicting roles emerge for counsellors, they must clarify, adjust, or withdraw from roles appropriately.

own values, beliefs, and biases borne of past and present relationship experiences, the likes of which can adversely affect the counselling relationships from both ethical and therapeutic fronts. Not surprisingly, multiple approaches to secrecy have arisen in the counselling literature.

When seeing a family or couple, some counsellors take the position that "the relationship is the client" (Gobbel, 2013). Taking this position can be very useful in inviting the couple or family to work together, and helping the clients and the counsellor decide what actions will benefit the relationship. The metaphor falls short, however, because "the relationship" is not an entity that can provide consent for treatment or exercise discretion over how information is used. Therefore, it is necessary to have clear practices in mind. A common approach is simply to adopt a "no secrets" policy. Here the couple is informed during the consent process that no secrets will be kept regardless of how they are communicated, because doing so leads to a therapeutic triangle that can compromise respect and the needs of one party. The counsellor goes on to state that if one party has a secret that he or she must discuss with a counsellor, it is best that he or she retain the services of another professional. A no secrets policy is often accompanied by a further stipulation that the counsellor will only meet with the couple conjointly. Proceeding in this fashion greatly reduces the telling of secrets; however, it also precludes the possibility of individual sessions that could be beneficial to the conjoint work.

Butler, Seedall, and Harper (2008) believe that an "open disclosure" policy is the only ethical way to proceed; in their words,

Where the profession holds forth a professional practice expectation and assurance of equal and unequivocal advocacy for each person in therapy, the safeguarding of a relationship-relevant secret can be viewed legally and ethically as creating a conflict-of-interest between the two partners. (p. 269)

Conversely, the argument can be made that keeping a secret, such as infidelity, could be in the best interest of the aggrieved partner if disclosure is for the purpose of hurting the aggrieved, assuaging one's feeling of guilt, or setting a course for divorce. Yet another argument favours

nondisclosure of infidelity if disclosure would lead to a marked decline in the unsuspecting partner's mental health.

These two arguments lead some to advocate that disclosing secrets should be left to the counsellor's discretion. Such decisions are ostensibly made upon the counsellor's clinical judgment regarding what, ultimately, is of greatest benefit to the couple (Wilcoxon, et al, 2012).

Managing secrets within counselling goes beyond work with couples. Should a counsellor agree to see individual family members outside of regularly held family sessions, there will also be a need to clearly articulate one's policy such that participants know how confidentiality will be managed throughout counselling. Many family counsellors prefer a flexible approach in which they can choose whether to see a family member individually, and if so, what information will or will not be shared with the absent family members. A typical scenario involves a counsellor who, after a few family sessions, requests to see an angry and combative adolescent on his or her own. Insights gained from such a session could help kindle much needed momentum in the stalled therapy. Proceeding this way, however, creates a relational triangle where apparent or actual allegiances and brokered secrecy agreements could easily compromise the therapeutic and ethical integrity of the counselling.

Irrespective of one's approach to confidentiality, it is paramount that the details are clearly articulated at the outset of counselling and throughout as needed (Bass & Quimby, 2006). A frank, detailed, and transparent discussion should ensue prior to commencing counselling such that the clients can decide whether to pursue services.

### **Informed Consent**

A theme that runs throughout this chapter is the central role that informed consent plays in ensuring ethical couple and family counselling. A misstep during the informed process can lead to undesirable ethical complications as service unfolds. Given that it is difficult for clients to identify ethical situations and forecast their impending importance, it is essential that enough information is shared at the outset to ensure clients are adequately informed prior to deciding to participate. Careful attention to the informed consent process also helps alleviate family members' anxiety

### **B4. Client's Rights and Informed Consent**

When counselling is initiated, and throughout the counselling process as necessary, counsellors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and other such pertinent information. Counsellors make sure that clients understand the implications of diagnosis, fees and fee collection arrangements, record-keeping, and limits of confidentiality. Clients have the right to participate in the ongoing counselling plans, to refuse any recommended services, and to be advised of the consequences of such refusal.

by "demystifying" the therapeutic experience (Fisher & Oransky, 2008, p. 577). In addition to standard information included in one's informed consent process, when counselling couples and families one should also include the following:

1. Theoretical orientation
  - A non-technical explanation of how you view families/couples, their problems, and their solutions
2. Procedural information
  - The types of activities that counselling will entail
  - Who will meet and how often
3. Confidentiality parameters
  - How secrecy will be managed
  - What information will be shared with non-attending family members and how this information will be shared
  - For children and youth, what information will be shared with parents and how this information will be shared
  - How the releases of confidential information will be managed
4. Client definition
  - Who will participate in sessions
  - Whether additional family members can be included later in counselling
5. Risks and benefits
  - Forewarning couples that counselling can lead to an undesired outcome
  - Forewarning family members that difficult and emotional topics may be broached

The amount of detail included within the informed consent process varies widely among CFC practitioners. This variation is likely due to differences in theoretical orientation, training, personal beliefs, and conceptual views regarding informed consent (Haslam & Harris, 2004). A qualitative analysis of informed consent forms by Haslam and Harris (2004) found a range in length from 1/3 to 6 pages, and although the categories of information were relatively consistent, the details within varied considerably.

### **B5. Children and Persons with Diminished Capacity**

Counsellors conduct the informed consent process with those legally appropriate to give consent when counselling, assessing, and having as research subjects children and/or persons with diminished capacity. These clients also give consent to such services or involvement commensurate with their capacity to do so. Counsellors understand that the parental or guardian right to consent on behalf of children diminishes the child's growing capacity to provide informed consent.

In the absence of a standardized form, CFCs must proceed by adhering to the CCPA (2007) *Code of Ethics*' general standards while also tailoring the informed consent process to the particular counselling setting (Pope & Vasquez, 2007).

The informed consent process is best conceived as just that: a process – and one that goes beyond the initial signing of an informed consent document. In the words of Pope and Vasquez (2007), we must resist the temptation to “push all the responsibility off onto a set form and let the form do the work” (p. 148). This conceptualization of informed consent is especially relevant to CFC where differing views regarding problem definition, the goals of counselling, and who should attend, necessitate negotiation among multiple participants. In CFC it is wise to assess the voluntariness of participation, which is a requirement for consent. It is common that individuals come to CFC with varying degrees of interest and enthusiasm. In some instances, one or more individuals may arrive for an initial counselling appointment ostensibly for no other reason than a coercive threat. In such situations the counsellor must work to engage the reluctant party(ies) to an extent that participation is voluntary (a task that may take more than one session), or renegotiate the critical question, “Who is the client?” Success in this regard draws upon the therapeutic skill of the counsellor, and herein illustrates the overlap of therapeutic and ethical content. It can sometimes be helpful when meeting reluctant clients to raise the spectre of “informed refusal” (Pope & Vasquez, 2007; Sommers-Flanagan & Sommers-Flanagan, 2007), which involves discussing the potential negative consequences of not participating in counselling (e.g., escalating parental worry, marital separation).

### Separation and Divorce

Separation and divorce is one of the most stressful disruptions in family life. Structurally, living arrangements change, and the amount of time children spend with a particular parent may increase, decrease, or become compartmentalized. Children may have to contend with parents' new partners, and extended family relationships may shift. Functionally, tasks such as driving to appointments and attending to healthcare are reassigned – often

haphazardly. Emotionally, the spouse initiating the separation may have had time to prepare, while the other spouse and the children may be shocked, hurt, or anxious about the future. The legal status of the family changes, and a new parenting regime may be specified by court order, usually based on the agreement of the parents, but sometimes after protracted litigation. For counsellors, ethical dilemmas can emerge in four main areas: (1) change in therapeutic agenda and the participants in counselling; (2) parents' informed consent on behalf of children; (3) requests for information in litigation; and, (4) competence in new areas of practice.

### Change in Therapeutic Agenda and Participants

Practically speaking, separation can change who participates in counselling. Upon deciding to separate, one spouse may decide to cease counselling. Article B13 of the CCPA (2007) *Code of Ethics* requires counsellors to clarify the relationship when the unit of treatment consists of more than one person. If one spouse requests to continue counselling, the counsellor may feel torn between competing demands to provide continuity of care and not abandon the client, and managing a dual relationship. The partner who does not continue counselling may believe the counsellor is siding with the remaining spouse. At the very least, the withdrawal of one person from counselling requires a re-clarification of confidentiality provisions and a conversation about how the relationship dynamics might change with both partners. In a recent case, a practitioner's conduct was found lacking, not because the practitioner saw a client individually after doing couple therapy, or failed to discuss with each party, but failed to document this in the file (College of Alberta Psychologists, 2012).

### Counselling Children of Separated or Divorced Parents

Another ethical dilemma can emerge when counsellors are asked to see children of separated or divorced parents. This is trickiest, both emotionally and legally, when a separation is recent. When a married couple brings their child to counselling, counsellors can usually assume that one parent may give informed consent on a child's behalf. However, when a separation is recent, and before a Court has considered parenting issues, it is not safe to assume that

### B13. Multiple Clients

When counsellors agree to provide counselling to two or more persons who have a relationship (such as husband and wife, or parents and children), counsellors clarify at the outset which person or persons are clients and the nature of the relationship they will have with each person. If conflicting roles emerge for counsellors, they must clarify, adjust, or withdraw from roles appropriately.

both parents are in favour of counselling. They may simply disagree about the need for counselling. Or, one parent may be suspicious that the other is enlisting the counsellor's aid to build a case for a favourable parenting regime. When receiving a request from one parent to support a child through a marital separation, it is wise to inquire about whether both parents are in agreement. It is necessary to firmly take the position with both parents that you aim simply to support their child, not their position in litigation, and reaffirm that they have equal access to information.

In other situations, parenting issues have been finalized (usually, but not always when a divorce has been granted). A parent requesting services for a child may state that he/she has "sole custody," or suggest that the other parent is uninvolved. Some parents may interpret the parenting arrangement, generously in their favour. Therefore, it is worthwhile to remember that "custody" generally refers to decision making on issues such as education, healthcare, and religion, and is a separate issue from residence (Slinko, 2013). Currently, divorcing spouses are generally granted "joint custody," which requires that decision making be shared. It is unusual for a Court to grant decision making on education or healthcare to one parent, unless the other parent's conduct has been found to be egregious. We recommend that counsellors review the Court Order that describes the parenting arrangement. In some cases, the parents are relatively friendly and a telephone conversation with a less involved parent with joint custody will reveal that he/she would like to participate in the child's counselling, or is perfectly happy to let the other parent have his or her way.

Even in situations where "sole custody" permits one parent to consent to counselling for a child, it is useful to remember that divorce seldom alters guardianship. Clients have access to their healthcare records (*McInerney v. MacDonald*, 1992), and normally a guardian exercises this on behalf of a child. Accordingly, counsellors should be prepared to deal with a parent who has heretofore not been very involved in the child's life, but may access the file. Although a counsellor may be legally and ethically "in the clear" seeing a child whose parent has sole custody, doing so without the knowledge of the other parent replicates the kind of secret-keeping that may be operating in the

### B7. Access to Records

Counsellors understand that clients have a right of access to their counselling records and that disclosure to others of information from these records only occurs with the written consent of the client and/or when required by law.

Clients normally have a right of full access to their counselling records. However, the counsellor has the responsibility to ensure that any such access is managed in a timely and orderly manner. (CCPA, 2008, p. 16)

family, and exposes counsellors to the unpleasant possibility that the noncustodial parent will find out the counsellor is seeing the child and feel aggrieved. It is both ethically careful and clinically astute to invite a noncustodial parent to help you help his or her child.

## Divorce Litigation

Approximately 80% of divorces proceed without conflict and litigation, while another 10 to 15% require just one Court appearance, leaving about 5 to 10% that are highly litigious (Carter & Hebert, 2012). Despite measures like parent education, mediation, and parent coordination, which are intended to reduce conflict, the Canadian legal system defines parents as adversaries. Legal processes, such as placing evidence before the Court by way of affidavit or testimony, cross-examination, and disclosure can exacerbate conflict. In this context, parties and lawyers may attempt to draw counsellors in to the proceedings, most often regarding disputes about parenting.

Often, the first indication that one party thinks you, as a counsellor, have something useful to their position is a letter from a lawyer requesting a file release. This could be a file for couple counselling, individual work with one of the adults,<sup>8</sup> or services to a child. Counsellors unaccustomed to legal issues may find a letter from a lawyer officious, or even intimidating. Note that a letter from a lawyer has no special power, and release of records still requires the consent of all competent persons (both spouses in the case of couple or child counselling), or a Court Order. Counsellors should respond to such a request (and irrespective of its tone, it is a request) promptly, make every attempt to discuss with clients the implications of release of information, and document their actions carefully.

If the spouses do not consent, the next step is for one side to obtain a *subpoena duo tecum*, a Court Order requiring the release of records and/or the counsellor's appearance. CCPA's (2008) *Standards of Practice* includes an excellent section on guidelines for dealing with subpoenas and court orders. If you choose to provide a written report based on your work as a counsellor, you should restrict it to observations, without stating opinion. This defines you as a *fact witness*; if you are called upon to give evidence, you may only testify about matters on which you have *direct*

*knowledge* – what you have actually seen or heard. Keep in mind that a written report, if placed in evidence by one party, gives the other party the right to cross-examine the author of the report.

**New practice areas.** Working with high conflict divorce is stressful, but for counsellors, especially private practitioners who can tolerate the stress, the work is rewarding, in high demand, and lucrative. *Mediation* focuses on formal dispute resolution. Although a mediator is not acting as a counsellor, one's skills at interacting with families in distress are necessary for mediators. *Parenting coordination* is another alternate dispute resolution process practiced by counsellors. Parenting coordination combines educating parents about the needs of children with collaborative decision making, and can include arbitration where the parenting coordinator may make binding decisions, if permitted by law. *Custody evaluation* entails a formal assessment suitable for filing as evidence in court, which gives specific recommendations for parenting schedules, custody, and access. In each of these valuable practice areas, counsellors require specialized expertise in assessment processes, child development, dispute resolution techniques, post-divorce dynamics for children and adults, relevant family law, and court procedures.

## Summary

Providing counselling services to couples and families brings added complexity to most every aspect of our work. Instead of one client in the consulting room, there are two or more, each with their own intersecting histories, beliefs, values, interests, and (often to the vexation of the counsellor), ideas regarding "the problem" and how it ought to be addressed. Navigating these therapeutic waters is as rewarding as it is challenging, with even the most seasoned counsellor feeling humbled when in the midst of volatile relational standoff. In this chapter, we argued that the unique features of CFC necessitate a tailored approach to ethical practice. Specific areas that were addressed include competency/training, gender issues, counsellor values, confidentiality, secrecy, informed consent, and separation and divorce. Guidelines based on the CCPA (2007, 2008) *Code of Ethics*, and *Standards of Practice*, and current professional literature, were presented to help Canadian counsellors provide services to families and couples in an ethically congruent fashion.

## Learning Activities

1. *Role-Play*. In groups of three, choose one of the case studies presented in Part VII as a role-play. Have two members of the group role-play the vignette, while the third acts as a recorder/observer. You are free to add contextual information as needed. Share your experience with the larger group.
2. *Debate*. Divide the class in half and debate the following statement: Be it resolved that if a counsellor meets alone with children during the course of family therapy, the parents have a right to know what is said in their absence.
3. *Family Genogram*. Have students create a personal genogram depicting three generations of their family. Instruct students to look for themes and patterns that run across generations. Encourage students to attend to family roles and how these have evolved over time. Then have students share in small groups each other's genogram, paying particular attention to personal values, beliefs, and experience that may bias their work with families. Debrief the small-group discussions within the larger class.

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