CODE OF ETHICS

INTRODUCTION

The following is a code established to set minimum standards as guidelines for the ethical behaviour and conduct of Members in their practice.

ETHICAL PRINCIPLES

1. Members respect the essential humanity, worth and dignity of all people and promote this value in their work.

2. Members recognise and respect diversity among people and oppose discrimination and oppressive behaviour.

3. Members respect the privacy of their clients and preserve the confidentiality of information acquired in the course of their work.

4. Members protect the rights of their clients, including the right to informed consent.

5. Members take steps to maintain and develop the highest standard of professional competence and integrity in the application of hypnotherapeutic knowledge and techniques throughout their professional careers.

6. Members abide by the laws of the society in which they practise.

ETHICAL RESPONSIBILITIES

1. Responsibilities to the Client

(i) Members take all reasonable steps to avoid harm to the client as a result of the therapeutic process.

(ii) Members promote client autonomy and encourage clients to make responsible decisions on their own behalf.

(iii) Members consider the social context of the client and their connections to others.

(iv) Members are responsible for setting and maintaining professional boundaries within the therapeutic relationship.

(v) Members do not have any relationships with clients during and for a period of 2 years after therapy.

2. Exploitation

(i) Members must not exploit clients, past or present, in a financial, sexual, emotional or any other way.

(ii) When publicly advertising hypnotherapy services, the information contained in such announcements shall be factual and explanatory, not claiming superior competence and not offering guarantees or exaggerated claims of a particular outcome as an inducement.

(iii) Members will not accept or offer payments for referrals, or engage in any financial transactions, apart from the ordinary fee charged to clients for interviews.

(iv) Sexual relations between a Member and the client can never be acceptable and constitutes unethical behaviour. This is not restricted to sexual intercourse and includes any form of physical contact, whether initiated by the client or the Hypnotherapist, which has as its purpose any form of sexual gratification, or which may be reasonably construed as having that purpose.

(v) Members should consider that the deeper the involvement with a client's emotional life during therapy, the less likely is the possibility of a subsequent equal relationship following termination of therapy. Members must seek professional supervision should any attempt to build a relationship with a former client be considered.

3. Confidentiality

(i) Members treat with confidence any personal information about clients, whether obtained directly or by inference. This applies to all verbal, written or recorded material produced as a result of the relationship. All records, whether in written or any other form, need to be protected with the strictest of confidence.

(ii) The client must not be observed by anyone other than their therapist without having given informed consent. This applies both to direct observation and to any form of audio or visual transmission or recording.

(iii) Exceptional circumstances may arise which give the therapist good grounds for believing that the client will cause serious physical harm to others or themselves. In such circumstances, the breaking of

confidentiality may be required, preferably with the client's permission, or after consultation with the therapist's supervisor.

(iv) Any breaking of confidentiality should be minimised both by restricting the information conveyed to that which is pertinent to the immediate situation and by limiting it to those persons who can provide the help required by the client.

(v) Agreements about confidentiality continue after the client's death unless there are overriding legal considerations.

(vi) Special care is required when writing about specific therapeutic situations for reports and publication. The author must have the client's informed consent should there be any possibility of identification of the client.

(vii) Members and supervisors are responsible for protecting the client's rights of confidentiality and any shared information should be disguised where appropriate.

4. Contracts

(i) Therapeutic activities are to be undertaken only with professional intent and not casually and/or in extra professional relationships.

(ii) Contracts involving the client should be realistic and clear.

(iii) Any publicity material and all written and oral information should accurately reflect the nature of the service offered and the training, qualifications and relevant experience of the Hypnotherapist.

(iv) Members are responsible for clearly communicating the terms on which therapy is being offered.

(v) Members will disclose any conflict of interest which may arise in relation to a client and will seek supervision to resolve appropriate action which may include referral.

5. Responsibilities to Self as a Therapist

(i) Members have a responsibility to themselves to maintain their own effectiveness, resilience and ability to help clients. They are expected to monitor their own personal functioning and to seek help or withdraw from their therapy practice when their personal resources are sufficiently depleted to require this.

(ii) Members will not continue to practise when their functioning is impaired due to personal or emotional difficulties, illness, alcohol, drugs or for any other reason.

(iii) Members will have regular suitable supervision and will use such supervision to develop their skills as a therapist, monitor performance and provide accountability for their practice.

6. Responsibilities to Other Professionals

(i) Members do not conduct themselves in their practice-related or private activities in any way, which undermines public confidence in either their role as a therapist or in the work of other professionals.

(ii) Members are committed to the ethical code of the Australian Hypnotherapists' Association and breaking such code may lead to withdrawal of membership for unethical practice.

(iii) Members who suspect unethical conduct by other therapists that cannot be resolved or remedied after discussion with the professional concerned should approach the Ethics Committee of the relevant professional body.

(iv) Members do not solicit the clients of other therapists. They have an obligation not to impair the work of their colleagues. Nevertheless, therapists need to be aware of the client's right to seek a second opinion.

7. Responsibilities to the Wider Community

(i) Members work within the law.

(ii) Members take all reasonable steps to be aware of current legislation affecting their work.

(iii) Members are committed to protect the public against incompetence and dishonourable practices and are prepared to challenge these practices by using the appropriate channels and professional bodies for such challenges.

(iv) Members are not to publicly or privately represent a personal point of view or opinion as being that of The Australian Hypnotherapists Association, but only on behalf of their own professional framework as a Hypnotherapist.

8. Complaint Procedure

(i) Complaint procedures are clearly defined in the Association's Articles and on the Associations web site; www.ahahypnotherapy.org.au

Research Ethics

The psychological well-being of the individual subject is always more important than the research itself.

For all practical purposes, a "research subject" should be considered identical with a "client" and accordingly, all relevant Clauses within the general section of the "Code of Ethnics" remain applicable

Members must ensure that informed consent has been obtained prior to the commencement of any research project. This is especially so in the case of Minors or Persons with Special Needs. (N.B. This does not apply where general research of a purely statistical nature is carried out)

Members accept that all participation by subjects must be on a completely voluntary basis and that no pressure of any type should be exerted in order to secure participation

Members maintain complete openness and honesty with regard to both the purpose and nature of the research being conducted

Prior to asking for the subject's consent, Members consider any potential adverse consequences to the subject as a result of any intended research project and take all necessary steps to ensure that the subject will not suffer harm from any such a study.

Confidential data obtained during research studies must never be disclosed in situations or circumstances which might lead to identification of the subject, unless prior consent to the disclosure of such information has been received

Members are not to use a position of authority to place pressure on prospective subjects for the purpose of securing their participation and consent in any research.

Where relevant, Members provide for the ongoing care of participants with regard to any adverse effects that might arise as a consequence of and within a reasonable time period after, their involvement within any research project

Research must be carried out so that bias is not deliberately introduced into the planning, conducting, or reporting of a research study.

Members must give adequate supervision to those who may be assisting them with their research to ensure that AHA ethical principles are not disregarded.

Writing and Publishing Ethics

Members are not to publish as their own something which is essentially not their own work, or to which they have not made a major contribution.

Members are not to try to prevent the publication of a review that is critical of their work.

Guidelines for AHA Members working with clients in contexts in which issues related to false memories of childhood sexual abuse may arise.

Preamble

The following guidelines are intended to apply to AHA members working in all professional contexts in which 'false memories of childhood sexual abuse' issues may arise. It is clearly part of the professional duty of such members to seek to maintain an awareness of the debate about 'recovered memory therapy' and to develop an empirical and professional
perspective on false memory/recovered memories, and base their practice on sound principles and evidence as a counter-balance to the polarised beliefs that currently abound in this emotive area.

As the result of extensive reviews by various professional bodies there is no doubt that child sexual abuse is a serious social and individual problem, commonly with long-

lasting effects. In addition there can be little doubt that at least some recovered memories of Child Sexual Abuse are recollections of historical events. However, there is also genuine cause for concern that some methods of intervention and questioning can lead clients to develop illusory memories or may foster false beliefs concerning Child Sexual Abuse.

AHA Guidelines

1. The welfare and interests of their clients are to be the primary concern of all AHA members. This concern includes the requirement to maintain respect for the client's autonomy and confidentiality, the extent of which should be clarified and agreed to at the outset of the professional engagement.

2. Thus, the AHA strongly cautions against any member becoming involved in any therapy or counselling that focuses on probing for forgotten or repressed memories of child sexual abuse.

3. Members need to be aware that the question of whether traumatic memory is processed, stored and recalled differently from normal memory is currently still unresolved. Unusual, dramatic, powerful or vivid memories, and 'flashback' bodily sensations cannot always be relied upon as evidence of the historical truth or falsity of the memories.

4. However it is important always to take the client who recovers Child Sexual Abuse memories seriously. The first response of members should be to accept that what the client tells them reflects their reality and respect their feelings. Nevertheless the member should draw no conclusions about the historical truth of a memory.

5. Members need to tolerate, and help their client tolerate, uncertainty and ambiguity regarding the client's possible early experience/s, as eventually they may both have to accept that the historical truth cannot be known for certain, and that helping the client to make reasonable sense of their lives is not the same as discovering objective facts.

6. Members need to be alert to a range of possibilities; for example that a memory may be literally/historically true or false, or may be partly true, thematically true or metaphorically true, or may derive from fantasy or dream material. Discovering that some aspects of a 'memory' are displaced, metaphorical, or part of a construction or narrative derived from the therapeutic relationship, should not lead members to immediately discount the rest of that memory. Likewise, the discovery that some aspects of a memory are factually accurate does not imply that the whole content of the memory is factual. It is not really possible to establish whether a memory represents factual events without external corroboration.

7. Whilst it may be part of a member's work to help clients to think about their early experiences they should avoid imposing their own conclusions about what took place in childhood.

8. Members should seek supervision before engaging in activities and techniques that are intended to reveal indications of past sexual abuse of which the client has no memory. Members must be aware that these techniques may make memory more confident but less reliable.

9. If a client wishes to come with the sole purpose of uncovering a Child Sexual Assault memory, the AHA recommends referring him/her to a forensic specialist. Members need to be aware that only those especially trained in this area, know the correct procedures required to deal with this type of request.

10. Members must be alert to the dangers of suggestion. Potential sources of suggestion include subtle cues about the member's attitudes and beliefs that may be inferred from the therapeutic context (e.g. particular books on the shelf) or client contact with 'survivor literature' and subcultures of abuse. Members must be aware that there may be situations in which clients are motivated to recall memories of child sexual abuse for a variety of reasons.

11. When working therapeutically, members must be aware of their inevitable engagement in the client's narrative. Whilst taking care about the implications of active investigation and suggestion, they should not seek to manage these risks simply by refusing to deal with past events and 'work in the present', since this actively denies the client's experience and is unlikely to meet their needs.

12. Members should be clear about the circumstances in which they would feel ethically or legally obliged to breach client/therapist confidentiality. They should carefully assess the risk of self-harm and the risk of abuse to minors. Members should be aware of current child protection guidelines and procedures: http://www.community.nsw.gov.au/documents/caypcapa_act1998.pdf and abide by them. Members should also be aware of their ethical responsibilities to protect others from significant harm.

13. Members are reminded of their ethics for good practice.