COUNSELING CLIENTS NEAR THE END OF LIFE

A PRACTICAL GUIDE FOR MENTAL HEALTH PROFESSIONALS

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Counseling Clients Near the End of Life
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I dedicate this book to my parents and my wife, all of whom have had serious health scares during the time that this book was in development.

The fierce commitment that my mother and father demonstrated as each of them received surprise diagnoses of cancer, and each ended up in the hospital, demonstrated the true meaning of partnership. My sister’s willingness to drop everything and help out during these trying times was remarkable.

Finally, when my wife, Theresa, woke up exhibiting the symptoms of a stroke while at a conference many hours from home, I wasn’t sure what to expect when I arrived at the hospital. Fortunately, she had been rushed to a stroke center, received excellent care, and has fully recovered. Her two sons, Paul and Campbell, and I are very happy that she is back to her spirited self.

The strength and resilience of all of these important people in my life have continued to amaze and inspire me.
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In a review of the counseling literature, I found very few articles focused on end-of-life issues, and the majority of those that could be placed in this content area were related to aspects such as grief and loss as opposed to providing counseling to persons who were dying and their loved ones (Werth & Crow, 2009). This is remarkable because the American Counseling Association (ACA, 2005) amended its ethics code to specifically include a standard on counseling terminally ill persons (A.9) and referred to this standard within the very important confidentiality section (see B.2.a). The ACA is alone among the large national mental health associations in discussing end-of-life issues in its ethics code, but members of other professions have books aimed directly at them that discuss how they can work with clients who are dying and their loved ones. Similarly, there are dozens of books on working with people after their loved ones have died but there are few resources that address pre-death issues. Thus, this book is designed to fill this gap.

Professional counselors want and need resource material that is practical, evidence-based, and accessible. This book takes these requirements into account by having chapters written by mental health professionals who have experience providing counseling services and, therefore, who can speak from experience, while also basing the information on the empirical literature. The chapters include reader-friendly aspects such as “clinical pearls,” which are brief take-home points that have specific, direct relevance to practice and can be put to use by the reader immediately but would not necessarily be obvious to the novice counselor. In addition to these pithy take-home messages, each chapter incorporates at least two cases from the authors’ experience to highlight the issues that are raised in the chapter.

The content of the book is based on my own and my colleagues’ experience providing counseling to people who are facing end-of-life issues and material appearing in the literature documenting what frontline mental health service providers need to know in order to provide counseling to persons who are dying and their loved ones.

The first section of the book is focused on foundational information that is important for service providers across all types of end-of-life situations.
Louis Gamino and Michael Bevins review ethical challenges and offer a model for addressing these dilemmas. Next, Jung Kwak and Elise Collet provide an overview of diversity considerations and focus on ethnicity/race, older age, and religion/spirituality. In the third chapter, Rebecca Allen, Morgan Eichorst, and JoAnn Oliver review advance directives and how they can be used to assist dying individuals and their loved ones. The final chapter in this first section is on working with teams when providing services to individuals who are dying and their loved ones, and Kimberly Hiroto and Julia Kasl-Godley provide practical tips on how to use teams to their fullest.

The second section of the book focuses on working with clients who are dying. In Chapter 5, I offer a primer of sorts that sets the stage for the more specialized chapters that follow, using a comprehensive framework developed by a Working Group of the American Psychological Association. Then, Illene Noppe Cupit, Deirdre Radosevich, and Gail Trimberger review lifespan considerations and provide information regarding special issues faced by people who are dying at various ages from the very young to the very old. The next chapter focuses on mental health issues, with Jackson Rainer and Johnathan Martin reviewing a number of conditions such as depression and anxiety. The last chapter in this section is by Mary Lewis and Jessica Moeller and they examine the pressing issue of cognitive impairment.

The final two chapters address how to assist loved ones before and after death. Deborah Waldrop and Abbie Kirkendall discuss how to help caregivers when a loved one is dying. Finally, Robert Neimeyer and Laurie Burke provide guidance on helping people who are experiencing complicated grief after the person has died.

I hope that readers will find these chapters useful regardless of whether they are working with their first client who is dying or have been doing this type of work for many years. I know that, as the book’s editor, I found myself making my own notes in the margins for things I needed to keep in mind.

REFERENCES

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I

End-of-Life Service Provision
“Begin with the end in mind” is a common admonition to goal-oriented individuals who set out on an endeavor attempting to achieve a specific outcome. While all health care, including psychotherapy, is designed to accomplish some salutary purpose, “beginning with the end in mind” has particular significance when treating or counseling clients nearing the end of their lives. The proximity of death as a physical endpoint serves, temporally and existentially, as an organizing principle for the clinician’s work with the client and may, in effect, be the “chief complaint.” Facilely handling the rigors of end-of-life counseling requires death competence on the part of the provider—specialized skill in tolerating and managing clients’ problems related to dying, death, and bereavement (Gamino & Ritter, 2009).

Both hospital-based palliative care and end-of-life counseling in outpatient settings generate a host of ethical challenges and dilemmas to consider: ensuring autonomy, assessing capacity for decision making, honoring advance directives, respecting cultural diversity, keeping confidentiality, grappling with medical futility, maintaining boundaries, and including families in the scope of care. Such challenges are not intermittent events but part and parcel of everyday clinical practice. Therefore, conscientious professionals must remain constantly vigilant regarding ethical dilemmas that may arise and remember that “… good counseling practice requires sound ethical practice” (Gamino & Ritter, 2009, p. xviii).

Through the vehicle of case studies, the authors explore and delineate some of the most common ethical challenges that occur when counseling clients nearing the end of life. In the first section, the focus is on hospital-based palliative care where end-of-life counseling involves issues such as how to maximize patient autonomy when deciding whether to stop curative
treatment. In the second section, the focus shifts to outpatient settings where end-of-life counseling can strain the boundaries typically enforced in psychotherapy and pose novel challenges to client confidentiality, including after death. The authors present a coherent decision-making model to guide clinicians in maintaining ethical integrity when counseling clients under such emotionally charged circumstances.

HOSPITAL-BASED PALLIATIVE CARE

Palliative care is specialized medical care for people with serious illness. Although palliative care is not limited to patients near the end of life or to those foregoing curative treatment, palliative care teams are often called to assist in the care of dying patients and their families. Palliative care is generally delivered by a team, which typically consists of a physician, social worker, and chaplain. This interdisciplinary approach is meant to holistically address patients’ physical, emotional, and spiritual needs. Care is typically extended to patients’ families as well. In the hospital, clinicians often find patients at a time of crisis or transition in their illness journey. At the same time, patients do not usually stay in the hospital for more than several days, compressing the time available to provide counseling for end-of-life issues. Yet, valuable and meaningful counseling can be performed in this short interval, often precipitating a variety of ethical and legal concerns for clinicians.

CASE 1:

“Ruth” was a 59-year-old woman who drove a school bus until about 18 months ago when she was diagnosed with amyotrophic lateral sclerosis (ALS or “Lou Gehrig’s disease”)—a neuromuscular disorder that causes progressive weakness, eventually robbing the afflicted of the ability to swallow and breathe. Ruth had been admitted to the hospital four times in the past 6 months for infections and altered mental status caused by retention of carbon dioxide in the blood, which is a consequence of weakness in the breathing muscles. She was confined to bed and unable to speak or swallow on her own. She received artificial feeding through a gastrostomy (stomach) tube, and she required noninvasive assistance breathing by wearing a tight fitting “positive air pressure” mask 24 hours a day. She could, however, still write.

In conversation with multiple physicians, Ruth had consistently expressed her preference not to receive cardiopulmonary resuscitation (CPR) or invasive mechanical ventilation (intubation). However, Ruth’s husband had indicated that he would not honor these wishes and instead do whatever he could to keep her alive as long as possible. Ruth and her husband had two adult children living out of state.
As stated in the American Counseling Association’s (2005) Code of Ethics, counselors should work to “enable clients to exercise the highest degree of self-determination possible” (p. 5). Preserving and promoting a patient’s self-determination is a fundamental aspect of ethical care at end of life. The ethical norm of respecting a patient’s right to self-determination is often expressed as the principle of autonomy (Beauchamp & Childress, 2008). Simply put, when a person enters into a therapeutic relationship, she retains the right to determine what is done to her and for her. Respect for autonomy is fundamental to Western biomedical ethics, and is the basis for practices such as obtaining informed consent for treatment and employing advance directives. Accelerated by the exposure of unscrupulous human subjects research and by prominent court cases asserting patients’ rights to determine their own medical care, the discipline of bioethics emerged, in the United States at least, as a way to extend and protect the rights of patients (Jonsen, 1998; Rothman, 1991). It is worth bearing in mind, however, that people from non-Western cultures may value autonomy differently; for example, placing more value on the individual’s role within the family or community than on the individual’s personal interests.

Though the principle of respecting patients’ self-determination is now firmly entrenched in medical ethics and in American case law, the reality of making treatment decisions for individual patients can get complicated. Not every patient is able or willing to make her own decisions. Often the first step is to determine if the patient has the capacity to make the decision being considered. Capacity is not the same as competence, the latter being a legal determination that can only be made by a judge or jury. Capacity has four components: understanding the medical condition; understanding the proposed treatment or test including the risks, benefits, and alternatives; using reason to make a decision; and communicating his or her decision (Miller & Marin, 2000; Sessums, Zembrzuska, & Jackson, 2011).

Capacity is task relative. In other words, a patient may have the ability to make some decisions but not others. For example, a patient might be able to decide if she wants medicine to ease her pain, but may not be able to make
the more complex decision about whether to undergo surgery to repair an aortic aneurysm. Because a person’s capacity can change over time, it is important to evaluate capacity at the time each decision is to be made. Furthermore, one should avoid making generalized or blanket statements about a patient’s lack of decision-making capacity, which risk limiting the person’s ability to make whatever decisions she can. Capacity assessments can take a long time, and often require extended interviews. Unfortunately, the contemporary health care system often does not allow sufficient time to fully evaluate a patient’s capacity to make decisions. A clinician in a counseling role who has come to know the patient well can often provide valuable information to the medical team regarding capacity.

**CASE 1: (continued)**

In Ruth’s case, it was clear that she had the capacity to decide to forego CPR and invasive ventilation. She had consistently expressed this preference over time. In her case, the assessment was tedious because she was very fatigued and could communicate only by writing. Her husband was not present during the assessment. The team first validated Ruth’s decision and then explored with her what could happen when she is no longer able to communicate her wishes. Such a situation was foreseeable and inevitable. If her husband were present to demand CPR and intubation, it is likely that Ruth’s wishes would be overruled. Of note, the palliative care physician felt Ruth would likely die within days. This short time frame, coupled with Ruth’s husband’s infrequent presence at the hospital, made it unlikely the team would be able to adequately address his concerns regarding Ruth’s decision. It was imperative, therefore, to empower Ruth to take steps to protect herself from receiving undesired medical interventions.

Any patient can defer end-of-life medical decision making to someone else. Some patients prefer that their family members make decisions on their behalf, including people from non-Western cultures. If a patient lacks the capacity to make a decision, most states have laws directing decision-making authority to pass down a hierarchy of individuals related to the patient. The list may vary by jurisdiction, but usually consists of the patient’s spouse (but usually not unmarried life partners), adult children, parents, siblings, and available next of kin. In Ruth’s case, when she became incapacitated, her husband would have the legal right to make decisions on her behalf. If he were unavailable or unwilling to do so, authority would have passed to the majority of her adult children.

There were several options for helping protect Ruth’s self-determination. It is important to know what tools are available in the
practitioner’s jurisdiction. For example, many states now have POLST (Physician Orders for Life-Sustaining Treatment) or a similar program. Such programs allow physicians to write orders for end-of-life care based on the patient’s wishes. These orders can accompany the patient to different health care facilities and so carry authority at home, in the hospital, or at a nursing facility without having to be reissued.

In Ruth’s jurisdiction, such a program did not exist. Instead, two other legally recognized tools were available from the category of advance directives: directive to physicians and medical power of attorney (MPOA). Basically, with a directive to physicians, the patient states what treatments she does or does not want if diagnosed with a terminal illness. Unfortunately, many clinicians find such directives unhelpful, and they are often overruled by a proxy decision maker (Silveira, Kim, & Langa, 2010). An MPOA can be useful because it allows the patient to appoint a person of her choosing to make decisions on her behalf.

CASE 1: (continued)

Given that Ruth’s husband had expressed an unwillingness to follow her wishes, we discussed an MPOA appointing someone else to make the decisions, effectively removing decision-making authority from her husband. Ruth wanted her daughter to decide stating, “She agrees with me.” Further complicating matters, Ruth insisted that no one tell her husband of the MPOA. Within a few days of completing her MPOA, Ruth died peacefully one night in the hospital while her husband was at home. Staff notified her daughter by phone when Ruth was close to death, and her daughter asked that Ruth be allowed to die according to her wishes, without CPR or intubation.

Ruth’s case demonstrates both the importance of and the difficulties involved in protecting a patient’s self-determination. Ruth’s request to forego CPR and intubation was difficult for her husband to accept and, ideally, the palliative care team would have helped him address his concerns. The first priority, however, was to protect Ruth’s self-determination. Also, it is notable that Ruth’s decision was easily accepted by her medical team. In fact, it was the recommendation of Ruth’s physicians that she not have CPR or intubation as these interventions would have provided minimal benefit and considerable burden. Jones and Holden (2004) explained how medical providers are less likely to question a patient’s capacity for decision making when the patient’s preferences correspond with the providers’ views. So, providing palliative care is not always so easy, especially when patients or their families request interventions against the advice and judgment of the medical team.
CASE 2:

“Mattie” was an 81-year-old African American woman who came to the hospital because of weakness and shortness of breath. Previously, she had been living alone in a rural community and performing independently all of her activities of daily living (ADLs). She was involved in her local church and often cooked for large gatherings. Her husband and children had died years before, and her only blood relative was a granddaughter whom Mattie had raised and who still lived nearby.

At the time of her hospital admission, Mattie was diagnosed with aplastic anemia resulting in severe pancytopenia (low amounts of blood cells and platelets). No treatment was available to reverse the disorder, and a consulting hematologist recommended that Mattie return home with hospice services. But Mattie declined the recommendation and wanted “everything” done. She required almost daily transfusions of blood and platelets and would have been unable to survive long without them. Because her white blood cell counts were so low leaving her vulnerable to infection, anyone entering her room was required to wear a mask.

Both the consulting hematologist and her primary medical team expressed frustration with Mattie’s insistence that “everything” be done. Given that she was frail and prone to bleeding, they thought it would be harmful for her to undergo CPR, but she would not agree to have a “do not resuscitate” (DNR) order. Based on what staff believed were irrational decisions, and based on Mattie’s habit of abruptly cutting off conversation without much discussion, her physicians were uncertain whether she fully understood her condition and wondered if she had dementia. The palliative care team was consulted to speak with the granddaughter to “convince her” to take Mattie home with hospice care. Her attending physician even considered calling the hospital ethics committee for advice on whether her treatment should be considered futile and therefore could be discontinued.

After obtaining Mattie’s permission, the palliative care team met with the granddaughter, who stated she understood her grandmother’s condition was irreversible and terminal despite all available treatments. The granddaughter was willing to care for Mattie at home until she died and agreed that CPR should not be attempted. She also insisted that Mattie was “in her right mind” and should be allowed to make her own decisions. Mattie’s granddaughter agreed to speak further with her grandmother about the staff’s concerns.

The palliative care team then met with Mattie and her granddaughter together, employing common techniques of effective communication, including open-ended questions such as “What have the doctors told you so far about your condition?” and “What would you say is most important to you at this point in your life?” (Back, Arnold,
It seemed as though Mattie was insisting on treatments that her medical team thought inappropriate, and even futile. Ethically and legally, medical personnel are not obligated to provide futile treatments, even if a patient wants them (Jonsen, Siegler, & Winslade, 2010). But it can be difficult to determine when a treatment is futile, and physicians are often reluctant to withhold treatment that an otherwise rational patient requests. Further, there is no single, universally accepted definition of futility. One commonly accepted definition of medical futility is when an intervention will not advance the achievement of a particular goal (Kasman, 2004). Others define futility more broadly, as when an intervention has no reasonable chance of benefiting the patient (Schneiderman, 2011). Additionally, patients and their medical teams sometimes have different goals. Therefore, medical teams may call a treatment futile when it fails to achieve their goals.

When questions of treatment futility arise near the end of life, such as with the continuation of life-sustaining interventions when recovery is impossible, it is important to know statutory law in that jurisdiction. In Mattie’s state, a hospital ethics committee can determine that treatment is futile. If so determined, the hospital, along with the patient or her proxy, then has 10 days to arrange transfer to another facility before the treatment can be discontinued by the hospital. Conspicuously, the statute does not contain a definition of futility, so the process is almost always adversarial and protracted. It may also be helpful to involve the facility’s ethics committee, legal department, and risk management advisors.

Initiating a futility proceeding with a hospital ethics committee is not the only approach to a patient who wants “everything” done. In such cases, it is imperative to explore what is meant by “everything.” Patients are not usually demanding that any and all conceivable interventions be performed. A patient might in fact want everything that will facilitate going home, or being comfortable, or living until a grandchild is born. Furthermore, the patient may be expressing fear of abandonment or of anticipated suffering, or distrust of the medical system. Such thoughts and feelings can only be elicited by engaging the patient in a discussion of what is important to her. Quill, Arnold, and Back (2009) proposed a six-step approach for patients who want “everything,” the purpose of which is to partner with the patient in achieving identified goals. A constructive approach must surely begin by trying to elicit the patient’s goals and values.

In the case of Mattie, the problem was that she did not want to engage in such a discussion. There is some evidence that her reaction to the medical
team may have been culturally based. Research supports the notion that
different ethnic or racial groups may approach end-of-life decisions dif-
ferently. For example, African Americans tend to prefer the use of life
support and eschew advance care planning (Kwak & Haley, 2005), while
having lower rates of utilizing of hospice services (Washington, Bickel-
Swenson, & Stephens, 2008). African Americans may also be more likely
to use spirituality to cope with illness and death (True et al., 2005). Specific
spiritual beliefs may influence treatment preferences among African Amer-
icans, such as a belief that the physician is God’s instrument, only God can
decide life and death, and divine intervention and miracles do occur
(Johnson, Elbert-Avila, & Tulsky, 2005). Indeed, patients who strongly
believe in deferring to God’s will tend to prefer life-prolonging measures
when presented with a poor prognosis (Winter, Dennis, & Parker, 2009).

In Mattie’s case, it is also possible that she had previously experienced
discrimination and medical mistreatment so that her behavior reflected mis-
trust of the medical establishment and a mechanism to protect her from
unfair treatment (Kwak & Haley, 2005). Generalizations based on culture,
race, or other personal characteristics are always tenuous and should be
viewed skeptically. Because high-quality and ethical end-of-life care requires
a degree of cultural competence, clinicians should always strive to be sensi-
tive to their own and their patients’ cultural preferences and biases, while
avoiding making assumptions about an individual patient based on culture.

CASE 2: (continued)

Mattie had expressed belief that her situation was “in God’s hands” and
that she wanted “everything” done. Rather than being clear statements
of treatment preferences, her statements were interpreted as a starting
point for discussion. But after Mattie declined to speak further with the
palliative care team, the team did not visit her for the next couple of days
but remained in touch with her granddaughter. Unfortunately during
this time, Mattie and her granddaughter developed an adversarial
relationship with Mattie’s attending physician, perceiving him to be
condescending and belligerent. The palliative care team then met again
with Mattie.

A different approach was taken this time. For one thing, Mattie was
dying. The blood and platelet transfusions on which she was dependent
were of diminishing effectiveness and she had developed transfusion
reactions making additional transfusions risky. Contracting an infection
had become a negligible concern so the palliative care team entered
Mattie’s room without masks and knelt by her bed. No attempt was made
to draw her out and elicit her understanding of her condition or her
concerns and goals. She had made it clear she did not want to participate
in such discussions. Her medical situation was explained and she said
she understood. The palliative care physician recommended a change in
tactics—treat her symptoms but discontinue transfusions. It was stated clearly that Mattie was near the end of her life, which was regrettable, but CPR would not be performed when she died because it would not help her. Mattie looked at the team and said that sounded alright to her. A plan exclusively for comfort care was ordered. Mattie died peacefully and comfortably several days later with her family at her side.

At first blush, it may not seem like much counseling took place with Mattie. Though she was in the hospital for almost 2 weeks, she never engaged in a traditional counseling session. One of the lessons to be learned from Mattie is the need to tailor practice and techniques to the individual patient. Mattie neither wanted nor needed extensive counseling. It might be assumed that anyone facing death must have myriad existential and spiritual concerns to work out before death or that the dying person must need help to find meaning in dying. Many people do need these things, of course, but not everyone does. It seems what Mattie needed most of all was to remain in control of her life and her death, and to resist being drawn into others’ notions of what was right for her. The palliative care team was privileged to play a part in Mattie’s dying, but in the end they were just along for the ride.

OUTPATIENT END-OF-LIFE COUNSELING

Clients/families come to end-of-life counseling in outpatient or ambulatory treatment settings via three main avenues: current clients who develop a terminal condition during the course of ongoing psychotherapy/counseling, clients who enter mental health treatment specifically because they have been diagnosed with a terminal illness, and hospice patients who seek counseling during the trajectory of their decline. In the following case study, the patient came to psychological treatment after a diagnosis of terminal cancer.

Consistent with standards established by the American Counseling Association (ACA, 2005), resolving ethical dilemmas requires “… a credible model of decision making that can bear public scrutiny and its application” (p. 3). In what follows, the authors utilize the Five P Model for ethical decision making formulated by Gamino and Ritter (2009). Case analysis emphasizes challenges to confidentiality including postmortem disclosures, boundary maintenance in light of multiple relationships, and the role of transference/counter-transference.

CASE 3:

“Ronnie” was a 50ish White male referred for outpatient psychotherapy because of depression related to a diagnosis of advanced (stage IV) prostate cancer discovered 3 years previously. He had radical
prostatectomy (i.e., removal of his prostate gland), but did not qualify for chemotherapy. Following his surgery, he became despondent and distant—trying to separate himself from his family so that it would not be so hard on them when he died.

Ronnie had a checkered past. His natural father was never in the picture and his mother remarried a stepfather who physically abused Ronnie. Furthermore, Ronnie considered himself to be a sex addict, treated women as conquests, and flaunted the notion of fidelity. He married and divorced seven times, the last two times to the same woman. She was the mother of his only natural children—fraternal twins—a boy and a girl, age 12. Following Ronnie’s last divorce, his daughter went to live with her mother and became estranged from him. Meanwhile, his son was living with him but, when the common authority conflicts of adolescence arose, the son also went to live with his mother and likewise became estranged.

Initially, the psychotherapy focused on Ronnie’s depression over his multiple losses: his health, his sexual potency, his career in the Marines and law enforcement, and his family. Two years after cancer surgery, he had a life-changing religious conversion and came to believe that “God allowed [him] to have the prostate cancer to solve the problem” (i.e., sexual addiction). From that point forward, he made it his life’s work to “tell people about the Lord.” Eight years after his initial cancer diagnosis, and after 5 years in psychotherapy, Ronnie’s cancer recurred aggressively and his oncologist gave him a revised prognosis of “weeks to months.” Experimental chemotherapy had little effect on his tumor.

At this point, the nature of the psychotherapy changed from addressing family problems to helping Ronnie prepare for death. Specifically, the clinician prodded him to write letters of love and affirmation to his two children in the event that they did not find a way to reconcile. After months of defensive procrastination, he produced two eloquent, loving letters that conveyed unwavering support and deep affection for his children. The clinician asked for and retained copies of these letters, together with appropriately executed releases of information, allowing the clinician to convey the letters to his children in the future if they had not already received them.

Over time, Ronnie developed a tremendous fondness for the clinician and, in the uninhibited style of those who realize they are approaching death, would often exploit the parting handshake to announce in a loud voice before support staff and even other patients, “I love you, Doc!” The nature and duration of the psychotherapeutic relationship made the patient someone who was “difficult to forget.”

Ronnie agreed to videotape one of his psychotherapy visits during which he told a very poignant story of encountering a former nemesis from work after he had been diagnosed with cancer. Even though the bump-in occurred in a retail store, Ronnie barked out the other man’s name to get his attention and then proceeded to apologize for his
obstinate behavior that was so much to blame for their enmity. The other man accepted his apology and they became good friends from that point.

The clinician was so impressed with this story of reconciliation that he asked Ronnie to “tell his story” at a monthly men’s prayer breakfast at the clinician’s local church. The patient eagerly accepted, partly as a favor to his beloved doctor but primarily because the invitation afforded him a platform for delivering a message of Christian love. By the time the breakfast could be scheduled, Ronnie was too sick to speak in person. However, he signed a release for the clinician to relate a synopsis of his conversion story and show an edited videotape. The response from the men in attendance was overwhelmingly positive, which Ronnie found very gratifying.

As Ronnie’s medical situation deteriorated, hospice care was recommended by the oncologist but he resisted that option as “giving up” and sought the clinician’s opinion. When the clinician supported transition to hospice, Ronnie finally agreed and the clinician offered to continue psychotherapy via home visits.

Approximately 1 week later, a family friend notified the clinician that Ronnie was dying. The clinician arrived at the residence just a few minutes after he died. The clinician joined in a bedside prayer led by the hospice chaplain and offered condolences to the patient’s mother whom the clinician had met several times in the hospital.

The family asked the clinician to deliver one of three eulogies at the funeral because, "You knew him in a way other people didn’t.” In the clinician’s remarks, Ronnie’s status as a psychotherapy patient was revealed and his general character was described but no details of the treatment were disclosed. The family subsequently asked for a written copy of the eulogy.

Ronnie’s two children were in attendance at the funeral. The clinician carried in a pocket the two letters from Ronnie to his twins. In the receiving line after the service, the clinician mentioned the letters to the twins who both said they had never received such a letter. Both indicated they would like to have their letter so the clinician conveyed the letters to them on behalf of Ronnie.

Several months later, the clinician received high school graduation announcements from the patient’s twins. In response, he wrote two congratulatory, affirmative letters declaring that there was no doubt their father was proud of them on this occasion, and that he loved them despite their differences. The clinician’s letters were later acknowledged on standard thank-you cards as if they had been a material gift, and each twin seemed genuinely appreciative.

The Five P Model for ethical decision making (Gamino & Ritter, 2009) provides a conceptual structure for higher order, critical-evaluative reasoning that goes beyond an immediate, intuitive response to a situation based
only on the facts and ordinary moral sense to incorporate knowledge of statutory law, practice regulations, codes of conduct, and ethical principles (Kitchener, 1984). The Five P Model takes into account the person with a challenging ethical problem in a particular contextual place, while applying appropriate ethical principles in a deliberate decision-making process.

Person

Who is this person? Ronnie is a middle-aged White male dying of prostate cancer. Formerly “tough” and controlling in his work and personal habits, he came to prize his Christian beliefs as his primary identity and adopted evangelization as his life purpose. Nonetheless, his family relationships with his ex-wife and two children were fractured to the point of estrangement so that his elderly mother was his chief supporter. He developed a close bond with his treating clinician. His “acceptance” of the dying process was mixed and some degree of denial was present in his pursuit of experimental chemotherapy and resistance to hospice.

Problem

What is the specific ethical challenge to be resolved? Actually, three main ethical problems emerge from the case scenario. First, the problems pertaining to confidentiality are prominent throughout the trajectory of care, and after death. To what extent is Ronnie’s family, especially his mother, privy to the details of his treatment or involved in decisions regarding chemotherapy or hospice? What about revealing Ronnie’s status as a psychotherapy patient at the prayer breakfast and again at his funeral? Can information from the treatment be revealed to participants at the prayer breakfast, to sympathizers hearing the eulogy, or to the children in the letters from the clinician? Is there any justification for these various disclosures? What are appropriate guidelines regarding postmortem disclosures?

Second, the clinician’s behavior raises questions about appropriate boundaries as a consequence of multiple relationships. Besides the formal provider–client relationship, the clinician simultaneously took on two other less formal relationships: a “social” one engendered by the invitation to the prayer breakfast that implied status for the client as a peer/friend; and a “personal” one inherent in accepting an invitation to eulogize the client at his funeral (along with two other work associates of the patient). Do these boundary crossings pose either potential harm to Ronnie or impair the clinician’s objectivity/neutrality in discharging the functions of the professional role? Did Ronnie have free choice to decline the speaking
invitation without affecting his access to continuing treatment? Did the provider inappropriately take advantage of the therapeutic relationship to “further” a personal (religious) agenda?

Third, transference-counter-transference dynamics, if unacknowledged or misunderstood, can cloud the clinician’s ability to exercise sound judgment about Ronnie’s case. Is the clinician always acting in the best interest of the client guided by core values of beneficence and fidelity, or is the clinician “acting out” a camouflaged personal agenda of attention-seeking or over-identification with the client? Were transference-counter-transference issues thoroughly addressed in the psychotherapeutic encounter so as to minimize or eliminate such problems?

Place

Initially, the grief counseling took place in a traditional office setting wherein the provider was largely in control and the patient was like a “guest.” Stringent confidentiality standards existed to protect the patient’s health information and demand characteristics of the office environment reinforced conventional provider–client boundaries.

However, the action in this case shifted at one point from an outpatient office to a community setting (i.e., church fellowship hall) and later to a hospital. These alternate settings strongly influence how the provider protects client confidentiality, maintains boundaries, and manages the interpersonal dynamics of the provider–client relationship. For example, in community settings, it is entirely at the client’s discretion whether status as a client of the provider, or any other information about treatment, will be disclosed; the provider follows the client’s lead. In hospitals, confidentiality is strictly enforced but, given that the hospital room is the patient’s “temporary domicile” and/or the fact that the patient’s ability to care for self is compromised, family and guests in attendance often participate in evaluations and receive information directly from hospital staff (cf., Gamino & Ritter, 2009).

Beyond these physical designations of place, the end-of-life period may be considered a metaphorical “place” at the terminus of the lifespan with its own unique rules governing ethical behavior. For example, current palliative care standards identify the family as the “unit of care” (National Quality Forum, 2006), so dealing with the family network is essential and that may include routine sharing of information with loved ones. Also, physical contact between provider and client—and between provider and family members—at the end of life may involve physical proximity or touch not otherwise typical. Reconsiderations of such traditional provider–client boundaries when counseling near the end of life are displayed in Table 1.1.
The principles that guide ethical decision making near the end of life include not only the traditional quintet of ethical principles—nonmaleficence, beneficence, autonomy, justice, and fidelity (Kitchener, 1984)—but also federal standards, statutory law, case law, practice regulations, and professional codes of ethics. Each of the three ethical challenges posed by the case example draws on different aspects of these factors in order to resolve the dilemma.

Confidentiality, a cornerstone of health care and end-of-life counseling, is based on the ethical principle of fidelity. A fiduciary relationship between provider and client means telling the truth, proving oneself trustworthy with confidences, exercising loyalty to the client, acting with integrity, taking responsibility, and advocating for the client when necessary and appropriate. Fidelity implies that the provider will act in the best interest of the client (i.e., beneficence) and avoid actions or measures that may harm the client (i.e., nonmaleficence). Fidelity flatly prohibits disclosing client health information with family and loved ones, especially when client’s consciousness is compromised.
information or pre-empting the client’s prerogative to disclose (or not), barring certain exceptional circumstances such as imminent danger to self or others.

The prospect of postmortem disclosures presents a unique challenge to confidentiality. It is important to remember that a deceased person’s right to confidentiality does not expire at death. The ACA Code of Ethics (2005) directly addresses this topic, “Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies” (p. 8). Families may request a deceased client’s medical record, for example, seeking information about the care or the cause of death. Recognizing that physicians need guidance about how to handle such situations, the American Medical Association (AMA) Council on Ethical and Judicial Affairs (2000) urged that a deceased person’s medical record be kept confidential to the greatest extent possible and provided guidelines for a judicious approach to such disclosures. Berg (2001) wrote a detailed assessment of conditions that may justify postmortem disclosure of client information. However, Werth, Burke, and Bardash (2002) warned that the public’s trust in the enterprise of psychotherapy as a confidential endeavor may be undermined if patients fear that their personal disclosures may one day be revealed after their deaths. Some major considerations to follow when contemplating postmortem disclosure are summarized in Table 1.2.

The boundary issues embedded in the case example arise in large part from the clinician’s decisions to assume some degree of personal relationship with Ronnie and his family beyond the confines of a strictly professional stance. Taking on an additional personal or professional association in addition to the original provider–client dyad is referred to as multiple relationships. The Code of Ethics of the Association for Death Education and Counseling (ADEC, 2006) contains a clear provision on why assuming multiple relationships is risky:

Members refrain from multiple relationships if (1) such relationships could reasonably be expected to impair the objectivity, competence, or effectiveness of the member in performing his/her responsibilities; or if (2) such relationships otherwise risk exploitation or harm to the person(s) with whom the professional relationship exists or formerly existed. (ADEC Code of Ethics, II. General Conduct G)

Maintaining objectivity and impartial judgment toward the client pertains primarily to the principle of fidelity. Avoiding exploitation or harm to the client is the personification of nonmaleficence as an ethical principle. Instances of boundary crossings, such as occurred in the case example with the invitation to speak at the prayer breakfast, involve a deliberate decision by the counselor to cross a customary division or separation of roles in order to achieve something helpful or beneficial to the client that
may not occur otherwise (cf., Welfel, 2006). In doing so, the counselor must be very vigilant that personal agendas do not hitchhike on the purported goal of helping the client. This injunction is clearly stated in the ADEC (2006) Code of Ethics, “Members do not use their professional relationships to further their personal, political, religious, or business interests” (ADEC Code of Ethics, II. General Conduct E). Because purity of motive is so rare in boundary crossings, Simon and Williams (1999) suggest providers ask themselves, “Am I making this intervention or taking this action for the benefit of the [client’s] treatment or for my own personal benefit?” (p. 1441).

Gottlieb (1993) offered a decision-making tool for professionals contemplating whether to assume a second (or third) association with a client. In considering multiple relationships prospectively, Gottlieb encouraged providers to assess the current relationship with the client along three dimensions: degree of power the provider exerts in relation to the client;
duration of relationship, with longer relationships implying more influence; and clarity of termination, referring to the likelihood of the provider and client having further professional contact. Then, these same considerations are applied to the contemplated relationship. When the counselor’s power and influence are high, the duration of the relationship has been or will be lengthy, and termination is ambiguous, multiple relationships should be avoided.

Giving primacy to client welfare should always be evaluated from the perspective of the client (Gottlieb, 1993). Nowhere is this evaluation trickier than when accounting for the roles of therapeutic transference and counter-transference in the counseling dynamic. Katz (2006b) warns providers counseling clients nearing the end of life about striking a delicate balance between maintaining a professional perspective as provider and “being present” in a human manner to share the profound vulnerability of the dying process with a client. Her advice is reminiscent of Karl Menniger’s oft-quoted dictum, “When in doubt, be human” (Gutheil & Gabbard, 1998, p. 413). The sacred and mysterious aspects of dying create untold elements of ambiguity for providers traversing such delicate emotional territory. Death competence and accurate self-awareness on the part of providers is so crucial in these circumstances that its importance is difficult to overstate. The ADEC (2006) Code of Ethics contains a key provision regarding such self-knowledge among providers, “The member strives to understand his or her death-related feelings and experiences and the ways in which these may impact his or her thinking and work in the field” (ADEC Code of Ethics, Basic Tenets 2).

Process

Having reviewed the ethical principles most applicable to the dilemmas inherent in the case example as well as some of the key statutory and practice-specific guidelines available, the final step in the Five P Model is the process used in resolving the identified dilemmas related to confidentiality, boundaries, and transference/counter-transference. Ideally, the process respects all significant stakeholders in the dilemmas and allows all pertinent “voices” to be heard when deliberating a decision.

Regarding confidentiality, Ronnie was clearly “in charge” of his health information in the early stages of the case example and permitted his mother to be included in some discussions of his care status. Although this assurance of confidentiality became a bit more ambiguous in the hospital setting when his mother was present at the time of the clinician’s visits, it was a relatively simple matter for the clinician to ask for some time alone with Ronnie, or to clarify if he wanted/needed the consultation to be private or “communal.” Such an approach kept Ronnie in charge of any disclosures.
The use of the Ronnie’s image/voice (via videotape) and basic case information at the prayer breakfast constituted a clear departure from the usual type of information release (e.g., transmission from one health care provider to another). In that instance, the recipients of the information were congregation members of a specific church. When the plan was for Ronnie to present his “story” in person, he retained complete prerogative to share whatever information about himself that he wished. However, once Ronnie was unable to speak in person, the clinician obtained written permission to disclose treatment information at the breakfast. A formal release document notwithstanding, deciding how much to disclose required sensitivity and judgment on the part of the clinician to avoid bringing any harm to Ronnie as a result (e.g., sullied reputation) or unnecessarily conveying any other “protected health information” (Health Insurance Portability and Accountability Act, 1996).

Similarly, the clinician had Ronnie’s written permission to convey his affirmation letters to the children—permission he gave knowing full well it was the clinician’s belief that the children should receive them. Technically, according to statutory law in the jurisdiction of record (e.g., Texas), only Ronnie’s personal representative could authorize disclosure of the letters to the children after his death (Texas Rules of Evidence, 1998; Vernon’s Texas Codes Annotated, 1998). Clearly, the clinician preempted this line of authority. By operating according to Ronnie’s declared “pre-mortem” intentions that his children receive the letters (see Table 1.2), the clinician could argue that the “spirit of the law” guided the decision because the clinician was carrying out Ronnie’s (autonomous) intent (cf. Werth et al., 2002). The clinician acknowledged that delivery of these letters felt like a posthumous “mission accomplished” of therapy work urging Ronnie to seek reconciliation with his children as part of “the four things that matter most” near the end of life (Byock, 2004).

Delivering a eulogy at the funeral de facto revealed Ronnie’s status as a psychotherapy patient and included insights into his character acquired through the treatment. Again, understanding Ronnie’s wishes regarding postmortem disclosure was a major consideration. The clinician reasoned that Ronnie would be more than happy to reveal to anyone that he was in therapy if he thought it might “help someone else get to heaven.” Because the family invited the clinician to give a eulogy, their request implied the prospect of receiving comfort from the provider’s remarks. To the extent that Ronnie’s family and others would be helped by the clinician’s eulogy, the standard of beneficence as a rationale for postmortem disclosure could be invoked. At the same time, guarding against a mere satying of curiosity by others about Ronnie’s treatment demanded selectiveness (i.e., fidelity), and avoiding references to family conflicts ensured a minimum of risk to the family’s or Ronnie’s reputations (i.e., nonmaleficence).
Likewise, when the clinician subsequently received graduation announcements from the patient’s children, competing considerations came into play. Above all, protecting confidentiality was still required. Yet ordinary rules of social courtesy call for a response to written invitations. By writing letters of congratulations that reiterated the patient’s pride in his children, the provider adopted a type of proxy position by speaking words on behalf of the patient that he could no longer deliver himself. Again, the potential “gain” in helping the children seemed to be the strongest argument for writing while any possible postmortem harm to the patient seemed negligible. In the end, a simple act of human kindness appeared to be the proper response.

In regard to crossing traditional boundaries by inviting Ronnie to speak at the church prayer breakfast, one question was whether this action was therapeutic or exploitative. The invitation could be seen as giving a dying man an otherwise unavailable opportunity to “witness” to fellow Christians about how cancer changed his life in a positive way, thereby affording him a chance to find meaning in his suffering, practice altruism, and generate a positive outcome from a negative life event—all consistent with Ronnie’s self-professed evangelical mission. Yet embedded in the invitation was an alteration in the dynamic of the provider–client relationship brought about by introducing a peer association as fellow believers.

This “softening” of the formal boundaries in the context of end-of-life counseling (see Table 1.1) was judged to be less worrisome in light of it being a single event and in consideration of the impending, final termination of the treatment relationship at death (cf., Gottlieb, 1993). The clinician discussed with Ronnie possible “collateral consequences” of presenting at the prayer breakfast, for example, enhanced status for the provider because of recruiting a speaker, displaying a successful example of professional work, and being admired by the client. Ronnie perceived the invitation as an honor and an “obligation” not to the provider, but to his “Higher Power.” From Ronnie’s perspective, if presenting made his doctor “look good” in the process that was merely well-deserved recognition incidental to the real purpose of witnessing about his faith beliefs. He did not feel exploited but rather grateful for the opportunity.

However at another level, the invitation to the prayer breakfast brought up the issue of counter-transference and the need for self-awareness (Katz, 2006a). Mulling over this invitation beforehand required the clinician to consider the role of several possibilities: over-determined helping (i.e., doing more than what was professionally indicated), over-identification with the client (i.e., sharing a faith life), over-involvement with the client (i.e., enacting friendship), or unfilled needs of the provider (i.e., enhancing status in the church community). In the end, the decision was influenced somewhat by the “small town” setting where overlapping relationships tend to be more common and more tolerated (Gripton & Valentich, 2004).
and fidelity is maintained by compartmentalizing roles, not relationships (Barnett & Yutrzenka, 1994). In retrospect, the clinician acknowledged that utilizing peer consultation prior to extending this invitation may have been a helpful way to assure “stereoscopic” accuracy regarding several possible interior motivations (cf., Gamino & Ritter, 2009).

The request by Ronnie’s family for the provider to deliver a eulogy at the funeral involved counter-transference elements as well. In this case, even though the clinician did not seek out this invitation, it nonetheless tapped into unexpressed interior aspirations to “preach” (even though ministry had not been chosen as a life vocation). Accordingly, the clinician weighed whether accepting was more about meeting the family’s apparent need or gratifying a personal desire. Asking what Ronnie would have wanted was a critical consideration and the answer to that question clearly seemed to be affirmative (i.e., he would have readily endorsed the idea as a good one). Thus, accommodating the family’s wishes and inferring Ronnie’s preferences constituted the primary reasons why the invitation was accepted—to accomplish something beneficial for the family as the “unit of care”—while the clinician’s personal aspiration remained an (undisclosed) secondary factor.

**CONCLUSION**

The case examples detailed in this chapter illustrate some of the key ethical issues that arise in counseling clients nearing the end of life. In hospital settings, autonomy over treatment preferences and end-of-life decision making is paramount. Treating the family as the unit of care in palliative care is important. Delivering clinical care in concert with adherence to legal and ethical considerations can be tricky. In hospice or clinic settings, issues pertaining to confidentiality and boundaries require special attention. In all cases, the counselor must be well aware of the operation of transference and counter-transference forces that may influence the nature and course of the provider–client interaction in salutary or deleterious ways while at all times maintaining client welfare as the highest priority.

**REFERENCES**


1. Ethical Challenges When Counseling Clients Nearing the End of Life


Vernon’s Texas Codes Annotated, Occupations Code §159.005 (a)(5), Consent for Release of Confidential Information. (1998).


