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Abstract

The complicated field of healthcare as it relates to grief counseling presents a number of moral conundrums. Practitioners must make difficult decisions on a daily basis that can have a significant impact on their work, patients, and clients. Moral precepts that direct a person's behavior or how they conduct themselves in their particular profession are the essence of ethics. Healthcare professionals, including clinicians, are frequently guided by a multitude of varying rules, principles, and opinions. This particular book chapter addresses the significance of ethics in grief counseling with regard to decision-making. It defines professional codes of ethics in detail and stresses their significance for the delivery of moral counseling. It also examines boundary crossings and boundary violations, the necessity of a moral process in decision-making, counselors' and clinicians' practice guidelines, which source of ethics is most significant, transference and countertransference as well as dual/multiple roles. It is noteworthy to note that healthcare professionals have a fiduciary duty to uphold the ethics and standards of their professional associations and regulatory bodies. As a result, managing an ethical conundrum is constant.

Keywords: *Ethics, Boundary Crossings, Boundary Violation, Transference and Countertransference*

1. Introduction

The same ethical guidelines that govern counseling in general also apply to grief counseling. Grief counseling is an ethical profession that requires one to assist clients and their families in overcoming their suffering while acting with moral rectitude. To practice their profession, counselors must make every effort to comply with all applicable laws, rules, and ethical guidelines. Whether one is providing grief counseling (psycho-education, supportive listening, normalizing bereavement-related symptoms) for people with simple bereavement or grief therapy (complicated, prolonged, delayed, exaggerated, or masked bereavement), an ethical approach is always required if one is to be technically accurate (Reeves & Bond, 2021).

Since, relationships are the main focus of counseling. People who are grieving can be extremely vulnerable. Because of this vulnerability, it is critical that mental health and counseling professionals uphold the ethical standards established by their association and have personal integrity (Reeves & Bond, 2021). These standards include: protecting client privacy, avoiding harm to clients or others, ensuring professional competence, and upholding standards of behavior. Making decisions is what ethics is all about. All of us deal with these issues on a daily basis. What matters are the factors that are considered and the guiding concepts that guide those decisions.

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The need for industry standards that guarantee the basic competency of professionals who assist the dying and bereaved is growing (Neimeyer, 2000), considering the deluge of literature on thanatology, counseling manuals, and the vast array of medical and mental health practitioners who profess to provide grief counseling (Doka, 2003), industry standards are important.

As an ethical professional, grief counselors must help clients and their families get over their suffering while upholding moral principles. To practice as a counselor, one must adhere to all relevant laws, rules, and ethical standards. Technical accuracy always requires an ethical approach, regardless of whether one is providing grief therapy or grief counseling for people with simple bereavement.

2. Professional Ethics

Professional ethics serve as the cornerstone for the practice and public trust in a service that is rendered during a period of personal distress or increased vulnerability, claim Reeves and Bond (2021). Avoiding the exploitation of a client in what may be a close emotional and psychological relationship with the counselor and involving the disclosure of private information about the client and others are the two main ethical challenges (p. 18–19).

Professional codes of ethics are, in fact, essential to the practice of ethical counseling because they influence the choices of counselors and clinicians in one way or another. But understanding these codes is just the first step. It is essential to have the critical thinking skills necessary to apply broad ethical concepts to particular circumstances. While some guidance is provided by the ethical codes of counseling, not all situations or questions are addressed by these guidelines. It is crucial for counselors to comprehend the sources of ethics, which include moral philosophy, agency policy, therapeutic models of choice, personal ethics (including those from religious and political sources), and the law (Reeves & Bond, 2021).

Accordingly, the decision-making process depends heavily on the values of self-respect, autonomy, justice, fidelity, beneficence, non-maleficence, honesty, and veracity (American Counseling Association, 2014; British Association for Counselling and Psychotherapy, 2018). Counselors are therefore accountable to their clients, their professional association, and, if one is present, the regulatory body, for their ethics and standards.

In reference to the principles for practice, Reeves and Bond (2021), declared that:

"1. Counselling requires that a counsellor puts aside their own concerns and interests to focus attention on the client.

2. The goal is to address the issue, concern or problem that motivated the client to seek counselling.

3. The counsellor will be trained to undertake the role.

4. The methods used will vary according to the training, experience and knowledge of the counsellor, the characteristics of the client, and the setting.

5. Counselling usually takes place in a formal and agreed way between counsellor and client.

6. Professional ethics provide the basis for practice and public trust in a service that is usually provided at a time of personal distress or heightened vulnerability. The characteristic ethical challenges are avoiding the exploitation of the client in what may be an intimate emotional and psychological relationship with the counsellor and involve the disclosure of sensitive information about the client and others." (p. 18-19).

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Counselors must therefore answer for their ethics and standards to their clients, their professional association, and, if one is present, the regulatory body. These guiding concepts distinguish counseling from other talking and listening assistance models like mentoring, guidance, and advice-giving (Reeves & Bond, 2021).

3. Boundaries

Ethics and boundaries are closely related in counseling and psychotherapy. As Reeves advises "few would argue that boundaries lie at the heart of ethical counselling and psychotherapy and that, without them, not only is the potential for change undermined, but the likelihood of harm to the client is increased" (Reeves, 2011, p247).

Boundaries can be defined as the limits of what is appropriate in a given circumstance. Gutheil and Gabbard (1993) describe boundaries as what is proper in a certain situation. Although boundaries are a natural part of all human relationships, they are particularly important in a professional psychology practice, where it is the psychologist's responsibility to make sure the right boundaries are upheld (Jorgenson et al., 1997). Similarly, Webb (1997) states, it involves drawing a line.

4. Boundary Crossings and Boundary Violations

Zur (2019), notes that in therapy, boundary violations are not the same as boundary crossings. While therapists who cross their own boundaries can be detrimental to their patients, doing so can also have significant therapeutic benefits.

Gutheil and Gabbard (1993) provide additional support by highlighting the fact that boundary crossings are often positive and important social responses to a patient's need, loss, or suffering that help to maintain the therapeutic relationship.

For example, a psychotherapist might reach across a physical boundary to give a patient who is grieving the news that their illness is terminal a hug or assist a patient who has fallen to the ground in getting back up to a sitting position. Other instances of typical positive boundary crossings include the therapist and client having multiple nonsexual relationships, the client giving gifts, the therapist shaking hands with the client, and so on. Accordingly, boundary crossings in psychotherapy were viewed by Gutheil and Gabbard (1993) as variations from standard clinical practices of boundary setting or maintenance, which could occasionally be beneficial and/or harmful.

Conversely, boundary violations usually violate ethics and are frequently against the law because they are usually exploitative and/or interfere with the therapist's objectivity (Zur, 2004). In fact, the majority of previous research on boundary violations has focused on the issue of therapists abusing and exploiting their patients sexually (Gutheil and Brodsky, 2008; Pope and Vasquez, 2016). In fact, the majority of the writing on this topic came from American authors. Originally, sexual relationships between a therapist and their client were referred to as "boundary violations" (Gutheil and Brodsky, 2008).

When therapists are involved in exploitative dual relationships, like having sex with clients or engaging in exploitative business relationships, then harmful boundary violations usually result. Another instance, according to Brown (1994), was a therapist who offered to lower his fees to professional athletes in exchange for the athlete's permission to use their name in future psychotherapy service advertisements. Another example is having alcoholic beverages with a client.

A well-meaning action may be interpreted as a boundary violation if it is not done in compliance with accepted community standards and other factors like the client's diagnosis, history, values, and culture. Furthermore, boundary crossings are frequently beneficial and significant social reactions to a patient's loss, need, or suffering that support the preservation of the therapeutic relationship, according to Gutheil and Gabbard's 1993 article.

Boundary crossings (role changes) and boundary violations (participation in the client's exploitation) are distinguished by Gutheil and Gabbard (1993). In fact, the term "boundary violations" has come to refer to unethical behavior on the part of therapists (Glass, 2003). A boundary violation is a major lapse that causes harm to clients and is therefore unethical; a boundary-crossing is a departure from generally accepted practices that may benefit clients. Keep in mind that not every crossing of a boundary qualifies as a boundary violation. Thus, boundary violations, on the other hand, are unethical because they have the potential to harm clients, whereas boundary crossing may not bring harm to the client.

Regarding matters of boundaries, Herlihy (2017) highlighted that context is crucial and puts across some recommendations that could help practitioners become more effective and ethical if they work with ethnically diverse clients in the US or want to work overseas to expand your experience. Herlihy alluded that counselors and mental health professionals should bear the following suggestions in mind when considering boundaries:

1. Before you enter an unfamiliar community or culture, educate yourself about the norms and customs of that setting. Developing cultural literacy can go a long way toward avoiding boundary related mistakes.
2. If possible, talk with a counselor or other mental health professional who is familiar with the community or culture and who can advise you regarding what boundary issues you might encounter and how they might best be resolved in a culturally appropriate manner.
3. Seek consultation, even if geographical distance necessitates that it occurs through electronic communication. It is risky to rely solely on self-monitoring because our judgment becomes cloudy when our own needs are involved.
4. When boundary issues arise, work with the client to resolve them whenever possible. This can be a mutual learning experience.
5. Be open to the possibility of working collaboratively with other helpers and healers in the culture, such as community elders, religious leaders and indigenous healers. These individuals can help you navigate boundaries in ways that are appropriate to the context.
6. Because the boundaries you customarily establish with clients are frequently challenged in new environments, make self-reflection a habit. Some questions to ask yourself:
    - Does this boundary enhance or threaten the client's sense of safety in our relationship?
    - Is setting this boundary meeting my needs or the needs of my client? If I enter into a dual relationship with this client, will the secondary relationship enhance the therapeutic relationship?
    - Before shifting a boundary, have I thoroughly discussed the shift with my client to ensure that the client understands and accepts the change?
    - Have I conducted a risk-benefit analysis before engaging in a dual relationship, giving careful thought to the what-if question of "What's the best that could happen and the worst that could happen?"
7. Come from a humble stance when entering and working in a new community or culture. Be willing to learn from and be changed by the experience (Herlihy, 2017, p.17-18).

Furthermore, ethical standards are critical to counseling as a whole. It is significant to remember that the development of biomedical ethics by Beauchamp and Childress (2008) affects moral standards for mental health professionals in general as well as counseling. Consequently, Beauchamp and Childress put forth these four moral precepts, which are crucial to the counseling process. Among them are:

1. Respect: People are free to choose how they want to spend their lives, provided that they do not infringe upon the rights or well-being of others.
2. Justice: Fairness, be just and equal when delivering services to the community.
3. Nonmaleficence: Do no harm to the client
4. Beneficence: Commitment to benefiting the client

Nonetheless, Thompson (1990) adds two more principles. These are:

5. Fidelity: The basis of the trust between client and counsellor
6. Self-interest: The counsellor is entitled to all of the above

It would be so easy and convenient if one could just be able to look up the one right course of action when faced with an ethical dilemma, but it is not just clear in black and white, and therefore, Ethics Code can offer this particular guidance for dealing with ethical problems, which are situations where there are obvious acceptable and unacceptable courses of action. These guidelines establish the ethical floor, which Knapp and VandeCreek (2017) define as the minimal requirement that must be fulfilled and the "prohibited acts", (p. 13) that must be avoided. As clinicians and counselors and health care practitioners, care should be taken to avoid any behavior that is unethical and breaches the ethics code. Remembering that we have a fiduciary duty to our clients.

Thus, examples from the Ethics Code (APA, 2017) are provided to include, "Psychologists do not engage in sexual intimacies with current therapy clients/patients" (Ethical Standard 10.05, p. 14), "Psychologists do not misrepresent their fees" (Standard 6.04c, p. 9), and "Psychologists do not present portions of another's work or data as their own…" (Standard 8.11, p. 11). Other standards postulated by the Ethics Code (APA, 2014) include: "Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service" (Standard 10.10a, p. 14).

In summary, in the context of psychotherapy, boundary crossing has traditionally been used to describe any departure from the strict, "only in the office," emotionally detached forms of therapy that are part of traditional analytic and risk management practices. They mostly discuss topics like gifts, touch, bartering, self-disclosure, and house visits. A subtype of boundary crossing known as dual relationships describes circumstances in which a client and therapist have multiple connections.

When used appropriately, boundary crossings can improve therapeutic outcomes and clinical effectiveness but are not the same as harmful boundary violations. In many small and interdependent communities, including rural, military, minority, church, university campus, and among gays, the deaf, etc., dual relationships and other forms of boundary crossing are inevitable. Boundary crossing and dual relationships are not unethical or below the standard of care, unlike sexual or exploitative relationships and harmful boundary violations. behavioral, family, group, and cognitive-behavioral.

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Boundary crossings ought to be used in accordance with the particular circumstances, problems, personality, culture, and background of each client as well as the therapy environment. As with any therapeutic intervention, boundary crossing justifications should be stated (in writing) in the treatment plan, and in more complicated cases, expert consultations are recommended. Sound clinical judgment should be flexible and individually tailored to clients' needs rather than therapists' dogmas or fears. This is often interfered with by the overly restrictive analytic risk-management emphasis on clearly defined, rigid, and inflexible boundaries.

5. The Need for a Moral Process in Making Decisions

Clinicians and counselors ought to be moral beings in practice since morality compels people to think through the consequences of their decisions, particularly how those decisions might affect other people. Therefore, a moral code that suppresses negative impulses can enhance the therapeutic alliance. Thus, when faced with an ethical dilemma, it is essential to use a moral process when making decisions. The “Five P Model” is an ideal model to apply when making moral decisions because it addresses “a person with a challenging ethical problem in a particular contextual place applies appropriate ethical principles in a deliberate decision-making process.” (Gamino and Ritter, 2009, p.21). The "Five P Model" speaks to:

1. Person: Who is this person?
Age. Sex. Education. Work history. Economic background.
Single, married, partnered. Home/family. Friends. Social support
Ethnicity, culture, religion. Community/civic activities.
Strengths/resources. Personal resilience.
Other personal history (. e.g., previous losses, decision-making style).

2. Problem: What is the specific ethical challenge to be resolved?
Statement of the problem. What is the ethical dilemma?
Who is formulating the problem? Who else has an interest in the problem?
Is the problem properly stated? Other variables?

3. Place: Where is the ethical dilemma manifested?
Physical location. Medical setting: clinic, hospital, hospice, nursing home?
Other: private home, funeral home, place of worship, educational setting?
Public or private place? Are there agency/institutional considerations?

4. Principles: What ethical principles are the focus of the problem?
Ethical principles: autonomy, beneficence, nonmaleficence, justice, fidelity;
Ethics of the profession. ADEC Code of Ethics [or the relevant code of ethics]
State/federal [country] laws. Personal narrative. Religious, ethnic, cultural “rules.”
5. Process: How will the decision be made?
How will information be gathered? How will all voices be heard?
Time limitations. Ethical history. Resolution of the dilemma.

Professionals who work with counseling and other helping fields, frequently encounter a variety of difficult ethical and clinical situations. Because of this, mental health practitioners must follow a Code of Ethics when making decisions about how to handle these difficulties and conundrums.

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In summary, morality acts as a road map for behavior and decision-making, assisting Professionals in navigating tricky social situations and selecting actions that are consistent with their values and beliefs. Additionally, assisting them in weighing the moral ramifications of their choices and promoting morally sound decisions.

6. Principles for practice for counselors and clinicians

Reeves and Bond (2021) have articulated these principles of practice that govern counselors and clinicians. These include: "1. Counselling requires that a counsellor puts aside their own concerns and interests to focus attention on the client. 2. The goal is to address the issue, concern or problem that motivated the client to seek counselling. 3. The counsellor will be trained to undertake the role. 4. The methods used will vary according to the training, experience and knowledge of the counsellor, the characteristics of the client, and the setting. 5. Counselling usually take place in a formal and agreed way between counsellor and client. 6. Professional ethics provide the basis for practice and public trust in a service that is usually provided at a time of personal distress or heightened vulnerability. The characteristic ethical challenges are avoiding the exploitation of client in what may be an intimate emotional and psychological relationship with the counsellor and involve the disclosure of sensitive information about the client and others." (p. 18-19).

7. Which source of ethics then is the most important?

Neither the client nor the counselor are above the law when it comes to privacy in the counseling relationship. Counselors who are aware of the law are better able to safeguard both themselves and their clients. Understand the law as it pertains to matters like contract law, record disclosure, confidentiality, and testifying in court. Understand the laws that apply to your specific field of expertise and making sure the conditions of the contracts you have with employers, clients, and professional associations align with the services you provide to your clients. When a matter of law and ethics prevail, which takes precedence?

Reeves and Bond (2021) state "When there are so many different sources of ethical insight how can these be prioritized? The law carries the greatest authority as it is enforceable by courts...The next level of authority is the commitments entered into by counsellors as part of their contractual obligations to clients, employers and professional bodies... "State law and contractual obligations set the framework within which ethical judgements have to be made. The most common dilemmas for counsellors concern the protection or disclosures of 'personally sensitive' client information, conflicts of interest, dual relationships and respecting the client choices when the counsellor feels strongly that a client could have made a better choice." (p54-55).

8. Dual/Multiple Role

A multiple relationship is one in which a practitioner has a professional relationship with an individual and also has a relationship in another capacity with the same individual or with a person who is close to them, according to the APA's 2002 ethics code. In regard to multiple roles, Herlihv and Corey (2006) highlighted that when professionals take on two or more roles with a client concurrently or sequentially, multiple relationships arise. This could entail playing multiple professional roles (like therapist and instructor) or combining a professional and personal relationship (like friend and counselor or business partner).

Having multiple relationships can also involve doing business with a client, borrowing money from a client, lending money to a client, providing therapy to a friend's or relative, socializing with clients, getting emotionally or sexually involved with a client or former client,

combining the roles of supervisor and therapist, etc. In addition to dealing with the power imbalance that is a fundamental component of most professional relationships, managing boundary issues, and working to prevent the misuse of power are all skills that mental health professionals need to acquire in order to manage multiple relationships in an ethical and effective manner.

According to Moleski and Kiselica (2005), there are two types of multiple relationships: therapeutic and destructive. While some multi-relationships are detrimental, other side relationships strengthen, support, and improve the therapeutic alliance. Therefore, Counselors are advised to consider the possible advantages and disadvantages of a secondary relationship for the primary counseling relationship. They advise counselors to think about establishing several relationships only when it is evident that the client would benefit most from them. Ethical issues need to be taken into account when clinicians mix a professional relationship with a client with another type of relationship. It is frequently challenging to decide in these circumstances what is best for the client.

In addressing multiple relationships, Younggren and Gottlieb (2004) recommend that practitioners address these questions to make sound decisions about multiple relationships: Is it necessary to get into a relationship outside of my work life, or should I stay away from it? Can the client possibly suffer harm from the multiple relationships? Would the additional relationship prove beneficial if harm seemed unlikely? Is there a chance the therapeutic relationship might be ruined by the multiple relationships? Can I assess this issue impartially? Practitioners must carefully consider the possibility of a conflict of interest, the loss of objectivity, and the implications for the therapeutic relationship when responding to these questions.

Counselors should actively involve their clients in decision-making and discuss with them the possible issues that could arise from a multiple relationship. Consent forms should be signed by the client and the therapist should be documented if the multiple relationship is deemed appropriate and acceptable.

Therapists would also do well to approach the issue from a risk-management perspective. In order to do this, a number of factors must be carefully considered, including the diagnosis, functional level, therapeutic orientation, community norms and practices, and professional consultations with those who may be able to support the choice.

When practitioners are analysing a scenario involving the benefits and drawbacks of a multiple relationship, Younggren and Gottlieb (2004), advise that they apply an ethnically based, risk-managed decision-making model. They acknowledge that "these types of relationships are not necessarily violations of the standards of professional conduct, and/or the law, but we know enough to recommend that they have to be actively and thoroughly analyzed and addressed, although not necessarily avoided" (p. 260). Therefore, behavior that is unethical and breaches the ethics code is below this ethical floor.

Psychologists do not engage in sexual harassment (Ethical Standard 3.02, p. 5), they do not have sexual relationships with current therapy clients or patients (Ethical Standard 10.05, p. 14), they do not misrepresent their fees (Standard 6.04c, p. 9), and they do not present parts of another's work or data as their own (Standard 8.11, p. 11). These are just a few examples from the APA's 2017 Ethics Code.

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In summary, when answering these questions, practitioners need to be very aware of the potential for a conflict of interest, the loss of objectivity, and the implications for the therapeutic relationship. counsel professionals to think about the following questions in order to make informed decisions about multiple relationships.

Additionally, counselors should actively involve their clients in decision-making and discuss with them the potential issues that could arise from a multiple relationship and ask this question: do I need to be in a relationship in addition to my professional one, or should I avoid getting into one? (Younggren and Gottlieb, 2004). Before beginning a dual or multiple relationship, all of the aforementioned factors should be taken into account, and it should be entered into with extreme care and caution. It is the duty of all counselors and clinicians to avoid unethical/potential harm to their clients. Thus, clients should be given an explanation of boundaries at the start of treatment and on a regular basis afterward, both through the informed consent document and in-person discussions.

Additionally, counselors and clinicians should not "play favorites" but maintain their ethical objectivity while providing each client with the best services possible. In any case, the counselor's responsibility is to respect the 2014 ACA Code of Ethics and thoroughly assess situations that could be problematic for counselling, and so should prioritize their clients' needs at all times.

9. Transference and Countertransference

Patients' views and actions toward their therapists are often shaped by dysfunctional patterns, presumptions, and beliefs that affect the way patients perceive other people. Psychoanalysis is among the oldest psychological theories, having its roots in the work of Sigmund Freud in the early 1880s. Actually, the first people to identify and define transference and countertransference in a therapeutic context were Freud and Breuer (1895). In actuality, Freud discovered and treated hysterical symptoms between 1885 and 1895, which is when he first became aware of the "transference" phenomenon. Many studies have been conducted on the relationship between the therapist and the client in terms of transference and countertransference. Bion (1994) claims that "An emotional storm is created when two personalities meet," (p. 321).

According to Cartwright (2004), transference is the process through which a client enters a therapeutic relationship with relating patterns from their early years. Conversely, countertransference describes the therapist's cognitive-affective reactions to the patient. When the therapist's response to the client is predicated on their own dysfunctional beliefs or unresolved issues, the countertransference may occasionally be characterized as personal.

In other words, transference is the act of projecting one's emotions from one person onto another. It usually refers to a patient projecting his/her feelings onto his/her therapist during a therapeutic session. Conversely, countertransference describes the therapist's cognitive-affective reactions to the patient. When the therapist's response to the client is predicated on their own dysfunctional beliefs or unresolved issues, the countertransference may occasionally be characterized as personal (Cartwright, 2004).

Another definition put forward by Berzoff et al. (2008) is that transference is the concept of ideas and feelings that are derived from prior interactions and feelings with other people. While countertransference refers to the therapist's personal beliefs and emotions toward their clients that are derived from their own prior experiences.

On the other hand, when a therapist projects his/her emotions onto a patient, this is known as countertransference. Usually, transference and countertransference occur unintentionally (Freud 1985).

Overstreet (2021) gave the following instances of countertransference: Rather than hearing about the client's experiences, a clinician gives advice. During the session, a clinician inappropriately shares personal experiences with a client, and when a clinician does not set any boundaries. Transference is a term that traditionally describes a client's unconscious feelings toward a significant other, like their therapist. The transference of emotions and reactions provides important insight into the inner world of a client. When a therapist works with a client, countertransference describes the emotions the therapist may experience (Jenks & Oka, 2020).

According to Smitha (2023), transference - whether positive or negative - can be beneficial in a therapeutic setting and help therapists address past issues by applying the insights they receive from your transference. Through transference, the therapist can thus learn a great deal about the client's past and potential areas of need. Transference in therapy can help the therapist spot it in other aspects of the client's life. Your therapist may recommend journaling or other reflective exercises as a way to help you understand why and when you experience transference in particular areas of your life. Although each therapist employs a unique strategy and adheres to a distinct set of theories, therapists can manage their own anxiety by using the following advice:

1. Build genuine relationships with your clients.
2. Steer clear of defensiveness when there is negative transference.
3. Be mindful of the possibility of countertransference.
4. Acknowledge their own historical tendencies

Additionally, therapists can be more aware of countertransference in a few ways:

1. Make an effort to understand yourself
2. Use psychological theories to understand their clients and their relationships with them.
3. Put themselves in their clients' shoes to develop empathy.
4. have the capacity to differentiate themselves from others
5. manage their own fear
6. Strive to comprehend oneself (Smitha, 2023).

Therefore, practitioners must be aware of the fact that the inner lives of the patient, therapist, and supervisor can be better understood through the use of transference and countertransference and so transference and countertransference provide useful insights into the inner world of the patient, therapist, and supervisor. However, an effort should be taken to maintain positive transference and countertransference in a therapeutic session.

In summary, it is critical that we, as mental health professionals and clinicians, refrain from unethical behavior, and recognize the advantages of fostering ethical behavior in our work. In addition, we have to respect the standards of our profession and act with honesty, decency, and justice while understanding the dos and don'ts of our line of work. At all times, we must be conscious of our fiduciary duties to our clients.

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