



PEARSON NEW INTERNATIONAL EDITION



Ethical, Legal, and Professional Issues  
in Counseling  
Theodore P. Remley   Barbara P. Herlihy  
Fourth Edition

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# Introduction

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# Introduction

## FOCUS QUESTIONS

1. Assuming that you are a moral and responsible person (as are most counselors), why do you think it is important for you to study ethical and legal principles and the decision-making process?
2. What are the differences among legal standards, ethical standards, and best practice?
3. What resources can you use when you need help in resolving an ethical dilemma?
4. How should you get legal advice when a legal issue presents itself?

## PROFESSIONAL ORIENTATION

This chapter is intended primarily for prospective counselors; thus, most readers are likely to be graduate students in counselor education programs. As you, the reader, digest and discuss the material, we hope you will develop a thoughtful understanding of ethical, legal, and professional issues in counseling. These issues, collectively, make up the *professional orientation* content area of your graduate studies. The Council for Accreditation of Counseling and Related Educational Programs (CACREP), an organization that sets standards for counselor preparation and accredits training programs that meet these standards, requires the curriculum for counselors in training to include studies that provide an understanding of professional functioning. These required studies include but are not limited to the history and philosophy of the profession, counselor roles and functions, professional organizations, professional credentialing, advocacy, ethical standards, and applications of ethical and legal considerations (CACREP, 2009).

The National Board for Certified Counselors (NBCC), a voluntary organization that credentials counselors, also requires the counselors it certifies to complete course work in the area of professional orientation to counseling (NBCC, 2011a). If you plan to become licensed as a professional counselor, you should be aware that state counselor licensure boards mandate that licensees demonstrate knowledge of professional orientation issues, which include ethical and legal issues.

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Beyond external requirements, an important part of your professional development as a counselor is to acquire a firm grounding in the area of professional orientation. This content area includes three main components:

- ***Developing a professional identity as a counselor.*** This includes understanding the history and development of counseling and related professions, knowing the professional roles and functions of counselors and how these are similar to and different from other professions, learning about and becoming involved in professional organizations, gaining awareness of counselor preparation standards and credentialing, and knowing how to advocate for your clients and your profession.
- ***Learning about ethics.*** This involves becoming familiar with ethical standards for counselors, understanding the ethical issues that counselors encounter, developing ethical reasoning and decision-making skills, and being able to apply your knowledge and skills in your day-to-day professional activities.
- ***Learning about the law as it applies to counseling.*** This includes being able to distinguish among legal, ethical, and clinical issues; acquiring a basic knowledge of legal issues in counseling and laws that affect the practice of counseling; and knowing what to do when you are faced with a legal problem.

It is essential that you develop a strong professional identity as a counselor during this time in our history when we are still a relatively new profession. Counselors today are constantly being asked questions such as “What kind of counselor are you?” or “Is being a counselor like being a psychologist?” These are legitimate questions, and you must be prepared to clearly explain who you are as a member of a professional group, what you believe, how you are similar to other mental health professionals, and, more importantly, how you are different. You must also be prepared to practice in ways that are ethically and legally sound and that promote the welfare of your clients. Information presented in this chapter will provide you with an understanding of your chosen profession of counseling and will prepare you to practice in an ethical and a legal manner.

We hope that seasoned practitioners, as well as counselors in training, will read this chapter and find it useful. Professional, ethical, and legal standards are constantly changing, and it is important to keep up to date. Also, as Corey, Corey, and Callanan (2011) have pointed out, issues that students and beginning practitioners encounter resurface and take on new meanings at different stages of one’s professional development.

### **Interrelated Concepts: Morality, Values, Ethics, Law, Professionalism, and Best Practice**

The terms *ethics*, *morals*, and *values* are sometimes used interchangeably, and they do have overlapping meanings. All three terms involve judgments about what is good and bad, or right and wrong, and all pertain to the study of human conduct and relationships. Here, however, we define these terms differently. *Moral* actions are determined within a broad context of a culture or society. Thus, it is important to remember that what you view as moral behavior is based on the values you espouse. Values guide individual choices and behaviors, and each of us holds some values more strongly than other values (Strom-Gottfried, 2007). Although your value system is unique to you, it has been influenced by your upbringing, the culture in which you live, and quite possibly your religious beliefs. What is important about your personal values as they relate to professional practice is that you have a high level of self-awareness of your values and how those values may influence your decisions within a counseling relationship.

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The term *moral* is derived from the Latin word “mores,” which means customs or norms. Thus, conduct that you evaluate as moral might be judged as immoral by another person or by people in another society. Although some moral principles, such as “Do no harm to others,” are shared by most civilized groups of people, how these moral principles are interpreted and acted on will vary from culture to culture and from individual to individual within a culture. Thus, when we refer to moral conduct, we ask you to think in terms of your *personal* belief system and how this affects your interactions with others in all aspects of your life.

*Ethics* is a discipline within philosophy that is concerned with human conduct and moral decision making. Mental health professionals have defined ethics as “acceptable or good practice according to agreed-upon rules or standards of practice established by a profession” (Cottone & Tarvydas, 2007, p. 4). Certainly, you have developed your own individual ethical stance that guides you in the ways you treat others, expect them to treat you, and make decisions about what behaviors are good or right for you. Here, however, we think of ethics as it relates to the profession of counseling; that is, ethics refers to conduct judged as good or right for counselors as a professional group. When your fellow professionals have come to sufficient consensus about right behaviors, these behaviors have been codified and have become the ethical standards to which you are expected to adhere in your professional life (American Counseling Association [ACA], *Code of Ethics*, 2005). Therefore, think about ethics as referring to your *professional* behavior and interactions. Keep in mind that ethics must prevail over your personal values when value conflicts arise within a counseling relationship. Because the counseling relationship exists to benefit the client, you must avoid imposing your own values on your clients.

*Law* is different from morality or ethics, even though law, like morality, is created by a society and, like ethics, it is codified. Laws are the agreed-upon rules of a society that set forth the basic principles for living together as a group. Laws can be general or specific regarding both what is required and what is allowed of individuals who form a governmental entity. Criminal laws hold individuals accountable for violating principles of coexistence and are enforced by the government. Civil laws allow members of society to enforce rules of living with each other.

Our view is that there are few conflicts between law and ethics in professional counseling. Keep in mind, though, that there are important differences. Laws dictate the *minimum* standards of behavior that society will tolerate, whereas ethics represent the *ideal* standards expected by the profession. Laws are created by elected officials, enforced by police, and interpreted by judges. Ethics are created by members of the counseling profession and are interpreted and enforced by ethics committees and licensure and certification boards.

Rowley and MacDonald (2001) discussed the differences between law and ethics using concepts of culture and cross-culture. They argued that “law and ethics are based on different understandings of how the world operates” (p. 422). These authors advise you to learn the different culture of law, seek to understand how law operates, and develop collaborative partnerships with attorneys. We agree with the perspective that the cultures of counseling and law are different and that seeking legal advice is often an important step in the practice of counseling.

Where does the notion of *professionalism* fit into the picture? Many factors, including the newness of the counseling profession, the interpersonal nature and complexity of the counseling process, and the wide variety of types of counselors and their work settings, make it essential for counselors to conduct themselves in a professional manner. It is not easy to define what it means to be *professional*. At this point, we note that professionalism has some relationship to legal and ethical behavior and that professionalism is closely related to the concept in a profession of *best practice*. And perhaps the concepts of law, ethics, and best practice in the field of counseling are on a continuum. Legal standards are the minimum that society will tolerate from a professional. Ethical standards

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occupy a middle ground: Some ethical standards prescribe the minimum that other counselors will tolerate from fellow professionals (for example, sexual or romantic relationships with clients are prohibited), and some standards describe ideal practices to which counselors should aspire (for example, counselors aspire to foster meaningful and respectful professional relationships). Best practice is the very best a counselor could be expected to do. Best practice guidelines are intended to provide counselors with goals to which they can aspire, and they are motivational, as distinguished from ethical standards, which are enforceable (Marotta & Watts, 2007).

There is no consensus among counseling professionals about what constitutes best practice, (Marotta, 2000; Marotta & Watts, 2007). However, you will want to strive to practice in the best possible manner and provide the most competent services to your clients throughout your career. Meeting minimum legal standards or minimum ethical standards is not enough for the truly professional counselor. Professionalism demands that you be the best counselor for your clients that you are capable of being.

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## 1 The Case of Alicia

Alicia will be seeing a 16-year-old minor for his first counseling session. Alicia knows that legally and ethically she must have one of his parents sign an agreement for her to disclose information regarding his sessions to his parent's health insurance company so that the parent will be reimbursed partially for the cost of her counseling services. Alicia also is aware that, according to the American Counseling Association *Code of Ethics* (2005), she may include parents in the counseling process, as appropriate (§B.3.d.; B.5.c.; B.5.b). However, she realizes how important confidentiality is to adolescents, and she wants to provide services to this minor in a way that would meet best practice standards.

- What are some of the things Alicia might do in this situation to go beyond what is minimally required by law or the code of ethics?
- How will Alicia know if what she finally decides to do is best practice?

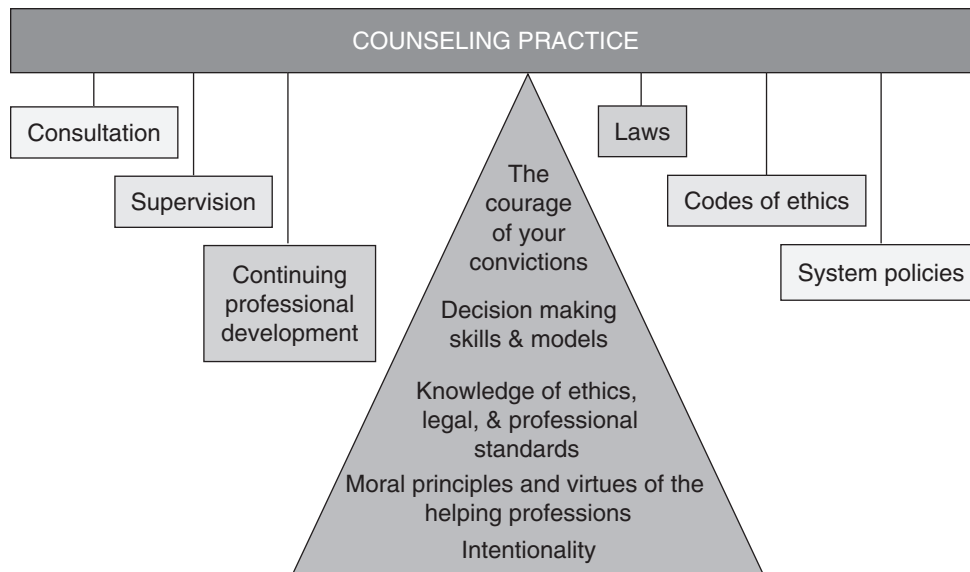
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**Discussion:** You will have the information you need to answer these questions after you have read material on ethical decision making, informed consent, confidentiality, and counseling minor clients. For now, a brief answer is that Alicia would be well advised to hold a conversation with both the client and his parent(s) present, in which she discusses confidentiality and its limits (including the information she would share with the insurance company). Including the client in the decision-making process is good practice, and Alicia can ask the client to sign the agreement to signify his assent, in addition to having the parent(s) sign to give legal consent. Best practice for Alicia will mean keeping a careful balance, honoring both her minor client's right to privacy and his parents' rights to information about their son, and working to establish and maintain a cooperative relationship with all parties.

## A Model for Professional Practice

One source of very real frustration for prospective and beginning counselors is that there are so few absolute, right answers to ethical, legal, or best practice questions. Throughout your career, you will





**FIGURE 1** Professional practice—built from within and balanced from outside the self

encounter dilemmas for which there are no “cookbook” solutions or universally acceptable answers (Bersoff, 1996). We visualize professional practice as entailing a rather precarious balance that requires constant vigilance. We also see counseling practice as being built from within the self but balanced by outside forces, as shown in Figure 1.

In this model of professional practice, the internal building blocks are inside the triangle. The most fundamental element, at the base, is *intentionality*. Being an effective practitioner must start with good intentions, or wanting to do the right thing. The overwhelming majority of counselors have the best intentions; they want to be helpful to those they serve.

The second building block contains *principles and virtues*. Principles and virtues represent two philosophies that provide the underpinnings for ethical reasoning. Moral principles are a set of shared beliefs or agreed-upon assumptions that guide the ethical thinking of helping professionals (including physicians, nurses and other medical specialists, teachers, and mental health professionals). Basic moral principles include respect for autonomy (honoring freedom of choice), nonmaleficence (doing no harm), beneficence (being helpful), justice (fairness), fidelity (being faithful), and veracity (being honest). Virtue ethics focuses on the traits of character or dispositions that promote the human good. We discuss these in more detail later in this chapter.

The third element is *knowledge* of ethical, legal, and professional standards. You will find that there is a wealth of resources available to you as you work to gain, maintain, and expand your knowledge base. Texts, casebooks, professional journals, codes of ethics, workshops and seminars, professional conferences, and your supervisors and colleagues are all excellent resources that can help to increase your knowledge.

Knowing the rules is not sufficient, however. It is necessary to have *skills* for applying your knowledge and reasoning through the questions and dilemmas that will arise in your practice. It also helps to have a *model* that will serve as a road map to guide your ethical decision making and bring some consistency to the process.

The final internal element is *the courage of your convictions*. This element can challenge even the most conscientious counselors who have the best intentions. As a counselor, you will face

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ethical quandaries. It can take courage to do what you believe is right, especially when there is a high cost to yourself, when your personal needs are involved, when you know that others may not agree with or approve of your actions, or when (as is the case in ethical dilemmas) there is no single, clear, right answer to the problem.

The following are some examples of ethical quandaries that take courage and that involve the behavior of other counseling professionals: What if you know that one of your professors has published, under his or her own name only, an article based largely on a paper you wrote? What if your supervisor at your internship site is engaging in a behavior that you strongly believe is unethical? What if you know that one of your fellow interns, who is also your friend, is engaging in inappropriate relationships with clients? In such instances, it can be easier to “turn a blind eye” than to confront the individual involved and run the risk of retaliatory action by the professor, a poor evaluation from your supervisor, or the loss of a friend.

Examples of ethical dilemmas that involve your own behavior include the following: What if you know that you are supposed to maintain personal boundaries between you and your clients, but just once, you agree to allow a client to buy you a cup of coffee and have a social conversation immediately after a session has ended? What if you know you are supposed to render diagnoses of mental and emotional disorders for your clients based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (American Psychiatric Association [APA], *DSM-IV-TR*, 2000), yet you generally render the same diagnosis of *adjustment disorder* for every client, because you think this diagnosis is the least stigmatizing? What if you report to a counselor certification board that you attended a continuing education workshop you paid for, even though you did not actually attend it? In these situations, it might be tempting to make some minor compromises to your usual ethical behavior, especially when you feel no harm comes to a client or to anyone else as a result.

Nonetheless, if you do nothing when you know the behavior of other professionals is unethical, or if you compromise your own ethical behavior, you have set foot on an ethical slippery slope. The *slippery slope phenomenon* is a term used by moral philosophers to describe what happens when one begins to compromise one’s principles—it becomes easier and easier to slide down the slope, diminishing one’s sense of moral selfhood along the way.

The diagram of the model also includes external forces that can support counselors in their efforts to maintain sound, professional practice. External sources of guidance and support include consulting with colleagues, seeking supervision, and increasing your knowledge and skills through continuing education activities. Your code of ethics is certainly a major source of guidance. Some laws support counselors in fulfilling ethical obligations; for example, privileged communication statutes can help you to uphold your clients’ confidentiality when called to testify in court or produce records. The system (school, agency, or institution) in which you are employed may also have policies on which you can rely when confronted with a challenge or a request to compromise your ethics.

## PROFESSIONAL ETHICS

Concern about ethics acknowledges the awesome responsibilities inherent in the practice of counseling. A counselor’s work can make a difference in whether an abused child’s life situation is recognized and addressed, whether a battered spouse finds the self-affirming courage to move to a safe environment, or whether a suicidal client finds the hope needed to choose life. Other clients come with less dramatic, more mundane problems, yet counseling can play a vital role in their struggle to lead more meaningful and effective lives (Pope & Vasquez, 2007). Ethical counselors take these responsibilities seriously.

## Foundations of Ethics

For many centuries, philosophers have debated the questions of what characterizes a moral and ethical person and how to behave in a moral and ethical manner, and these issues have been addressed within the helping professions since ancient times. The Hippocratic Oath was written about 2,500 years ago in ancient Greece, and in fact Greek philosophers such as Plato and Aristotle created most of the ethical principles that helping professionals use today.

## Ethical Theories

Ethical theories provide a framework that counselors can use to decide whether an action or contemplated action is ethical. It is important for you to have an ethical theory because it will enable you to resolve the ethical dilemmas you encounter in your work and help you defend the solutions you reach. There are a number of ethical theories that take opposing positions on what it means to be and act as an ethical person. Having some familiarity with a few of these positions may help you become aware of the approach you take in your ethical decision making as a counselor and perhaps challenge the assumptions you make. Remember that ethical reasoning is an acquired skill, not an inherent gift, and it can be sharpened through practice.

One set of opposing viewpoints on ethics is *ethical absolutism* versus *ethical relativism*. Ethical absolutists believe that there are some absolute moral standards that are universally applicable; that is, they must prevail in all circumstances and are not dependent on a person's beliefs or cultural values. These standards exist a priori (they exist before a situation arises) and independently of whether or not one believes in them. Ethical relativists, on the other hand, do not believe that there are any absolute moral standards that can be universally applied. Rather, they take the position that if the members of a culture believe an action is morally right, then it is morally right to perform that act in that culture (Freeman, 2000). As you begin to study the codes of ethics for counselors, these codes may seem to you to be written in absolutist terms. They are written in terms such as "counselors do not ..." and "counselors ensure that ..."—which appears to suggest that there are absolute "dos" and "don'ts" of ethical behavior. We believe, however, that ethical standards must be interpreted in a relativistic manner, taking into account the uniqueness of the client, the situation, and any cultural variables that are involved.

A related issue that is raised by philosophers of ethics is that of *utilitarianism* versus *deontology*, or consequential versus nonconsequential ethics. Utilitarian thought, represented by thinkers such as John Stuart Mill, argues that people should choose the act that will do the greatest good for the greatest number. In other words, an act is evaluated by the consequences it has. By contrast, deontologists, represented by the thinking of Emmanuel Kant, believe that an action is justified by its being inherently right, not by its consequences. Another way to state this idea is that what makes an action right is the principle that guides it. This philosophical question underlies much of the reasoning that counselors use in attempting to determine what is ethical professional behavior.

A third set of opposing philosophical viewpoints has to do with what motivates people to act morally or ethically. *Egoism* is the term used to describe actions taken out of self-interest, whereas *altruism* is the word that describes actions taken to benefit others (Freeman, 2000). Most people who choose counseling as their life's work tend to see themselves as altruists, and indeed, one of the most fundamental ethical values of counselors is that "client welfare comes first." Although this ethical value is well established in the counseling profession, this does not mean that there is no place for egoism or self-interest in our work. When we consider the possible consequences of

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a decision or action we might take, we would be prudent to reflect on the effects that action could have on us as well as on our clients. This dual consideration of altruism and self-interest, in fact, is reflected in the differences between the ethical and legal perspectives. The ethical perspective is focused more on the welfare and protection of the client, whereas the legal perspective is focused more on protecting the counselor.

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## 2 The Case of Edward

Edward is a high school counselor. His administrative supervisor is the school principal, Ms. Wilcox. Although Ms. Wilcox has no training as a counselor, she generally has been supportive of the counselors on her staff. She asks Edward to provide, for her eyes only, a list of his clients and presenting concerns. Edward trusts the supervisor to be responsible and refrain from sharing the list with others. Nonetheless, Edward believes it would be wrong to produce the list because it would violate his clients' right to confidentiality. At the same time, he realizes he could be at risk for disciplinary action for refusing to produce the list. He thinks that no real harm would be likely to result from giving it to Ms. Wilcox. He is also concerned that a refusal could negatively affect Ms. Wilcox's supportive attitude toward the counselors.

- What should Edward do? Do you believe the *principle* of confidentiality is the overriding consideration?
  - Or, do you believe that it is more important for Edward to consider the *consequences* of the decision?
- 

**Discussion:** If Edward reasons that the ethical principle is most important, he would be committing himself to uphold the moral principle of fidelity. *Fidelity* refers to fulfilling a responsibility of trust in the counseling relationship: Counselors strive to be faithful to the promises they make, such as keeping clients' disclosures confidential. If Edward adheres to this line of reasoning, he could be said to be thinking as an ethical absolutist—that the principle always applies, regardless of the situation. He would also be thinking as a deontologist, by deciding that keeping the students' confidentiality is the right thing to do, regardless of the consequences. Additionally, he might be relying on altruism, in that he believes that his actions must uphold client welfare rather than serve his own interests.

If Edward decides to produce the list for Ms. Wilcox, he might be motivated by egoism, or a focus on protecting himself and his fellow counselors from negative repercussions. He could be using utilitarian reasoning as suggested by Mill, that because no harm is likely to come to the students, his decision will do the greatest good for the greatest number of people—not only himself and his fellow counselors, but also the students who would be better served by having a supportive school administration.

We believe the best course of action in this situation would be for Edward to have an open discussion with his principal regarding his concerns about providing her with the list of students he has seen in counseling. Hopefully, his principal will either understand his concern and withdraw her request or convince Edward of the need for the list that would override his ethical concerns about the privacy of his students.

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All of the theories discussed up to this point have focused on the question of what constitutes ethical action. Other theories focus on what constitutes ethical character. Virtue ethics, which originated with Aristotle, explores the question of what character traits or dispositions form the basis for right action. Aristotle believed that positive personal character is developed when individuals consistently take actions that are based on their society's values. Virtue ethics focuses on individuals rather than actions, and evaluates the whole individual instead of isolated decisions the individual makes. Virtue ethicists believe that moral choices cannot be made by rule; what is needed instead is good judgment.

The ethic of care, or relational ethics, is based on the recognition that human beings exist in relationship and connection with one another. Psychologist Carol Gilligan, who represents this perspective, believes that ethics exist in a world of relationships in which the awareness of connection between people gives rise to a recognition that we are responsible for each other. Thus, the solution to an ethical dilemma is not found in a contest between opposing philosophies, but in a strengthening of the relationship on which the actors in the dilemma depend. Feminist ethicists have further articulated the ethic of care. Manning (1992) has stated, "An ethic of care involves a morality grounded in relationship and response.... In responding, we do not appeal to abstract principles... rather we pay attention to the concrete other in his or her real situation [and to] the effect of our response on the networks that sustain us both" (p. xiv). Relational or feminist ethicists do not disagree with principle ethicists, but their focus is different—they view moral actions as those that empower individuals, promote social justice, and ensure that all people are cared for and nurtured to develop their potentials (Vasquez, 2008).

With these general ethical theories in mind, we now turn to a consideration of ethical reasoning as it has been applied in the field of counseling.

### Linking Theory to Practice: Principles and Virtues

Thoughtful mental health professionals have struggled with questions of ethical ideals, concepts, principles, and values, and how to link these to ethical decisions in professional practice (Beauchamp & Childress, 1994; Jordan & Meara, 1990; Kitchener, 1984; Meara, Schmidt, & Day, 1996). Two helpful perspectives are *principle ethics* and *virtue ethics*. Even though these two approaches are quite different from one another, they are complementary. When integrated into a holistic framework for ethical decision making, they can serve as a bridge from philosophy to practice.

*Principle ethics* have their foundation in moral principles, which are agreed-upon assumptions or beliefs about ideals that are shared by members of the helping professions. They are *prima facie* obligations that are always considered in ethical decision making (Meara et al., 1996). Although moral philosophers do not agree about the nature or number of moral principles, the following six often are discussed in the professional literature on counseling:

- *Respect for autonomy* means to foster self-determination. According to this principle, counselors respect the rights of clients to choose their own directions, act in accordance with their beliefs, and control their own lives. Counselors work to decrease client dependency and foster independent decision making.
- *Nonmaleficence* means to do no harm. This principle, long established in the medical profession, obligates counselors to avoid actions that risk hurting clients, even inadvertently.
- *Beneficence* is the counterpoint to nonmaleficence. It could be argued that the obligation of ordinary citizens in our society ends with doing no harm to others, whereas professionals have a higher obligation to provide a service that benefits society. Thus, counselors actively do good or are helpful and work to promote the mental health and wellness of their clients.

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- *Justice* refers to the counselor's commitment to fairness in professional relationships. Counselors' actions and decisions must be fair to all concerned. Justice demands equality, which has implications for nondiscrimination and equitable treatment of all clients.
- *Fidelity* refers to fulfilling a responsibility of trust in the counseling relationship. Counselors strive to be faithful to the promises they make, such as keeping clients' disclosures confidential.
- *Veracity* means truthfulness and addresses the counselor's obligation to deal honestly with clients and others with whom they relate professionally.

Some writers have suggested additional principles such as *respect for persons*, which refers to a duty to honor others and their rights and responsibilities (Kenyon, 1999). Another principle that may have increasing salience in the future is *reparation*, which is the duty to make up for a wrong. This principle seems foundational to our profession's commitment to social justice and advocacy.

In theory, all of these principles have equal value and each should be considered along with all the others when weighing an ethical decision. In reality, however, these principles can compete with one another, and counselors may need to sacrifice one in order to uphold another. For example, a counselor who is counseling a suicidal client may decide to intervene by notifying family members against the client's wishes (thus breaching confidentiality and sacrificing fidelity) or by seeking involuntary hospitalization (thus sacrificing client autonomy) in order to uphold the obligations to prevent harm and do good (nonmaleficence and beneficence).

*Virtue ethics* start from a premise very different from principle ethics. The basic assumption of virtue ethics is that professional ethics involve more than moral actions; they also involve traits of character or virtue. Virtue ethics focus on the actor rather than on the action. Principle ethics ask the question, "What should I do?", whereas virtue ethics ask, "Who should I be?" Patterns of virtuous behavior are evident throughout the career of a professional, rather than being found in any particular action or decision. Thus, this perspective asks you to look at who you are, rather than at what you do. Some characteristics of virtuous agents that have been suggested as appropriate for mental health professionals (Meara et al., 1996) are discussed in the following section. We hope that you will read about these characteristics with an eye to whether you see them as representing the ideals you hold for yourself, and that you will assess their relevance for you as an aspiring counselor.

- ***Integrity.*** Virtuous agents are motivated to do what is right because they believe it is right, not because they feel obligated or fear the consequences. They have stable moral values and are faithful to these values in their actions.
- ***Discernment.*** Discerning counselors are able to perceive the ethically relevant aspects of a situation, know what principles apply, and take decisive action. Discernment involves a tolerance for ambiguity, the ability to maintain perspective, and an understanding of the links between current behaviors and future consequences.
- ***Acceptance of emotion.*** Without discounting the value of logic and systematic deliberation about ethical issues, virtuous agents also recognize the role of emotion in ethical decisions. Rather than assume that emotion hinders reason, they believe that emotion informs reason. For instance, compassion is an important virtue for health care professionals.
- ***Self-awareness.*** Virtuous agents know their own assumptions, convictions, and biases and how these may affect their relationships and interactions with others.
- ***Interdependence with the community.*** Virtuous agents realize that values cannot be espoused without awareness of context. They are connected with their communities.



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Both perspectives—a focus on principles and a focus on virtues—can contribute to your understanding of the basis for professional ethics. Principle ethics help you to systematically evaluate what you should do when trying to resolve an ethical dilemma. Virtue ethics can help you examine your ideals and define the kind of person you aspire to be as a helping professional. Thinking about principles and virtues requires you to look inward in order to identify internal resources that can assist you in ethical decision making. There are external resources as well, and primary among these is your professional code of ethics.

### Codes of Ethics

Promulgating a code of ethics is one way that a group of practitioners can establish their professional status. Codes of ethics serve a number of other important purposes as well. Most fundamentally, they exist to protect and promote the welfare of clients.

Some counselors practice *mandatory ethics*; that is, they function at a level of ethical reasoning that merely keeps them in compliance with minimal standards. By complying with these basic *musts* and *must nots*, they meet the letter but not the spirit of the ethical standards. According to Pope and Vasquez (2007), counselors who set their sights at this level are vulnerable to denial and to other means of distorting, discounting, or dismissing ethical questions they encounter. Some of the self-statements that these counselors use to justify their actions include the following:

- “It can’t be unethical if I don’t see it as an ethical issue.”
- “It isn’t unethical if there is no ethical standard that specifically prohibits it.”
- “It can’t be unethical if I know other practitioners who do it.”
- “It isn’t an ethical problem so long as no client has ever complained about it.”
- “It’s not unethical as long as no one finds out about it.”

Other counselors practice *aspirational ethics*, a term that describes the highest standards of conduct to which counselors can aspire. They understand the spirit behind the code and the moral principles on which it rests. They not only look outward to established standards, but also look inward and ask themselves whether what they are doing is best for their clients. Aspirational ethics is closely related to the concept of best practice. Corey et al. (2011) have emphasized that clients’ needs are best met when counselors monitor their own ethics and challenge their own thinking and behavior.

Herlihy and Corey (1997); Mappes, Robb, and Engels (1985); and Van Hoose and Kottler (1985) have suggested that codes of ethics have the following purposes:

- Protect the public.
- Educate members of the profession about what constitutes sound, ethical conduct.
- Provide a means to ensure accountability by enforcing the standards.
- Serve as a catalyst for improving practice.
- Protect the profession from government, allowing the profession to regulate itself and function more autonomously.
- Help control internal disagreement, thus promoting stability within the profession.
- Protect practitioners—if professionals behave according to established guidelines, their behavior is more likely to be judged in compliance with accepted standards in a malpractice suit or licensing board complaint.

A code of ethics that would address every possible situation that a counselor might encounter would probably fill an entire library. You cannot expect your code of ethics to provide an answer

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to every question you might have. Codes are a crucial resource, but they are not a substitute for an active, deliberative, and creative approach to fulfilling your ethical responsibilities (Pope & Vasquez, 2007). You must attend to both the letter and the spirit of the code and work to understand the intentions that underlie each standard (Herlihy & Corey, 2006; Remley & Huey, 2002). As Herlihy and Corey have noted, there is a very real difference between merely following the ethics code and living out a commitment to practice with the highest ideals.

Your primary professional association, the ACA, has established a code of ethics to guide you in your practice. Figure 2 presents a brief overview of the eight sections of the code and their general provisions.

**Preamble** describes the American Counseling Association and its members and discusses professional values.

**Purpose** sets forth five purposes for the *Code of Ethics* and describes how the code should be utilized by members.

**Section A: The Counseling Relationship** addresses important issues in forming, maintaining, and ending the counseling relationship. This section includes guidelines to help counselors keep client welfare foremost and respect client rights. It contains standards that emphasize the importance of respecting diversity and being aware of one's own personal needs and how these can influence the counseling relationship. It provides guidance on how to handle troublesome issues such as multiple relationships, serving as an advocate for clients, group work, end-of-life care, fees, termination, referral, and the use of technology and the Web in counseling.

**Section B: Confidentiality, Privileged Communication, and Privacy** addresses the client's right to privacy of information shared during counseling sessions and of records. Exceptions and limitations to confidentiality are specified, and special considerations in working with minors, families, and groups are addressed. Guidelines are offered for maintaining confidentiality when consulting or conducting research.

**Section C: Professional Responsibility** contains standards related to competence. It emphasizes the importance of advertising services and credentials in an accurate manner. It also addresses the counselor's responsibilities to the public.

**Section D: Relationships with Other Professionals** offers guidelines for employer/employee and consultative relationships. This section highlights the importance of respecting and establishing good working relationships with professionals in related mental health professions.

**Section E: Evaluation, Assessment, and Interpretation** includes standards on competence to select, use, and interpret tests. Client rights in testing, test security, and proper testing conditions are addressed. This section also includes standards related to diagnosis of mental disorders and forensic evaluations.

**Section F: Supervision, Training, and Teaching** presents guidelines for counselor educators and trainers, counselor preparation programs, and students and supervisees. Guidance is provided on issues such as relationship boundaries, evaluation, and endorsement of students to enter the profession.

**Section G: Research and Publication** describes research responsibilities, informed consent practices, and the reporting of research results. A range of issues is covered from protection of human subjects to ethical procedures in seeking publication.

**Section H: Resolving Ethical Issues** addresses the responsibility of counselors to know their ethical standards and explains procedures for resolving and reporting suspected ethical violations.

**Glossary of Terms** provides definitions of terms used in the code that might need particular attention.

**FIGURE 2** ACA Code of Ethics: A synopsis



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The current ACA *Code of Ethics*, adopted in 2005, is the sixth version of the ethics code established by ACA and its predecessor organizations (Kocet, 2006). Development of the first code was initiated in 1953 by Donald Super, then president of the newly formed American Personnel and Guidance Association (APGA). The code was adopted in 1961. It was revised in 1974 and has been revised approximately every 7 to 10 years since that time. The current document, the result of a lengthy revision process that began in 2002, was adopted after the membership gave input and suggestions. In the fall of 2011, a code revision task force was appointed to revise the 2005 code. It is anticipated that this newest, seventh iteration of the ACA *Code of Ethics* will be adopted in 2014.

As you learn about ethical standards that you will be expected to uphold, keep in mind that codes of ethics are living documents that change over time. They are periodically revised as the profession's knowledge base grows and as consensus emerges about new and controversial ethical issues. Although the fundamental ethical principles do not change, new questions are constantly arising as to how to apply them in a changing world of counseling practice. For instance, when computer technologies first became widely available, ethical concerns centered around the security of client information stored on computers. Later, as Internet usage burgeoned, many questions arose around the ethics of Internet counseling. Today, the popularity of social media has raised new issues, such as whether counselors should *friend* clients, former clients, or supervisees. You must stay aware of these issues and ongoing developments throughout your professional career.

It is also important to keep in mind that historically, counseling has not been a unified profession. Codes of ethics have proliferated as various specialty groups within counseling (Jordan, 2001a; Kelly, 2001), certification bodies, and state licensure boards have developed their own ethical standards. When you are established in your own professional practice, it is likely that you will hold multiple affiliations and will be bound to know and adhere to multiple codes. For instance, you might be a member of ACA and several of its divisions that have published specialty guidelines, be a National Certified Counselor (NCC), and be licensed as a counselor in your state. Holding each of these credentials will require you to abide by its particular code of ethics. The existence of multiple codes of ethics creates difficulties in enforcement, confusion for consumers of counseling services, and confusion for counseling professionals themselves (Herlihy & Remley, 1995). Until a single, universally accepted code of ethics for the counseling profession is established, you must thread your way carefully through this maze.

## Ethical Decision Making

Ethical decisions are rarely easy to arrive at, and dilemmas can be complex. Numerous writers (Blocher, 1987; Corey, Corey, & Callanan, 2011; Forester-Miller & Davis, 1995; Garcia, Cartwright, Winston, & Borzuchowska, 2003; Herlihy & Watson, 2006; Jordan & Meara, 1990; Kenyon, 1999; Kitchener, 1984; Rave & Larsen, 1995; Stadler, 1986; Van Hoose & Paradise, 1979; Welfel, 2010) have offered models for ethical decision making, all of which help bring order and clarity to the reasoning process.

Cottone and Claus (2000) reviewed nine ethical decision-making models for counselors that had been promulgated between 1984 and 1995. Although no two models were alike, they had much in common. Most included the following as steps to be taken in the decision-making process: identifying the problem, consulting ethics codes, considering the consequences of any decision, and choosing an action. Although some of the models recommended consulting with peers or supervisors, all seemed to conceptualize the ethical decision-making process as something that occurs

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intrapsychically or internally. Feminist and social constructivist theorists have offered a differing view—that ethical decision making is a relational or interactional process.

Feminist writers (Hill, Glaser, & Harden, 1995; Meara et al., 1996; Rave & Larsen, 1995) have cautioned that most ethical decision-making models represent the information processing style of White males. Traditional models have tended to be linear, logical, rational, dispassionate, abstract, and paternalistic. Feminists have suggested that ethical decision making that is also holistic, intuitive, emotional, compassionate, personal and contextual, and mutual may be more inclusive of other processing styles and more culturally appropriate. Multicultural scholars also have been critical of traditional models. Herlihy and Watson (2006) offered a model based in a social justice perspective that puts multicultural competence at the core of the ethical reasoning process. The model is grounded in virtue ethics, cultural identity development, and collaborative decision making.

Social constructivism is a relatively recent movement in the mental health field that purports that a person cannot know reality through individual contemplation because reality does not exist as objective fact. Rather, reality is socially constructed through interactions with others. Social constructivists see ethical decision making not as a process that occurs in the mind of the decision maker, but as a process that is always made in interaction with at least one other person and that involves negotiating and consensualizing (Cottone, 2001). This person-in-environment perspective requires that counselors consider how context influences ethical decision making (Mattison, 2000).

Other writers have argued for a hermeneutic or interpretive approach, recognizing that the counselor is not a detached observer but rather is an inextricable part of the decision-making process (Betan, 1997). These writers emphasize the importance of ethical self-reflection to better understand the lens one uses in making ethical decisions.

In describing the ethical decision-making process, we do not endorse any one particular model as being the *right* one for everyone. Instead, what follows is a description of steps that many of the models seem to have in common. We have tried to incorporate lessons that can be learned from principle and virtue ethics, feminist and multicultural ethics, and social constructivism. We caution you to keep in mind that a listing of steps portrays ethical decision making as a linear progression, when in reality counselors rarely follow a set sequence of steps to resolve an ethical dilemma.

***Identify and define the problem.*** Before deciding what action to take when faced with an ethical problem, it is prudent to take time to reflect and gather information. Although you may feel some sense of urgency, rarely will decisions that have ethical dimensions have to be made immediately. Take time to consider what you know (or what you can find out) about the situation, applicable ethical guidelines, and any laws that might be relevant. Review the professional literature and your code of ethics. If a legal issue is involved, consult with an attorney. Try to examine the problem from several perspectives and avoid searching for simplistic solutions.

***Consider the principles and virtues.*** Reflect on how the moral principles apply to the problem. Identify ways that they compete with each other, and rank them in order of their priority in this situation. Consider how *virtue ethics* might apply in the situation as well, and the effect of any possible actions on your sense of moral selfhood.

***Tune in to your feelings.*** Virtue ethicists believe that emotion informs judgment. Consider what emotions you are experiencing as you contemplate the situation and your possible actions. To what extent are you being influenced, for instance, by emotions such as fear, self-doubt, or an overwhelming sense of responsibility? Your emotions can help guide you in your decision making.

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**Consult with colleagues or experts.** Decisions made in isolation are rarely as sound as decisions made in consultation. In addition, consultation would serve as an important element of your defense in court if your decision were challenged legally.

**Involve your client in the decision-making process.** This is not a separate step in ethical decision making; rather, it should occur throughout the process. Walden (2006) reminded counselors that the client is an integral part of the ethical community of the counseling relationship. Including clients in the process both empowers them and is culturally appropriate practice. We can think of very few situations that would preclude making the client an active partner in decisions affecting that client. Counselors should avoid making decisions *for* the client when those decisions can be made *with* the client.

**Identify desired outcomes.** Even after thoughtful consideration, a single desired outcome rarely emerges in an ethical dilemma. There may be a number of outcomes you would hope to see achieved in a situation; some may seem essential, and others may be desirable but not altogether necessary. Two helpful strategies are brainstorming to generate new options and consulting with colleagues who may see possibilities that have not occurred to you.

**Consider possible actions.** Consider possible actions that you could take to achieve the desired outcomes. It may even be useful to list desired outcomes on one side of a page, and on the other side generate possible actions that would facilitate the achievement of each of those outcomes. Ponder the implications and consequences of each option for the client, for others who will be affected, and for yourself. If possible, review these options with the client.

**Choose and act on your choice.** Once you have selected an action or series of actions, check to see whether your selected options are congruent with your ranking of the moral principles. Pay attention to how you feel about your choice. This final step involves strengthening your ego or gathering the moral courage to allow you to carry out your decision.

Even after the most careful deliberation, conscientious counselors cannot help but ask the question, “How can I know whether I’ve done the right thing?” Van Hoose and Paradise (1979) suggested that decisions are probably ethically responsible if the counselors (a) maintained personal and professional honesty, coupled with (b) promoting the client’s best interests (c) without malice or personal gain; and (d) can justify their actions as the best judgment regarding what should be done based on the current state of the profession.

You can also apply several self-tests after you have resolved an ethical dilemma. The first three tests were suggested by Stadler (1986). First is the test of *justice*, in which you ask whether you would treat others the same in this situation. Second is the test of *universality*, which means that you would be willing to recommend the course of action you followed to other counselors who find themselves in a similar situation. Third is the test of *publicity*: You would be willing to have your actions come to light and be known by others. Another test is the *reversibility* test, which is a version of the Golden Rule; in this test you would ask yourself if you would have made the same choice if you were in the client’s shoes or if your child or life partner were subject to that choice. The *mentor* test asks you to consider an individual whose integrity and judgment you trust and admire, and ask how that person might solve the dilemma (Strom-Gottfried, 2007). Finally, you can check for *moral traces*, which are lingering feelings of doubt, discomfort, or uncertainty that counselors may experience after they have resolved an ethical dilemma, particularly when expediency, politics, or self-interest have influenced the decision. Moral traces are unpleasant but perform an important function. They act as a warning sign that you may have set foot on an ethical slippery slope, which was defined earlier in this chapter.



**Note:** MyHelpingLab is a Web site that contains some useful and helpful resources to help you apply what you are learning. One such resource is a series of video vignettes that illustrate ethical and legal issues. After each vignette, the authors discuss their perspectives on the issue presented. Now is the time to go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 7 and view the video clip entitled “An Ethical Decision to Make,” which illustrates the difficulty counselors have when faced with boundary issues regarding their clients. After viewing the vignette, try applying a decision-making model to the counselor’s dilemma.

In summary, being an ethical professional involves a combination of knowledge, problem-solving skills and strategies, understanding of philosophical principles, and a virtuous character that leads one to respond with maturity, judgment, and wisdom (Bersoff, 1996). It is a task that requires a lifelong commitment and is never really finished. Even the most experienced counselors who are intimately aware of the ethical standards wrestle with difficult ethical issues and dilemmas (Walden, Herlihy, & Ashton, 2003).

### 3 The Case of Carla

Carla has been counseling a 15-year-old girl, Danielle, for several weeks. Carla has had to work hard to gain Danielle’s trust. Danielle was raised by abusive parents until she was 13, when she went to live with her grandparents. Today she tells Carla that she is having some problems with her boyfriend. As Danielle describes these problems, Carla realizes that the boyfriend is treating her in an abusive manner. When Carla expresses her concern about this, Danielle replies that she loves him and can get him to change, that her grandparents don’t know about his behavior, and that she absolutely does not want Carla to tell them or anyone else.

- How might you apply each of the six moral principles (found on pp. 10–11) to this situation? In this case, which moral principle do you think must take precedence? How might you apply the ethic of care or relational ethics to this dilemma?
- Try to apply to this scenario the steps of the ethical decision-making process described in this chapter. To what course of action does this process lead you? How well did it work for you?

**Discussion:** The moral principles could be applied in several ways. The principle of respect for autonomy would support deferring to Danielle’s wishes and not telling anyone about her abusive boyfriend. The principle of nonmaleficence would require Carla to weigh the risk for harm. Telling someone who could prevent further abuse would support nonmaleficence. However, if Danielle becomes upset by this action and refuses to continue in counseling, telling someone also could violate the principle of do no harm. Likewise, beneficence could be interpreted in more than one way. Beneficence means that professionals have an obligation to provide a service that benefits society, so taking action that would stop the abuse would best serve society’s interests. Yet, beneficence also means to promote clients’ mental health, and Carla could respect Danielle’s wishes and continue to work to increase her awareness and self-esteem, which, for now, could be the most

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beneficent thing to do. How Carla adheres to the principles of justice, fidelity, and veracity will depend largely on whether she has informed Danielle that she would have to breach confidentiality to prevent harm to Danielle. If so, then telling her grandparents would be just and truthful, and would not be breaking her promise to keep Danielle's disclosures confidential.

If Carla reasons through her dilemmas from the perspective of the ethic of care, she will put primary importance on preserving and nurturing her relationship with Danielle. She would also be concerned about Danielle's other supportive networks, such as her relationship with her grandparents and what she considers to be a loving relationship with her boyfriend despite his problem behaviors.

Obviously, there is no one correct way to reason through this dilemma and there is no single, clear, right answer. We believe it would be a good learning experience for you to work your way through the decision-making process and then discuss your decisions with your classmates.

## Power and Ethics

Professionals, by the nature of the relationship, have power over their clients (Haug, 1999). Because professionals possess knowledge and skills beyond those of the ordinary citizen, our society extends privileges to professionals. Individuals who seek services from professionals must trust those professionals to practice in a manner that is helpful, and not harmful, to them. Citizens may not know whether professionals are treating them in a way that benefits them or are taking advantage of their lack of knowledge or understanding of how the counseling process is supposed to proceed.

For example, counselors have been educated to understand the human condition and to talk with their clients in a way that is helpful to them. The goals of counseling are to alleviate client distress, assist clients in accomplishing goals they have set for themselves, and help clients resolve problems they are experiencing in their lives. Counselors have the education and the interpersonal skills to be able to help clients in professional counseling relationships.

But counselors, like other professionals, could use the power they have in professional counseling relationships to meet their own personal needs rather than the needs of their clients. For example, counselors who are personally lonely could very easily use clients to satisfy their need for interpersonal relationships. Because clients are vulnerable and have a need for their counselors to be strong and powerful and perhaps even omnipotent, counselors could overcharge clients for their services, meet their sexual needs through their clients, borrow money from clients, or engage in other behaviors that are not in their clients' best interest.

Members of the counseling profession have recognized that clients generally are vulnerable and that counselors have power over their clients. While individual counselors have an obligation to avoid the misuse of their power, the profession of counseling, as a whole, has an obligation to ensure that vulnerable clients are not abused by counselors. State licensure boards require that counselors practice in an ethical manner and have the authority to bar unethical counselors from practicing. Ethical standards and codes of ethics for counselors were developed by members of the counseling profession as guidelines for counselors to follow to avoid abuses of power.

## LEGAL ISSUES

The discussion of professional ethics that preceded this section emphasized the serious responsibility you have to clients, the difference you can make in their lives, and the duty you have to practice in an ethical manner. Understanding the legal system and your role in it, the legal rights of your clients, and your legal responsibilities to clients is also essential to practicing counseling in a professional manner. Legal issues

within counseling are somewhat frightening because the law is an area that is complex, often vague, threatening, antithetical to the nature of counselors, and difficult to fully grasp. The process of decision making around legal issues is presented in this chapter.

### Origins of Law

There are a number of sources of law in the United States. The basic source is the U.S. Constitution. The 50 states, the District of Columbia, and the U.S. possessions also have constitutions. Laws created by the federal, state, district, and possession governments cannot violate either federal or state constitutional principles. The United States has adopted the English common law. It includes a set of societal principles that were not written into documents, but have been accepted over time as obvious within our society. An example of common law that is very important to counselors is the law of torts. Tort law relates to the principle that individuals will be held responsible for any harm they cause to other members of society. Malpractice is an area of tort law that holds professionals accountable for any harm they might cause to the public. The public relies on professionals to provide services in a manner that benefits and does not harm them.

A primary source of law is statutes passed by federal and state legislatures. These statutes may modify the common law, but may not violate constitutional principles. Governmental regulations, both federal and state, are procedures adopted by agencies to carry out laws created by statutes. Regulations, which are created by governmental agencies, may implement statutes, but may not exceed the authority of the statute. Finally, federal and state courts interpret the law. Whereas some accuse judges of creating law, courts are limited to interpreting constitutions, common law principles, statutes, and regulations.

Almost all areas of counselor practice are affected by law. Most counselors are keenly aware of the law of malpractice and the fact that they might be sued by a client. You will probably come to share this awareness. You also must be aware of laws related to confidentiality, records, parental rights, and licensing statutes, among others. In addition, you must be able to identify legal problems as they arise, and you must adhere to legal requirements when you are involved in any way with a legal proceeding. Legal issues are an important part of the day-to-day professional practice of counselors in all settings.

### Recognizing Legal Issues

Many of the ethical and professional judgment questions you will encounter as a counseling practitioner will have legal implications as well. Many counselors find it difficult to determine when they have a legal problem or to know what to do once a legal problem has been identified. This section of the chapter discusses how to recognize legal issues, how to get legal advice, and what steps to take to ensure proper and professional practice.

The following are examples of legal issues that counselors face in their practices:

- The secretary tells you that there is a deputy sheriff in the reception area asking for you. When you introduce yourself, the deputy hands you a subpoena that orders you to produce your case notes and any other documents related to one of your current clients.
- One of your clients asks you to come to a child custody hearing that will determine whether she will get permanent custody of her children.
- One of your clients has been arrested for drug possession. You receive a subpoena in the mail that orders you to appear at her criminal trial.
- A new client tells you that his lawyer sent him to see you. He is suing his employer for having fired him and wants you to verify that he has emotional stress that is job related.



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- A client tells you that her former husband's lawyer called and told her she had to let her former husband have their children for the summer. She wants to know if the lawyer is right.
- A former client has sent you a letter demanding her money back. She thinks the 10 sessions she had with you were a waste of money because you did not help her. She has sent a copy of the letter to her lawyer.
- A client you are seeing appears suicidal and refuses to go voluntarily to the local hospital for a psychiatric evaluation.
- You receive a notice from your state licensure board that a formal complaint has been filed against you and that a hearing will be held on the matter.
- In your office mail, there is a formal legal complaint against you that has been filed with the local court, accusing you of professional malpractice. One of your clients murdered his girlfriend 9 months ago. The complaint alleges that you were responsible for the girl's death and asks for \$1 million in damages.

A simple test to determine whether there is a legal issue involved in a situation you are facing is to review the situation to see if any of the following apply: (a) legal proceedings of some type have been initiated, (b) lawyers are on the scene in some capacity, or (c) you are vulnerable to having a complaint filed against you for misconduct. If you are providing professional counseling services and any of these three components exist, then you definitely are dealing with a legal issue. Sometimes, all you need to do with a legal situation is clarify the nature of a counselor's role with your client and refer the client to attorneys for legal advice. When you are dealing with a legal issue and you are unsure which course of action you should take, often you will need to consult a lawyer.

## Obtaining Legal Advice

Most counselors are employed by organizations or entities that provide counseling services, such as community mental health agencies, schools, businesses, hospitals, outpatient treatment programs, colleges, and others. These entities all have administrators and organizational structures that require the regular services of attorneys. It is the employees' responsibility to request legal advice when dealing with an issue that has legal implications beyond their ability to resolve. It is the obligation of employers to provide employees with the legal advice they need to perform their jobs appropriately.

Counselors seldom have direct access to lawyers, primarily because the cost is prohibitive. Also, administrators seek the advice of lawyers, but they must maintain their authority in making administrative decisions. When a counselor identifies a legal issue in the work setting and defines the legal questions to ask, the counselor should pose the questions to the immediate supervisor and ask for assistance. If the counselor thinks an attorney needs to have special information regarding the situation in order to render sound advice, the counselor should request a personal consultation with the attorney, although such consultations are not normally allowed. The supervisor will then either answer the counselor's questions based on previous experience with similar issues or seek legal advice through proper administrative channels within the organization.

In some circumstances, it is possible for counselors to give their legal problems to administrators within their agency. Many legal issues that arise are administrative in nature and should be handled by administrators rather than by counselors. Examples of legal issues that counselors might easily turn over to administrators include the following:

- A noncustodial parent demands from a school counselor that he be allowed to see his child's academic records.
- The police arrive at a counselor's door and want to see the counseling file for a current client.

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- A health insurance company representative calls a counselor and wants to know why the counselor's agency has so many claims signed by the same psychiatrist.
- A client becomes irate because a counselor terminates the counseling relationship after five sessions because that is the agency's policy.
- A lawyer for a former client calls a counselor and threatens to sue if the counselor does not immediately give the lawyer the information being sought.
- A secretary who reports to an administrator appears to be revealing confidential information about clients to friends.
- A client tells a counselor that the counselor's colleague in the agency has made sexual advances during a counseling session.

If legal problems cannot be handed over to an administrator, then counselors themselves must take responsibility for resolving situations in an appropriate manner. Once counselors have disclosed their legal questions to their immediate supervisors and have received a response either from the supervisor or an attorney advising them as to the proper course of action, counselors must follow that advice. It is essential for counselors to follow legal advice given to them, even if they do not agree with it. Only then will counselors be indemnified by their employers and supported if problems arise later. By seeking and following legal advice when legal questions arise, counselors are taking steps that may protect them from being held individually responsible in the event their actions are challenged.

Counselors in independent private practice do not have the luxury of seeking legal advice without charge within their work environment, and they are not protected from responsibility because they do not have employers. Private practitioners must establish relationships with attorneys for legal advice just as they must retain accountants to handle their financial and business affairs. The cost of legal advice for a counselor in private practice is a necessary expense related to establishing and maintaining a business. However, finding a lawyer who understands the nature of mental health practices and is prepared to represent counselors effectively is not always an easy task (Remley, 1991). Counselors who are planning to open private practices are advised to identify an attorney while they are establishing their business so they will have a working relationship in place when problems arise. The best attorney probably would be a local one who is already representing one or more successful mental health practitioners—counselors, social workers, or psychologists. Such an attorney would already have been educated regarding the special issues surrounding mental health practices. If an attorney who is experienced in representing mental health professionals is not available, then a lawyer who represents other types of professionals, such as accountants, other lawyers, or physicians, would be a good alternative.

Some counselors have jobs in which they testify in court on a routine basis or provide services to clients who frequently are involved in litigation. These counselors learn their roles over time and do not need to consult attorneys for advice each time they encounter a legal situation. For most counselors, however, it is infrequent that they deal with legal proceedings, have clients who are represented by lawyers, or think they are in danger of being sued. When such situations arise for the majority of counselors, it is essential for them to obtain legal advice.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 5 and view the video clip entitled “A School Counselor Tries to Help a Colleague,” which illustrates how easily a counselor can slip into giving legal advice.



### Exercising Professional Judgment

Throughout the workday, counselors often have to exercise their professional judgment in areas that are difficult. They are held accountable for making professional decisions that are sound and reasonable, given the information they have available when they make such judgments. If a client believes that he or she was harmed because of a professional decision made by a counselor, then the client might sue a counselor for malpractice. As a result, when a counselor exercises professional judgment, there is always a risk afterward of being accused of wrongdoing.

A few of the areas particularly vulnerable to later legal challenges in which counselors make judgments include the following:

- Determining whether a client is suicidal or a danger to others
- Deciding what to do to prevent harm after determining that a client is a danger to self or others
- Rendering a clinical diagnosis that could have negative implications for a client at a later time
- Terminating a counseling relationship over the client's objections
- Deciding whether to enter into a counseling relationship with a client who has a problem that you have not treated before or have not been specifically trained to treat
- Reacting appropriately to a client who has expressed an interest in having a sexual relationship with you
- Using a paradoxical intervention with a client

Just as counselors must obtain legal advice when legal questions arise in their practice, they must obtain professional consultation to the extent possible when making difficult professional judgments. It is inappropriate to ask counselor colleagues about how to handle legal problems, and at the same time, it is inappropriate to consult with an attorney when making difficult clinical decisions. A counselor colleague might give you advice about a legal situation, but you cannot rely on the accuracy of that advice because your counselor colleagues are not lawyers. Likewise, a lawyer might give you advice about how to handle a difficult clinical issue, but lawyers are not educated as mental health professionals. If you ask attorneys about what to do in difficult clinical situations, they will focus on protecting you rather than on knowing what might be best for your client.

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## 4 The Case of Fatima

Fatima is a counselor in a university counseling center who is in the process of planning for a month-long vacation. She will be leaving in 2 months. She has been having a series of conversations with her supervisor and several of her colleagues at the center about the proper way to handle her existing clients: when to tell them she is leaving; whether to refer them permanently to other counselors; whether to refer them temporarily to other counselors and take them back when she returns; whether to terminate with those who are nearing readiness; and what to do about those clients who have been at risk for suicide in the recent past. At the staff meeting today, the counseling center director announced that he had talked to the university attorney about the situation and her advice was to just tell all of Fatima's clients that she will be gone for a month and to let them decide what to do in the interim. The director said that the attorney said that Fatima had no other legal obligations to the clients.

- To what degree should the university attorney's advice on this issue affect Fatima's decision making?
  - Because the director told Fatima and the staff about the advice of the university attorney, how should Fatima interact with the director if she decides to do something different from what the attorney advised?
-

**Discussion:** It is good for counselors to get advice from attorneys regarding their legal obligations. However, a counselor's ethical obligations may go beyond what is required legally. Fatima will want to be careful not to offend the director, so perhaps she could thank the director for obtaining legal advice. Later and in private, she might share the *ACA Code of Ethics* with the director and point out some of the ethical obligations she wants to meet. She could continue by suggesting that a good goal for the center would be to follow ethical and best practice guidelines, in addition to legal obligations, in order to provide the best possible service to clients.

When counselors face issues that require them to exercise their clinical judgment, particularly where there are no clear right or wrong responses, it is essential to consult with colleagues to the extent possible. In some situations consultation might be impossible, such as when emergencies arise. When time does allow, however, consulting about clients provides a substantial protection to counselors whose clinical decisions are later challenged. The legal standard of care for counselors is that counselors must practice in a manner consistent with the way in which a reasonable, similarly educated counselor would practice under the same set of circumstances. By consulting with others, counselors can prove later that they indeed met the standard of care by doing what other, presumably reasonable, counselors advised or agreed on. If experts are available for consultation, it is wise to talk with them as well. Experts might include former university professors, counselors who are known for their expertise in a particular area, or counselors with extensive clinical experience.

It is impossible for counselors to know for certain whether they are making decisions that will protect their clients or others from harm. Because of this uncertainty, it is essential that counselors maintain a current personal professional liability insurance policy at all times.

### **Personal Values Systems of Counselors**

Because it is so important that counselors avoid imposing their own personal values on their clients, we wanted a discussion of this issue to appear in this chapter. The *ACA Code of Ethics* (2005) has a number of standards that require that counselors respect the dignity and values of the individuals they counsel (see Section A).

Probably one of the most difficult lessons that must be learned by beginning counselors is to avoid giving advice. Most people believe helping someone solve a problem is best accomplished by giving them advice. To complicate matters, clients often ask for their counselors' personal beliefs and request advice. Even though giving advice might seem natural when people ask for help, counselors come to learn and accept that advice giving is based on the personal values of the person giving the advice, and those values may be very different from those of the person receiving the advice.

Your personal values system may often cause conflicts in your work as a counselor. For example, if you believe deeply that a fetus is a human being and that abortion is morally wrong, then it will be challenging for you to keep your values in check as you counsel a woman who is considering having an abortion (Millner & Hanks, 2002). It might be difficult for an ordained Protestant minister to avoid becoming the counselor, spiritual advisor, and minister to a couple in his or her church (Frame, 2000). Similarly, it may be difficult for counselors who hold religious beliefs different from their clients to counsel those clients about their divorce within a religious context (Murray, 2002).

## Introduction

Counselors face situations like those outlined previously on a regular basis. One of the hardest lessons counselors must learn is to respect values that are different from their own and to avoid imposing their own personal values on their clients. Some of our colleagues may believe that counselors who hold strong values should simply refer clients when the counselors' values interfere with providing quality counseling services. We believe, however, that counselors should strive to learn to counsel individuals with values that differ from their own. Seeking consultation when values conflicts arise between counselors and clients often helps counselors meet this challenge in a professional and appropriate manner. If a counselor's values were so strong that he or she could not counsel clients who held differing beliefs, we would be concerned that the counselor is not well suited for the counseling profession (Hermann & Herlihy, 2006).

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## Summary and Key Points

This chapter has familiarized you with some key concepts that form the foundation for studying ethical, legal, and professional issues in counseling. The professional orientation content area of graduate training involves the study of professional identity, ethics, law, and best practice. *Morality*, *values*, *ethics*, *law*, *best practice*, and *professionalism* are all interrelated terms, but they have different meanings. As used in this chapter, the term *morality* refers to personal beliefs and how these beliefs affect your conduct, whereas *ethics* refers to professional values and behaviors. *Laws* are agreed-on rules that set forth principles that allow people to live together in a society. Laws dictate minimal standards of behavior, and ethics represent ideal standards. *Best practice* goes beyond what is minimally required by laws or codes of ethics and is the very best a counselor could be expected to do.

A model of professional practice was presented as one way to conceptualize how all these terms might fit together in your actual practice as a counselor. In this model, both internal and external building blocks contribute to the development and maintenance of sound, professional practice.

Following are some of the key points made in this chapter about ethics and law in counseling:

- Principle ethics, based on the moral principles of the helping professions, and virtue ethics, focused on traits of character, are two complementary ways of looking at the foundations of counselor ethics.
- Codes of ethics, vital resources in ethical decision making, cannot answer every question that might arise in actual practice.
- Of critical importance to counselors is the development of ethical decision-making skills and a useful model to reason through the ethical dilemmas confronting them.
- Most areas of counselor practice are affected by law.
- Counselors must know how to recognize legal issues and know how to obtain legal advice.
- Counselors should seek advice from fellow mental health professionals when they have clinical or ethical questions, and seek advice from lawyers when they have legal questions.
- There is no substitute for professional judgment on difficult ethical or legal questions encountered by counselors, although many helpful resources exist.
- Counselors must respect values that are different from their own and must avoid imposing their values on clients.



# Professional Identity of Counselors

## FOCUS QUESTIONS

1. How do you respond when your friends and relatives ask you what you are studying in graduate school?
2. How do you think the wellness model of mental health espoused by counselors is different from the illness model or medical model of mental health?
3. What are some of the major challenges facing the counseling profession today?

Counselors are a relatively new professional group compared to other mental health professionals such as psychologists, social workers, and psychiatrists. Potential consumers of mental health services often are unaware that counseling is a distinct profession that can be clearly distinguished from similar mental health professions. Even counselors themselves sometimes find it difficult to describe the distinctions. Thus, a vital professional task for counselors is to adopt a strong professional identity and to be able to articulate that unique identity to others (Gale & Austin, 2003; Healey & Hays, 2012; Smith, 2001).

Professional identity is a nebulous concept, but it is vital to the long-term success of a profession. In discussing the professional identity development of school counselors, Brott and Myers (1999) argued that professional identity is a process rather than an outcome, and that seasoned counselors must constantly reexamine their identities to meet new challenges. Individuals who have a strong professional identity can easily explain the philosophy that underlies the activities of their professional group, describe the services that their profession renders to the public, describe the training programs that prepare them to practice their profession, explain their qualifications and the credentials they possess, and articulate the similarities and differences between members of their own profession and other similar groups. In addition, those with a strong professional identity feel a significant pride in being a member of their profession and can communicate this special sense of belonging to those with whom they interact.

From Chapter 2 of *Ethical, Legal, and Professional Issues in Counseling*, Fourth Edition. Theodore P. Remley, Jr., Barbara Herlihy. Copyright © 2014 by Pearson Education, Inc. All rights reserved.

## 1 The Case of Rebekah

Rebekah is a third-grade teacher who recently completed her master's degree in counseling. Because her school district employs counselors only at the high school level, she has assumed that she will have to move to another district in order to fulfill her goal of being an elementary school counselor. She is very excited when her principal calls to tell her that the school board is going to consider hiring either counselors or school social workers for the elementary schools. The principal asks her to attend the next school board meeting and speak about what an elementary school counselor does and how counselors differ from social workers. Rebekah wants to give a very persuasive talk so that the board will decide to hire counselors and, she hopes, offer her one of the new positions. She asks you for advice on what to say and how to say it.

- What advice would you give Rebekah, in terms of the information she should present?
- What arguments do you think would be most persuasive in influencing the board members to hire counselors?

**Discussion:** Rebekah might gather all the information available from the American School Counselor Association (ASCA) regarding the unique role of school counselors in elementary schools. She should summarize this information for the school board members. She should also be prepared to explain the differences between the roles of school social workers and school counselors at the elementary school level.

The most influential information Rebekah could present would be data showing that elementary school counselors make a difference in schools in terms of students' academic achievement, satisfaction of parents with the school, and satisfaction of parents, teachers, and administrators with elementary school counseling programs. Providing testimonials from students, parents, teachers, and principals in schools that have effective elementary school counseling programs might also be very effective.

We hope this chapter helps you clarify your professional identity as a counselor and also helps you tell others about the profession of counseling. It is also intended to help you understand and appreciate the history of the counseling profession, the professional associations that serve counselors, graduate program accreditation, and the credentials available to counselors.

## PHILOSOPHY UNDERLYING THE COUNSELING PROFESSION

Counselors have a distinct belief system regarding the best way to help people resolve their emotional and personal issues and problems. This belief system provides the foundation for the professional identity of counselors. Basically, counselors share the following four beliefs regarding helping others with their mental health concerns:

1. The best perspective for assisting individuals in resolving their emotional and personal issues and problems is the wellness model of mental health.
2. Most of the issues and problems that individuals face in life are developmental in nature, and understanding the dynamics of human growth and development is essential to success as a helper.



3. Prevention and early intervention are far superior to remediation in dealing with personal and emotional problems.
4. The goal of counseling is to empower individual clients and client systems to resolve their own problems independently of mental health professionals and to teach them to identify and resolve problems autonomously in the future.

### **The Wellness Model**

The first belief that counselors share is that the wellness model of mental health is the best perspective for helping people resolve their personal and emotional issues and problems (Hermon & Hazler, 1999; McAuliffe & Eriksen, 1999). Myers, Sweeney, and Witmer (2000) have developed a comprehensive model of wellness specific to counseling. Historically, the primary model used by other mental health professionals in the United States to address emotional problems was the medical or illness model, an approach created by physicians in caring for persons with physical illnesses.

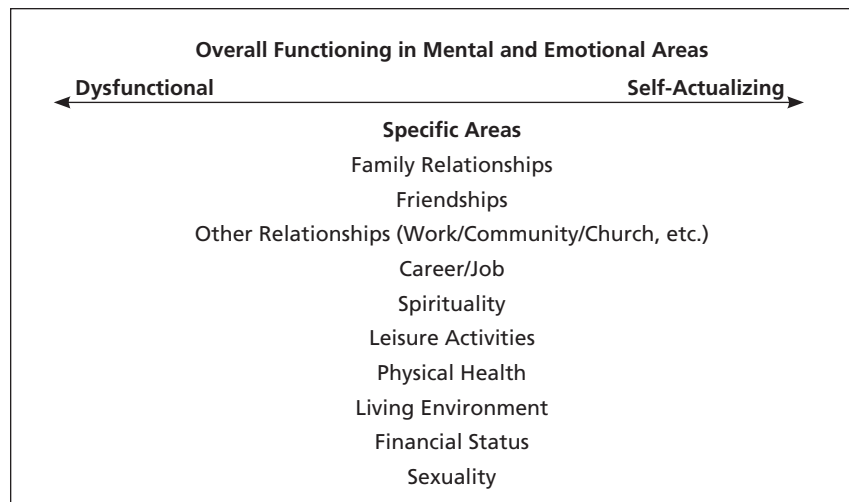
In the medical model, the helper identifies the illness presented by the person asking for assistance. The diagnosis of the illness is always the first step in helping. This perspective assumes that the client is diminished in some significant way. The goal of the professional helper is to return the help seeker to the level of functioning enjoyed before the illness occurred. Once the illness has been isolated, the helper applies scientific principles in curing the illness. If the helper is successful and the illness is cured, the client then goes on about life. If another illness negatively affects the client's well-being, the client returns to the helper to be cured again.

Psychiatrists who are physicians are educated to approach mental health issues utilizing the medical model. Other mental health professions, including clinical psychology, psychiatric nursing, and clinical social work, came into existence when the medical model was prevalent and have their roots in this tradition as well.

Counselors, on the other hand, belong to a newer profession with a different tradition. Counselors have adopted the wellness model of mental health as their perspective for helping people, and there is evidence that counseling from a wellness perspective is an effective method of helping clients (Myers & Sweeney, 2004b; Prochaska, DiClemente, & Norcross, 1992; Tanigoshi, Kontos, & Remley, 2008; Westgate, 1996). In the wellness model, the goal is for each person to achieve positive mental health to the degree possible. From a wellness perspective, mental health is seen as occurring on a continuum (Smith, 2001). At one end of the scale are individuals who are very mentally healthy. Maslow (1968) described people who are fully functioning mentally and emotionally as *self-actualizing*. At the other extreme are persons who are dysfunctional because of mental problems. Such people might include persons with schizophrenia who do not respond to any kind of treatment or intervention.

In addition to this general continuum of mental health, the wellness orientation also views mental health as including a number of scales of mental and emotional functioning (see Figure 1). These scales represent an individual's mental and emotional wellness in important areas of living. Counselors assess a client's functioning in each of these areas to determine where attention within counseling might best be focused to increase wellness. They include family relationships, friendships, other relationships (work/community/church, etc.), career/job, spirituality, leisure activities, physical health, living environment, financial status, and sexuality.

Counselors assess clients' current life situations and help determine which factors are interfering with the goal of reaching their maximum potential. Many persons are limited by physical disabilities or environmental conditions that cannot be changed. Keeping such limitations in mind, counselors assist their clients in becoming as autonomous and successful in their lives as possible.



**FIGURE 1** The wellness orientation to mental health

Although the distinctions between the medical model and the wellness model can be clearly articulated, there is considerable overlap when they are put into practice. Many individual practitioners within the other mental health professions deviate from the illness model. In fact, evidence that the medical profession has adopted many elements of the wellness model can be seen in current trends toward preventive medicine, consumer education, and patient rights. Increasingly, medical practitioners are coming to view patients as partners in their own health care, and this trend is also evident in the approaches of many psychiatrists, psychologists, and other mental health professionals. At the same time, today's counselors are educated to use the medical model of diagnosing mental disorders (the *DSM* system) and often render such diagnoses as a component of the services they provide.

Within the counseling profession there is an increasing recognition of the importance of advocating for clients who face societal and institutional barriers that inhibit their access or growth and development (Hunt, Matthews, Milsom, & Lammell, 2006; Ingersoll, Bauer, & Burns, 2004; Myers & Sweeney, 2004a). Client advocacy has long been a tradition in social work practice, but until recently it has not been emphasized in the training of counselors, other than rehabilitation counselors. Two new standards in the 2005 *ACA Code of Ethics* (A.6.a. and A.6.b.) reflect the commitment of the entire counseling profession to client advocacy.

Mental health professionals who operate from the illness model might treat patients or clients in ways that appear similar to the way they would be treated by mental health professionals who embrace the wellness model. For example, mental health professionals who espouse either model would most likely provide individual or group counseling services, spend time talking with clients, take clinical notes, and render a diagnosis of any mental disorders the person may have. Perhaps the primary differences between the two are in the attitude of the professional toward the client and the focus of the professional's clinical attention. Counselors see the client as having both the potential and the desire for autonomy and success in living rather than having an illness that needs to be remediated. In addition, the goal of counseling is to help the person accomplish wellness rather than cure an illness. Hansen (2003, 2005, 2006, 2007) has written a series of articles that question many of the current practices and language used by counselors, suggesting that the counseling profession may be moving away from its foundational beliefs by classifying itself as a health care profession.

### **A Developmental Perspective**

A second belief that counselors share is that many personal and emotional issues can be understood within a developmental perspective. As people progress through the life span, they meet and must successfully address a number of personal challenges. Counselors believe that most of the problems people encounter are developmental in nature and therefore are natural and normal. Problems that some other mental health professionals might view as pathological, and that counselors would see as developmental, include the following:

- A 5-year-old crying as if in terror when his mother drops him off for the first time at his kindergarten class
- An 11-year-old girl who seems to become obsessed with boys
- A teenager vigorously defying his parents' directives
- A 19-year-old boy becoming seriously depressed after breaking up with his girlfriend
- A young mother becoming despondent soon after the birth of a child
- A 35-year-old man beginning to drink so much he is getting into trouble after 15 years of social drinking
- A 40-year-old woman feeling worthless after her youngest child leaves home for college
- A 46-year-old man having an affair with a younger woman after 23 years of a committed marriage
- A 65-year-old woman feeling very depressed as her retirement approaches
- An 80-year-old man forgetting so much that he is concerned that he is losing his mind

By studying the developmental stages in life and understanding tasks that all individuals face during their lives, counselors are able to put many problems that clients experience into a perspective that views these problems as natural and normal. Even problems viewed as psychopathological by other mental health professionals, such as severe depression, substance addiction, or debilitating anxiety, could be seen as transitory issues that often plague people in our society and that must be dealt with effectively if individuals are to continue living in a successful fashion.

### **Prevention and Early Intervention**

A third philosophical assumption of counselors is our preference for prevention rather than remediation of mental and emotional problems (Conyne & Horne, 2001; Kulic, Dagley, & Horne, 2001; McCarthy & Mejía, 2001; Owens & Kulic, 2001; Sapia, 2001; Wilson & Owens, 2001). When prevention is impossible, counselors strive toward early intervention instead of waiting until a problem has reached serious proportions.

A primary tool that counselors use to prevent emotional and mental problems is education. Counselors often practice their profession in the role of teacher, using psychoeducation as a tool. By alerting clients to potential future areas that might cause personal and emotional distress and preparing them to meet such challenges successfully, counselors prevent problems before they arise. Just a few examples of prevention activities are parenting education programs, assertiveness training seminars, career exploration groups, and premarriage counseling.

When the time for prevention has already passed and a client is experiencing personal or emotional problems, counselors prefer seeing clients early in the process. Counselors believe that counseling is for everyone, not just for individuals who have mental illnesses or emotional disorders. By providing services to individuals when they begin to experience potentially distressing events in their lives, counselors hope to intervene early and therefore prevent problems from escalating. For instance, counselors would prefer to see a client who is beginning to have feelings of depression



rather than someone who could be diagnosed as having an episode of severe depression. Counselors would encourage couples who are beginning to experience problems in their relationship to seek counseling rather than wait for their problems to escalate into serious marital discord.

### **Empowerment of Clients**

The fourth belief that counselors share regarding the helping process is that the goal of counseling is to empower clients to problem-solve independently (Chronister & McWhirter, 2003; Lynch & Gussel, 1996; Savage, Harley, & Nowak, 2005). Through teaching clients appropriate problem-solving strategies and increasing their self-understanding, counselors hope that clients will not need assistance in living their lives in the future. Realizing that individuals often need only transitory help, counselors also try to communicate to clients that asking for and receiving help is not a sign of mental or emotional weakness, but instead is often a healthy response to life's problems.

It is quite easy for individuals to become dependent on those who provide help to them. Some systems of mental health care seem to encourage a pattern of lifelong dependence. Counselors recognize this problem and encourage clients to assume responsibility for their lives and learn to live in a manner that allows them autonomy and independence as those concepts are understood within the clients' cultures. Although some people may need assistance throughout their lives because of a physical or mental disability, all clients are helped to become as independent as their circumstances will allow. Counselors do not present themselves as experts in mental health who must be consulted when problems arise. Rather, counselors communicate the belief that clients are capable of developing the skills they need for independent living and wellness.

## **COUNSELING SERVICES**

To achieve a strong professional identity as a counselor, it is essential that you understand the philosophy of helping we have just described. In addition, you need to be knowledgeable about the kinds of services that counselors provide to the public, even though the services that counselors provide do not define the profession. Actually, counselors engage in a number of the same activities as do other professionals. The key to a strong professional identity is the philosophy underlying the services, not the services being rendered.

The basic service that counselors provide is counseling—with individuals, couples, families, and groups. All other mental health professionals counsel patients and clients, too. A major difference between counselors and other mental health professionals who counsel is that counseling is the *primary* professional service that counselors provide. By contrast, the primary service that psychiatrists provide is the diagnosis and medical treatment of mental disorders as a physician; psychologists primarily provide assessment; psychiatric nurses provide management of mental health care within a hospital setting; and social workers link clients to community resources. For mental health professionals other than counselors, counseling may be a secondary or ancillary service.

In addition, a number of other professionals outside the mental health field call the service that they provide to clients *counseling*. For example, attorneys provide legal counseling, accountants offer financial counseling, and physicians offer counseling to their patients regarding their physical health. Counselors, in contrast to these non-mental-health professionals, provide mental health counseling services to clients.

In conjunction with counseling, counselors also perform a number of other professional services. These services include assessment, teaching, diagnosing, case management, and advocacy. Despite performing these other duties, the primary service provided by counselors is mental health counseling.

## Professional Identity of Counselors

Counselors have a number of job titles, roles, and duties in their professional positions. In order to develop a strong professional identity, you must know when you are functioning as a counselor and when you are performing other roles in your professional position. You must also be able to identify the types of professional services that counselors render to the public.

## COUNSELOR PREPARATION PROGRAMS

Ask lawyers what they were taught in law school, physicians what they were taught in medical school, and engineers what they were taught in engineering school, and they can easily and clearly describe the courses they were taught, the practical components of their educational experience, and the topics covered in their preparation programs. To develop a strong professional identity, it is vital that you are also able to describe your training program components. By describing the educational programs that prepare counselors, you summarize the essential nature of counseling as a profession and emphasize the basic knowledge required for becoming a counselor.

An essential aspect of counselor training is that the profession considers individuals to be professionals after they have completed a master's degree. Although master's degrees are the required professional degree in both psychiatric nursing and clinical social work, psychiatry requires a medical degree and residency in psychiatry, and psychology requires a doctoral degree for the achievement of professional status. One of the primary differences between counseling psychology and the profession of counseling is that counseling psychologists must hold doctorates to be considered professionals, whereas counselors are considered professionals at the master's degree level.

In addition, counseling skills are the primary focus of the counseling master's degree training programs. Although other subjects are taught, all of the training emphasizes competency in the areas of individual and group counseling. The other courses required in master's degree programs, such as research, assessment, multicultural counseling, and career counseling, are meant to strengthen the counseling skills of graduate students.

Counseling graduate programs generally are located in colleges of education within universities. The profession of counseling has its foundations in pedagogy and psychology, particularly in counseling psychology and human growth and development. All these fields have their roots in colleges of education, which is why counseling graduate programs are usually located there. Some counselor educators and counselors are concerned that this implies that counselors are being prepared to function only in educational settings, such as schools or colleges. They believe that the general public's perception is negatively affected when they think of all counselors as being prepared and practicing in the same way that school guidance counselors were prepared and practiced at the beginning of the school counseling movement in the 1950s. The reality is that the counseling process is educational in nature, and although counselors do not educate in formal classrooms like traditional teachers, counselors do educate their clients. Being located in colleges of education strengthens counseling graduate programs because the colleges emphasize pedagogy, human growth and development, applied research, and field placements as essential components of learning skills.

The counseling profession created the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to set national standards for the preparation of master's- and doctoral-level counselors (CACREP, 2009). CACREP was begun during the 1960s under the leadership of Robert O. Stripling, a counselor educator at the University of Florida. CACREP began as a project of the Association of Counselor Education and Supervision (ACES), a division of the ACA, and now functions as a separate corporation affiliated with ACA (CACREP).

CACREP has established standards for the preparation of counselors (CACREP, 2009). These standards require a minimum of 2 years or 48 to 60 semester hours in master's degree programs that prepare counselors. In addition, the programs must include instruction in the following content areas: (a) human growth and development, (b) social and cultural foundations, (c) helping relationships, (d) group work, (e) career and lifestyle development, (f) appraisal, (g) research and program evaluation, and (h) professional orientation. CACREP requires that students complete a 100-hour practicum and a 600-hour internship. The CACREP standards also require that program faculty be counselors themselves, that programs have a laboratory for training, and that a number of other requirements for quality instruction be met.

Currently, of the more than 1,600 master's and doctoral degree programs in counseling in the United States (Schweiger, Henderson, McCaskill, Clawson, & Collins, 2011), 525 programs, housed in 216 different colleges and universities, are CACREP accredited (CACREP, 2009). Many programs that are not yet accredited have patterned their master's degree programs after the standards developed by CACREP. Although not all of the counseling graduate degree programs in the United States are accredited by CACREP, it is accurate to say that CACREP standards have been accepted by the profession as the model curriculum for preparing master's- and doctoral-level counselors. Because graduation from a CACREP-accredited program is one type of credential that a counselor might possess, CACREP accreditation will be discussed further in the next section.

## **CREDENTIALING**

One of the greatest challenges faced by those entering the profession is to understand counselor credentialing. Credentialed individuals possess some type of indicator that they are legitimate professionals. Credentialing comes in many forms, which is the basic reason people are so confused by it. Additionally, some credentials are essential to the practice of the profession, others are desirable but not necessary, and still others are of questionable value or even worthless.

This section contains a discussion of credentials and should assist you in conceptualizing and understanding counselor credentials. A major problem that causes confusion among counselors and the public is that terminology is not consistent within the area of credentialing. The major types of counselor credentials are degree, state license, state agency certification, national voluntary certification, and program accreditation.

### **Degree**

The most obvious credential that counselors hold is the master's degree. Other degrees, such as specialist or doctorate degrees, are credentials as well.

Counselors hold a variety of master's degree titles. A legitimate counselor might hold a Master of Education (M.Ed.), Master of Arts (M.A.), Master of Science (M.S.), Master of Divinity (M.Div.), or another, more unusual master's degree title. Most of the titles of master's degrees given in various universities were decided long ago and generally have little to do with any differences in the actual program content. The degree title in no way indicates whether a degree program requires a specified number of credits, includes a thesis, or has other specific requirements. In many universities, degree titles are decided politically among the various faculties. For example, a number of counseling master's degree programs award M.Ed. degrees because the degree programs are offered within university colleges of education.

Although the basic credential for a professional counselor is a master's degree in counseling, many counselors hold higher degrees, including specialist's degrees, certificates of advanced study,

and doctoral degrees. Doctoral degrees in counseling usually are either the Doctor of Philosophy (PhD) or the Doctor of Education (EdD), although some counseling doctoral programs might have titles such as Doctor of Arts (DA) or Doctor of Divinity (DDiv).

### State License

In most states, a license issued by the state is required before a person is allowed to practice counseling in that state. This licensure affects private practice counseling most directly because most licensure statutes state that counselors who practice in many other settings are exempt from the licensure requirement. For example, in most states, counselors who practice in local, state, or federal agencies; in nonprofit corporations; or in schools or other educational institutions are exempt from the licensure requirement. Often when professions are first licensed, many exemptions are granted to the licensure requirement. This occurs because of a concern that, if licensure were required for all members of that profession, agencies that traditionally pay less for the professionals' services would not be able to attract employees. For example, when physicians were first licensed by states, physicians employed in a number of settings were exempt from licensure. Over the years, these licensure exemptions have been removed for physicians, and now almost all physicians, no matter where they practice, must have a state license. The same removal of exemptions will most likely occur over time in the counseling field as well.

Unfortunately, counseling licensure statutes have various titles. In some states, counselors credentialed by the state are called *licensed*, and in other states they are referred to as *certified*. In some states, they have even been called *registered*.

In the more general arena of state regulation of professions, the terms *licensed*, *certified*, and *registered* have separate and specific meanings. A licensure law is referred to as a *practice law*, which means that the professional must be licensed to practice that profession in that state. A certification law is what is known as a *title law*, which means that a person must be certified to use the title of *certified professional*, but that the practice of that profession is not regulated by the state. Finally, a registration law was intended to mean that a professional had to *register* with the state, but that no credentials would be required for registration. These terms, however, have been used interchangeably from state to state and from profession to profession. For example, registered nurses in almost all states really are licensed. In addition, most current state registration laws do require that registered persons have some type of credentials before they will be added to the state registry.

Currently, in some states licensed counselors actually function under title laws, and some certified counselors, in reality, are operating under practice laws. As an individual counselor who wants to practice in a particular state, you should ascertain exactly what the state credential (whether a license, a certificate, or a registry) entitles the credentialed person to do. You do not have to fully understand the complexity of all state regulatory laws to understand what the particular law means in your state. The American Association of State Counseling Boards (AASCB) provides a listing of contact information for state licensure boards (AASCB, 2008). In addition, the National Board for Certified Counselors (NBCC) provides contact and testing information for state counselor licensure boards (NBCC, 2008a). All 50 states, the District of Columbia, Puerto Rico, and Guam now have laws that regulate the profession of counseling.

To add to the confusion regarding state counselor licensure laws, states have given a number of titles to counselors who are licensed. The most common title is that of professional counselor. However, other states use titles such as mental health counselor or clinical counselor. The individuals who proposed the counselor licensing laws in each state decided which title to use. In some cases, titles were chosen to satisfy political compromises that had to be made to obtain legislative support for the bills.

### **State Agency Certification**

As the term is used here, *state agency certification* is different from state licensure. It was explained previously that in some states, counselors are certified rather than licensed. However, in this section, the term *certification* is used to refer to the process whereby official agencies of the state certify individuals as qualified to hold certain state jobs. In most states, this agency process is referred to as *certification*, although some call it *licensure*.

The most obvious state agency certification process is for school counselors. In each state the department of education determines which counselors may be certified as school counselors. Schools in that state must hire certified school counselors, just as they must hire only certified school teachers, in order to maintain their school accreditation. The requirements for being certified as a school counselor vary widely from state to state. In some states, school counselors must first be certified, experienced school teachers before they can become certified as school counselors, although this teacher certification requirement is being eliminated in most states. The requirements for state school counselor certification should be obtained from the state department of education in the state in which you wish to practice.

Another area in which counselors are certified by the state is in substance abuse counseling. Most states have different levels of certified substance abuse counselors, sometimes including counselors who hold less than a bachelor's degree. State agencies that provide substance abuse treatment services are required to hire only certified counselors who meet state requirements for certification. Information regarding state requirements for substance abuse counselors can be obtained from the National Association of Alcoholism and Drug Abuse Counselors.

Rehabilitation counseling is another specialty area that involves varying state requirements. Although state rehabilitation agencies do not certify vocational rehabilitation counselors, they have established minimum requirements for rehabilitation counselors that vary from state to state. Information regarding the requirements for being hired as a vocational rehabilitation counselor can be obtained from each state's rehabilitation agency.

### **National Voluntary Certification**

The two national certification agencies of the counseling profession are the National Board for Certified Counselors (NBCC) and the Commission on Rehabilitation Counselor Certification (CRCC). NBCC has certified more than 80,000 counselors since its inception and currently certifies more than 40,000 (NBCC, 2012b) and, in 2012, CRCC had over 16,000 certified rehabilitation counselors and has certified over 35,000 since it began (CRCC, 2012). National certification is voluntary in that there is no governmental requirement for private practice that a counselor be certified. Even though a counselor may be required to be licensed in a state to practice counseling, there is no legal need for that same counselor to be certified by NBCC or CRCC. Counselors choose to become nationally certified to demonstrate they have met the highest national standards developed by their profession. National certification is sometimes used as a job prerequisite as well, especially in the field of rehabilitation counseling.

The counseling profession created the NBCC in 1982 as the national agency to certify counselors who had met the minimum requirements of the profession (Stone, 1985). A National Certified Counselor (NCC) is an individual who has met the requirements set forth by NBCC. NBCC now functions as an independent corporation with its own board of directors. It was important for the profession to create NBCC so that the profession, rather than each individual state legislature, could determine the minimum requirements for being a professional counselor. In the same vein, it is

important for counselors to support NBCC by becoming NCCs as soon as they are qualified to do so. In addition, counselors who hire other counselors should indicate that NCCs are preferred.

In order to become an NCC, a counselor must complete a master's degree in counseling, have 2 years of post-master's experience, and pass the National Counselor Examination. The 2 years of post-master's experience is waived for graduates of CACREP-accredited programs.

Every profession has national voluntary certification of specialists within that profession. NBCC has created specialty certification for the counseling profession. Although some believe that states should license counselors as specialists (Cottone, 1985; Emener & Cottone, 1989), Remley (1995) has argued that states should license counselors generally and NBCC should certify specialists. His position is that the role NBCC plays in certifying counselors as specialists within their chosen areas is vital to the success of the counseling profession. He believes that specialty designations should be voluntary and should be offered by a national body such as NBCC.

To become certified as a specialist by NBCC, a counselor first must be an NCC. Currently, NBCC offers specialty certification in mental health, school, and addictions counseling. The specific requirements for becoming specialty certified in one or more of these fields can be obtained by contacting NBCC. In addition, an affiliate of NBCC, the Center for Credentialing and Education (CCE), offers an additional specialty certification, clinical supervision (CCE, 2012).

Rehabilitation counseling specialists began certifying rehabilitation counselors before NBCC was formed. As a result, that specialty certification is offered by a separate certifying agency, the CRCC.

In addition to NBCC and CRCC, there are a multitude of other national voluntary counselor certifications available to counselors. Some of these certifications have high standards and are multidisciplinary in nature. Others are simply designed to make money for the individuals who created them. If you are interested in a national certification for counselors offered by a group other than NBCC or CRCC, you should investigate the group's reputation among members of the counseling profession, the organizational structure of the group, and the general legitimacy of the credential.

NBCC is providing leadership in helping other countries establish the profession of counseling. The international affiliate of NBCC, known as NBCC International, has established relationships with counselors in a number of countries and is helping them become recognized as professionals (NBCC International, 2012).

### **Program Accreditation**

In an earlier section in this chapter, the training of counselors is summarized. The standards for preparing counselors that have been agreed upon by the counseling profession are included in the accreditation standards of CACREP, detailed in the earlier section. The Council on Rehabilitation Education (CORE) accredits master's degree programs in the specialty area of rehabilitation counseling.

A counselor's graduation from a CACREP-accredited or CORE-accredited counseling graduate program is a credential. Although many highly competent counselors are graduates of non-CACREP-accredited programs, the CACREP credential does distinguish counselors as having completed a preparation program that meets the standards of excellence for the profession. Counselors can indicate on their resumes that they are CACREP-accredited or CORE-accredited program graduates. Many job announcements now indicate that CACREP-accredited or CORE-accredited program graduates are preferred.

The most comprehensive listing of graduate programs in counseling is found in a directory produced by Schweiger, Henderson, McCaskill, Clawson, and Collins (2011). In the most recent edition of that directory, over 1,000 master's-level programs and over 200 doctoral programs were listed. The master's degree programs focus on the following specialty areas: community counseling,



marriage and family counseling or therapy, mental health counseling, pastoral counseling, rehabilitation counseling, school counseling, college counseling, and miscellaneous specialty areas. The doctoral programs listed are divided into the following areas: counselor education and supervision, counseling psychology, marriage and family counseling/therapy, rehabilitation counseling, college counseling, pastoral counseling, and miscellaneous specialty areas.

Only master's and doctoral degree programs offered by regionally accredited universities are listed in the directory. Nonaccredited universities also offer graduate degrees in counseling. However, individuals who graduate from these nonaccredited university degree programs often are unable to have their degrees recognized for the purposes of licensure, certification, or employment.

Accreditation of the university that offers degree programs in counseling, therefore, is essential for recognition. In addition to university accreditation, separate accreditation of counseling programs is important. Many state licensure statutes for counselors require the same preparation courses and field experiences as CACREP requires. In addition, NBCC has essentially the same preparation standards as CACREP.

Because the rehabilitation counseling specialty established a mechanism for accrediting master's degree programs before counseling in general began accrediting master's and doctoral degree programs, the counseling profession has two recognized program accreditation groups—CORE and CACREP. CORE accredits only master's degree programs in rehabilitation counseling. CACREP accredits master's degree programs in career counseling; student affairs and college counseling; clinical mental health counseling; marriage, couple, and family counseling; school counseling; and addiction counseling, and doctoral programs in counselor education and supervision.

In 2008, CACREP adopted program accreditation changes that went into effect in 2009 (CACREP, 2009). One major change was that the community counseling and mental health counseling specializations were combined into one program that includes 60 semester credits and requires 600 hours of internship rather than 900. Another major change was that newly hired full-time faculty members now must hold a doctoral degree in counselor education if they do not have previous experience teaching in a counselor education program.

CORE and CACREP reflect the minimum preparation program standards that have been agreed upon by the profession for master's and doctoral degree programs in counseling. If you want to determine whether programs that are not accredited by CORE or CACREP reflect these minimum standards, you could compare the degree requirements of these programs to the CORE or CACREP standards.

In established professions such as medicine, law, and even psychology, all preparation programs are either accredited by their professional accreditation bodies or are actively pursuing accreditation. Graduates of nonaccredited programs in those professions are unable to obtain state licenses to practice or are unable to secure desirable jobs (LaFountain & Baer, 2001). It is likely that, eventually, all master's and doctoral degree programs in counseling will be either CORE accredited or CACREP accredited as well.

### **Ethical Standards Related to Credentialing**

Professional counselors are ethically required to present their credentials accurately. According to the *ACA Code of Ethics* (2005), counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. They clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training (Standard C.4.a.). With respect to degrees held, counselors may advertise only the highest degree earned that is in counseling or a closely related field (Standard C.4.d.). Some counselors hold a master's degree in counseling and a doctoral degree in another field.



As you acquire various professional credentials, you certainly will want to advertise them. Your professional association's code of ethics imposes few restrictions on advertising (Standard C.3.), and those are limited to restrictions that can be clearly justified to protect the public. Nonetheless, you must know precisely what limits are contained in the code. In some circumstances, however, it is difficult to determine what the ACA *Code of Ethics* allows.

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## 2 The Case of Kevin

Kevin earned his master's degree in counseling 8 years ago and has been working as a staff counselor in a psychiatric hospital since he graduated. In addition to this employment, he opened a part-time private practice when he became licensed as a professional counselor. Kevin recently completed his doctorate in health care administration from a nontraditional distance learning university in California. He is now focused on his goals of moving into an administrative position within the hospital as well as building up his private practice in case an administrative job opportunity does not occur. He decides to update the business cards and brochures he uses in his private practice, and changes the wording to present himself as "Kevin Smith, PhD, MS, LPC, Professional Member of the American Counseling Association."

- Do you see anything wrong with the wording on Kevin's cards?
  - Do you believe a doctorate in health care administration could be considered a doctorate in counseling or a closely related field?
- 

**Discussion:** All of his credentials on his card are directly related to counseling except his PhD, which is in health care administration. If his doctorate was earned from a university that was not accredited by one of the regional accrediting bodies, then the legitimacy of his degree would be questionable. He must be careful not to mislead the public into believing that he has a legitimate doctoral degree. Whether the university from which he earned his degree is accredited by a regional accrediting body is not known. Many nontraditional distance learning universities do hold regional body accreditation.

There are arguments for and against recognizing a PhD in health care administration as a doctorate in a closely related field to counseling. On the one hand, counseling is a form of health care, and a specialty within health care could easily be mental health care administration. On the other hand, general health care administration is not a mental health field. Perhaps the best way for Kevin to ensure that he is acting ethically, even though it might be a bit awkward, would be for him to spell out on his business cards that his PhD degree is in health care administration and his MS degree is in counseling.

Basically, advertising must be accurate and must not be false, misleading, deceptive, or fraudulent (Standard C.3.a.). When you become aware of any misrepresentation of your credentials that might be made by others, you are responsible for correcting the misinformation (Standard C.3.c.). Because many counselors hold multiple credentials, their business cards and advertising brochures can sometimes resemble a kind of alphabet soup. A counselor's degrees, licenses, certifications, and professional memberships might include, for instance, MS (Master of Science) from a CACREP

accredited counseling program, LPC (Licensed Professional Counselor), NCC (National Certified Counselor), CCMHC (Certified Clinical Mental Health Counselor), CADAC (Certified Alcohol and Drug Abuse Counselor), and ACA Professional Member. It is important for counselors to make efforts to ensure that the *meaning* of these credentials is clear to potential consumers of their services.

Finally, as a credentialed counselor, you must be careful not to attribute more to your credentials than the credentials actually represent (Standard C.4.a.), and you should not imply that other counselors are not qualified because they do not possess the same credentials as you do or because they lack certain credentials (Standards C.4.a. and D.1.a.). For example, it would be inappropriate for a Certified Alcohol and Drug Abuse Counselor to say or infer that a mental health professional had to have that credential in order to be competent to counsel clients regarding substance abuse or dependency problems. Also, it would not be professional to denigrate the preparation of licensed psychologists by inferring that their degree programs have prepared them less adequately for mental health practice than have the degree programs of licensed professional counselors.

## **EVOLUTION OF THE COUNSELING PROFESSION**

History is in the eye of the beholder. In other words, people view history from their own personal perspectives. A number of authors have attempted to summarize the history of the counseling profession, and each summary is different (Bradley & Cox, 2001; Gibson & Mitchell, 2008; Hershenson, Power, & Waldo, 1996; Sweeney, 2001). Various authors emphasize different events and give their own interpretations to facts that have led them to various conclusions. The following summary represents a brief view of the history of the counseling profession that recognizes the input of others and adds our perspectives based on our observations as leaders and members of the profession.

### **Origins of the Profession**

At the same time that the psychology profession was establishing the doctoral level as the requirement for professional status and counseling psychology was developing as a specialty area within it, historical events were leading to the rapid development of school counseling programs and vocational rehabilitation counseling. Eventually, changes within counseling psychology, the school counseling movement, and federal funding of vocational rehabilitation counseling led to the emergence of the new profession of counseling.

### **Counseling Psychology**

The counseling profession basically shares its history with the emergence of counseling psychology as a specialty within the psychology profession (Goodyear, 2000). Early leaders in the specialty of counseling psychology distinguished themselves from other psychologists by declaring that they were interested in the normal, healthy development of human beings rather than in illness and psychopathology. In counseling psychology, the focus was on developmental stages in people's lives and career concerns. World War I and the work of Frank Parsons on career classifications provided the impetus for the development of counseling psychology as a separate specialty within psychology. Parsons created a concept in the United States that citizens should be assisted in selecting careers that would be rewarding and matched to their abilities and interests (Gibson & Mitchell, 2008).

Although the field of psychology has offered doctoral degrees for quite some time, at the beginning of its political movement to become a profession, psychology recognized individuals with

master's degrees as professional psychologists. Several decades ago, the American Psychological Association (APA) declared that, in the future, only psychologists who held doctoral degrees would be recognized as professionals. The profession decided to continue to recognize all existing psychologists who held master's degrees and allow them to practice, but in the future to allow only individuals who held doctoral degrees in psychology into the profession. Licensure laws in psychology throughout the United States were changed to reflect this new political position.

Despite APA's declaration that only psychologists at the doctoral level would be recognized as professionals, universities throughout the United States continue today to offer master's degrees in clinical and counseling psychology. Essentially, these master's degree programs in psychology have produced and are continuing to produce graduates who have limited or no professional recognition in psychology. Graduates of these master's degree programs most often seek and obtain licensure as counselors in states that have counselor licensure laws. When graduates of master's degree programs in clinical or counseling psychology become counselors through the process of state counselor licensure, the professional identities of both psychologists and counselors become blurred, and the public becomes more confused about the differences between the two professions. In addition, a number of licensure boards have adopted rules in the last few years that do not recognize master's degrees in psychology as acceptable for licensure as professional counselors.

### **School Counseling**

When the Russians launched the first spacecraft, Sputnik, in 1957, politicians in the United States feared that, because the Russians had exceeded our technology and beat us in the "race to space," they might overpower us politically as well. In response to this fear, Congress created and funded substantial programs to encourage young people to seek careers in technical and scientific fields. Part of this effort included placing counselors in high schools to channel students into math and science courses. Throughout the United States, universities created summer institutes in which high school teachers were given basic courses that led to their placement in high schools as guidance counselors. In most instances, high school teachers were given two or three courses in *guidance* or *counseling*, which then allowed them to be certified as school counselors and assume guidance counselor positions within schools. Because the primary purpose of this effort was to encourage students to take math and science courses, it did not seem necessary for counselors to be prepared beyond the training provided in these summer institutes.

In a very short time, school accreditation groups required that high schools have guidance counselors in order to receive or continue their accreditation. Today, middle and high school accreditation requires that these schools have counselors, and in some areas of the country elementary schools are required to have counselors as well. Almost all states now require that certified school counselors have received the master's degree and have completed specified courses and an internship. For a school counseling program to achieve CACREP-accredited status, the master's degree must include a minimum of 48 semester hours.

### **Vocational Rehabilitation Counseling**

In the 1950s, there was a recognition in the United States that citizens with physical and mental disabilities were not being given the help they needed to become productive members of society. As a result, legislation was passed that provided counseling and educational resources that were meant to rehabilitate persons with disabilities so that they could function as autonomously as possible.

A major component of this rehabilitation legislation was funding to prepare counselors to help disabled persons evaluate their disabilities, make plans to work, and find satisfactory employment.

As a result of this funding, master's degree programs in rehabilitation counseling were developed and existing programs were expanded. State rehabilitation agencies created positions in rehabilitation case management and counseling for the graduates of these programs.

In summary, the dynamics around the creation of the specialty of counseling psychology, the decision within the psychology profession that professionals would be recognized only at the doctoral level, the emergence of school counseling, and the funding of vocational rehabilitation counseling programs led to the creation of counseling as a separate profession. Clearly, the origins of the profession lie in the convergence of several disparate forces rather than in a single event.

### **Counseling as a New Profession**

An entire area of scholarly inquiry in the field of sociology studies the emergence of new professions. Scholars within this field have identified the essential factors that define what a profession is and what steps a group must go through to establish itself as a legitimate, separate, and unique profession. In relation to other professional groups in general and to mental health professional groups in particular, counseling is a relatively new professional entity. In order to understand some of the difficult problems facing the counseling profession today, it is important for counselors to compare counseling to other, older mental health professions, to ascertain where we are in the process of becoming a fully recognized profession.

Toren (1969) defined a fully developed profession as one that has the following traits: a body of theoretical knowledge, members who possess competence in the application of this knowledge, and a code of ethics focused on the client's well-being.

A different concept of a profession has been offered by Hughes (1965). He has said that, compared to nonprofessions, emerging professions demand more independence, more recognition, a higher place, a clearer distinction between those inside and those outside the profession, and more autonomy in choosing colleagues.

Six criteria for determining professional maturity have been described by Nugent (1981). According to Nugent, a mature profession and its members have the following characteristics:

- They can clearly define their role and have a defined scope of practice.
- They offer unique services (do something that members of no other profession can do).
- They have special knowledge and skills (are specifically trained for the profession).
- They have an explicit code of ethics.
- They have the legal right to offer the service (have obtained a monopoly, through licensure or certification, over the right to provide the services).
- They have the ability to monitor the practice of the profession (the profession can police itself).

By considering these traits, conceptualizations, and definitions of a mature profession, it is possible to see that the field of counseling fully meets the criteria in some areas and is still struggling in others. Certainly counselors have a well-established code of ethics and have achieved societal recognition through state licensure. Areas that are still weak include identifying services that are uniquely offered by counselors, developing a body of knowledge that belongs specifically to counseling and does not borrow so heavily from psychology, and achieving a higher status within society.

### **Steps in Becoming a Profession**

According to sociologists who have studied emerging professions within society (Abbott, 1988; Caplow, 1966; Dugan, 1965; Etzioni, 1969; Friedson, 1983; Hughes, 1965; Scott, 1969; Toren,

1969), there is a developmental process that professions must go through if they are to be successful in establishing themselves as fully recognized professions.

Caplow (1966) maintained that the steps whereby a group achieves professional status are quite definite, and that the sequence of steps is explicit. The first three steps toward professionalization are (a) forming associations, (b) changing names to reduce identification with the previous occupational status, and (c) developing a code of ethics. Certainly the counseling profession has accomplished these three steps. First, the ACA was chartered in 1952 from three long-standing subgroups. Second, the association's name was changed from the American Personnel and Guidance Association (APGA) to the American Association for Counseling and Development (AACD), and then to the ACA. Each change reduced the identification with words such as *guidance*, *student personnel*, and *student development* and embraced more fully the word *counseling*. Finally, ACA has had a code of ethics since 1961.

Caplow's fourth step in accomplishing the goal of becoming a profession is prolonged political agitation. Members of the occupational group obtain public sanction to maintain established occupational barriers. Counselors have been involved in substantial political agitation since the first counselor licensure law was passed in Virginia in 1976. That political activity has been continued as similar licensure laws have been passed in state after state. In addition, counselors have lobbied state legislators to mandate school counseling programs, to include counselors as providers in health care programs, and to ensure that the professional services of counselors are reimbursed by health care insurance companies. Clearly, counselors have engaged in Caplow's prolonged political agitation, and this process is continuing today.

Counselors have been fighting hard and making a number of changes to overcome the deficiencies that have hindered the development of the profession. Some of the changes that have taken place in the last 20 to 30 years in the field of counseling include the following: The length of most training programs has increased from 30 to 48 or 60 semester hours; efforts have been made to improve the professional status of counselors through credentialing and legislation; laws are continually passed in states granting privileged communication to interactions between counselors and their clients; the body of knowledge is being increased through scholarly publications specifically in counseling, as distinguished from psychology; and counselor licensure laws have brought autonomy from being supervised by others to practice counseling. Evidence suggests that counseling is now close to being a fully recognized profession in the United States.

### **Progress Toward Professionalization**

It is discouraging for graduate students preparing to enter the field to realize that counseling, despite its progress, still has some way to go before achieving recognition on a par with other mental health professions within our society. On the other hand, it is encouraging to note that counseling is making progress toward recognition as a profession at a relatively fast rate when compared to professionalization efforts in other fields. For example, as late as 1982, scholars within psychology wrote in one of their own profession's journals that they doubted that psychology could validly claim to be a profession (Phillips, 1982). The first law establishing psychologists as independent health practitioners was passed in 1968 in New Jersey (Dorken & Webb, 1980), and there are still some states that do not require a license to practice psychology. In comparison, the first counselor licensure bill was passed in Virginia in 1976, and already all states and the District of Columbia have passed licensure bills for counselors.

Although counselors are continuing to work toward full professional status, we will continue to refer to ourselves as professionals and to our field as a profession.

## PROFESSIONAL ASSOCIATIONS OF COUNSELORS

Professional associations are formed by professional groups for a number of reasons. First, associations provide a forum for professionals to gather to discuss issues and problems that exist within the profession. An association allows the members of a profession to address issues as a group rather than work independently on behalf of the profession. Second, professional associations provide leadership by speaking for the profession on critical legislative issues that affect the profession at all levels of government. Professional associations also provide continuing education for their members. Earning a master's degree in counseling is only the beginning of the learning process for counselors. As new information becomes available, counselors must attend conferences and workshops to update their skills and expertise. Professional associations provide such learning opportunities and also publish scholarly journals, texts, monographs, and other media resources for the continuing education of their members. Finally, professional associations publish and enforce a code of ethics for their members. Important hallmarks for professionals are having a code of ethics and policing themselves.

### American Counseling Association

ACA has a number of divisions and state branches that represent the counseling profession and serve counselors in various ways.

You should join ACA when you begin your graduate degree program in counseling and maintain active membership throughout your career as a counselor. Students receive discounted membership. All members, including students, receive a subscription to the counseling professional journal, the *Journal of Counseling & Development*. In addition, members receive a monthly magazine and an on-line news bulletin, *ACAeNews*, which include current political and professional news related to counseling as well as announcements of professional development opportunities, job openings, and advertisements for professional products. Other benefits of membership include the ability to purchase professional liability insurance policies, reduced registration fees for the national convention and national workshops, and discounted prices for texts and media products published by ACA. In the last few years, ACA has begun providing professional liability insurance free to student members of ACA.

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## 3 The Case of Juanita

Juanita recently received her master's degree in counseling and has taken her first full-time job as a counselor at an outpatient substance abuse treatment facility. Although her beginning salary was lower than she anticipated, Juanita is confident that with hard work and determination, she will get promotions and pay raises in the next few years. Immediately after beginning her job, Juanita paid a \$200 fee to register with her state counselor licensure board so that she could complete her 2 years of supervised experience required to become licensed. She also made arrangements with a local licensed counselor to meet weekly at \$50 per meeting for supervision. During her 2 years in graduate school, Juanita had been a student member of ACA and two ACA divisions, the American Mental Health Counselors Association (AMHCA), and the International Association of Addiction and Offender Counselors (IAAOC). In addition, she had been a student member of her state counseling association and the same two state branch divisions. Juanita is also a member of the national counseling scholarship honorary, Chi Sigma Iota, and is a National Certified Counselor (NCC). Both the organization and the certification board require annual dues or renewal payments. Juanita



is on a tight budget and she is thinking that maybe she will not rejoin ACA and the two national divisions or her state counseling association and its two divisions.

- What will Juanita miss if she drops her ACA and national division memberships?
- What will Juanita miss if she drops her state counseling association and two state division memberships?
- How would you advise Juanita?

**Discussion:** Most importantly, if Juanita drops her ACA and national division memberships, she will miss the opportunity to stay informed of new developments in the counseling profession from a national perspective. She will no longer get ACA and division newsletters, announcements of national conferences, discounts for texts and conference registration fees, and bulletins on important matters of interest to counselors. Juanita will also miss opportunities for continued development of her professional identity as a counselor by not knowing what is going on in the counseling profession at the national level.

If she drops her state association memberships, Juanita will miss the opportunity to stay informed of new developments in the counseling profession at the state level, where state licensure issues are addressed, funding for counseling positions is monitored, and state laws affecting counselors are monitored. She will no longer get state counseling association and division newsletters, announcements of state conferences, discounts for conference registration fees, and bulletins on important matters of interest to counselors in her state. Juanita will also miss opportunities for continued development of her professional identity as a counselor by not knowing what is going on in the counseling profession at the state level and not being connected professionally to her state colleagues.

You might remind Juanita that she has spent considerable amounts of money to earn her master's degree in counseling. Not only has she paid for tuition and texts, but she has also lost income she would have earned working while she was taking her graduate classes. Although all of these expenses may seem overwhelming to a new professional, if Juanita is to be successful in her career as a counselor, she will need to continue her professional association affiliations and maintain her counseling credentials. Counselors who isolate themselves from their professional peers seldom have successful careers. Professionals in all fields have similar expenses. They are part of the costs of being a professional.

### ACA Divisions

Currently, ACA has 19 divisions. ACA members, if they choose, may join one or more divisions in addition to their basic ACA membership. Division members receive scholarly journals from divisions that publish them, periodic newsletters, and from time to time information related to the divisions' special purposes.

There are two types of divisions within ACA, and all divisions are subgroups of ACA. One type of division has as members counselors who practice in various employment settings, such as schools, colleges, or mental health centers. The other type of division has as members counselors who have special interests within counseling such as group counseling, multicultural counseling, or marriage and family counseling. Figure 2 provides a listing of the 19 ACA divisions with a description of their members.



## Professional Identity of Counselors

<b>NAME OF ACA DIVISION</b>	<b>MEMBERSHIP INCLUDES</b>
<b>Association for Assessment in Counseling and Education (AACE)</b>	Counselors who are interested in testing
<b>Association for Adult Development and Aging (AADA)</b>	Counselors who have a special interest in counseling issues of adults and those who specialize in gerontology
<b>Association for Creativity in Counseling (ACC)</b>	Counselors who have an interest in understanding creative approaches to counseling (such as art, music, or dance therapy)
<b>American College Counseling Association (ACCA)</b>	Counselors who work in college and university settings, including technical and community colleges
<b>Association for Counselors and Educators in Government (ACEG)</b>	Counselors employed by federal and state governments
<b>Association for Counselor Education and Supervision (ACES)</b>	University professors who teach in counseling graduate programs, supervisors of counselors, and individuals who specialize in counseling supervision
<b>Association for Humanistic Counseling (C-AHC)</b>	Counselors who are oriented toward humanistic principles
<b>Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)</b>	Counselors who have a special interest in providing counseling services to lesbian, gay, bisexual, and transgender clients
<b>Association of Multicultural Counseling and Development (AMCD)</b>	Counselors who have a special interest in multicultural issues in counseling
<b>American Mental Health Counselors Association (AMHCA)</b>	Counselors who practice in community mental health settings and who are in private practice
<b>American Rehabilitation Counseling Association (ARCA)</b>	Counselors who work in government and private vocational rehabilitation settings
<b>American School Counselor Association (ASCA)</b>	Counselors who practice at all levels of school counseling: elementary, middle, and secondary
<b>Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC)</b>	Counselors who have special interests in spiritual, ethical, or religious values issues in counseling
<b>Association for Specialists in Group Work (ASGW)</b>	Counselors who have a special interest in group counseling
<b>Counselors for Social Justice (CSJ)</b>	Counselors who are interested in the eradication of oppressive systems of power and privilege
<b>International Association of Addictions and Offender Counselors (IAAOC)</b>	Counselors who work in substance abuse or prison settings
<b>International Association of Marriage and Family Counselors (IAMFC)</b>	Counselors who specialize in marriage and family counseling
<b>National Career Development Association (NCDA)</b>	Counselors who have a special interest in career counseling
<b>National Employment Counseling Association (NECA)</b>	Counselors who work in employment agency settings

**FIGURE 2** The 19 divisions of the American Counseling Association

### **ACA State Branches**

All states plus the District of Columbia, the Virgin Islands, Puerto Rico, and Europe have ACA branches. Although these branches are chartered by ACA, they are separate, independent organizations. In order to join a state branch, you must contact that organization. Most branches offer discounted membership rates for graduate students. Telephone and address information for state branch associations can be obtained by contacting the ACA. State branches hold annual conventions, represent counselors from their states in legislative matters, publish periodic newsletters, and sometimes provide publications and workshops for members.

Most state ACA branches have state branch divisions that parallel the national ACA divisions. So, in addition to a state ACA association, often there will exist, for example, state divisions for school counselors, mental health counselors, and counselors interested in multicultural counseling issues. When you join your state ACA branch, you will also have the opportunity to join any divisions that exist in your state that interest you.

Many important professional issues, such as licensure and school counselor certification, can be addressed only at the state level. In addition, it is very important for counselors to know and interact with their colleagues throughout the state in which they are practicing. Therefore, counselors should belong to their ACA state branch in addition to belonging to ACA throughout their professional careers.

### **Other Associations**

In addition to ACA and its national divisions and state branches, there are a number of national and international associations to which counselors belong. These associations represent a variety of interests. Associations consist of multidisciplinary groups of mental health professionals, professionals interested in specializations within the mental health field, special political purpose groups, and even associations that are in opposition to the professional and political interests of the ACA and counselors. It might be beneficial for counselors to join multidisciplinary professional associations to gain from cross-disciplinary interactions and fresh perspectives on mental health issues. Counselors may also want to purchase materials developed by other associations or attend workshops these associations sponsor.

One association that was created as a result of ACA's success in the area of state licensure for counselors is the American Association of State Counseling Boards (AASCB). This group has as its members state boards that license counselors and individuals who have been appointed to those boards or who administer them. The group meets annually to update members regarding developments in the area of counseling licensure.

Not all other mental health professional associations are supportive of counseling as a profession. The American Psychological Association (APA) opposed counselors as they achieved recognition in state legislatures as an independent profession and currently opposes licensed counselors' efforts to pass legislation making it clear that counselors can diagnose and treat mental disorders, can test, and can be reimbursed by health insurance companies for their services. There are a number of associations that focus on the certification of counselors and the accreditation of facilities that offer counseling services.

## **CURRENT ISSUES RELATED TO PROFESSIONAL IDENTITY**

One of your tasks as a graduate student preparing to enter the counseling profession is to develop a strong identity as a counselor. Yet, as we have seen, the profession itself seems confused about its identity. Highlighting and discussing some of the current professional identity problems in the

profession may help you acknowledge and put these problems in perspective as you develop your own professional identity as a counselor.

### **Specialties Versus One United Profession**

Probably the most significant problem that the counseling profession faces today is determining whether the profession will develop a strong identity as one united profession with a common philosophical foundation and knowledge base, or whether the specialties will emerge as the dominant force within counseling (Myers & Sweeney, 2001). If the specialties prevail, counseling has little chance of becoming a unified and societally recognized profession.

The problems associated with the specialties within the counseling profession were discussed in the November/December 1995 issue of the *Journal of Counseling & Development* (Myers, 1995b). In that issue of the primary professional journal of the counseling profession, authors discussed the following established and emerging counseling specialties: career counseling (Engels, Minor, Sampson, & Splete, 1995), college counseling (Dean & Meadows, 1995), school counseling (Paisley & Borders, 1995), marriage and family counseling (Smith, Carlson, Stevens-Smith, & Dennison, 1995), mental health counseling (Smith & Robinson, 1995), rehabilitation counseling (Leahy & Szymanski, 1995), addictions counseling (Page & Bailey, 1995), and sports counseling (Miller & Wooten, 1995).

A complex profession needs to have specialties because no one practitioner can be proficient in all areas of the profession (Abraham, 1978; Kett, 1968; Napoli, 1981). Specialties are necessary to ensure that research, training, and improved practice occur in specialized areas of counseling that have unique needs and issues. If members of subgroups within a profession believe that their specialties are significantly different from the general profession, however, then those specialty groups will attempt to establish themselves as separate professions (Etzioni, 1969). This phenomenon seems to be occurring in counseling at this time, particularly within the specialties of mental health counseling (Messina, 1999), marriage and family counseling, school counseling (Johnson, 2000), and career counseling. It would be wise for new counseling professionals to recognize that the specialty groups with whom they wish to affiliate may be working against the overall goal of establishing counseling as a strong, viable, and societally recognized mental health profession (Fox, 1994).

Our position on this issue is that counseling is our primary profession, and that counselors who are members of specialty groups should support the overall profession while paying attention to their special interests and needs within the counseling profession. When you enter the profession, you will have opportunities to voice your own position, and you will want to consider carefully the issues involved.

### **Organizational Structure of ACA**

Historically, some specialty groups in counseling (school counselors, college counselors, career counselors, and counselor educators) came together to form the first professional association, which they named the American Personnel and Guidance Association (APGA) in 1952. The name was later changed to the American Association for Counseling and Development (AACD) and is now the ACA.

An unfortunate event occurred during the history of the association when, at some point, the divisions within ACA were incorporated as separate legal structures. This makes ACA appear to be a federation, or a group of groups, rather than one unified organization with subgroups of specialties. The separate incorporation of the divisions within ACA has led to many disagreements among association leaders as to whether ACA is a manager meant to serve the interests of the divisions, or whether the divisions are subgroups of individuals whose primary interest is in being members of a unified professional association.

## Professional Identity of Counselors

These disagreements led the American College Personnel Association (ACPA) to disaffiliate from ACA in 1992 and become a separate, autonomous professional association. Three additional ACA divisions have seriously discussed, and taken, some actions that could lead to disaffiliation. They are the American School Counselor Association (ASCA), the American Mental Health Counselors Association (AMHCA), and the National Career Development Association (NCDA). Leaders and members of the association have spent energy on the conflict rather than on the tasks of strengthening the counseling profession and ensuring that members' continuing professional development needs are met.

When ACPA left ACA, ACA immediately created a new division, the American College Counseling Association (ACCA), for members who worked in higher education settings. Some ACA leaders have stated their intent to do the same thing if the mental health counseling, school counseling, or career counseling associations disaffiliate from ACA. In the future, AMHCA (Beck, 1999), ASCA, NCDA, and perhaps others might disaffiliate from ACA and establish themselves as separate autonomous associations. If major divisions within ACA leave, ACA probably will create entities within ACA to replace them. In any eventuality, ACA members will be able to continue their affiliation with ACA and will have opportunities within ACA to affiliate with members who have their same specialty interests.

A basic aspect of human nature is that people tend to identify with the group they know best and with which they are the most familiar. Members and leaders within the specialty subgroups in counseling have naturally tended to create well-organized entities that represent their specialized interests. It also is clear that counseling is at a critical stage of development (Collison, 2001). Either the profession of counseling will find a way through its conflict and will emerge as a unified profession, or it will fragment and its various specialties will attempt to establish themselves as separate independent professions. Bradley and Cox (2001) have suggested that perhaps a new organizational structure is needed that will allow the larger ACA to accommodate the differences within its divisions. Only time will reveal the outcome of the current struggles.

### **CACREP Accreditation of Specialties**

Sweeney (1995) has pointed out that CACREP actually accredits master's degree programs leading to specialty degrees in counseling, rather than accrediting general master's degree programs in counseling. If a university that offers a master's degree program in counseling wants to obtain CACREP accreditation, the program must declare that it prepares master's-level counselors for one or more of the following specialty areas: addictions counseling; student affairs and college counseling; career counseling; marriage, couple, and family counseling; clinical mental health counseling; or school counseling (CACREP, 2009). Even though CACREP accredits master's degree programs leading to specialty degrees in counseling, a core curriculum that includes basic instruction for all counselors is required for accreditation in any of the specialty areas.

This requirement that students specialize at the master's degree level does cause some professional identity problems for graduate students. Although professors encourage graduate students to develop identities as counselors in general, these same graduate students are being told that they must choose and prepare for one specialty area within counseling. There are questions as well about what constitutes a particular specialty, such as clinical mental health counseling, and what makes it different from other specialties (Hershensen & Berger, 2001).

### **Varying State Licensure and Certification Requirements**

As explained earlier in this chapter, the states that license counselors vary significantly in requirements. Licensure statutes require from 30 to 60 hours of graduate course work and from 1 to 3 years

of post-master's-degree supervision, and they include a variety of requirements that are unique to the state (ACA, 2012a). State requirements for certification as a school counselor also vary considerably from jurisdiction to jurisdiction.

These differences in licensure and certification standards reflect a profession that has not been able to establish an agreed-upon set of standards and then get those standards accepted by political entities throughout the United States. Because of this lack of uniformity, individual counselors who move from state to state often find that they must take additional course work or even earn another master's degree in order to meet the new state's standards. Established professions, such as law, medicine, and even psychology, have been able to establish licensing laws across the United States that are uniform and allow members of their professions to be licensed and practice no matter where they live. Eventually, the licensing and certification laws for counselors will become more uniform, but currently the lack of uniformity causes problems for counselors who relocate. Leaders in the ACA and the AACSB are working to resolve problems associated with licensure *portability* from state to state.

## LEGAL AND POLITICAL ISSUES

In addition to the professional identity problems that currently exist for counselors, there are a number of legal and political issues with which you must be familiar. The successful resolution of these issues is critical to the continued movement of counseling to establish itself as a legitimate societally recognized profession.

### Challenges to the Scope of Practice of Counselors

Counselors believe that they are qualified to perform a number of professional services for clients, based on their training and expertise. Two areas in which counselors have been challenged by psychologists and other mental health professionals are testing and the diagnosis and treatment of mental and emotional disorders. Some psychologists and social workers claim that they are adequately prepared to perform these professional services and that counselors are not.

There is an economic component to these issues. Counselors who test and who diagnose and treat mental and emotional disorders in their practices often compete in the marketplace with psychologists and social workers. Many health insurance companies and health maintenance organizations require that mental health professionals be qualified to perform these two tasks before they will reimburse their insured for the services of these professionals. Therefore, there is a significant economic advantage for psychologists and social workers to claim that counselors are not qualified in these professional practice areas.

This debate has taken place in the forum of state legislatures, in the form of arguments over the language in state statutes that license counselors for practice. In most states, counselors have been successful in inserting language into their licensing statutes that says they are competent and therefore qualified to test and to diagnose and treat mental and emotional disorders. There are some states, however, where these issues are still unresolved.

**TESTING** One of the core curriculum requirements for preparation of counselors is in the area of testing, or assessment. All counselor master's degree programs require at least one graduate course in testing principles that includes evaluating the validity and reliability of tests, selecting appropriate tests for clients, test administration, and interpretation of test results. Counselors have used tests in their practices since the profession was first established.

Of course, testing is a very broad area, and there are a number of psychological tests that counselors might not be prepared at the master's degree level to administer and interpret, such as individual intelligence tests or projective tests. Psychologists have claimed that counselors should not be allowed to test at all within their practices, or should be allowed to use tests only in a very limited fashion. Counselors, on the other hand, believe that they have the basic education needed to test and that each counselor should determine the particular tests he or she is qualified by education or experience to administer and interpret.

Some state licensure statutes give counselors broad testing privileges, whereas others either are silent on whether testing is part of a counselor's practice or are very restrictive in enumerating which tests a counselor may administer and interpret. In some states (Butler, 1998), counselors have been accused of practicing psychology without a license because of their testing activities. In states in which the testing practices of counselors are restricted, political activities are taking place to change the statutes to broaden the authority of counselors to test.

**DIAGNOSIS AND TREATMENT OF MENTAL AND EMOTIONAL DISORDERS** Counselors are taught to diagnose and treat mental disorders as part of their specialized training (Seligman, 1999). Ivey and Ivey (1999) have explained how counselors, with their wellness orientation, can utilize a developmental approach to the *DSM-IV-TR* (American Psychiatric Association, 2000). In most states, course work is required in this area for counseling licensure. In addition, counselors are tested before they are licensed to determine whether they are proficient in the diagnosis and treatment of mental and emotional disorders. Despite the preparation of counselors in this area, it appears that the general public may need to be better educated regarding the skills of counselors in the area of diagnosis and treatment of mental disorders (Fall, Levitov, Jennings, & Eberts, 2000).

The *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* published by the American Psychiatric Association (2000) clearly states that many mental health professionals are engaged in the diagnosis and treatment of mental disorders and that the manual is meant to be a reference for all of those professionals. The use of this standard manual is taught to counselors who wish to be licensed.

As with the testing issue, in many states the scope of practice of licensed counselors includes the diagnosis and treatment of mental disorders. In states in which the authority of counselors to diagnose and treat mental disorders is being challenged, efforts are being made to change the language of the licensure statutes to state clearly that counselors are qualified to perform this professional activity.

### **Job Classifications for Counselors**

Positions for counseling professionals exist in many state and federal agencies. In some of these agencies, however, no job classification categories have been established for counselors. As a result, when counselors are hired, their job titles might be *psychologist I*, *social worker I*, or *mental health technician I*. Although being hired into these positions gives counselors jobs and entry into agencies, counselors may be discriminated against later because promotions might require a license in psychology or social work or a graduate degree in one of those fields.

As a result of this problem, efforts are being made to have job titles established specifically for counselors. Convincing a state or federal agency that job titles or classifications need to be changed is not an easy task. Bureaucracies are very slow to change. Nonetheless, professional associations and leaders within the counseling profession need to address this problem if counselors are to be fully accepted as professionals within these agencies.



In Louisiana, a series of job categories for counselors who work in the state civil service system was created in 2003 (C. Gagnon, personal communication, September 10, 2003). Up until that time, counselors were hired in job categories that limited their ability to receive promotions. Creating these new counselor job categories (which are equivalent to those that existed already for social workers) was completed in a unique manner because of the political and legal environment in that state. The success in this endeavor will have a significant positive impact on all counselors currently working in that state and future counselors who will be hired there.

### **Third-Party Reimbursement**

It is essential for counselors in private practice that their clients be able to access counselors' mental health services as part of clients' health care plan (Palmo, 1999). If clients are participating in health maintenance organizations (HMOs) or preferred provider organizations (PPOs), then counselors must be on the list of eligible providers for the clients. If clients are part of an indemnity health care plan, then counselors must be acknowledged as qualified mental health care providers so that clients can be reimbursed for counselor services.

HMOs, PPOs, and health insurance companies can voluntarily acknowledge counselors as qualified mental health care providers, and most do. However, these health care organizations have a legal right to refuse to give their clients access to counselors unless there is legislation to the contrary. This type of legislation, called *freedom of choice legislation*, requires health care providers to give access to licensed counselors for mental health care if they give access to other mental health care providers such as psychologists or social workers. Many states have passed freedom of choice legislation. In states that have not, counselors are active in trying to get freedom of choice legislation passed.

ACA and NBCC are active in seeking national legislative and regulatory changes that would allow Medicaid recipients, military personnel, and federal employees to receive mental health services from counselors as a part of their health benefits. An important goal is for all Americans to have access to mental health services from counselors, not just from psychiatrists, psychologists, or social workers.

Recently counselors have been successful in being recognized as providers for individuals who are on active duty in the military and their dependents through TRICARE and for individuals who are war veterans (American Counseling Association, 2012b; National Board of Certified Counselors, 2012c).

## **IDENTITY AND PROFESSIONALISM**

### **Counseling and Other Mental Health Professions**

As we noted at the beginning of this chapter, counselors are a relatively new professional group, and counselors are often asked what they do. A weak answer would be that counselors do things similar to what psychologists do. A strong answer would be to describe the process of counseling, including its philosophical foundations, the services that counselors provide, and the components of training programs that prepare master's-level counselors. A counselor or prospective counselor with a strong professional identity will be able to describe the process of counseling without reference to other mental health professions.

The material provided in this chapter should allow you to state clearly what a counselor does. However, a further challenge for counselors is to be able to describe objectively, accurately, and dispassionately the similarities and differences between counselors and other mental health professionals. Listeners should take away from a conversation with a counselor the conclusion that counselors



## Professional Identity of Counselors

have a clear and unique identity within the field of mental health and that the counselor with whom they have been talking takes pride in her or his chosen profession.

How are counselors similar to other mental health professionals, including psychiatrists, psychologists, and social workers? We are all prepared at the master's degree level or higher, and we all provide mental health services for clients. All mental health professionals follow a similar process of assessing a person's mental health needs, developing a plan for assisting the person, and then providing mental health services consistent with the assessment and plan for treatment. All mental health professionals counsel clients in some fashion. Mental health professionals of all types can be found in agencies and institutions where mental health treatment is offered to individuals.

How are counselors different from other mental health professionals? The primary difference between counselors and other mental health professionals is that counselors espouse the wellness model of mental health instead of the illness or medical model. The wellness model of mental health emphasizes helping people maximize their potential rather than curing their illness. Counselors believe that human growth and development stages and processes make life's problems normal and natural rather than pathological. Counselors emphasize prevention and early intervention rather than remediation. Empowerment of clients is a goal of counselors. The training of counselors focuses on teaching counseling skills rather than skills in physical health care, psychopathology, assessment, or social service linkages.

Figure 3 provides official definitions of the mental health professions, including counseling, which have been published by professional associations. The definition for *counselor* is from the American Counseling Association (2008); the definition for *social worker* is from the Council on Social Work Education (2008); the definition for *psychologist* is from the American Psychological Association (2008); and the definition for *psychiatrist* is from the American Psychiatric Association, as provided by MedicineNet (2008). These official definitions provide insight into how professional organizations view themselves. The *counselor* definition focuses on the counseling process that was derived from mental health, psychological, and human development principles. The *social worker* definition emphasizes the goals of promoting social justice, human rights, and quality of life as well as eliminating poverty. The *psychologist* definition states the requirement that psychologists must hold doctoral degrees and says that psychologists focus on the understanding of human behavior. The *psychiatrist* definition begins by saying that psychiatry is a specialty for physicians who focus on mental illnesses.

Figure 4 summarizes the differences in preparation program requirements for the major mental health professions of counseling, social work, psychology, and psychiatry. This figure was developed using information provided by the organizations that accredit these four mental health professions: for counseling, the Council on Accreditation of Counseling and Related Educational Programs (CACREP, 2009); for social work, the Council on Social Work Education (CSWE, 2008); for psychology, the American Psychological Association Commission on Accreditation (CoA, 2008); and for psychiatry, the Liaison Committee on Medical Education (LCME, 2008) and the American Board of Psychiatry and Neurology (ABPN, 2008). This figure illustrates the differences in the amount of post-bachelor's-degree study required (ranging from 2 years of graduate study for counseling and social work, and 3 years of graduate study for psychology, to 7 years of graduate study for medicine). The content of the course work requirements demonstrates that the counseling curriculum has a primary focus on counseling, the social work curriculum emphasizes social issues, the psychology curriculum has a heavy emphasis on evaluation and research, and the curriculum for psychiatry prepares physicians who specialize in behavior disorders and neuroscience. An examination of the actual required courses within accredited counseling, social work, psychology, and psychiatry programs would further demonstrate these different emphases among the preparation programs of these mental health professions.

### **DEFINITIONS OF THE MENTAL HEALTH PROFESSIONS PROVIDED BY PROFESSIONAL ASSOCIATIONS**

#### **Counselor**

<http://www.counseling.org/CareerCenter>

The Practice of Professional Counseling: The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral, or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Professional Counseling Specialty: A professional counseling specialty is narrowly focused, requiring advanced knowledge in the field founded on the premise that all professional counselors must first meet the requirements for the general practice of professional counseling.

#### **Social Worker**

<http://www.cswe.org>

*From the Educational Policy and Accreditation Standards*

The purpose of the social work profession is to promote human and community well-being. Guided by a person and environment construct, a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work's purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons.

#### **Professional Psychologist**

<http://www.apa.org/about>

*From Definition of Psychology*

Psychology is a diverse discipline, grounded in science, but with nearly boundless applications in everyday life. Some psychologists do basic research, developing theories and testing them through carefully honed research methods involving observation, experimentation and analysis. Other psychologists apply the discipline's scientific knowledge to help people, organizations and communities function better.

As psychological research yields new information, whether it's developing improved interventions to treat depression or studying how humans interact with machines, these findings become part of the discipline's body of knowledge and are applied in work with patients and clients, in schools, in corporate settings, within the judicial system, even in professional sports.

Psychology is a doctoral-level profession. Psychologists study both normal and abnormal functioning and treat patients with mental and emotional problems. They also study and encourage behaviors that build wellness and emotional resilience. Today, as the link between mind and body is well-recognized, more and more psychologists are teaming with other health-care providers to provide whole-person health care for patients.

#### **Psychiatrist**

<http://www.medterms.com/script/main/art.asp?articlekey=5107>

Psychiatrist: A physician who specializes in the prevention, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. He or she may also have additional training in a psychiatric specialty, such as child psychiatry or neuropsychiatry. Psychiatrists can prescribe medication, which psychologists cannot do.

**FIGURE 3** Definitions of the mental health professions

COMPARISON OF PREPARATION PROGRAM REQUIREMENTS FOR THE MENTAL HEALTH PROFESSIONS	
Profession & Graduate Education Required	Summary of Required Courses & Required Supervised Field Experience
<b>Counseling</b> 48–60 graduate credits required for master's degree	Graduate coursework required in professional identity; social and cultural diversity; human growth and development; career development; helping relationships; group work; assessment; research and program evaluation; and specialty area (mental health counseling, community counseling, school counseling, career counseling, marriage and family counseling/therapy, college counseling, gerontological counseling, and student affairs).
<b>Social Work</b> 60 graduate credits required for master's degree	A 100-hour practicum and 600-hour internship are required. Coursework required in professional social worker identity; ethical principles; critical thinking; diversity and difference; advancing human rights and social and economic justice; research-informed practice and practice-informed research; human behavior and the social environment; policy practice; contexts that shape practice; and engaging, assessing, intervening, and evaluating individuals, families, groups, organizations, and communities.
<b>Psychology</b> 3 full-time years of graduate study required for doctoral degree	A total of 900 hours of field experience is required. Coursework required in biological aspects of behavior; cognitive and affective aspects of behavior; social aspects of behavior; history and systems of psychology; psychological measurement; research methodology; techniques of data analysis; individual differences in behavior; human development; dysfunctional behavior or psychopathology; professional standards and ethics; theories and methods of assessment and diagnosis; effective intervention; consultation and supervision; and evaluating the efficacy of interventions; cultural and individual diversity; attitudes essential for life-long learning, scholarly inquiry, and professional problem solving.
<b>Psychiatry</b> 130 weeks required for medical degree (usually 4 years) plus 36-month residency in psychiatry required	One full-time year of residency required. MD requires coursework in anatomy; biochemistry; genetics; physiology; microbiology and immunology; pathology; pharmacology and therapeutics preventive medicine; the scientific method; accurate observation of biomedical phenomena; critical analysis of data; organ systems; preventive, acute, chronic, continuing, rehabilitative, and end-of-life care; clinical experiences in primary care, family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery in outpatient and inpatient settings; multidisciplinary content areas, such as emergency medicine and geriatrics; disciplines that support general medical practice, such as diagnostic imaging and clinical pathology; clinical and translational research, including how such research is conducted, evaluated, explained to patients, and applied to patient care; communication skills as they relate to physician responsibilities, including communication with patients, families, colleagues, and other health professionals; addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse; the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments; gender and cultural biases; medical ethics and human values.

**FIGURE 4** Comparison of preparation program requirements for the mental health professions

## Professional Identity of Counselors

The psychiatry residency must prepare physicians in the psychiatric areas of development through the life cycle; behavioral and social sciences; epidemiology and public policy; diagnostic procedures; clinical aspects of psychiatric disorders; treatment of psychiatric disorders; special topics (suicide; dangerousness; seclusion/restraint; risk management; child abuse, sexual abuse, and domestic violence; psychiatric consultation; professionalism/ethics; other). In addition, the psychiatry residency must prepare physicians in the neurologic areas of development through the life cycle; basic neurosciences; diagnostic procedures; clinical aspect of neuropsychiatric disorders; treatment of neuropsychiatric disorders; diagnostic and clinical evaluation of neurologic disorders/syndromes; and management and treatment of neurologic disorders.

**FIGURE 4** (continued)

The similarities to and differences from other mental health professionals, as previously summarized, are easy to articulate. It is vital that counselors learn to state both the traits we share in common with our other mental health colleagues and the differences that make us unique as mental health care providers (Sweeney, 2001).

In addition to understanding differences and similarities, it is important to keep in mind that you will also have working relationships with other mental health professionals when you enter practice as a counselor. Psychologists often contribute articles to counseling professional journals (Weinrach, Lustig, Chan, & Thomas, 1998; Weinrach, Thomas, & Chan, 2001). In addition, many counselors work closely with other mental health professionals on a day-to-day basis, for example, as members of multidisciplinary treatment teams in hospitals or as members of school teams that provide services to students with special needs. Increasingly, collaboration with other mental health professionals is regarded as best practice, so it is vital for counselors to understand the scope of practice of these other professionals. There is some evidence that counselors hold stereotyped views of psychologists as primarily focused on testing and of social workers as primarily experts in case management (Mellin, Hunt, & Nichols, 2011).

In the previous section we discussed some conflicts that currently exist between counselors and certain other mental health professional groups. Despite the likelihood that you and your colleagues will disagree about professional issues, in the practice environment these differences are always set aside in the interest of providing clients with the best possible mental health services (ACA *Code of Ethics*, 2005, Standard D.1.c.). You have an ethical obligation to respect approaches to mental health treatment that are different from your own, and to know and take into account the traditions and practices of other professional groups with which you work (Standard D.1.a.).

### **Pride in the Counseling Profession**

We define *professionalism* as an internal motivation to perform at the level of *best practices* that represent the ideals of the profession, enhance its image, and promote its development. A crucial component of professionalism is having a sense of pride in one's chosen profession. Counselors who have strong professional identities are proud to be members of their profession. By understanding and appreciating the counseling profession's history, philosophical foundations, services that are offered to the public, training program contents, and similarities to and differences from other similar mental health professions, counselors with strong professional identities are satisfied with their chosen profession and communicate this pride to those with whom they come into contact.

It is important for members of a profession to be self-critical and to seek advancements in knowledge and improvements within the profession. At the same time, members of a profession must be comfortable with the career choice they have made in order to develop a professional identity that serves them and the profession well.

Counselors with strong professional identities express pride in their profession by defending the profession when inaccurate statements are made concerning the profession itself or members of the profession. To represent the profession vigorously to the public, counselors must be thoroughly familiar with the information presented in this chapter. Individual counselors who provide quality counseling services are responsible for the positive reputation that the counseling profession enjoys. Similarly, individual counselors who can articulate the strengths of the counseling profession are responsible for informing the public about the unique contribution to society that members of the counseling profession are making.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 1 and view the video clip entitled “What Is a Counselor?” to see what can happen when a counselor is unprepared to articulate her role and functions.

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## Summary and Key Points

The aim of this chapter is to help you clarify and strengthen your professional identity as a counselor. We hope that after reading the material in this chapter, you will have a clear sense of your professional identity and be able to do the following:

- Explain the philosophy that underlies the activities of your professional group
- Describe the services your profession renders to the public
- Describe the components of your profession’s preparation programs
- Articulate the similarities and differences between members of your profession and other, similar professional groups
- Communicate your pride in being a member of the counseling profession

We begin the chapter with a discussion of the philosophy underlying the counseling profession. This philosophy, which makes the counseling profession unique and distinguishes us from other mental health professions, includes the following four components: the wellness model of mental health,

a developmental perspective, a strong preference for prevention and early intervention into problems, and a goal of empowerment for clients.

Other aspects of professional identity presented in this chapter include counselor preparation programs; credentialing; professional associations for counselors; and current professional, political, and legal issues. A brief history of the counseling profession provided a foundation for a careful look at its present status as an emerging profession. Following are some of the key points of this chapter:

- A vital professional task for counselor trainees is to develop a strong professional identity and to be able to articulate that identity to others.
- Counselors espouse the wellness model of mental health as their perspective for helping people. Other mental health professions have their roots in the tradition of the medical model. Although the differences between the two traditions are clear, in actual practice many other mental health practitioners use the wellness model and counselors are educated

## Professional Identity of Counselors

- to use the medical model of diagnosing mental disorders.
- Counselors take a developmental perspective to understanding people's personal and emotional issues and problems. From this perspective, problems that other mental health professionals might view as pathological are seen by counselors as natural and normal.
  - Counselors believe that prevention of and early intervention into mental health problems is far superior to remediation.
  - The goal of counseling is to empower clients so that they will be able, in the future, to resolve their problems independently of counselor assistance.
  - For counselors, mental health counseling is the primary service they provide. By contrast, other mental health professionals provide counseling as a secondary or ancillary service.
  - Counselors are considered to be professionals after they have completed the master's degree. Preparation programs emphasize the development of counseling skills and are generally located in colleges of education within universities.
  - Credentialing in counseling is complicated and can be confusing. It is important that you are able to distinguish among state licensure, state certification, national voluntary certification, and program accreditation. It is also important that you plan your program of studies carefully so that you will qualify for the credentials you will need in order to practice effectively.
  - Professional codes of ethics impose only a few restrictions, designed to protect the public, on advertising one's credentials in counseling. You must attend carefully to these restrictions as you prepare to practice and as you develop your business cards, brochures, or other advertising materials.
  - The counseling profession emerged out of a convergence of several disparate forces, including counseling psychology, school counseling, and vocational rehabilitation counseling.
  - The field of counseling meets the criteria generally accepted as constituting a mature profession and is making rapid progress toward becoming a societally recognized profession.
  - The primary professional association for counselors is the ACA. This organization has various divisions and state branches that serve the particular needs and interests of its members. You should join ACA now, if you have not already done so.
  - Currently, there are several professional identity problems with which the counseling profession is struggling. One issue presently being debated is whether counseling will develop as a united profession or as separate specialties. Another issue that is being decided is the organizational structure of ACA. A third problem is that requirements for becoming licensed as a counselor vary from state to state.
  - Contemporary legal and professional issues include challenges to the scope and practice of counselors, particularly in the areas of testing and of diagnosis and treatment of mental disorders; job classifications for counselors; and third-party reimbursement for counseling services.
  - Counselors have an ethical obligation to maintain positive working relationships with other mental health professionals and to respect and understand their differing approaches.
  - Having a sense of pride in being a member of the counseling profession is essential both for your own internal satisfaction with your chosen career and for the continued progress of counseling toward being a societally recognized profession.



# Client Rights and Counselor Responsibilities

From Chapter 4 of *Ethical, Legal, and Professional Issues in Counseling*, Fourth Edition. Theodore P. Remley, Jr., Barbara Herlihy. Copyright © 2014 by Pearson Education, Inc. All rights reserved.



# Client Rights and Counselor Responsibilities

## FOCUS QUESTIONS

1. Do you believe a counselor should be allowed to refuse to provide counseling services to some groups of people who request them? If so, which groups and in which circumstances?
2. What kinds of information do you think clients need, in order to be able to give their fully informed consent to enter into a counseling relationship? When does the information given become too much information so that it inhibits clients from entering into counseling relationships?
3. Under what circumstances do you think it would be acceptable to terminate counseling services to a client?

Trust and respect are the cornerstones on which the counseling relationship is built. If clients are to make progress in achieving personal goals in counseling, they need to feel safe in the relationship and to trust that the counselor is committed to safeguarding their welfare and respecting their rights. In your work as a counselor, it is fundamental that you put client welfare first and foremost. The counseling profession attaches such importance to this principle that it is the very first ethical standard in the American Counseling Association's (ACA) *Code of Ethics* (2005). Standard A.1.a. states that the "primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." There are very few exceptions to this principle, and exceptions occur only in rare circumstances when the good of others in society outweighs what might appear to be best for a particular client.

Counselors have what is known in law as *fiduciary relationships* with their clients. Although the exact meaning of *fiduciary* is debatable, it is agreed that an individual who is a fiduciary has a position of trust and confidence (Ludes & Gilbert, 1998). Clients rely on their counselor fiduciaries to act only in their best interests. The duties of fiduciaries are so strong that any transaction between a fiduciary and the recipient of services is presumed to be fraudulent and void if the fiduciary benefits from it. Transactions that benefit a fiduciary (or counselor) will be upheld in court only when the counselor can present clear and convincing proof that the transaction was legitimate (Ludes & Gilbert, 1998). Because of the law related to fiduciaries, counselors have a significant legal burden

to protect the best interests of their clients and to avoid any interactions or transactions with clients that benefit the counselors themselves at the client's expense.

## COUNSELOR RESPONSIBILITIES

Counselors have numerous responsibilities related to safeguarding client welfare. These include honoring diversity, being aware of one's own needs and values, avoiding dependent relationships, respecting the rights of involuntary or mandated clients, using appropriate counseling techniques, managing interruptions of counseling relationships, terminating services in an appropriate manner, and avoiding abandonment of clients.

In our pluralistic society, honoring diversity is fundamental to counselors' efforts to promote the welfare of their clients and to respect their dignity. In this chapter we draw attention to diversity issues as they relate to specific topics.

## COUNSELOR NEEDS AND VALUES

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### 1 The Case of Lynn

Lynn has been counseling Elaine, a 30-year-old client. During this session, Elaine states that she wishes she could just walk away from her marriage, but she can't do it because it would traumatize the children. Lynn, herself a child of divorce whose father abandoned the family, further explores Elaine's fears for the children. At one point Lynn says to her client, "Well, yes, the statistics do show that a lot of kids lose touch with their fathers after a divorce. It would be really hard for them if that happened. It could even have repercussions well into their adult years."

- What do you think motivated Lynn to respond the way she did?
  - Do you see any problem with Lynn's response?
- 

**Discussion:** It appears that the counselor, Lynn, is interjecting her own feelings about paternal abandonment into the session. Lynn is focusing on her own feelings rather than trying to help Elaine clarify her own feelings about the issue. By focusing on the client's children rather than the client herself, Lynn is discounting the client's feelings and imposing her own values about the effects of divorce on children onto the client.

This case example illustrates that, if counselors lack self-awareness of their "unfinished business," areas of vulnerability, and defenses, there is a risk that they will inadvertently be working on their own issues in the counseling relationship rather than the client's issues. As Corey, Corey, and Callanan (2011) have noted, counselors who are unaware of their own issues are in a poor position to recognize the ways in which their personal lives are influencing their interactions with clients. This is particularly true when the client's problems or issues are similar to the unresolved issues of the counselor.

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We are not suggesting that counselors do not have their own needs or that it is unethical to get some of these needs met by choosing counseling as a profession. In fact, most counselors would probably say that they get a real sense of satisfaction or fulfillment from their work and from knowing that they have made a difference in the lives of others. Still, it is important for you to explore your own answers to the questions, “What do I get out of being a counselor? What needs of mine am I getting met?” Knowing your own needs will help you identify potential areas of vulnerability and sources of therapeutic error.

To give some examples, if you have a strong need to nurture others, you may be tempted to encourage client dependency. If you have a strong need to be liked and appreciated, you may avoid confronting your clients. If you have a strong need to feel useful or prove your competence, you may want to rush in and give answers or advice. If you can recognize your potential areas of vulnerability, you will be better able to keep the best interests of your clients foremost and less likely to allow your needs to intrude into your work with clients. You will be better able to avoid actions that meet your personal needs at the expense of your clients.

Standard A.4.b. of the ACA *Code of Ethics* (2005) requires that counselors be aware of their own values, attitudes, beliefs, and behaviors and avoid imposing their values on clients. This ethical obligation is easy to state, but it can be extremely difficult—if not impossible—to uphold in practice. A counselor’s values will influence the counseling process in many ways, including which goals are considered appropriate or desirable in counseling, whether and how the client will be diagnosed, and which client issues will become the focus of therapy. Even the theory from which the counselor operates can influence the counseling process in value-laden ways. Certain theories promote specific values. For instance, the Adlerian approach emphasizes the development of social interest as a benchmark of mental health, whereas the existential approach emphasizes individual freedom and responsibility. The influence of counselor values on the counseling process can be very subtle, but it can significantly affect counseling outcomes. Research has shown that the degree of congruence between the values of the counselor and those of the client can influence therapeutic outcomes and that clients tend to change in ways that are consistent with the values of their counselors.

Both the client and the counselor enter counseling relationships with their own sets of values that they have acquired through years of experience and exposure. Value conflicts may never become a problem in counseling when the value systems of the client and counselor are similar or compatible. When the value systems of the counselor and clients differ, however, particularly around emotionally charged issues, these differences can become problematic (Barrett & McWhirter, 2002; Kiselica & Robinson, 2001; Millner & Hanks, 2002). Some issues that might cause problems include the following:

- Abortion
- The right to die and assisted suicide
- Beliefs and behaviors of members of cults
- Beliefs and behaviors of gang members
- Child or elder neglect or abuse
- Genetic engineering
- Interracial dating and marriage
- Premarital sex or extramarital sex
- Sexual orientation

Value-laden issues can create problems in the counseling relationship if counselors have not clarified how their own beliefs might affect their therapeutic work with clients who present with

these issues. To illustrate, we discuss briefly three of these issues: abortion counseling, the right to die, and sexual orientation.

**ABORTION COUNSELING** In recent years, the controversies over late-term abortions and stem-cell research have generated renewed public debate between two vocal subcultures in the United States—“prochoice” advocates and “prolife” advocates. Thus, it is somewhat surprising that the counseling literature has given little mention to counselors’ value conflicts and ethical decision making related to clients who are contemplating abortion (Millner & Hanks, 2002). It is vital that you clarify your own moral position and values regarding abortion before you are faced with this issue in counseling a client. Knowing what women are seeking when they consult with a counselor regarding an abortion is also important (Moore, Frohwirth, & Blades, 2011).

Before you decide whether you can provide professional counseling services to women who are considering abortion, you must answer for yourself some crucial questions. Do you believe that abortion is ever an acceptable response to an unwanted pregnancy? If so, in what circumstances? When pregnancy is endangering the mother’s life or health? When pregnancy has resulted from rape or incest? When an unmarried woman does not want to marry the father or assume the responsibilities of single parenthood? When parents are living in poverty and cannot afford to raise another child?

In addition to formulating your own responses to these questions, you must know your state laws regarding abortion. Counselors can be sued for negligence under tort law if they do not act with skill, if they withhold pertinent information or provide false information, fail to refer, or make an inadequate referral (Millner & Hanks, 2002).

**THE RIGHT TO DIE** Another controversial issue in today’s society is whether people who are terminally ill, have an incurable condition, or are in intolerable pain have the right to choose the time and means of their own deaths (Herlihy & Watson, 2004). As more members of our society live to an advanced age and as life-sustaining medical technologies continue to advance, it is likely that counselors will be called upon more frequently to counsel clients who are considering hastening their own deaths (Manis & Bodenhorn, 2006). In recognition of this growing need, the ACA signed on to an *amicus* brief submitted to the United States Supreme Court in 1997 in support of the role of mental health professionals in assisting individuals with their end-of-life decision making.

Counselors who provide professional services to clients facing end-of-life decisions can find explicit guidance in the 2005 ACA *Code of Ethics* regarding ethical issues they inevitably will confront. Standard A.9. (End-of-life care for terminally ill clients) describes measures that counselors should take to ensure quality of care (A.9.a.) and clarifies that counselors have the option of upholding or breaking confidentiality in these situations, depending on the circumstances (A.9.c.). Additionally, the standard acknowledges that not every counselor will feel comfortable or competent to work with terminally ill clients who wish to explore their end-of-life options (A.9.b.). If you are firmly opposed to the practice of hastening one’s own death, you will need to refer any such clients to another mental health professional.

Before you decide whether you are willing to work with terminally ill clients, you will need to answer a number of questions for yourself. Under what circumstances is hastening one’s own death an acceptable option to explore? When a person is terminally ill and death is imminent? When the illness is fatal but the person could live for several more years if he or she undergoes multiple, painful surgeries or must take potent medications with severe side effects? When a condition is not terminal but has left a person in constant, intolerable pain? When a terminally ill person wants to



hasten his death to avoid being a burden to his family? When the person already has lived well into her nineties? What if the individual is only 30 years old? If you choose to work with clients who want to consider end-of-life options it is essential that you do not impose your own values, even inadvertently, about such issues as living and dying, quality of life, or religion or spirituality.

## SEXUAL ORIENTATION

In recent years, a series of court cases have generated a great deal of discussion surrounding the question of whether counselors can use their religious beliefs as the basis for refusing to counsel LGBTQIQ clients. In two court cases counselors were terminated from their employment, and in two other cases counseling students were dismissed from their training programs after they refused to counsel LGBTQIQ clients regarding same-sex relationships.

In *Bruff v. North Mississippi Health Services, Inc.* (2001), a client asked her EAP counselor (Bruff) for help with improving her relationship with her same-sex partner. Bruff explained that “homosexual behavior” was against her religious beliefs and offered to refer the client to another counselor. Although the client accepted the referral, she did not return for counseling and eventually filed a complaint with Bruff’s employer. The employer tried to accommodate Bruff’s religious beliefs, but determined that it would place too great a burden on Bruff’s fellow counselors if Bruff were allowed to refer all clients whose issues presented a conflict with her religious values. Bruff was placed on leave without pay and was terminated from employment after she refused opportunities to transfer to other positions within the company. Bruff filed suit; one of her claims was that her employer had violated her right to freedom from religious discrimination under Title VII of the Civil Rights Act of 1964. Eventually, the Fifth Circuit Court of Appeals ruled against Bruff. The court determined that, although employers do have a legal obligation to make reasonable accommodations for religious beliefs, Bruff’s “inflexible” position caused undue hardship to her fellow EAP counselors.

A second legal case, *Walden v. Centers for Disease Control and Prevention* (2010), presented issues very similar to those in *Bruff*. In this second case, an employee of the Centers for Disease Control and Prevention (CDC) sought same-sex relationship counseling from Walden, an EAP counselor. Walden told the client that same-sex relationships conflicted with her religious values and referred the client to another counselor. The client later brought suit, stating that she had felt judged and condemned even though the referral had been satisfactory. Walden’s employer tried to accommodate her religious beliefs by asking her to refer future clients without telling them about her religious objections or personal values. When Walden refused, she was laid off and was later terminated after she did not avail herself of opportunities to apply for other positions within the CDC. Like Bruff, Walden filed suit, and the court ruled against Walden due to her rigid position regarding referrals.

Both the Bruff and Walden rulings were based primarily on issues of employment law rather than on the ethical issues related to refusing to counsel LGBTQIQ clients regarding their same-sex relationships. Ethical issues related to values conflicts have played a more prominent role in the cases of two counseling students who were dismissed from counselor education programs at Eastern Michigan University and Augusta State University in Georgia after they refused to counsel LGBTQIQ clients because same-sex affectional relationships were not acceptable to their religious beliefs. Both students sued their universities. The students claimed that the counseling graduate programs violated their constitutional right to express their religious beliefs.

In *Ward v. Wilbanks, et al.*, Julea Ward, a master’s degree student in the counseling program at Eastern Michigan University, was dismissed from the program in 2009 after she refused to counsel an LGBTQIQ client. Ward was enrolled in her practicum course when she learned that a clinic



client she had been assigned to counsel had previously sought counseling for same-sex relationship issues. Ward told her faculty supervisor that she would not be able to counsel this client effectively due to conflicts with her religious beliefs. The supervisor reassigned the client. Later, the faculty held an informal review meeting with Ward to express their concern that Ward was not complying with the counseling program's policies or the ACA *Code of Ethics*, which prohibits discrimination based on sexual orientation. The faculty suggested a remediation plan for Ward, which she refused. After a formal review, Ward was dismissed from the graduate program.

The United States District Court for the Eastern District of Michigan granted a motion made by the university for summary judgment (*Ward v. Wilbanks*, 2010), which means that the judges on the court found that the student did not have a foundation for her lawsuit based on the pleadings that had been filed by both sides (the claim of discrimination by the student plaintiff and the response by the university). A higher court (the U.S. 6th District Court of Appeals) overturned the lower court's summary judgment decision (*Ward v. Wilbanks*, 2012) and remanded the case back to the district court for a jury trial. A jury will decide whether the student's constitutional rights were violated when the university dismissed her for refusing to counsel an LGBTQIQ student.

In *Keeton v. Anderson-Wiley, et al.* (2011), Jennifer Keeton was asked by faculty at Augusta State University in Georgia to complete a remediation plan after completing her first year of the master's degree program in counseling. In classes, Keeton had often expressed her condemnation of homosexuality based on her religious beliefs, and the faculty was concerned that she "might not be able to separate her religious views on sexual morality from her professional counseling responsibilities" (*Keeton v. Anderson-Wiley, et al.*, 2011, p. 4). When Keeton failed to complete the remediation plan, she was dismissed from the master's degree program. She brought suit against the faculty and the university, claiming that her rights to freedom from religious discrimination had been violated. The student also asked for a preliminary injunction to prevent ASU officials from dismissing her from the program if she did not complete the remediation plan. The federal district court denied the student's motion for a preliminary injunction and the student appealed the decision. The U.S. Court of Appeals upheld the lower court's denial of the preliminary injunction.

The particular circumstances surrounding this case are included in the court's written decision, *Keeton v. Anderson-Wiley, et al.*, U.S. Court of Appeals, 11th Circuit, 664 F3d 865; 2011 U. A. App. LEXIS 25007; 23 Fla. L. Weekly Fed. C 647 (2011). The Court of Appeals concluded that "the evidence in this record does not support Keeton's claim that ASU's officials imposed the remediation plan because of her views on homosexuality. Rather, as the district court found, the evidence shows that the remediation plan was imposed because she expressed an intent to impose her personal religious views on her clients, in violation of the ACA Code of Ethics, and that the objective of the remediation plan was to teach her how to effectively counsel LGBTQIQ clients in accordance with the ACA Code of Ethics" (p. 17). The court found that ASU officials did not tell the student that she had to change her religious beliefs, as she had claimed, but instead had required her to separate those beliefs from her work counseling clients. Keeton's motion for a preliminary injunction to keep the university from dismissing was denied, and her lawsuit against the university claiming that her rights were violated was dismissed by a federal judge in a U.S. District Court in June of 2012.

The issues raised by the students in these two law suits have not been confined to the courts; they have been introduced into the legislative arena as well. A bill entitled the Julea Ward Freedom of Conscience of Act has been approved by a Committee of the Michigan legislature (Heflin, 2012). A law has been enacted in Arizona that prohibits a state university from discriminating against or disciplining a student in a counseling or related mental health program because the student "refuses to counsel a client about goals that conflict with the student's sincerely held religious beliefs" (AZ 15-1862, 2011).

## Resolving Value Conflicts

Although several ethical issues—including nondiscrimination, multicultural competence, and referral—are relevant to all four of the lawsuits just discussed, the issue that seems to have created the most controversy is that of value conflicts between counselor and client. The counselor educators involved in the lawsuits, with support from counselor educators at several other universities and the ACA, have taken the position that it is not acceptable for counseling students to use their religious beliefs as the basis for refusing to counsel certain groups of clients. They argue that, although it is certainly acceptable for counselors to hold strong personal and moral values (Welfel, 2010), these values must not be imposed on clients. They point to the standard in the *ACA Code of Ethics* that states, “Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals” (A.4.b.). In addition, they argue that refusal to counsel an entire class of clients, such as LGBTQIQ individuals, is discriminatory according to several standards in the code. The introduction to Section C states, in part, that counselors “practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics.” Counselors also are obligated to “gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population” (C.2.a.), and they do not “condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law” (C.5.).

If you are a student in a counseling program, you may be wondering what these court cases portend for you as you progress through your program of studies. We believe that it is crucial that you reflect on how you will manage the value conflicts that inevitably will arise between you and your future clients. For example, if you are a strong feminist you might find it difficult to counsel a client whose religious beliefs dictate subservience to her husband. You will need to keep in mind that it is not your job to convert the client to feminism, but rather to assist this client in finding her own way. It is essential that you learn to bracket or set aside your values while engaged in a counseling relationship, so that you promote the welfare of the client and avoid imposing your own values. If, during, your training experiences, you find it difficult to work with certain clients whose behavior conflicts with your personal or religious values, you will need to be open to learning the knowledge and skills to assist these clients as well as future clients who may present with the same or similar issues.

**DIVERSITY CONSIDERATIONS** Values and value conflicts in the counseling relationship often can be understood within the context of differing worldviews, or ways that people see the world. An individual’s worldview is influenced by culture and is the source of that person’s values, beliefs, opinions, and assumptions (Pedersen et al., 2002). Worldviews affect how people think, make decisions, act, and interpret events (Sue & Sue, 2007). Values of cultures vary in how they relate to nature, time, social relations, activity, and collectivism versus individualism, among other dimensions (Hopkins, 1997). When a counselor and a client are from different cultural backgrounds, they may hold differing worldviews, which can lead to misinterpretations, misunderstandings, and conflicts (Chung & Bemak, 2002). This mismatching can, in turn, lead to clients dropping out of counseling or terminating prematurely (Sue, Fujino, Takeuchi, Hu, & Zane, 1991).

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## 2 The Case of Brian

Brian is a counselor who works in an urban community agency. The agency provides reduced-fee services to some clients who cannot pay the standard fee. Three months ago, Brian began coun-

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selling with Kimberly, a 28-year-old single mother. Kimberly works as a maid in a local hotel and receives Aid to Families with Dependent Children (AFDC). During the weekly staffing conducted by the agency counselors, Brian presents the case of Kimberly and states that she often calls to cancel her appointments at the last minute and sometimes simply fails to show up, and when she does keep her appointments, she usually arrives late. When Kimberly attends sessions, she talks at length about the problems she encounters in daily living but self-discloses very little. Brian questions whether she has a sincere commitment to counseling.

- What might be some possible explanations for Kimberly's behavior?
- What do you think of Brian's questioning the sincerity of Kimberly's commitment to counseling?

**Discussion:** If Brian had considered Kimberly's life circumstances in attempting to understand his client, he might have given a different explanation of her behavior. Had Brian explored with Kimberly the context of her daily life, he might have learned that she gets to the counseling agency by bus, transferring twice. Brian might have discovered that she relies on various family members to babysit for her when she comes for counseling. When the buses don't run on time or when family members fail to keep their promise to babysit, Kimberly is late for appointments or is unable to come at all.

Kimberly may be focusing on her problems in daily living because she expects the counselor to help her solve these problems rather than disclose her feelings. Brian may be blaming the client for his inability to establish a therapeutic alliance with her.

A growing body of literature suggests that counselors must develop *cultural empathy* in order to be effective in counseling clients who hold worldviews and come from cultures different from their own (Chung & Bemak, 2002; Pedersen et al., 2002; Ridley, 1995; Ridley & Lingle, 1996). Acquiring cultural empathy requires counselors not only to have fundamental empathy skills but also to learn advanced skills that will enable them to decode cultural messages (Chung & Bemak, 2002). Some of these skills or strategies include the following:

- Expressing lack of knowledge or awareness of some aspects of the client's cultural experience
- Communicating an interest in learning more about the client's culture
- Conveying a genuine appreciation for cultural differences
- Acquiring knowledge about the historical and sociopolitical background of the client's culture
- Being sensitive to the oppression, marginalization, and discrimination that clients may encounter on a daily basis
- Clarifying language and other modes of communication
- Incorporating culturally appropriate strategies and treatment goals into the counseling process

## Client Dependency

Counselors must avoid fostering dependent counseling relationships with clients. Clients have a right to expect that the counseling process will help them move toward increased autonomy and independence. In counseling, clients learn new skills for living, including an increased ability to make decisions without the counselor's help.

## Client Rights and Counselor Responsibilities

Earlier we mentioned the possibility that some counselors might encourage client dependency on them. There are a number of ways this could happen to you if you are not alert to the potential problem. During your internship, you must complete a certain number of contact hours with clients, and you might be tempted to keep some clients in counseling longer than necessary in order to fulfill your requirement. You also might do so in hopes of demonstrating to your supervisors that your clients keep coming because you are so helpful to them. After you graduate and are in practice, temptations to foster dependency might arise out of a need to feel needed, a need to nurture others, a need to feel that you are important or indispensable to your clients, or even a need for income from client fees if you are in private practice.

Sometimes it is not the counselor's needs but rather the client's needs that work to foster a dependent relationship. Some clients may attempt to maintain or even increase their dependency on the counselor. They may request more frequent sessions, have a new crisis every time the counselor suggests that they may be nearing the end of their work together, or engage in other strategies to avoid progress toward autonomy. For these clients, remaining dependent on the counselor is less risky than learning to live autonomously. Counselors must find ways to balance ongoing support for them while encouraging independence and risk taking.

The dramatic increase in the number of clients who participate in managed care health plans has had an impact on this issue. Managed care plans limit clients to a certain number of sessions and require counselors to justify any requests for additional sessions. Thus, it is much more difficult for counselors to unnecessarily prolong a counseling relationship. Nonetheless, counselors are obligated to work toward client autonomy regardless of whether the motivation for doing so comes from an external source such as managed care or from an internalized sense of responsibility to promote client welfare.

**DIVERSITY CONSIDERATIONS** When counselors work to uphold their ethical obligations to avoid fostering dependency and to promote client independence and autonomy, they sometimes misapply the principle of autonomy. Counselors need to keep in mind that autonomy is a highly individualistic concept (Meara, Schmidt, & Day, 1996) and that the counseling goal of achieving individual independence or autonomy may not be appropriate for clients whose choices are made in the context of family, group, or community (Herlihy & Watson, 2003). For example, Yamamoto and Chang (1987) suggested that, in counseling Asian Americans, counselors could incorporate knowledge of the family-oriented Asian culture by acknowledging and communicating cultural empathy toward the client's family and by including the family in treatment. At the same time, counselors must not lose sight of the fact that there are within-group differences and that each client is unique. Cultural misunderstandings often occur because counselors indiscriminately apply textbook norms regarding racial and ethnic groups and fail to maintain their stance as learners (Ridley, 1995).

### **Involuntary or Mandated Clients**

Special ethical considerations exist when counselors are assigned to work with reluctant clients (Borsari & Tevway, 2005; Kiracofe & Wells, 2007). In some situations, clients may attend counseling sessions because someone else has pushed them in that direction, even though they are not convinced that counseling is a good idea for them. In other, more serious circumstances, clients may have been ordered to attend counseling or suffer negative consequences. Sometimes judges require individuals to attend counseling or go to jail. School principals often require students to attend counseling or face expulsion from school or other disciplinary action. There is nothing unethical about accepting clients in such circumstances.

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The term *involuntary client* probably is inaccurate. A client who chooses to enter into counseling rather than accept an alternative or an unwanted consequence is, in fact, making a choice. Mandated counseling situations might appear to conflict with the ACA *Code of Ethics* (2005) Standard A.2.a., which states that clients must be offered the freedom to choose whether to enter into or remain in counseling relationships. However, mandated clients do choose counseling over other options (such as jail or school expulsion), even though the choice may be made reluctantly.

Involuntary clients usually are required to sign a waiver of their privacy rights when they begin a counseling relationship. Because they are being required to participate in counseling and would suffer some type of negative consequences if they refused, the person or entity requiring the counseling also requires some type of report regarding their participation in the counseling process.

The legal issue involved in these situations is to ensure that involuntary clients know that reports must be made and understand the types of information that will be included in the reports. The privacy waiver form that involuntary clients sign should contain as much specific information as possible. Because different individuals and entities require that various types of information be reported, the form should allow for detailed information to be added.

An ACA *Code of Ethics* (2005) provision (Standard C.6.b.) addresses counseling involuntary or mandated clients. This standard says that counselors are accurate, honest, and objective in reporting their professional activities and judgments to third parties, including courts or those who receive evaluation reports. We believe that counseling and evaluation are two separate processes and that counselors who counsel individuals should refuse to evaluate those same clients. Reporting on counseling attendance and progress toward reaching counseling goals set by clients is different from evaluating clients for issues such as fitness for parenting, ability to work after an injury, or a mental condition.

Sometimes counselors do perform such evaluations, but counselors who evaluate individuals must be unbiased. If they have counseled a client in the past, they are biased and should not agree to evaluate that same person. If a counselor is evaluating a client, the counselor must make clear to the client that the purpose of their meetings is to gather information for an evaluation, not to provide counseling services. Further, clients must understand there is no confidentiality in such situations and that their counselors will report their findings to a third party.

The ACA *Code of Ethics* (2005) addresses role changes in Standard A.5.a. When counselors change from a nonforensic evaluative role to a therapeutic role, or vice versa, they must obtain the client's informed consent for the change. Counselors must be particularly sensitive to the rights of reluctant, involuntary, or mandated clients. It is essential that counselors fully disclose to such clients any privacy rights that clients are waiving as they enter into such arrangements. For example, if a judge who orders an individual to counseling requires periodic reports to a court official (such as a probation officer) on the person's attendance and progress toward counseling goals, counselors must obtain written permission from the client for such reports and must ensure that the client has a full understanding of the types of reports that will be made. Granello and Hanna (2003) have suggested that counselors who provide services to individuals involved with the criminal legal system must develop a good understanding of the system in order to serve their clients well.

Because mandated clients may feel coerced into counseling, they may lack motivation to change. Counselors must self-monitor to ensure that they do not develop a cynicism in their work with these clients. If both the client and the counselor are just "going through the motions" in their counseling sessions, little (if any) meaningful work will be accomplished. It is the counselor's responsibility to engage the client in the counseling process, and if that cannot be accomplished, to terminate the counseling relationship.

### Counseling Techniques

Another consideration in promoting client welfare is the counselor's obligation to select appropriate counseling strategies or techniques. In recent years, the mental health professions have worked to develop guides for treatment planning that match client concerns with the strategies that research has demonstrated to be the most effective in treating those concerns. Lambert and Cattani-Thompson (1996) reviewed studies on counseling effectiveness and found that some specific techniques seemed to be more efficacious with certain symptoms and disorders. They cautioned, however, that successful client outcome is determined in large part by client characteristics such as motivation, locus of control, and severity and duration of symptoms. Hansen (2005, 2006) has expressed a concern that the movement in the counseling field in which a particular approach is required to treat a particular presenting problem takes away the essence of counseling in which human beings connect in a creative, meaningful, and therapeutic manner.

As a counselor, your selection of techniques will depend on a number of factors, including your theoretical orientation and your training. Corey et al. (2011) put it best when they advised that your strategies should fit your counseling style and be tailored to the specific needs of your client. Counselors must not use treatment modalities that are unsubstantiated (Standard C.6.e.), so, if you use any techniques that could be considered experimental or unusual (Ho, D'Agostine, Yadegar, Burke, & Bylund, 2012), you should do so very cautiously. The client should be informed of any potential risks and benefits and should consent to your use of such techniques. Before attempting them, you should be sure that you are adequately trained and have a sound clinical rationale for their use. Before employing an experimental or unusual counseling technique, think about how you would justify your procedures if a complaint were filed against you with a licensing board or in a court of law.

Of course, counselors should not use techniques when research has indicated that those techniques may cause harm to a client. One example of such a technique is conversion/reparative therapy, which has been used with some LGBTQIQ clients.

Counselors have an ethical responsibility to work jointly with clients to devise counseling plans that offer reasonable promise of success (*ACA Code of Ethics*, 2005, Standard A.1.c.). As we have mentioned, managed care organizations typically limit the number of sessions for which a client will be reimbursed and require counselors to justify any requests for additional sessions. Counselors will be more successful in making such requests when they can present empirical support for their clinical judgments. Managed care organizations demand accountability from their providers, and counselors must be able to present data that demonstrate their efficacy (Glossoff, Garcia, Herlihy, & Remley, 1999).

**DIVERSITY CONSIDERATIONS** Counselors who espouse traditional counseling theories and their associated techniques must be aware that these approaches have limited applicability in working with culturally diverse clients (Jencius & West, 2003).

Psychodynamically oriented counselors and ego psychologists who focus on their clients' early childhood relationships with their parents and on intrapsychic conflicts may overlook a client's historic experiences with discrimination and oppression. A psychodynamic therapist's strategy of remaining relatively anonymous in order to serve as a projection screen for the client's transferences could be a poor fit for clients from cultures that value cooperative relationships or for clients who expect the helper to take an active role.

Cognitive behavior therapists are more active in implementing strategies such as direct teaching of skills and assigning homework. However, techniques such as identifying cognitive distortions or irrational self-talk fail to consider the language-bound nature of cognitions. Cognitive behavioral



approaches, like psychodynamic approaches, may not incorporate variables such as race, ethnicity, class, gender, and culture that may be salient to the client's core identity.

Humanistic counselors, particularly those with a Rogerian orientation, offer clients acceptance, unconditional positive regard, and empathy, all of which may help to transcend cultural differences and establish a therapeutic alliance. However, these approaches may fail to consider that barriers to self-actualization may exist in the client's environment rather than within the self. Additionally, the nondirective stance may not meet the needs of clients who might benefit from advocacy and assistance in navigating an oppressive culture.

Today's counselors must have repertoires of helping strategies that extend beyond those offered by traditional counseling theories (all of which were created by and reflect the worldviews of White males). They must have training in multicultural counseling theory and techniques and in working in nontraditional roles.

### **Interruptions and Termination**

Termination is an important stage in the therapeutic relationship that sometimes is given inadequate consideration. Termination is an intentional process that occurs over time when a client has achieved most of the treatment goals, and it provides opportunities for consolidating, making plans for maintaining, and generalizing client gains made in counseling. Effective terminations model how healthy relationships should end and provide clients with opportunities to work through their feelings about ending their therapeutic journeys.

In an ideal world, once a counselor has accepted a client and begins providing services, those services will continue on a regular basis until the client is able to function effectively without the ongoing assistance of the counselor. In reality, however, counselors must sometimes interrupt counseling services for a period of time, and counselors occasionally terminate counseling relationships before clients are prepared to discontinue counseling services. Sometimes, clients will terminate counseling prematurely, for various reasons. From both an ethical and a legal perspective, counselors must be careful to protect the best interests of clients when services have to be interrupted or are prematurely terminated.

**INTERRUPTIONS IN SERVICES** There is truth in Pope and Vasquez's (2007) wry observation that both counselors and clients tend to find comfort in the fantasy that the counselor is invulnerable. The reality is, however, that counselors fall seriously ill, have accidents, or are called away by family emergencies. Counselors must plan ahead for emergency absences by developing procedures to safeguard their clients' welfare. Anticipating that unexpected events might occur, counselors should have plans in place regarding who will notify the clients, who has access to client records, and how the transfer of clients to another counselor will be handled.

Counselors are no different from other workers in that they take vacations, go out of town to attend conferences, and do other things that cause interruptions in the weekly rhythm of the therapeutic relationship. Clients sometimes have strong and even puzzling reactions to their counselor's absence, so it is important that counselors give clients adequate notice and ensure that clients know whom to contact in a crisis or emergency. The *ACA Code of Ethics* (2005) requires counselors to make appropriate arrangements for the continuation of treatment during interruptions caused by vacations, illnesses, or unexpected events (Standard A.11.a.).

Counselors who counsel clients at risk for harm to self or others are well advised to arrange for those clients to also be under the care of other professionals who have accepted responsibility for the well-being of the clients. Counselors should work to ensure that all clients are able to tolerate counselor absences for reasonable periods of time.

**TERMINATION** Proper termination of the counseling relationship conveys caring and helps to prevent harm, which are important ethical considerations (Vasquez, Bingham, & Barnett, 2008). Clients should be able to expect that their counseling sessions will end when they have received what they were seeking from counseling, when they have realized the maximum benefit from the services, or when they are not likely to benefit from counseling (ACA *Code of Ethics*, 2005, Standard A.11.c.). Counselors always anticipate termination as a phase or stage in the counseling relationship, and they provide pre-termination counseling or recommend other service providers when necessary (Standard A.11.c.). Counselors should raise and discuss the issue of termination with the client well in advance of the final session. This allows ample time to plan for the client's transition to functioning without the counselor and to deal with the natural and appropriate issues of separation and loss. Generally, counselors make termination decisions (Gibson & Mitchell, 2008), although it is best if the timing of the termination is mutually agreed upon. However, the ultimate decision might be made independently by either the counselor or the client depending on the circumstances.

**PREMATURE TERMINATION** Not all counseling relationships end smoothly by mutual agreement. In reality, circumstances can arise that allow the counselor to terminate the counseling relationship even against a client's wishes (Welfel, 2010). It is ethically permissible (Standard A.11.c.) for counselors to terminate counseling relationships in the following circumstances:


- It is clear that the client is no longer benefitting from counseling or is being harmed by continued counseling.
- Clients do not pay the fees as agreed upon.
- The counselor is in jeopardy of being harmed by the client or someone with whom the client has a relationship.

When counselors are unable to be of continued assistance to clients or decide to end the relationship over the client's objection, counselors must give adequate notice and give the client time to secure another mental health care provider (Hilliard, 1998). In addition, counselors should suggest an appropriate referral and do all they can to facilitate a smooth transition to the new mental health professional. If the client is unable to continue to pay the counselor's fee, an appropriate referral can be made to free services or to an agency that uses a sliding fee scale, if such alternatives are available. If a client refuses to accept the idea of a referral, the counselor is not obligated to provide free services. The ACA *Code of Ethics* (2005) specifies that counselors may discontinue the relationship if the client declines the referral (Standard A.11.b.).

Many clients are able to afford counseling services only because they have managed health care plans that will reimburse for a significant portion of the cost. Under managed care plans, people are given only the services that the managed care company deems to be necessary and appropriate through a process known as *utilization review*. Counselors face difficult ethical challenges when further treatment is denied by utilization review panels. Counselors maintain clinical responsibility for the clients' welfare, and when clients need further counseling, counselors cannot allow financially motivated decisions to supersede their clinical judgment. Vasquez et al. (2008) have advised that counselors always appeal, or have their clients appeal, adverse utilization review decisions.

Sometimes it is the client who terminates the counseling relationship prematurely. In fact, research has indicated that 30% to 57% of all psychotherapy clients drop out prematurely (Garfield, 1994). Even when the counselor believes that a client is making progress and that treatment goals are being met, clients may call and cancel with or without giving an explanation, fail to keep appointments,

or fail to reschedule. The counselor's ethical obligation in these situations is to attempt to communicate a willingness to continue to meet with the client, either to continue counseling or to summarize and end treatment, or to refer the client to another mental health professional. Vasquez et al. (2008) have offered sample letters that counselors can use when clients in need of continued counseling drop out, when clients making progress initiate termination, when counseling is being terminated due to lack of benefit to the client, and when counseling is being terminated due to a decision made by a managed care company.

 **ABANDONMENT** Abandonment can be considered a form of inappropriate termination and can occur when the client's counseling needs are not adequately addressed by the counselor, either when treatment ends or during the course of treatment due to counselor unavailability (Vasquez et al., 2008). Ethical guidelines (ACA *Code of Ethics*, 2005, Standard A.11.a.) and legal decisions related to physicians (*Allison v. Patel*, 1993; *Manno v. McIntosh*, 1994) prohibit counselors from abandoning their clients. Once a counseling relationship has been established, the counselor cannot arbitrarily end it if the client will be put at risk as a result.

As noted earlier, advance planning can help avoid the risk of clients feeling abandoned by their counselors. Counselors should take care to give clients ample advance notice when planned interruptions are anticipated, such as the counselor taking maternity or paternity leave, scheduling a surgical procedure, or taking a vacation.

No professional is required to provide services to a client if the professional chooses not to do so. The key to ending a professional relationship with a client properly, and thus not being exposed to charges of abandonment, is to give the client adequate notice that you are ending the professional relationship and ample opportunity to locate a new counselor. It might be important, too, to discuss with the client how to locate agencies and individuals who offer counseling services. Giving notice of termination and time for the client to find a new counselor may not lead to the client taking the initiative to find a new counselor, however. If a client refuses to see another counselor after you have given notice you are withdrawing your services, it will be essential for you to document carefully and fully the notice you gave, your assistance with the referral process, and the time you gave the client to locate a new professional.

Hilliard (1998), an attorney who represents mental health professionals who are sued by their clients, has observed the events that lead individuals to sue their mental health providers. As a practical consideration, Hilliard has recommended that mental health care providers never terminate a professional relationship over a client's objection when the client is angry or when the client is in a serious crisis situation. Taking the time to address a client's distress is very important to avoid unresolved angry feelings that could lead to a lawsuit. Also, a judge or jury probably would not support a mental health professional's decision to end a relationship in the midst of a crisis (*Allison v. Patel*, 1993; *Manno v. McIntosh*, 1994). Ending a counseling relationship because insurance benefits have run out, when the client is still at risk for suicide, is very risky (Packman & Harris, 1998) for both the client and the counselor.

Of course, counselors may always refer an at-risk client to a psychiatrist or health care facility that evaluates individuals for suicide or danger to themselves or others. This referral does not always lead to a transfer of that client to another professional or termination. In many circumstances, counselors continue to provide services to a referred client in collaboration with another mental health professional. When a referral of an at-risk client is made, however, it is very important that the counselor informs all parties whether the referral is a transfer of the client to another professional, or the counselor will be providing services in conjunction with another professional.

## Client Rights and Counselor Responsibilities

To protect mental health professionals from being held accountable for abandonment of their clients, Hilliard (1998) and Macbeth, Wheeler, Sither, and Onek (1994) have developed the following guidelines for mental health professionals to use when they are terminating clients in adverse circumstances:

- Honestly discuss with the client your intention to terminate and the specific reason for your decision.
- Give the client an opportunity to make changes that would be necessary to continue the relationship.
- Give written notice to the client that the relationship will be terminated.
- Offer the client one to three termination sessions.
- Give your client up to three good referrals.
- Give your client places to contact in the event of emergencies.
- Place a summary of your interactions with the client around the termination issue in the client's file. Do not transfer that document to another individual or entity without an express written request from the client.
- Give the client plenty of time to find another mental health professional. If more time is requested, allow it.
- Transfer records to the new mental health professional promptly.

**DIVERSITY CONSIDERATIONS** Earlier, we acknowledged that clients sometimes drop out of counseling without discussing their intentions with the counselor. There are many reasons why this can happen—sometimes clients just need to “take a break” from the intense personal explorations involved in counseling, or they may drop out or discontinue the counseling relationship because they do not believe they are benefitting from counseling. This scenario will occur occasionally in any counselor's practice, and it may be helpful to remember that no counselor is skilled enough to be able to assist every client. There is some evidence to suggest that when counselors are ethically or linguistically different from their clients, clients are more likely to terminate prematurely (Maramba & Nagayama Hall, 2002). Thus, it is important that you self-monitor to discern whether the clients who are discontinuing counseling with you are those who are culturally different from you. If you see such a pattern, this is a signal that you must work to increase your cross-cultural counseling skills.

## INFORMED CONSENT

As an ethical obligation, the rationale for informed consent is simple—clients have a right to know what they are getting into when they come for counseling. Most clients are not experts in counseling, so they must trust their counselors to provide them with the information they need to make a good decision (Handelsman, 2001). Providing clients with the opportunity to make an informed decision about entering into a counseling relationship demonstrates respect for a client's autonomy and self-determination and is integral to the formation of an effective therapeutic alliance. By communicating the client's role in making treatment decisions, informed consent can increase the client's sense of ownership over the process, establish that the counselor and client are partners working toward common goals, and reduce the client's anxiety by demystifying the counseling process (Fisher & Oransky, 2008; Margolin, Chien, & Duman, 2005).

Counselors believe that obtaining consent from clients before counseling begins constitutes best practice and is the proper and ethical way to proceed. In addition, there are concepts in law that

require that informed consent be obtained from clients before counseling relationships are initiated. Some state counseling licensing laws or regulations require that licensed counselors provide written documents to clients (e.g., La. Rev. Stat. Ann. 5 37:1101–1115). These written documents constitute informed consent (Madden, 1998). Counselors must provide prospective clients with information that will enable them to make wise choices. This includes deciding whether to enter into a counseling relationship and, if so, choosing the mental health professional who seems best suited to their needs and the type of counseling they will receive.

Marczyk and Wertheimer (2001) have noted that, in the past, it was difficult for mental health professionals to provide clients with adequate information regarding treatment choices because the field of counseling and psychology was “still very much a philosophy and not a science” (p. 33). They have suggested that mental health professionals should be required to provide clients with the success rates of various forms of mental health treatment based on empirical, research-based evidence, as do physicians who treat patients with conditions such as cancer. In the future, such a duty could be imposed on counselors, but at this point it certainly is not an ethical or legal requirement.

### **Contract Law**

Contract law is complex. Counselors do not need to understand the technical principles of contract law such as offer, acceptance, and consideration (Calamari, Perillo, & Bender, 1989) in order to appreciate their contractual obligations to clients, but a basic understanding of those principles can be helpful.

Generally, relationships with professionals who provide services are contractual in nature (Murphy, Speidel, & Ayres, 1997). In terms of contract law, a professional in a private practice offers services to a recipient for a fee. The professional says to the client that services will be provided that will benefit and not harm the recipient if the recipient will pay the professional the amount of money required. Once the client accepts the professional’s offer of services, a legal contract is formed, and all the laws of the contract govern the relationship. The process that leads up to professional services being rendered to a recipient does not look at all like a contractual process to nonlawyers. Because of the fiduciary duty owed to clients of professionals, and because clients must trust professionals to treat them appropriately, the idea of signing a contract before accepting services from a professional seems almost contradictory. If you trust someone, why would you need a contract?

Some contracts, such as real estate deals, must be in writing (Murphy et al., 1997). Contract law does not generally require, however, that contracts be in writing to be valid and enforceable. As a result, most contracts for professional services are not in writing. Although written contracts are generally not necessary under the law, many parties choose to execute them. One practical reason for reducing to writing the terms of a contract is to ensure that both parties understand exactly what they are agreeing to (i.e., the terms of the contract).

If two parties enter into a contractual arrangement, nothing goes wrong, and both are satisfied with the result, then a written contract was not needed. However, written contracts allow the parties to ensure they both understand the specifics in the agreement that they have reached. In addition, written contracts often anticipate changes or problems that might occur and set forth the agreement in the event such things happen. Agreements that are complex or must anticipate changes, therefore, should be in writing to protect both parties.

### **Informed Consent in Medicine**

The process of informing recipients of professional services and obtaining their consent to receive such services is a relatively new legal concept. The requirement that health professionals obtain

informed consent from their clients before rendering services began in medicine (Appelbaum, Lidz, & Meisel, 1987).

Twenty-five years ago, it probably rarely occurred to physicians that they should explain to patients what they knew about their medical conditions. Physicians probably never thought that they should tell their patients about various treatment options or allow their patients to decide which option to choose. Perhaps consumers of medical services were once less educated or less aware of their right to receive information. It has only been in the last half-century that courts have created the requirement that patients must be educated or informed regarding their medical treatment options and consequences before they are able to give valid consent to treatment that is legally binding. The first case in the United States that took this position was *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees* (1957).

The *Salgo* case provided the essential elements that physicians must give to patients. According to Appelbaum et al. (1987), these elements are “disclosure of the nature of the ailment, the nature of the proposed treatment, the probability of success, and possible alternative treatments” (p. 41). *Canterbury v. Spence* (1972), a later case, took a different position on informed consent. It found that physicians were required to disclose information about a proposed treatment that a reasonable person, such as the patient being treated, would find necessary to make a decision to either accept or refuse treatment.

After considering the case law on informed consent, Berner (1998) has argued that there are two elements to the informed consent legal standard. These elements are professional and materiality. The *professional element* is defined as information that a reasonable physician would have provided to a patient in similar circumstances. *Materiality*, on the other hand, is defined as the amount of information that the average patient would consider adequate in deciding whether to accept treatment. If Berner is correct, then courts will most likely require that physicians provide basic information to all patients *and* require that physicians ensure that the particular patient with whom they are dealing understands the information.

The Health Insurance Portability and Accountability Act (HIPAA), which went into effect April 15, 2003, has had a powerful impact on informed consent practices in medicine and mental health. Essentially, HIPAA requires all health care providers who transmit records electronically (which most likely includes all providers) to comply with procedures to ensure consumer privacy. The requirements include explaining to health care recipients in detail their rights related to privacy and records (which essentially is the informed consent process discussed earlier). This federal law has transformed the concept of informed consent, which once was rather vague, into a concrete framework that includes disclosure of steps taken to ensure client privacy and also requires that clients sign a document that they have been informed of their rights. Figure 1 includes a listing of essential elements for informed consent documents to ensure that counselors and agencies meet the legal HIPAA requirements.

### **Informed Consent in Mental Health**

At present, there have been no appellate legal cases involving the responsibility of mental health professionals to obtain informed consent from their clients. But like other legal areas in mental health, most of the precedents and rules are created first with physicians and later become verified for other mental health professionals through cases involving psychologists, counselors, and social workers. Beyond legal requirements, however, we believe it is best practice to provide clients with written information about the counseling relationship before the relationship begins (Herlihy & Remley, 2001).



## Client Rights and Counselor Responsibilities

To comply with the HIPAA law, here are some areas you must include on the form that your clients sign saying they have been informed about your proposed treatment and agreeing to the treatment and the arrangement with you:

- ✓ State that your client's personal information may be used and disclosed to complete their treatment. Also state that information may be provided to health care companies related to payment for your services.
- ✓ Develop a complete written description of the procedures you will follow in your office regarding keeping or disclosing personal information of clients.
- ✓ Tell your client that you have a more complete description of the way in which you will keep or disclose their personal information, and that the complete description is available for them to see. State that the client has a right to review the complete description before signing this consent form. Explain that your practices may change in the future and if they want to see any revisions, they must request to see them in writing and that you will then make them available.
- ✓ Tell your client that he or she may request that you restrict how the client's personal information is used or disclosed. Explain that you will consider any such requests and will notify the client whether you have agreed to them.
- ✓ Explain that the client has the right to revoke his or her consent in writing, except to the extent actions have already been taken by you based on prior consent.
- ✓ Get the client's signature and have him or her indicate the date on the form.
- ✓ Keep the form for at least 6 years.

**FIGURE 1** HIPAA requirements for informed consent disclosure statements

It is probably safe to conclude that counselors do have a legal obligation to obtain informed consent from their clients before they begin treatment with them. Further, the informed consent should include information that would be given to the client by other reasonable professionals and should be delivered in a way that the client understands. HIPAA requires that the informed consent of clients be verified with their signatures.

### Written Disclosure Statements

In mental health, written contracts for informed consent are commonly referred to as *disclosure statements*. These documents disclose to clients the nature of the counseling relationship they are entering into. Disclosure statements are also legal contracts. Often, they are signed by both the client and the counselor.

The *ACA Code of Ethics* (2005) spells out in considerable detail, in Standard A.2.b., the elements that need to be included in securing informed consent ethically. Therefore, these elements should be included in counseling disclosure statements:

- The purposes, goals, techniques, procedures, limitations, potential risks, and benefits of proposed counseling services

## Client Rights and Counselor Responsibilities

- The counselor's qualifications, including relevant degrees held, licenses and certifications, areas of specialization, and experience
- Arrangements for continuation of services if the counselor dies or becomes incapacitated
- The implications of diagnosis and the intended use of tests and reports
- Fees and billing information
- Confidentiality and its limitations
- Clients' rights to obtain information about their records and to participate in ongoing counseling plans
- Clients' rights to refuse any recommended services or modality change and be advised of the consequences of refusal

In addition to the elements addressed by the code, various writers have recommended that the following additional topics be included:

- A description of the counselor's *theoretical orientation*, in lay language that the client can understand (Corey et al., 2011), or a brief statement of the counselor's *philosophy* (how the counselor sees the counseling process)
- Information about *logistics* of the counseling process, such as length and frequency of sessions, procedures for making and canceling appointments, policies regarding telephone contact between sessions, and how to reach the counselor or an alternative service in an emergency (Haas & Malouf, 1995)
- Information about *insurance reimbursement*, including the fact that any diagnosis assigned will become part of the client's permanent health record; what information will be provided to insurance carriers and how this limits confidentiality (Welfel, 2010); and, if applicable, a description of how the *managed care* system will affect the counseling process (Corey et al., 2011; Glossoff et al., 1999)
- Information about *alternatives to counseling*, such as 12-step groups or other self-help groups, books, medications, nutritional or exercise therapy, or other services (Bray, Shepherd, & Hays, 1985)
- If applicable, a statement that sessions will be *videotaped or audiotaped*, along with the information that the client's case may be discussed with a supervisor or consultant (Corey et al., 2011)
- The client's *recourse if dissatisfied with services*, including names and contact information for supervisors, and addresses and telephone numbers of licensing boards and professional organizations (Welfel, 2010)



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 4 and view the video clip entitled “Misinformed Consent.” In this video a counselor, in his eagerness to help the client, creates unrealistic expectations for his client.

Beyond the informed consent areas required by the ACA *Code of Ethics* (2005) and areas suggested by others, some legal concerns need to be addressed in disclosure statements. The following informed consent areas are particularly sensitive and could lead to legal problems if not handled

properly. Examples of problems that could arise are included. A client might have the basis for a lawsuit against a counselor if the client believed, for some reason, that the counselor had done any of the following:

**1. Failed to include required HIPAA elements.** Example: A client was not notified when she began counseling that she had the right to review her counseling records. She complained to the federal government and the counselor was asked to verify that he had informed her of these rights.

**2. Guaranteed an outcome as a result of counseling.** Example: A wife reluctantly agreed to enter marriage counseling with her husband. She believed that, by agreeing to engage in counseling, she was guaranteed that her marriage would not end. She says the counselor told her that counseling was “the only thing that would save her marriage.” She felt betrayed by the counselor when, after five sessions, her husband moved out of their home and filed for divorce. She sued the counselor for breach of contract, conspiracy, and alienation of affection.

**3. Guaranteed privacy with no exceptions.** Example: A new client expresses concern to his counselor that others might find out what he tells the counselor in their sessions. To reduce the client’s anxiety, the counselor explains her ethical and legal responsibilities to protect his privacy. The client believes that his counselor told him that she would never, under any circumstances, reveal to anyone else information given to her in counseling sessions. Later the counselor informs the client’s wife, over his objection, that he has expressed suicidal ideas and that she believes he should be evaluated to determine whether he is at risk. He sues the counselor for breach of contract, malpractice, and intentional infliction of emotional distress.

**4. Agreed to fee arrangements different from what was intended.** Example: A counselor begins a counseling relationship with his client, charging the client his standard rate of \$75 per hour. After 3 months of sessions once a week, the counselor tells his client that his fees will be increased in 1 month to \$90 per hour. The client objects, saying that he believes the new hourly rate is too high. The counselor replies that he is not willing to provide further counseling services to the client unless the client agrees to pay the new rate. The client sues the counselor for breach of contract and abandonment.

**5. Touched without implied or actual permission.** Example: In the course of a group counseling experience, a counselor asks group members who are blindfolded to allow themselves to fall backward into the arms of another group member to demonstrate the difficulty of trusting another person. A female group member reluctantly participates and is caught by a male group member. The female group member is very upset after the exercise and leaves the session visibly shaken. The female client sues the counselor for breach of contract, breach of fiduciary duty, assault, battery, and sexual assault.

**6. Misrepresented credentials.** Example: A client begins counseling sessions with a master’s-level licensed counselor. The client tells his family members and friends that he is seeing a psychologist for therapy. The client makes out his checks to *Dr.*, notes on the checks that he is paying for *psychological services*, and gives the checks each week to the office receptionist, who deposits them. At the ninth session, the client calls the counselor, “Dr.,” and she corrects him. He then says, “You are a psychologist, aren’t you?” He is very upset when he realizes that she is a master’s-level licensed counselor. The client sues the counselor for breach of contract and fraudulent misrepresentation.

**7. Failed to communicate the nature of counseling.** Example: A client has taken a new job in which she is required periodically to give presentations to small groups of potential clients. She is very anxious about speaking before groups and has sought counseling to overcome her anxiety.

The counselor believes that her anxiety is the result of low self-esteem and focuses on positive reinforcement of the client's positive attributes. After five sessions, the client complains that she is still as anxious as she was when she began counseling. She tells the counselor that she had expected to be taught how to give presentations without being anxious and she does not understand why the counselor has not given her books to read, given her advice on how to be less anxious, or practiced making presentations with her. The client sues the counselor for breach of contract and malpractice.

**8. *Neglected to warn client about possible stigma.*** Example: After the first session with a new client, the counselor completes an insurance form at the client's request. The counselor indicates on the form that the client has had a single episode of depression and assigns the appropriate *DSM-IV-TR* diagnosis. The counselor counsels the client for 10 sessions, terminating when the client moves to a new city hundreds of miles away. Two years later the client contacts the counselor and complains that he has been denied a security clearance for a job he has applied for because she diagnosed him, without his knowledge or agreement, with a mental disorder. He sues the counselor for breach of contract, malpractice, and defamation.

These eight hypothetical situations illustrate the importance of ensuring that counselors and their clients have the same understanding regarding their relationship before counseling begins. All of these problems could have been avoided if the counselors had fully informed the clients regarding the counseling relationship. Since HIPAA has come into effect, all counselors must give their clients written informed consent documents to sign. To be effective, however, these documents must include essential information beyond the HIPAA requirements.

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### 3 The Case of Mark

Mark, a new Licensed Professional Counselor (LPC), works in a very efficient community mental health agency that utilizes the latest technology. Before he begins his first counseling session with each client, Mark types in the client's name and a personalized disclosure statement is printed out that includes all of the HIPAA, ethical, and legal requirements for such documents. Mark is counseling Maureen, a young mother, who discloses that her husband, Jake, gets angry with their infant daughter when she cries and shakes the child severely to stop her crying. Mark informs Maureen that he must report Jake's actions to the authorities as possible child abuse. Mark, being sensitive to Maureen's concerns, explains in detail what may happen as a result of the report and assures her that he will continue counseling her. Maureen complains that she never would have told Mark about Jake's actions if she had known he would make a report to authorities. Mark responds that Maureen signed the informed consent form when they began their counseling relationship, and that the form clearly stated that counselors are legally obligated to report incidents of suspected child abuse. Maureen responds that she didn't read the document. She says she just signed it along with all those other papers for insurance. Maureen says she will not continue her counseling relationship with Mark because she no longer trusts him.

- What could Mark have done at the outset of his counseling relationship with Maureen that might have prevented this unfortunate situation? What would have constituted *best practice* in this situation?
  - How can counselors balance the need to inform new clients of the limits of confidentiality in the relationship and to establish rapport at the same time?
-

**Discussion:** Mark might have considered the following actions to prevent this unfortunate situation:

- Mark might have spent some time with Maureen in their first session pointing out some of the major exceptions to confidentiality. One such major exception is a counselor's legal duty to report suspected child abuse.
- Mark might have asked the intake person in his agency, if such help was available, to go over some of the major details in the documents with Maureen before he began his first session with her.

In order to discuss confidentiality limits and establish rapport, counselors should consider taking the following actions:

- Focus on establishing rapport in a first session, and at the end, go over important details regarding the counseling relationship.
- Highlight certain parts of the many papers that clients sign in bold type or large type to draw clients' attention.
- Create a written brochure that explains the counseling relationship, including confidentiality limits, and send the brochure to prospective clients for them to read before their first appointment.

In the process of having clients sign counseling disclosure statements, counselors should attempt to ensure that clients know what they have read and what was in the document being signed. If questions arise later about what counselors may have said, a signed written document demonstrates the intent of the parties much more clearly than does a statement of what someone says he or she intended. In addition, counseling disclosure statements can be used to correct misunderstandings on the part of clients before counseling begins.

You may be thinking that a lot of information must be included in a disclosure statement, and, indeed, this is true. In order for clients to give truly informed consent, they must have considerable information before deciding whether to enter into a counseling relationship. This may raise your concern that inundating prospective clients with information will overwhelm them and give the impression that the counseling relationship is nothing more than a complex, contractual business arrangement. It is difficult for counselors to achieve the delicate balance between giving clients too little information and giving them so much information that they feel overwhelmed or intimidated (Barnett, Wise, Johnson-Greene, & Bucky, 2007). Written disclosure statements allow counselors to provide detailed information. Oral exchanges between counselors and potential clients can then focus on areas that the counselor wishes to emphasize or that cause particular concern for clients.

As noted earlier, every counselor should have a professional disclosure statement that can be given to clients. A complete signed disclosure statement will fulfill a counselor's legal obligation to obtain informed consent from a client. Keep in mind, though, that disclosure statements are necessary but not sufficient strategies for securing genuine informed consent. They cannot serve as a substitute for dialog with the client. We cannot rely on standard forms, no matter how well they are written, to do our work for us (Pope & Vasquez, 2007). Prospective clients are likely to have many questions, and some of these are best addressed in face-to-face conversation. Such a dialog gives clients an opportunity to clarify any information that seems confusing to them and gives counselors the opportunity to gauge the extent to which the clients comprehend the information. At the outset

of the relationship, informed consent discussions present a mutual opportunity for the client and the counselor to ensure that they understand their shared journey.

Pope and Vasquez (2007) also have noted that informed consent procedures must fit the situation and setting and be sensitive to the client's ability to understand. The *ACA Code of Ethics* (2005) affirms the obligation of counselors to communicate information in ways that are both developmentally and culturally appropriate (Standard A.2.c.). To ensure client comprehension, it may be necessary in some cases to arrange for a qualified interpreter or translator. Counselors are cautioned, though, that having a translator present may not be sufficient to ensure the client's informed consent if the translator lacks understanding of the counselor's role and the purpose of the informed consent information. Paone and Malott (2008) have advised counselors to have a pre-session briefing with a translator to review informed consent concepts and how these concepts should be communicated to the client.

Some clients may be presumed to lack the capacity to give informed consent. Such clients might include minors or adults who are developmentally disabled or who suffer from cognitive impairments or a severe thought disorder. In these cases, counselors seek the consent of legal guardians. Counselors should also seek clients' assent to services and include clients in the decision-making process to the extent possible (Standard A.2.d.). Bennett et al. (2006) have advised counselors to view informed consent capacity as being on a continuum rather than as an all-or-none ability. The informed consent process should be designed to fit each client's cognitive strengths, vulnerabilities, and decision-making capabilities (Fisher, Cea, Davidson, & Fried, 2006).

Managed care arrangements present some specific considerations in informed consent. Clients often do not understand how their health plans affect the duration of their treatment, the implications of diagnosis, or the extent to which their insurance providers require counselors to provide them with information about treatment plans and counseling progress (Glosoff, 1998). Because it would be impossible for counselors to know the details of each of the health care plans of their clients, it is preferable for counselors to stress to clients that they should investigate the terms and limits of their coverage, rather than for counselors to undertake that entire burden. Once the provisions of the plan are known, counselors should discuss with clients the limitations of their coverage; perhaps they will need to agree upon treatment goals that are more limited than if cost were no object (Vasquez et al., 2008).

From an ethical perspective, ensuring informed consent is not a one-time event. Rather, it is a recurring process that begins with the initial contact between client and counselor and continues throughout the counseling relationship. It is not always possible for counselors to provide complete informed consent information during the first session. For example, insurance policies often dictate the number of sessions that will be reimbursed, and counselors may not be able to accurately inform clients about the duration of reimbursed counseling until they receive the necessary information from the client's managed care company. Specific goals of counseling and the techniques that may be used to accomplish those goals are not always clearly formed during the initial meeting. Some elements of informed consent are best left until a trusting therapeutic relationship has been established; for instance, a client who suffers from a phobia might become anxious when told about exposure therapy, a technique that has proven effectiveness for treating phobias but includes elements (such as getting on an elevator) that might seem frightening at first (Fisher & Oransky, 2008). The *ACA Code of Ethics* (2005) describes informed consent as an ongoing part of the counseling process and advises counselors to document discussion of informed consent throughout the counseling relationship (Standard A.2.a.). As counseling progresses, the goals, issues, risks, and benefits often change, and clients need to have updated information so that they can continue to make sound decisions (Handelsman, 2001).

It is impossible to predict which clients will need what information and when they will need it, so it is best to be as thorough as possible in a written disclosure statement. Then later, in a face-



to-face discussion, issues that arise frequently in one's practice can be emphasized and rare events can be given less attention. For example, Weinrach (1989) has suggested that the two most common problems for private practitioners concern fees and billing, and late cancellations or no-shows. Thus, it behooves counselors in private practice to be clear with their clients about methods of payment and policies regarding missed appointments.

Research supports the wisdom of securing informed consent. Studies have suggested that clients want information about their prospective counselors (Braaten, Otto, & Handelsman, 1993; Hendrick, 1988); that they perceive counselors who provide informed consent information as being more expert and trustworthy (Sullivan, Martin, & Handelsman, 1993); and that clients who have received appropriate information are more likely to follow their treatment plans, to recover more quickly, to be less anxious, and to be more alert to possible negative consequences (Handler, 1990). In addition, some legal problems can be avoided by the use of disclosure statements. If allegations do arise that a counselor did not fully explain the counseling relationship to a client, a disclosure statement signed by a client often can go a long way toward vindicating an accused counselor who has done no wrong.

**DIVERSITY CONSIDERATIONS IN INFORMED CONSENT** It is important for us to question whether the individualism inherent in our concept of informed consent is truly respectful of people of all cultures. We need to be aware that the full and truthful disclosure that counselors value may be at variance with some clients' cultural beliefs about hope and wellness, that autonomous decision making may run counter to family-centered or group-centered values, and that uncoerced choices may contradict cultural norms about obedience to the wishes of elders or spouses (Gostin, 1995). The following two case examples illustrate this point.

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#### 4 The Case of Henry

Joseph, a Navajo Indian who espouses the traditions of his culture, is Henry's new client. During the initial interview, Henry wants to secure Joseph's informed consent, which would include giving him information about the implications of diagnosis and the potential risks associated with counseling. Henry says, "Sometimes, clients in counseling seem to feel worse before they feel better." He adds that, based on the symptoms Joseph has described, Joseph seems to be experiencing mild depression.

- What would Henry need to know about Joseph's culture that would help him conduct informed consent procedures in a culture-sensitive way?
- Can you identify any problems with what Henry told Joseph?

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**Discussion:** Henry should have made an effort to gain some basic understanding of the Navajo culture before meeting with Joseph. In traditional Navajo culture, it is believed that language has the power to shape reality and control events. Therefore Henry, in following his standard informed consent procedures, could be *creating* a reality for Joseph that he is depressed and will feel worse before he feels better.

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#### 5 The Case of Loretta

Soo Jung is a 22-year-old immigrant from Korea who is brought to the counseling center by her husband. During the intake interview, she tells her counselor, Loretta, that she has been having crying

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spells, has lost her appetite, and is not sleeping well. She gave birth to her first child 2 months ago. When Loretta suggests to Soo Jung that she may be experiencing postpartum depression, Soo Jung becomes upset and says, “Why are you telling me this? You need to talk to my husband.”

- Why do you think Soo Jung became upset?
  - How might have Loretta handled the intake interview differently to avoid upsetting this client?
- 

**Discussion:** Soo Jung appears to share a family-oriented worldview that is common among people from some Asian cultures. Because the counselor did not include this client’s husband in this discussion, Soo Jung may have interpreted the counselor’s actions as attempting to undermine her marital relationship. An awareness of the Korean culture and its views on marriage might have led Loretta to interview Soo Jung and her husband together as the counseling relationship was being established.

Joseph and Soo Jung illustrate the point that there are communities of clients in our pluralistic society who do not claim Euro-American values as their own. Counselors must remember to put the client’s needs first. Weinrach and Thomas (1996) suggest that counselors identify, and then focus on, the frame of reference or belief and value systems that are central to the client as one way to remain sensitive to differences. Expanding our frame of reference regarding informed consent does not mean that we must abandon our commitment to client autonomy, but it does encompass respect for the cultural values that our clients bring with them to counseling.

Counselors must also be sensitive to clients’ rights to informed consent when clients have been legally adjudicated as incompetent. Clients with developmental disabilities, older adults who have cognitive impairments, and persons who have been diagnosed with a psychotic or thought disorder often are judged to have diminished capacity to consent. Keep in mind that “diminished” capacity is not the same as an absence of capacity. You have an ethical obligation to discuss consent with these clients in a manner that they can understand and to obtain their assent to services even though their agreement may not be legally recognized (Fisher & Oransky, 2008; Handelsman, 2001).

The importance of using language that clients can understand is equally important with clients who are children, adults who are not well educated, and clients whose first language is not English. If you work with such clients, it would be wise to carefully check the readability level of your written disclosure statement. When English is a second language for clients, it would be helpful to have a copy that has been translated into the client’s primary language. The overarching principle is that consent procedures, both oral and written, must be developmentally and culturally appropriate.

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## Summary and Key Points

This chapter addresses two vitally important and inter-related ethical and legal issues in counseling: client rights and counselor responsibilities. Following are key points regarding these rights and responsibilities:

- Counselors are ethically responsible for putting client welfare first and foremost in their work.
- Counselors have a fiduciary relationship with their clients, which means that they have a

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legal obligation to protect their clients' best interests and to avoid interactions that benefit themselves.

- Respecting diversity is fundamental to protecting client welfare and promoting client dignity in our pluralistic society.
- It is vital for counselors to be aware of their own life issues, unfinished business, areas of vulnerability, and defenses so that they will not inadvertently be working on their own issues in the counseling relationship rather than on the client's issues.
- Counselors must be aware of their values and must not impose their values on clients. Recent court cases have highlighted issues related to value conflicts between counselors and clients.
- Counselors must avoid fostering client dependency. They have an obligation to promote client autonomy and independence.
- When counseling involuntary or mandated clients, counselors must inform these clients of the limits of confidentiality and the nature of any reports that may be made to courts or other entities that are requiring the clients to attend counseling. Counselors must be sensitive to these clients' rights and ensure that clients understand any privacy rights they may be waiving.
- Counselors have an obligation to select appropriate counseling strategies or techniques and to make clients active partners in treatment decisions.
- Counselors must protect the best interests and welfare of clients when counseling services have to be interrupted or terminated prematurely.
- It is unethical, as well as illegal, for counselors to abandon their clients. Although there are valid reasons for a counselor to end a counseling relationship, care must be taken not to put the client at risk when doing so. Several guidelines were offered for counselors to use when they are terminating counseling relationships in adverse circumstances.

The following are key points regarding informed consent in counseling:

- As an ethical obligation, informed consent is based on the rationale that clients have a right to know what they are getting into when they come for counseling.
- Counselors should understand that counseling services are contractual in nature. Agreements should be put in writing in an informed consent document.
- The requirement that health professionals inform prospective recipients of services and obtain their consent to treatment originated in the field of medicine. More recently, it has been applied to the mental health field. A number of model disclosure statements are available to assist counselors who work in various settings with a variety of clientele.
- The requirements of the HIPAA have transformed informed consent into a legal requirement, and counselors must ensure that their procedures are in compliance with this new law.
- Informed consent in counseling involves a number of elements that are required by the code of ethics, recommended by various writers, and suggested as a means to address legal concerns.
- Counselors should be aware of at least eight areas of informed consent that, if not handled properly, could lead to legal problems.
- It can be difficult to achieve a correct balance between providing prospective clients with too little information and giving them so much information that they feel overwhelmed or intimidated. Informed consent is an ongoing process that should be conducted both orally and in written form.
- It is important for counselors to be sensitive to the fact that informed consent as traditionally conceptualized may not be respectful of people of all cultures.

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# Confidentiality and Privileged Communication

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# Confidentiality and Privileged Communication

## FOCUS QUESTIONS

1. What do you think are the distinctions among the terms *privacy*, *confidentiality*, and *privileged communication*?
2. Some studies have shown that clients are not very concerned about privacy or confidentiality when they seek counseling services. What do you think about such findings?
3. How would you respond if a client asked to see the notes you have taken related to his or her counseling sessions?
4. What do you think should happen to clients' records after they die?

Confidentiality is one of the most fundamental of all professional obligations in counseling. It is also one of the most complex and problematic duties to manage in day-to-day practice (Younggren, 2002). Consider, for instance, what you would do if you were the counselor in each of the following situations.

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## 1 The Case of Elena

Elena has been working with Pete, age 28, who came for counseling to resolve some family-of-origin issues that he believes are creating problems in his relationship with his partner, Jacob. During their last counseling session together, Pete tearfully revealed that before he met Jacob, he had a series of casual sexual encounters and that he was terrified that he might have contracted the AIDS virus through these encounters. He comes to today's session with the news that he has been fully tested and is confirmed to be HIV positive. He says he cannot tell Jacob, because he is sure Jacob will leave him if he knows.

- As Pete's counselor, is Elena obligated to keep his secret? Or do you believe she has a duty to inform Jacob of Pete's condition, even though this would involve breaching Pete's confidentiality?



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- Suppose Pete tells Elena, after further discussion, that he realizes he must tell Jacob but needs some time to gather his courage. Should Elena keep his secret in this circumstance? If yes, for how long?
- 

**Discussion:** Counselors have both an ethical and a legal (except in Texas) duty to take action to prevent harm if they believe their client is intentionally harming someone else. The ethical duty exists because the obligation to prevent harm outweighs the rights of a client to privacy. The legal duty exists (except in Texas) because of the Tarasoff case (*Tarasoff v. Regents of University of California*, 1976).

Therefore, Elena cannot keep Pete's secret. It might be best if Elena were to contact Pete's physician (because only the physician knows for sure that Pete is HIV positive), inform the physician of the situation, and ask the physician to take action to protect Jacob.

If Pete asks for some time before he tells Jacob, it would be risky for Elena to agree to the request. If Jacob is later found to be HIV positive, there would be no way to tell whether he was infected before or after Pete told Elena about his condition. Therefore, Jacob might argue that Elena is responsible for his becoming HIV positive because she did not warn him. Perhaps, however, Elena might have Pete promise not to have unprotected sex with Jacob before telling him. Elena might then decide to agree to give Pete some time if she has been counseling him for quite some time and feels confident that he will honor his promise.

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## 2 The Case of Nancy

Nancy, a high school counselor, has been conducting a group for freshman and sophomore girls. The focus of the group is on building self-esteem and making wise choices. During the fourth session today, the group members begin discussing boyfriends and whether to "just say no" to sex. Marlee, a 15-year-old freshman, shares that she and her boyfriend are having sexual relations and that she thinks it's okay because they are really in love. She mentions, almost in passing, that her boyfriend is 20 years old and that her parents would "kill her" if they found out about him.

- Can Marlee's counselor keep her disclosure in confidence, or must she notify Marlee's parents?
  - If Nancy breaches confidentiality, what are the risks to her relationship with Marlee?
  - If Nancy breaches confidentiality, what are the risks to the group process, to the trust that other group members may have come to feel toward her, and to her reputation for trustworthiness among the student population in general?
  - Are these risks greater than the risks posed by keeping Marlee's relationship with her boyfriend a secret from her parents?
-

**Discussion:** Nancy cannot keep Marlee's disclosure a secret; she must notify Marlee's parents, although she should first inform Marlee of her obligation and explain why she cannot keep the secret. If Nancy does not tell the parents and Marlee becomes pregnant or is harmed by the relationship with an adult male, the parents might attempt to hold Nancy responsible. Nancy should check her state law, as she may also be required to report suspected child abuse to authorities.

It certainly is possible that Marlee will be very upset after Nancy tells her parents, and Marlee may not want to continue the counseling relationship. Nancy should do her best to maintain the relationship, however. This may be possible if she is able to convince Marlee that it is in her best interest for her parents to know, or if she can obtain Marlee's agreement that Marlee will tell her parents, perhaps in Nancy's office with Nancy present.

This group might not continue, although Nancy should try to keep it functioning and work through the issue with the other students. Hopefully, Nancy has already discussed the limits of confidentiality with the group members so they will understand why she cannot keep Marlee's secret. It is likely, however, that Nancy's reputation among the students for trustworthiness will be compromised and other students probably will be reluctant to tell her confidential information in the future.

After pondering these scenarios, you may not be surprised to learn that counselors encounter dilemmas of confidentiality more frequently than other types of ethical challenges and find them the most difficult to resolve (Fisher, 2008). Questions surrounding confidentiality can be very complex and often involve legal as well as ethical considerations.

A useful starting place may be to clarify the distinctions among three terms—*privacy*, *confidentiality*, and *privileged communication*. These terms are sometimes used interchangeably by counselors, but the concepts have important differences. Both confidentiality and privileged communication arise from our societal belief that individuals have a right to privacy. *Privacy* is the broadest of the three concepts and refers to the right of persons to decide what information about themselves will be shared with or withheld from others. Confidentiality and privileged communication both apply more specifically to the professional relationship between counselors and clients. *Confidentiality* is primarily an ethical concept that refers to the counselor's obligation to respect the client's privacy and to our promise to clients that the information they reveal during counseling will be protected from disclosure without their consent. *Privileged communication* is the narrowest of the three terms and is a legal concept. Privileged communication laws protect clients from having confidential communications with their counselors disclosed in a court of law without their permission (Shuman & Weiner, 1987). For a communication to be privileged, a statute must have been enacted that grants privilege to a category of professionals and to those whom they serve.

In this chapter, we first explore confidentiality as an ethical issue and then discuss privileged communication. Later, we look at the numerous exceptions that exist, both to confidentiality and to privilege.

## CONFIDENTIALITY

### Origins of Confidentiality

Helping professionals assume that an assurance of confidentiality is an indispensable requirement for effective therapy and that, without this assurance, many clients would not feel safe to discuss openly the intimate and personal aspects of their lives or would not seek counseling. Actual studies, however,

show only mixed support for this assumption. Some studies have supported the belief that privacy assurances are essential (McGuire, Toal, & Blau, 1985; Merluzzi & Brischetto, 1983; Miller & Thelan, 1986), whereas other studies have indicated that such assurances have little effect on encouraging disclosures (Muehleman, Pickens, & Robinson, 1985; Schmid, Appelbaum, Roth, & Lidz, 1983; Shuman & Weiner, 1982), or that limits to confidentiality matter only to some clients in some circumstances (Taube & Elwork, 1990; VandeCreek, Miars, & Herzog, 1987). Despite this lack of unequivocal evidence, confidentiality has become such an internalized norm in the counseling profession that it is rarely questioned. A brief look at some of the historical origins of the profession may be helpful in understanding how this norm developed.

Counseling represents the fusion of many diverse influences. One of these influences was the emergence of the field of psychiatry in the treatment of mental illness. Almost until the beginning of the nineteenth century, mental illness was viewed as mystical and demonic. These early times are associated with images of “lunatics” in chains in asylums. It was not until the 1800s that significant strides were made in the understanding of mental illness, and not until the 1960s that the deinstitutionalization of the mentally ill brought these individuals back into contact with society. Another force that bears mentioning is the emergence of psychoanalysis in the early to middle years of the twentieth century. Patients of Freudian analysts were expected to work through their socially unacceptable urges, sexual fantasies, and repressed feelings and thoughts, and to do so in a society that held Victorian social mores! Early notions about mental illness and negative impressions about the nature of personal material discussed in analysis helped to create a social stigma. In this climate, it is understandable that the patient’s need for absolute privacy was assumed and that people would want to hide any information related to their having sought and received treatment.

It was not until the middle of the twentieth century that other, countervailing influences emerged in the mental health field. Carl Rogers’s humanistic views, other theorists who emphasized the natural developmental life stages that all individuals pass through, and the career guidance movement all helped to shift thinking away from counseling as a service only for the mentally ill or the sexually repressed. Concurrently, as scientists began to discover the biological bases for some mental disorders and to find medications that could alleviate conditions formerly thought to be untreatable, the stigmatization associated with mental illness and psychotherapy began to decrease. Nonetheless, even in modern society, a notion stubbornly persists that there is something shameful about seeking the services of a mental health professional. Note, for instance, the language used by the U.S. Supreme Court in its 1996 decision in *Jaffee v. Redmond et al.* (1996, p. 8), a case we describe later:

Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause *embarrassment or disgrace*.

### **The Rationale for Confidentiality**

Whatever its origin, confidentiality is universally viewed today as being essential to the counseling process, which depends on an atmosphere of confidence and trust in which clients are able to tell their stories freely and honestly disclose their feelings, fears, thoughts, memories, and desires. Clients need to know that they can trust their counselors to respect their privacy, and the counselor’s confidentiality pledge is the cornerstone on which this trust is built (Herlihy & Corey, 2006).

Confidentiality is a strong moral force that helps shape the manner in which counselors relate to their clients. Bok (1983) has suggested that confidentiality is based on four premises. The first two premises relate to respect for client rights in counseling. The principle of *respect for autonomy* means

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that counselors honor their clients' ability to be self-determining and to make their own choices. Applied to confidentiality, it also means that counselors honor the rights of clients to decide who knows what information about them and in what circumstances. The second premise is *respect* for human relationships and for the secrets that certain types of relationships entail. In the professional relationship, the intimate context in which these secrets are shared is seen as essential to counseling. The third premise has to do with the counselor's obligation that arises from autonomy and respect. Bok contends that an additional duty is created by a *pledge of silence*, which is the offer of confidentiality extended by the counselor to the client. Counselors are bound to this pledge both in word and in deed; when they have given their word, they are obligated to actively work to protect clients' secrets from disclosure. The final basis for confidentiality is its *utility*. The rationale here is that confidentiality in counseling relationships is useful to society, because clients would be reluctant to seek help without an assurance of privacy. Society gives up its right to certain information and accepts the risks of not knowing about some problems and dangers in society in exchange for the benefit that is gained when its members improve their mental health. Stadler (1990a) has cogently summarized the essential meaning of these four premises for counselors:

The duties to respect autonomy, respect relationships, keep a pledge of silence, and reinforce its utility are *each* of great importance in counseling. When they are combined in support of the principles of confidentiality, they develop a powerful moral claim on counselors' actions. I believe the power of that claim makes confidentiality a compelling duty for counselors, more compelling than each of the duties taken separately. (p. 104)

Respect for autonomy is only one of the moral principles on which confidentiality rests. Another is *fidelity*, which means being faithful and keeping promises. Certainly, one of the most important promises that counselors make to clients is that they will keep the secrets shared in counseling. Today, confidentiality is an issue not only of counselor belief systems but also of consumer rights. Our culture has placed increasing emphasis on the rights of service recipients, and clients are more likely to hold an expectation that their privacy will be maintained by the professionals whose help they seek. This expectation of privacy has important legal as well as ethical implications, as you will discover later in the chapter.

### Counselor Practices and Confidentiality

How well do practicing counselors deal with confidentiality issues? There is some evidence to suggest that counselors feel confident of their ability to make sound ethical judgments about confidentiality issues. Gibson and Pope (1993) surveyed a large national sample of counselors regarding their beliefs about whether a wide range of ethical behaviors were ethical or unethical and how confident they were in making these judgments. Twenty-nine percent of the items for which the confidence rating was very high (at least 9.0 on a 10-point scale) concerned confidentiality. In a more recent survey, Neukrug and Milliken (2011) asked ACA members to rate 77 behaviors as ethical or unethical. In their study, two confidentiality-related behaviors about which the respondents were in overwhelming agreement (over 95%) were that it is ethical to break confidentiality if a client is threatening harm to self and that it is unethical to fail to reveal the limits of confidentiality to a client.

Counselors' confidence in their ethical judgments may be well founded. Complaints made against helping professionals for violations of confidentiality are not as common as one might expect. Various studies have shown that only 1% to 5% of complaints made to the ethics committees and state licensing boards of counselors involve violations of confidentiality (Anderson &

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Freeman, 2006; Garcia, Glossoff, & Smith, 1994; Garcia, Salo, & Hamilton, 1995; Neukrug, Healy, & Herlihy, 1992). It appears that mental health professionals take seriously their pledge to maintain their clients' confidentiality and are diligent in honoring it. Grabois (1997/1998) has reported that there are few cases in which mental health professionals have been sued for breaching confidentiality. Counselors should not become complacent about their confidentiality practices, however. Statistics regarding formal complaints may not accurately reflect the actual frequency of breaches of confidentiality. According to one study, 61.9% of psychologists reported that they had *unintentionally* violated their clients' confidentiality (Pope, Tabachnick, & Keith-Spiegel, 1987b). Clients may not have been aware of these unintentional breaches. Although it may be startling to think that the majority of practitioners may have violated their clients' confidentiality, it is somewhat understandable when we pause to consider the myriad ways that an inadvertent or careless breach could occur. The following examples illustrate this point.

Counselors do not always have the luxury of having a separate entrance and exit for their clients to use. When clients who are leaving their sessions must pass through a waiting area, counselors need to take special precautions to guard their clients' privacy. We know one very conscientious counselor in private practice who routinely left 15-minute intervals between the end of one scheduled appointment and the beginning of the next, and who avoided scheduling consecutively any clients from the same part of town. Nevertheless, one day she ran late with a client, who exited into the waiting room and ran into a friend from church. Both clients appeared uncomfortable to have encountered each other in this way.

Counselors are encouraged to consult with each other regarding clients who present challenges to them, and most consultations can be managed without revealing a client's identity. However, it is important not to obtain a colleague's advice while walking through the halls of an agency or institution, at a restaurant over lunch, or in another public place. Pope and Vasquez (2007) related the story of a counselor who was consulting a colleague about a particularly "difficult" client while they were on a crowded elevator. The counselor did not mention the client's name but gave enough detail that the client, who happened to be standing only a few feet behind them in the elevator, was able to ascertain that he was the subject of the discussion and to listen with intense interest and dismay.

Clearly, it is easy for even seasoned practitioners to violate a client's privacy unintentionally. Students in counselor training programs must also take special care to maintain client confidentiality. Although it may be tempting to share with family, friends, or fellow students your excitement about what you are learning in a practicum, a practice session with a peer "client," or an experiential group, it is important to keep in mind that the ethical obligations of students are the same as those of practicing counselors (Standard F.8.a.). Your conversations must not reveal any information that could conceivably allow listeners to ascertain the identity of a client. Case notes, test protocols and interpretations, audiotapes, and videotapes of work with clients must not be left in places where they might be seen by anyone other than authorized supervisors or professors. It is a good idea to get into the habit of zealously safeguarding client confidentiality from the very beginning of your graduate studies.

A question that surfaces quite often for beginning counselors is whether they have an obligation to keep confidential private information that is disclosed to them when they are not in the role of counselor, for example, when a neighbor tells a counselor about an event that occurred a few houses away. The answer is that confidentiality and privileged communication exist only when counselors are functioning in the role of professional counselor. As explained by Sydow (2006), even when a counselor is at work, courts have held that privilege exists only when the counselor is providing professional counseling services.

## Ethical Standards and Confidentiality

Confidentiality is the only specific ethical issue to which an entire section of the *ACA Code of Ethics* (2005) is devoted. *Section B: Confidentiality, Privileged Communication, and Privacy* emphasizes the client's right to privacy in the counseling relationship. Exceptions and limitations to confidentiality are addressed and, because exceptions to confidentiality may be mandated by legal as well as ethical considerations, the standards are carefully written to minimize conflicts between law and ethics. This section addresses special circumstances in counseling minors, families, and groups, and offers guidelines for maintaining confidentiality when consulting or conducting research.

The Introduction to Standard B is general and states, "Counselors recognize that trust is a cornerstone of the counseling relationship." An early standard in this section states, "Counselors respect their clients' right to privacy" (Standard B.1.b.). Sometimes counselors, in their zeal to protect a client's privacy, mistakenly believe that they should maintain a client's confidentiality even when the client asks them to share information with others (Herlihy & Corey, 2006). When clients request that information be disclosed, counselors should honor these requests. If the counselor believes that releasing the information might be detrimental to the client's best interests, these concerns should be discussed with the client, but the ultimate decision belongs to the client. In many instances, client requests for disclosure are not particularly problematic for counselors, such as when clients move and later request that their records be sent to their new counselor. Other situations may cause counselors some discomfort, such as when clients ask to see their own records. It is important to realize that records are kept for the benefit of clients and that counselors are obligated to provide clients with access to their records, unless the records contain information that may be misleading or harmful to the client (Standard B.6.d.). The Health Insurance Portability and Accountability Act (HIPAA), a federal statute, requires that clients be given access to their counseling records.

One of the reasons that confidentiality is such a difficult ethical issue is that *confidentiality is not absolute*. Although counselors should make every effort to avoid inadvertent breaches, there are other times when confidentiality *must* be breached. Counselors must inform clients at the outset that there are limitations to their confidentiality. It is important to discuss thoroughly these limitations and to identify foreseeable situations in which confidentiality must be breached (Standard B.1.d.). Prospective clients may not be aware at the time they seek your services that confidentiality is not absolute. In one survey of the general public, 69% of respondents believed that everything discussed with a professional therapist would be held strictly confidential, and 74% thought that there should be no exceptions to maintaining confidential disclosures (Miller & Thelan, 1986). Counselors may be hesitant to explain the exceptions to confidentiality to new or prospective clients for fear that clients will feel constrained in discussing their problems. However, some researchers have found very little evidence that explaining in detail the limits of confidentiality actually inhibits client disclosures. Others have concluded that the advantages of informing clients about limits outweigh any disadvantages in terms of inhibited disclosure (Baird & Rupert, 1987; Muehleman et al., 1985).

There are numerous exceptions to confidentiality. We have identified at least 15 types of situations in which compromising a client's confidentiality might be permissible or required. Because most of these exceptions to confidentiality have both a legal and an ethical basis, we will explore them in more detail after we have discussed the legal counterpart to confidentiality—privileged communication.

## PRIVILEGED COMMUNICATION

At the beginning of the chapter, we noted that privacy is a broad concept that provides the underpinnings for both confidentiality and privileged communication. The right to privacy is guaranteed to all citizens by the Fourth Amendment to the U.S. Constitution, which prohibits government



searches without warrants. This privacy right is not absolute, however. When the interests of society outweigh the individual's right to privacy, the privacy right is compromised in the interest of preserving a stable societal structure. The U.S. Supreme Court has never addressed the question of whether the Fourth Amendment supports the concept that some relationships are privileged because of this constitutional right to privacy. State and lower federal courts have been mixed in their results on the issue (Knapp & VandeCreek, 1987).

Basically, privileged communication means that a judge cannot order information that has been recognized by law as privileged to be revealed in court. The concept of withholding any relevant evidence is antagonistic to the entire system of justice in our country because legal procedures demand that all evidence relevant to a case be presented to a judge or jury. The legal system also demands that the opposing side in a court case have access to the evidence before the trial takes place through a process called *discovery*. As a counselor, you will surely want to guarantee that the information that clients give you will be kept confidential. The idea that information and secrets revealed in a counseling session might someday be disclosed in court is very unsettling for counselors. However, the idea that a judge or jury might have to decide the outcome of a court case without the benefit of essential privileged information is very unsettling to judges.

A good question to ask, then, is, "Why did the idea of privileged communication emerge in our legal system in the first place?" According to Slovenko (1966), "A trial is only as good as the evidence presented to the court." Despite the strong belief that all evidence should be available to the judge or jury who will decide the outcome of a case, federal and state legislators have realized that the requirement to make available all evidence compromises many important interactions in our society. These legislators have been convinced that, without a guarantee of absolute privacy for conversations between citizens and certain professionals, it would be impossible for the professionals to provide necessary assistance to those who seek their help. As a result, legislators have passed statutes that specifically exempt certain conversations between citizens and professionals from the general rule in law that all relevant evidence will be presented in a court case. These laws are called *privileged communication statutes*.

### **Origins of Privileged Communication**

According to Shuman and Weiner (1987), the first reference to courts recognizing a legal privilege between professionals and the citizens they served was in early Roman law. This privilege was based on the duty of servants (attorneys) to their masters (clients) rather than on the modern principle of a right to privacy.

Under the English common law, the foundation on which the legal system in the United States is based, there was no need for privileged communication. In early England, truth during trials was determined by various modes including "trial by oath or oath helpers, trial by ordeal, trial by battle, and trial by witnesses" (Shuman & Weiner, 1987, p. 50). Even when witnesses were used in trials, they were the jurors themselves, who relied on information they had gathered as members of the community. Individuals who were not jurors but volunteered information were viewed as meddlers and could be sued for interfering with the legal process.

About 1450, English equity courts began recognizing subpoenas for nonparty witnesses and started using them in law courts in 1562 (Wigmore, 1961). Yet, few communications were privileged under the English common law. Other than government secrets, the common law recognized as privileged only attorney–client and husband–wife relationships (Knapp & VandeCreek, 1987).

Once the English legal system allowed compelling witnesses to testify at trials, a question arose as to whether certain information obtained by professionals should be excluded

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from testimony for one reason or another. Wigmore (1961), the leading authority on evidence, described four requirements for a relationship to be privileged under the law:

1. The communications must originate in a *confidence* that they will not be disclosed.
2. This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
3. The *relationship* must be one that, in the opinion of the community, ought to be sedulously *fostered*.
4. The *injury* to the relationship that disclosure of the communications would cause must be *greater than the benefit* gained for the correct disposal of the litigation.

State and federal legislatures have used these requirements as criteria in considering whether to grant privilege to relationships between citizens and various categories of professionals. The question of which professional relationships meet these criteria and, therefore, should be accorded privilege has been a source of controversy that continues to this day. Some legal scholars have criticized all statutes that have been passed by legislatures granting privilege to relationships with professionals (Chafee, 1943; Cleary, 1984; Curd, 1938; Morgan, 1943; Wigmore, 1961). The attorney–client relationship was the first professional relationship to be recognized under the English common law, during the reign of Queen Elizabeth I. Currently in the United States, the attorney–client privilege is universally recognized (Rice, 1993).

Physicians, on the other hand, have been less successful at obtaining legal privilege with their patients. According to Shuman and Weiner (1987), most legal scholars agree that the concept of a physician–patient privilege fails Wigmore’s test. Every jurisdiction in the United States, except South Carolina and West Virginia, now has privileged communication statutes for physician–patient interactions (Shuman & Weiner, 1987). However, many of the statutes include a multitude of exceptions, including criminal cases, worker’s compensation proceedings, will contests, cases where the condition for which treatment or diagnosis was sought is raised by the patient to support a claim or defense, or cases in which the parent–child relationship is at issue.

According to Knapp and VandeCreek (1987), the clergy–communicant privilege is unique because it has its roots in the common law, but is now protected by statute. Every state except West Virginia now has a clergy–communicant privilege statute (Gumper, 1984). These statutes were passed to ensure that confessions by penitents to priests would be absolutely confidential. The clergy, in persuading legislators to pass such statutes, stressed that there was a substantial societal benefit in ensuring citizens that their confessions would never be repeated by priests or by members of the clergy outside the confessional. The clergy argued that unless citizens were absolutely convinced that their confessions would remain confidential, they would not confess their sins and this could cause serious disruption to the framework of society. They asserted that the need for privacy in the confessional far outweighed the need for all evidence to be presented in a trial. The notion of extending the clergy–communicant privilege to include counseling has been criticized by Knapp and VandeCreek. They argue that the privilege for recipients of mental health services should apply only when citizens have relationships with professionals with specialized training in counseling or psychotherapy, and that only a few specially trained pastoral counselors have such qualifications.

McCreary (2011) has explored the unusual situation in which a clergy member was also licensed as a professional counselor (LPC) and was providing mental health services. In a Texas case (*Westbook v. Penley*, 2007), a minister disclosed to his congregation private information about a female client’s extramarital affair that was revealed in a counseling relationship with the minister (it is standard practice in this church to discuss personal issues brought to the minister with the

entire congregation). The Texas court determined that the minister's action was church-related and a civil court should not interfere, despite the fact that the minister was also an LPC and would not have been allowed to reveal the private information of his client if he had not also been her minister. In this particular case, the court decided that the role of minister outweighed the role of LPC when the two roles were in conflict. It is very important for counselors who have other roles to avoid trying to assume both roles at one time. Counselors with dual roles should be clear in their own minds which role they are performing at a given point and communicate effectively their role with the persons they are helping.

Once citizens had been granted privileged communication with attorneys, physicians, and clergy, a variety of other professionals, including mental health professionals, began arguing successfully for privileged communication statutes for the benefit of their clients. Remember, though, that any exception to the general rule that all evidence will be presented in court is compromised by privileged communications statutes. Each time such a statute is passed, the legislators have to be convinced that making an exception to the rule is vital to the well-being of society, and that an individual citizen's need for privacy outweighs the need for evidence in court cases.

The earlier scholars who argued for a mental health professional–client privilege (Cottle, 1956; Fisher, 1964; Guttmacher & Weihofen, 1952; Heller, 1957; Slovenko, 1960; Slovenko & Usdin, 1961) did not base their arguments on the physician–patient privilege. Instead, they contended that citizens who sought the services of mental health professionals required more privacy than patients needed with physicians (Knapp & VandeCreek, 1987). Because of physicians' status in our society, you might think that physician–patient privilege could be considered more important than mental health professional–client privilege. However, some legal scholars (Guttmacher & Weihofen, 1952; Louisell & Sinclair, 1971; Slovenko, 1960; Wigmore, 1961) have concluded that it is more important to protect the privacy of clients of mental health professionals than it is to protect the privacy of physicians' patients because of the unique nature of the psychotherapeutic relationship.

Before World War II, no state had a privileged communication statute for mental health professionals, although some psychiatrists were covered under physician–patient privilege statutes (Knapp & VandeCreek, 1987). State legislative bodies meet annually, changing statutes each time they meet, and sections affecting privileged communication statutes might be found in obscure places in state statute volumes. Therefore, it is impossible to give a completely accurate picture of privileged communication statutes for counselors and other mental health professionals. However, it is true that all 50 states and the District of Columbia have enacted some type of privileged communication statute for mental health professionals and their clients (*Jaffee v. Redmond*, 1996).

Statutes making relationships between mental health professionals and their clients privileged vary substantially from state to state in their language and construction. States have taken four approaches in formulating privilege laws for relationships between clients and their mental health providers (Knapp & VandeCreek, 1987). Some privilege statutes are modeled on attorney–client privilege laws. Others take the approach of the proposed, but rejected, Rule 504 of the Federal Rules of Evidence. This rule has advantages over the attorney–client privilege laws because the proposed rules specified the extent and limitations of the privilege with great precision. A third approach provides for a privilege, but allows judicial discretion in its waiver. Finally, the last group of statutes is idiosyncratic and does not follow any special pattern.

### **The Rationale for Privileged Communication in Counseling Relationships**

Over the past few decades, counselors have been working to convince state legislators to enact privileged communication laws that protect their relationships with clients. Many of the arguments

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used to justify passage of these statutes were accepted and repeated by the U.S. Supreme Court (Remley, Herlihy, & Herlihy, 1997) when *Jaffee v. Redmond et al.* (1996) was decided in favor of the existence of such a privilege under the Federal Rules of Evidence.

Counselors have argued that society benefits when individuals seek counseling to help them lead more productive lives as citizens. Mental health professionals have argued that because clients must reveal personal secrets that could be embarrassing, sensitive, or against their best interests, clients must be assured that the content of their counseling sessions will not be revealed without their permission. Society benefits when clients receive counseling that allows them to be more independent and productive, and these benefits outweigh the negative consequences of some evidence being privileged and therefore unavailable in court cases.

However, after an extensive review and analysis of empirical research studies related to confidentiality and privileged communication in the mental health professions, Shuman and Weiner (1987) concluded that although confidentiality is important in therapeutic relationships, privilege is not. Among their more interesting findings were (a) few laypersons know whether privilege exists in their states, (b) many mental health professionals indicate that clients are reassured by their disclosure or threat of disclosure of potential harm to self or others, and (c) judges do not find privilege a great impediment to finding the truth at trials. The first two findings argue against privileged communication statutes that protect relationships with mental health professionals, whereas the last one would seem to support the existence of such statutes.

Another argument used to get counselor privileged communication statutes passed is that the evidence lost to courts because of privilege statutes would never have been produced in the first place if the statutes did not exist. Clients would not go to counselors and reveal their secrets if they did not have the protection of legal privilege. As a result, society does not lose important evidence in lawsuits by granting privilege to counselor–client relationships because the evidence would never have come into existence if there were no privilege.

Psychiatrists, psychologists, and social workers have been successful in their efforts to have statutes enacted that grant privileged communication to their relationships with clients. Counselors have argued that their services are similar to those of other mental health professionals and that they are as deserving of the protection.

Counselor–client privilege of some type existed in 44 of the 45 states that licensed counselors in 2000 (Glosoff, Herlihy, & Spence, 2000). Psychologist–client privilege statutes existed in all 50 states (Glosoff, Herlihy, Herlihy, & Spence, 1997). Privileged communication statutes vary, ranging from some that protect counselor–client relationships to the fullest extent allowed by law to others that are quite weak. Professional counselors in jurisdictions where there are no counselor–client privileged communication statutes, or where existing ones are weak, are continuing in their efforts to get such laws passed or strengthened. Auerbach (2006) has pointed out that clients who seek mental health services in a particular state have varying degrees of privacy, depending on the exact language found in multiple statutes that grant privilege of clients with physician psychiatrists, licensed counselors, licensed psychologists, licensed social workers, and other licensed mental health professionals. Auerbach has argued that states need to reform their privileged communication statutes, and clients should have the same privacy protection, no matter which category of mental health professional provides services.

Privileged communication statutes are not always limited to interactions between clients and licensed professional counselors. In some states, school counselors, substance abuse counselors, or other designated categories of counselors have privilege. On the other hand, if a category of mental health professional is not listed in a privileged communication statute, courts deny privilege to the relationships of clients with those professionals (Moberly, 2007). You must investigate the statutes

of the state in which you practice to determine whether your interactions with clients enjoy privilege and to determine exactly what *privilege* means in your state.

If you practice in a state that does not offer statutory privilege, you should inform your clients that you will keep confidential the content of your counseling sessions with them, but that one of the exceptions would be if a judge orders you to disclose information. You must include the same exception even if you practice in a state that does include a counselor–client privileged communication statute, but it is much less likely that a judge will order disclosure in a state with such a statute.

Occasionally, counselors will be involved in court cases heard in federal rather than state courts. The U.S. Supreme Court ruling, *Jaffee v. Redmond et al.* (1996), has interpreted the Federal Rules of Evidence to mean that there is a licensed psychotherapist–patient privilege in some cases heard in federal courts (Remley et al., 1997). In the Jaffee case, the psychotherapist was a social worker. It seems probable, but not guaranteed, that a similar privilege would be acknowledged for licensed counselor–client relationships in future cases. In a review of psychotherapist–patient privilege decisions in federal courts, Boumil, Freitas, and Freitas (2012) concluded, “The law that has evolved around the exercise of this privilege is complex and far from uniform around the country. In most cases, the goal is to balance the imperative of confidentiality with the need to disclose useful information” (p. 31). The same lack of uniformity in applying the law could be said for privileged communication statutes and case law in all states.

Counselors struggle with deciding the exact language to use when writing disclosure statements for clients or when informing clients orally regarding the confidentiality and privilege that might exist in the relationship. On one hand, counselors want to fully inform clients of the exceptions that exist to confidentiality and privilege, so that clients will be able to give truly informed consent to entering the counseling relationship. On the other hand, counselors do not want to be so technical and detailed in describing exceptions to confidentiality and privilege that clients become confused or lose confidence in the privacy of the counseling relationship.

### **Asserting the Privilege**

A statutory privilege belongs to clients rather than to counselors. If you or your records are subpoenaed or if you are asked during a legal proceeding to disclose privileged information, it is up to your client to assert the privilege so that you will not have to disclose the information (Boumil, Freitas, & Freitas, 2012). However, sometimes the client cannot be located or is not present when counselors are asked to disclose privileged information. In these circumstances, the counselor has an obligation to assert the privilege on behalf of the client. In our opinion, counselors should secure the advice of an attorney if they are put in the position of asserting a client’s privilege because legal procedures and questions regarding privilege are quite technical.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 5 and view the video clip entitled “Whose Privilege?” The counselor in this video apparently does not understand that confidentiality and privilege belong to clients, not counselors, and can be waived only by the clients or their representatives.

### **Responding to Subpoenas**

Subpoenas are legal documents that might require counselors to give a written response to a written list of questions, produce copies of records; appear for a deposition, court hearing, or trial; or appear and bring their records with them. Subpoenas are official court documents and cannot be ignored. Counselors who do not respond appropriately to subpoenas can be held in contempt of court and could be fined or jailed until they comply. Unless you deal with subpoenas on a regular basis in your work, legal advice should be obtained before responding to a subpoena.

An attorney will review a subpoena for you and will advise you in how to respond. If you must appear at a deposition, hearing, or trial as a result of a subpoena, you should ask your attorney to prepare you for what to expect, to advise you about how you should conduct yourself, and if possible, to go with you so you can be given advice throughout the proceeding.

### **Suits for Disclosure**

When counseling relationships are privileged under state or federal laws, clients have a right to expect counselors to keep information from their sessions private. With or without the privilege, counselors have a legal duty to maintain the privacy of their clients. Clients enter the counseling relationship with assurances of privacy and with very high expectations that information they disclose will not be revealed.

If a counselor discloses confidential information and the disclosure does not qualify as one of the exceptions to confidentiality and privilege, a client could sue the counselor for malpractice. The client would be required to prove the elements of a malpractice suit. Clients who could show that they were harmed by the counselor's disclosure might prevail in such lawsuits and collect damages from the counselor. Thus, it is crucial that you understand the exceptions to confidentiality and privileged communication and know how to apply these exceptions in your practice.

## **EXCEPTIONS TO CONFIDENTIALITY AND PRIVILEGED COMMUNICATION**

The general rule that counselors must keep their clients' disclosures confidential is easy to understand and follow. Exceptions to this general rule, however, occur frequently in the course of counseling, and counselors must understand these exceptions and be able to apply them to real situations (Standard B.1.d.). After reviewing counselor privileged communication statutes in all states, Glosoff et al. (2000) concluded that exceptions are numerous and extremely varied. As a result, it is very important for counselors to know the content of the privileged communication statute that exists in their state (if there is one) and the specific exceptions that are included. Glosoff et al. categorized exceptions into nine areas and listed those areas from the most to the least frequently cited in state statutes:

- (a) in cases of a dispute between counselor and client; (b) when a client raises the issue of mental condition in legal proceedings; (c) when a client's condition poses a danger to self or others; (d) in cases of child abuse or neglect (in addition to mandated reporting laws); (e) when the counselor has knowledge that the client is contemplating commission of a crime; (f) during court ordered psychological evaluations; (g) for purposes of involuntary hospitalization; (h) when the counselor has knowledge that a client has been a victim of a crime; and (i) in cases of harm to vulnerable adults. (p. 455)



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To facilitate understanding, we have organized the exceptions into clusters according to the purposes they serve. First, we discuss client waiver of the privilege or right to privacy and exceptions that deal with sharing information with subordinates or other professionals in order to improve the quality of services. Next, we turn to exceptions that involve protecting clients or others who may be in danger. Then we look at ways that confidentiality and privileged communication are different when working with multiple clients as opposed to individuals, and with minor clients as opposed to adults. Finally, we note some exceptions that are legally mandated.

### Client Waiver of the Privilege

Confidentiality and privilege belong to clients, not to counselors. As a result, clients can waive their privacy. This occurs most often when clients explicitly ask counselors to give information regarding the counseling relationship to third parties. Usually, clients who waive the privilege have an understanding that their secrets will be revealed. In some circumstances, however, clients may unknowingly waive the privilege by their actions (Knapp & VandeCreek, 1987). For example, clients might implicitly waive the privilege by filing a lawsuit seeking damages for emotional distress caused by an accident or by filing a malpractice lawsuit against a mental health professional, as discussed later in the section on exceptions. In *Cynthia B. v. New Rochelle Hospital* (1982), the court found that the client (rather than the mental health professional) had responsibility for any embarrassment or inconvenience that resulted from the disclosure of privileged mental health information in a lawsuit she had filed.

### Death of the Client

According to Cleary (1984), the common law doctrine is that privilege does not end with a person's death. In some states, statutes specify how privilege is controlled after an individual dies. When there is no statutory language dealing with privilege and the death of the holder, then the common law practice of allowing a legal representative of the deceased person to assert the privilege generally is followed (Knapp & VandeCreek, 1987). An executor of an estate is not always recognized by a court as a deceased person's legal representative for the purposes of privilege (*Boling v. Superior Court*, 1980). If you believe that a deceased client's privilege must be asserted or waived, you should contact his or her family members, probate attorney, or executor to determine whether a legal representative is available to deal with the matter. The *ACA Code of Ethics* (2005) states simply that counselors must protect the confidentiality of deceased clients according to legal requirements or agency policies (Standard B.3.f.).

### Sharing Information with Subordinates or Fellow Professionals

In some situations, the "umbrella" of confidentiality can be extended to cover others who assist or work with the counselor in providing services to clients. Although these situations do not involve a breach of the client's confidentiality, they do constitute exceptions to the general rule that only the counselor and client are privy to information shared in sessions. Sharing information with others in order to provide the best possible services to clients is permissible when (a) clerical or other assistants handle confidential information, (b) counselors consult with colleagues or experts, (c) counselors are working under supervision, and (d) other professionals are involved in coordinating client care.

 **CLERICAL OR OTHER ASSISTANTS MAY HANDLE CONFIDENTIAL INFORMATION** It is routine business practice for many types of professionals, including physicians and attorneys as well as

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counselors, to have clerical assistants, employees, and other subordinates who handle confidential client information. Some state statutes that grant privilege to counselor–client relationships may also specifically extend the privilege to communications when assistants are present or when assistants see privileged information, but such specific language is rare. Knapp and VandeCreek (1987) have concluded that common law principles most likely would extend privilege to unprivileged assistants who are involved in activities that further the treatment of the client.

Counselors should be aware, however, that they are ethically responsible for any breach of confidentiality by someone who assists them. Standard B.3.a. alerts counselors to “make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers.” Counselors may also be held legally responsible for breaches of confidentiality by their subordinates. Under the general legal principle of *respondeat superior*, employers are held responsible for the acts of their employees. Counselors, then, can be held accountable for assistants who breach confidentiality through the doctrine of vicarious liability. It is important for counselors to impress on their employees the importance of keeping information confidential and to supervise them in such a way as to ensure they are complying with this requirement.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professionals module from the Video Lab. Then select Module 4 and view the video clip entitled “A Helpful Receptionist” to see an example of how easily a client’s confidentiality can be breached inadvertently by a counselor’s receptionist.

There are some precautions that counselors can take to help ensure that their subordinates understand both the importance of confidentiality and the procedures for maintaining it. Counselors are obligated to determine whether individuals they may hire are trustworthy. Counselors could be held accountable for hiring persons notorious for disregarding the privacy of others if these persons later disclose confidential client information. Further, we suggest that counselors take an inventory periodically of everyone who may handle confidential information about their clients. This might include answering service personnel, an office receptionist, clerical assistants, billing service staff, counselor interns or supervisees, and paraprofessionals. The counselor can conduct training sessions for these employee groups to ensure that they understand the importance of confidentiality and they know how the counselor wants them to handle confidential material. The federal HIPAA law requires that employees be trained to protect the privacy of clients.

**COUNSELORS MAY CONSULT WITH COLLEAGUES OR EXPERTS** Counselors are encouraged to consult with peers or experts whenever they have questions about their ethical obligations or professional practice (Standard C.2.e.). If the questions have to do with clinical practice, counselors should seek consultation from a practitioner who has experience or expertise in the particular area of concern. If an ethical question is involved, it is a good idea to consult a fellow mental health professional who has expertise in ethics. In a particularly perplexing ethical dilemma that involves a difficult judgment call, it is wise to seek more than one opinion.

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Consultation usually does not need to involve a breach of confidentiality because most consultations can be managed without revealing the identity of the client. The *ACA Code of Ethics* (2005) gives some guidance in this respect. Standard B.8.b. states that “written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.” Standard B.8.c cautions that, during consultations, counselors should not disclose confidential information that could lead to the identification of a client. Nonetheless, nearly 30% of the counselors in Neukrug and Milliken’s (2011) study believed it was ethical to share confidential client information with a colleague. Although every effort should be made to protect confidentiality, it is sometimes impossible to avoid revealing the identity of the client because of the nature of a particular situation or because the identity of the client might be obvious. In these instances, the counselor should obtain client consent, if possible, and the identity of the consultant should be revealed to the client.

Finally, counselors should choose consultants who have the appropriate expertise for the question at hand. If you have an ethical or clinical question, consult with a professional colleague. If you have a legal question, ask an attorney.

### **CONFIDENTIAL INFORMATION MAY BE SHARED WHEN THE COUNSELOR IS WORKING UNDER SUPERVISION**

While you are a counselor in training, your work with actual clients will be supervised by experienced professionals. During your practicum, internship, and other field experiences, university supervisors and on-site supervisors will review your counseling sessions with you and provide you with feedback about your performance. After graduation, if you are planning to obtain a credential such as a license, your initial postmaster’s counseling work will also be under supervision. Someday, when you are an experienced counselor yourself, you may want to provide supervision to beginning professionals, or you may need to work under supervision while you are acquiring skills in a new specialty area of practice. Supervision is likely to be a part of your experience throughout your professional career.

Supervision situations are like consultation in that information about clients is shared with other professionals who subscribe to your ethic of confidentiality. But in supervision, unlike consultation, the client’s identity cannot be concealed. Supervisors may observe actual counseling sessions from behind a one-way mirror, review videotapes or audiotapes of sessions, and review your case notes and counseling records. Supervisors have the same obligations as you do; they must keep confidential any information revealed in counseling sessions that they are supervising. Nonetheless, your clients have the right to know that you are working under supervision. According to Standard F.1.c., *Informed Consent and Client Rights*, you have an ethical obligation to inform your clients that their confidentiality is limited because your supervisor will have access to information about them. When you are involved in group supervision, clients have the right to know that a group of your fellow practicum students or interns may also be discussing their cases. The *Code of Ethics* also requires counselors to obtain permission from clients before they observe counseling sessions or review transcripts or videotaped recordings of sessions with their supervisors, faculty, or peers (Standard B.6.c.).

You may feel some reluctance to divulge to your clients that you are working under supervision, or to explain to them all the circumstances in which information about them might be shared. You may be concerned that clients will have less confidence in your professional abilities, or that they will feel constrained about revealing personal information. These concerns must be set aside in the interest of your clients’ right to informed consent. It is best to inform your clients about the limits to confidentiality in a straightforward manner and to do so at the very outset of the counseling relationship. Clients can be told that the purpose of supervision is to help you do a better job and

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that the focus of the supervision will be on you and your performance rather than on them and their problems. Sometimes clients will be unnerved by the idea of a supervisor, who is a faceless stranger to them, sitting behind the mirror. In these cases, it is a good idea to arrange for the client to meet the supervisor and have the opportunity to express concerns and ask questions directly. In our experience as supervisors, we have seen that clients typically forget their initial concerns once they become engaged in the counseling process. You may be pleasantly surprised to find that this will happen for you, too.

The relationships between counseling students who are in supervision and their clients may not be privileged. As a result, students may be forced to reveal the contents of counseling sessions if ordered to do so by a judge in a legal proceeding. If the relationship between a client and the student's supervisor would be privileged if the supervisor were providing the counseling services, then it is likely privilege will exist between the client and the counselor-supervisee as well. Usually, under the law of privilege, a privilege is extended to assistants or supervisees of professionals who have statutory privilege with their clients.

**OTHER PROFESSIONALS MAY BE INVOLVED IN COORDINATING CLIENT CARE** In some settings, such as inpatient units in hospitals, treatment teams routinely work together in caring for patients. Although the benefits of coordinating the efforts of various professionals are obvious, as an ethical matter clients need to be told what information about them is being shared, with whom, and for what purposes (Herlihy & Corey, 2006). According to Standard B.3.b., when client care involves a continuing review by a treatment team, the client must be informed of the team's existence and composition, the information being shared, and the purposes of sharing the information.

There are numerous other situations in which you might want to share confidential client information with fellow professionals in order to ensure coordination or continuity of care. A client might be receiving psychotropic medications from a physician while seeing you for counseling. A client might be seeing you for individual counseling while being in group counseling with another counselor. Clients might move and later request that you send their records or communicate by telephone with their new counselor. In all these situations, it is ethically appropriate for you to communicate with the other professionals *when the client has given permission for you to do so*. Several standards in the *ACA Code of Ethics* (2005) address these kinds of circumstances. Standards A.3. and B.3. both speak to the need for mental health professionals to work cooperatively. When clients are receiving services from another mental health professional, the code directs counselors to obtain client consent and then to inform the other professional and develop clear agreements to avoid confusion and conflict for the client. Standard B.6.f. requires counselors to obtain written permission from clients to disclose or transfer records to legitimate third parties and reminds counselors that they are required to work to ensure that receivers of their records are sensitive to the client's confidentiality. HIPAA requires that client permission to give information to third parties be obtained in writing, and that counselors who transfer records notify the receiving third parties that the information being transferred is confidential and should be protected. Fisher (2008) suggests that counselors mark as "Confidential: Not to Be Re-Released" any records that contain identifiable client information.

From a legal perspective, situations in which counselors function in treatment teams or coordinate client care are similar to situations in which counselors' assistants or supervisors learn confidential information about clients. If the relationship between a counselor and a client is privileged, then it is likely that the privilege will continue to exist when confidential information is discussed in treatment teams or with other professionals when coordinating client care.

### **Protecting Someone Who Is in Danger**

Situations sometimes arise that require counselors to breach confidentiality in order to warn or protect someone who is in danger. Certain of these situations also involve a duty to report the dangerous situation to responsible authorities. These three types of duties—to warn, to protect, and to report—constitute some of the most stressful situations you will encounter as a practicing counselor.

Because these exceptions require that you make a deliberate decision to breach a client's confidentiality, there must be a compelling justification for doing so. Winston (1991) suggests that breaching a confidence can be justified by the concept of vulnerability. A duty to protect from harm arises when someone is especially dependent on others or is in some way vulnerable to the choices and actions of others. Persons in a vulnerable position are unable to avoid risk of harm on their own and are dependent on others to intervene on their behalf. When counselors, through their confidential relations with clients, learn that a vulnerable person is at risk of harm, they have a duty to act to prevent the harm. This is a higher duty than the duty to maintain confidentiality.

**COUNSELORS MUST TAKE ACTION WHEN THEY SUSPECT ABUSE OR NEGLECT OF CHILDREN OR OTHER PERSONS PRESUMED TO HAVE LIMITED ABILITY TO CARE FOR THEMSELVES** Counselors have both an ethical and a legal duty to protect a child or vulnerable adult if they suspect that person is being abused (Standard B.2.a.).

**COUNSELORS MUST TAKE ACTION TO PROTECT CLIENTS WHO POSE A DANGER TO THEMSELVES** When counselors determine that clients are suicidal, they must do something to prevent the clients from harming themselves (Standard B.2.a.). A leading cause of malpractice lawsuits against counselors is a charge by surviving family members that counselors were negligent and therefore committed malpractice if their clients commit suicide or harm themselves while attempting suicide.

**COUNSELORS MUST TAKE ACTION WHEN A CLIENT POSES A DANGER TO OTHERS** When counselors believe their clients may harm someone else, even when such information is communicated by someone other than the client (Edwards, 2006), counselors must take steps to prevent harm to the person who is in danger (Standard B.2.a.). This duty, like the duty to prevent clients from harming themselves, could lead to a charge of negligence or malpractice.

**COUNSELORS MUST DETERMINE WHETHER TO BREACH CONFIDENTIALITY WHEN A CLIENT HAS A FATAL, COMMUNICABLE DISEASE AND THE CLIENT'S BEHAVIOR IS PUTTING OTHERS AT RISK** This exception to confidentiality is the same as the exception to protect others if you believe your client may harm other people (Standard B.2.b.).

### **Counseling Multiple Clients**


Unique confidentiality problems arise when working with multiple clients. Generally, when your client and one or more additional persons are in the room, confidentiality is compromised and privilege usually is waived. Although you can make your own pledge not to disclose certain

## Confidentiality and Privileged Communication

information, you cannot guarantee the behavior of others such as group participants or family members. Despite the fact that others in the room might not keep a client's secrets, a counselor's responsibility is not diminished by the presence of additional persons in a counseling session.

**CONFIDENTIALITY CANNOT BE GUARANTEED IN GROUP COUNSELING** Confidentiality is a particularly difficult ethical issue in group counseling. Although confidentiality certainly is as important in group counseling as it is in individual counseling, it is difficult to enforce, and counselors should not offer guarantees. It appears that this caution may not be well understood—37% of the ACA members surveyed by Neukrug and Milliken (2011) believed it was ethical to guarantee confidentiality for group members. Group counselors frequently encounter problems with maintaining confidentiality among group members who are not bound by the same professional standards. They may inadvertently breach confidentiality or yield to the temptation to discuss group experiences with family or friends. The *ACA Code of Ethics* (2005) gives some guidance for dealing with confidentiality in groups in Standard B.4.a., which states that “counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.” A significant portion of the ethical guidelines of the Association for Specialists in Group Work (ASGW, 1989) is devoted to confidentiality among group members. This is an especially helpful resource with which you will want to familiarize yourself.

A few states specifically provide for privilege to extend to group counseling situations, but most privileged communication statutes are silent on this issue (Knapp & VandeCreek, 1987). It is important, then, that you read the privileged communication statute in your state (if one exists for counseling relationships) to determine whether group counseling sessions are privileged. In states where group counseling situations are not mentioned, at least one court has found privilege to exist (*State v. Andring*, 1984). As a result of the Andring case, it is possible that group counseling sessions would be found by courts to be privileged even if statutes do not specify that privilege exists for group counseling clients.

 **CONFIDENTIALITY CANNOT BE GUARANTEED IN COUPLES OR FAMILY COUNSELING** When the focus of counseling shifts from the individual to the family system, new ethical issues arise and existing ones become more complicated. Counselors who provide services for couples and families encounter some unique confidentiality concerns, such as how to deal with family secrets. For example, consider the situation in the following case example.

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### 3 The Case of Alexis

Bob and Carla, a husband and wife, are seeing Alexis for marriage counseling. Alexis often sees each partner in a couple alone for one or more sessions because she believes counseling progresses better that way. Bob shared during one of his individual sessions with Alexis that he is having an affair with another woman, but that Carla doesn't know it. Bob doesn't plan to tell Carla, and he insists that Alexis not tell Carla either.

- How should Alexis respond to Bob's insistence?
  - How might this situation have been avoided?
-



**Discussion:** According to Standard B.2.b. of the ACA *Code of Ethics*, “information about one family member cannot be disclosed to another family member without permission” in family counseling. Therefore, Alexis is ethically bound to keep Bob’s secret unless she had established ground rules to deal with such a situation at the outset of the counseling relationship. Alexis might have to refer the couple to another counselor if she cannot reconcile for herself that keeping Bob’s secret is acceptable. Alexis might have avoided the problem in several ways. She could have counseled the couple together only, and not individually. She could have told Bob and Carla at the outset that she would not keep any secret that would interfere with the goals or process of counseling, and if either of them objected to disclosing the secret, she would not be able to continue the counseling relationship. Finally, Alexis could have included an explanation of her policy on family secrets in her written disclosure statement.

This case example points out the importance of informed consent procedures. You must make clear to both marital partners at the outset the limitations of confidentiality and how you will handle confidentiality issues (Standard B.4.b.). In an analysis of the problem of *family secrets*, Brendel and Nelson (1999) pointed out that the ethical code of the International Association of Marriage and Family Counselors (IAMFC) specifically states that information learned by counselors in individual counseling sessions may not be repeated to other family members without the client’s permission. They provided guidelines for counselors on how to deal with situations similar to the previously cited case example.

Counseling couples or families can also lead to very difficult legal questions regarding confidentiality and privilege. Under general legal principles, any statutory privilege that exists between a counselor and client is waived if there is a third party present when information is being disclosed. However, privilege laws in some states specifically cover relationships between counselors and married couples or between counselors and family members (Knapp & VandeCreek, 1987). In these states, it is clear that a counseling relationship will be privileged despite specific additional persons being present during the counseling session. In states without such statutes, it is unclear whether an individual who is being counseled with a spouse or other family members present could assert the privilege. Appellate court decisions are split as to whether a privilege that otherwise would exist by statute would be extended to sessions that include a married couple (*Clausen v. Clausen*, 1983; *Ellis v. Ellis*, 1971; *Sims v. State*, 1984; Virginia Court, 1979; *Wichansky v. Wichansky*, 1973; *Yaron v. Yaron*, 1975).

A very difficult dilemma for counselors is posed when one spouse demands that the counselor not reveal information related in a marital counseling session, and the other spouse demands that the counselor reveal it. Situations like this often arise when a married couple enters counseling because of marital problems and then later engages in divorce proceedings.

The spouse who does not want the contents of the counseling sessions revealed should assert the privilege through his or her attorney. Of course, a counselor never wants to reveal in court private information that was related in a counseling session (Standard B.2.c.). Counselors generally will cooperate with the spouse and attorney as arguments are made to maintain the privilege of the client who does not want the private information revealed. Counselors are quite vulnerable legally in these situations because revealing privileged information inappropriately could lead to a malpractice lawsuit. On the other hand, refusing to disclose information that is not privileged could lead to being held in contempt of court by a judge. If you find yourself in a situation like this and are unsure of your legal responsibilities, you should consult your own attorney, who will advise you regarding your legal obligations and rights.

### **Counseling Minor or Legally Incompetent Clients**

**WHEN CLIENTS ARE MINOR CHILDREN OR LEGALLY INCOMPETENT, COUNSELORS CANNOT GIVE THE SAME ASSURANCES OF CONFIDENTIALITY AS THEY GIVE OTHER CLIENTS** Minors and adults who have been adjudicated incompetent in a court of law do not have a legal right to enter into contracts. Thus, their parents or guardians control their legal rights. As a result, counselors owe legal duties to the parents or guardians of minors or incompetent adults. At the same time, counselors have ethical obligations to the clients themselves (Standard B.5.).

### **Court-Ordered Disclosures**

**COUNSELORS MUST DISCLOSE CONFIDENTIAL INFORMATION WHEN ORDERED TO DO SO BY A COURT** There will be instances when counselors are called to testify in court, and their clients will ask them not to reveal information shared in counseling sessions. If the relationship is privileged, either the client or the counselor will assert the privilege. In cases where no privilege exists, counselors should ask the court not to require the disclosure and explain the potential harm that could be done to the counseling relationship (Standard B.2.c.). If the judge still requires the disclosure, only essential information should be revealed (Standard B.2.d.). Counselors who are ordered by a judge to reveal confidential information should not worry that clients may sue them for violating their privacy. Complying with a judge's order is a defense to any charge of wrongdoing (Prosser, 1971). Remember though, that a subpoena that a counselor receives may not be valid. Confidential or privileged information should not be revealed in response to a subpoena until an attorney representing the counselor has advised that course of action.

### **Legal Protections for Counselors in Disputes**

**COUNSELORS MAY REVEAL CONFIDENTIAL INFORMATION WHEN IT IS NECESSARY TO DEFEND THEMSELVES AGAINST CHARGES BROUGHT BY CLIENTS** When ethical or legal complaints are filed against counselors by their clients, the concepts of confidentiality or privilege could become problematic for counselors who must defend themselves. It would be odd if a client could claim that a counselor had done something wrong in a counseling relationship, and then the same client could claim that confidentiality or privilege prevented the counselor from explaining the details of the counseling relationship in presenting his or her defense. As a result, the law of privileged communication requires that clients waive their privilege when they bring complaints or malpractice lawsuits against their counselors (Knapp & VandeCreek, 1987).

### **Other Legal Exceptions**

**CLIENTS WAIVE THEIR PRIVILEGE WHEN THEY BRING LAWSUITS CLAIMING EMOTIONAL DAMAGE** If clients claim emotional damage in a lawsuit, then the law automatically waives their privilege associated with counseling relationships (Knapp & VandeCreek, 1987). It would be unfair to allow individuals to claim in court that they had been emotionally damaged and then to prohibit the counselor who had treated the person for the damage from testifying. The person accused of damaging the client must be given an opportunity in a court proceeding to cross-examine the counselor regarding the nature and extent of the damage.

Nonetheless, most courts have held that suits for normal distress or physical injuries arising out of a physical trauma do not automatically waive a plaintiff's right to privilege in counseling relationships (*Ideal Publishing Corp. v. Creative Features*, 1977; *Roberts v. Superior Court*, 1973; *Tylitzki v. Triple X Service, Inc.*, 1970; *Webb v. Quincy City Lines, Inc.*, 1966). Only when individuals bringing lawsuits claim that they were emotionally damaged and that damage required them to seek mental health treatment will their therapeutic privilege be waived.

**PRIVILEGE IS GENERALLY WAIVED IN CIVIL COMMITMENT PROCEEDINGS** Privilege is usually waived by law for individuals who are being evaluated by a court to determine whether they should be involuntarily committed to a psychiatric hospital. Obviously, the contents of an evaluation conducted for the purpose of rendering an opinion to a court concerning the advisability of a commitment will not be privileged. Evaluators should carefully explain the nature of the interview to individuals who are being evaluated to ensure that the individual does not misconstrue the relationship as involving mental health treatment (Standard E.13.b.; Knapp & VandeCreek, 1987). When a mental health professional seeks a commitment of a client who initiated treatment voluntarily, privilege may also be waived by the client by law (*Commonwealth ex rel. Platt v. Platt*, 1979), although in *People v. Taylor* (1980) a Colorado court refused to waive the privilege. Individuals who are involuntarily committed do not have privileged relationships with their treating mental health professionals at a judicial review of that commitment (*State v. Hungerford*, 1978; *State v. Kupchun*, 1977). The important distinction to remember is that evaluation interviews are different from counseling interviews in terms of privilege. Evaluation interviews conducted to help determine whether a client should be committed to a residential facility are not privileged.

See Figure 1 for a listing of the exceptions to confidentiality and privileged communication that are summarized in this chapter.

**Sharing information with subordinates or fellow professionals is permissible under the following circumstances:**

- Clerical or other assistants handle confidential information.
- A counselor consults with colleagues or experts.
- The counselor is working under supervision.
- Other professionals are involved in coordinating client care.

**Protecting someone who is in danger may require disclosure of confidential information when the following conditions exist:**

- The counselor suspects abuse or neglect of children or other persons presumed to have limited ability to care for themselves.
- A client poses a danger to others.
- A client poses a danger to self (is suicidal).
- A client has a fatal, communicable disease and the client's behavior is putting others at risk.

**Confidentiality is compromised when counseling multiple clients, including the following:**

- Group counseling
- Counseling couples or families

**There are unique confidentiality and privileged communication considerations when working with minor clients:**

- Counseling minor clients

**Certain exceptions are mandated by law, including the following:**

- Disclosure is court ordered.
- Clients file complaints against their counselors.
- Clients claim emotional damage in a lawsuit.
- Civil commitment proceedings are initiated.

**FIGURE 1** Exceptions to confidentiality and privileged communication

## **DIVERSITY CONSIDERATIONS IN CONFIDENTIALITY AND PRIVILEGED COMMUNICATION**

Counselors must be sensitive to the cultural meanings of privacy and confidentiality (Standard B.1.a.). Because U.S. society is becoming more diverse and the international movement in counseling is burgeoning, it is more important than ever before to be aware that some clients may not want their confidentiality upheld in the traditional manner. Confidentiality requirements in counseling have been a reflection of cultural values that emphasize autonomy and respect for individualism (Casas, Park, & Cho, 2010). In collectivist cultures the individual is seen as less important than the family or group, and clients might not place much importance on their individual privacy, although the privacy of their families or groups might be highly valued (Hoop, DiPasquale, Hernandez, & Weiss Roberts, 2008). In such cases, counselors might share confidential information with family members or members of the client's community, if the client so desires.

Maintaining client confidentiality becomes more complicated when the counselor and client do not speak the same language and an interpreter is required. If a family member is used as the interpreter, the counselor should carefully explain the purpose and importance of confidentiality and ask the interpreter to keep all disclosures completely confidential. It is preferable to use a professional interpreter, if one is available who understands the context of the client's life. The counselor can then hold a presession meeting with the interpreter to review confidentiality, its limits, and how the concept can be communicated to the client (Paone & Malott, 2008). During the initial session, the client should be informed of the limits to confidentiality and privilege that are created by the presence of the interpreter.

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### **Summary and Key Points**

After reading this chapter, we expect that you have developed a healthy appreciation for the complexities of the ethic of confidentiality and its legal counterpart, privileged communication. We also expect that you have a clearer understanding of why counselors encounter dilemmas of confidentiality more frequently than they encounter other types of dilemmas and find them the most difficult to resolve. The considerable amount of information contained in this chapter should be helpful. These dilemmas, nevertheless, will challenge you to use your clinical judgment and your skills in ethical reasoning and in researching the current status of professional knowledge and the law. We hope we have emphasized how important it is that you do not try to go it alone when you encounter questions about confidentiality and privileged communication, but rather that you seek consultation from colleagues or an attorney.

Following are some of the key points made in the chapter:

- Both confidentiality and privileged communication are based on the client's right to privacy. Confidentiality is an ethical concept, and privileged communication is a legal term.
- Although research does not clearly support the notion that assurances of privacy are essential to clients' willingness to disclose, counselors view confidentiality as a strong moral force and a fundamental ethical obligation.
- In general, counselors seem to do a very good job of protecting their clients' confidentiality. It is easy for an inadvertent breach to occur, however, and counselors need to be zealous in safeguarding client privacy.
- Privileged communication means that a judge cannot order a counselor to reveal information

## Confidentiality and Privileged Communication

in court that has been recognized by law as privileged. Because privileged communication is antagonistic to the entire U.S. system of justice, courts and legislatures have been reluctant to extend privilege to relationships between mental health professionals and their clients.

- Except for cases heard in federal courts, privileged communication in counseling is determined by state statutes. It is essential that you learn your state laws regarding privileged communication in counseling relationships.
- Confidentiality and privilege both belong to the client, not to the counselor, and clients can waive their privacy.
- Confidentiality and privilege are not absolute. There are at least 15 exceptions to confidentiality and privileged communication. You must understand each exception and be

able to apply exceptions to real situations you encounter in your practice.

- It is permissible to share information with subordinates and fellow professionals in order to provide the best possible services to clients.
- Stressful situations for counselors often involve decisions regarding the duties to warn, protect, or report when a client's condition poses a danger to self or others.
- Confidentiality cannot be guaranteed when counseling couples, families, groups, minors, or adults who have been adjudicated as legally incompetent.
- Certain exceptions to confidentiality and privileged communication are legally mandated.
- When in doubt about your obligations regarding confidentiality or privileged communication, consult!

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# Competence and Malpractice

## FOCUS QUESTIONS

1. What do you think should be done if a counselor becomes addicted to alcohol and is not counseling effectively?
2. How does a counselor determine whether a client is suicidal?
3. If a client makes a serious threat to harm another person, the law in all states except Texas requires the counselor to either warn the intended victim or inform the police of the threat. Do you think this legal requirement is good or bad? Why?
4. What are some measures you might take to minimize the risk that you could be sued for malpractice as a counselor?

When clients come for counseling, they invest a great deal of trust and reliance in their counselors. The client's role in the therapeutic relationship, which involves dependency, self-disclosure, vulnerability, and expectations of finding relief and solutions to problems in a safe environment, underscores the counselor's obligation to provide competent services. "When clients put their trust in us as professionals, one of their most fundamental expectations is that we will be competent" (Pope & Vasquez, 2007, p. 59). Herlihy and Corey (2006) noted that the trust that clients bestow on us is "a source of power that must not be abused; clients need to be able to rely on their counselor's competence as a helper" (p. 179).

Competence in counseling is not easy to define. According to Welfel (2010), competence involves a combination of *knowledge*, *skill*, and *diligence*. Knowledgeable counselors have a thorough grounding in the core areas of study required to practice the profession. The core areas identified by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) are professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation. Knowledge is acquired through attaining a graduate degree in counseling and is maintained through continuing education activities.

Skilled counselors are able to select and use appropriately a range of basic interviewing techniques and therapeutic interventions. Skill building is a complex process that begins in graduate

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school with applied courses such as counseling techniques, group work, and practicum and internship. Skills are then honed and expanded through postdegree supervised counseling experience.

*Diligence* has been defined by Welfel (2010) as a consistent attentiveness to the client's needs that means putting client welfare first and foremost, above all other concerns. The first standard of the ACA *Code of Ethics* is "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (Standard A.1.a.). Evidence of diligent practice includes being willing to do extra reading, research, training, consultation, and follow-up to ensure that clients are served effectively.

Counselors are neither totally competent nor totally incompetent, although legal arguments during malpractice lawsuits might imply otherwise. In discussing the competency of lawyers, Cramton (1981) distinguished between "the ability to perform a task at an acceptable level" and "the reality of actually doing so in a particular situation" (p. 161). From Cramton's perspective, competency is not an abstract concept; instead, it is based on performance. Neither is competency a dichotomous concept; there is a continuum of professional expertise with gross negligence at one end and maximum effectiveness at the other extreme.

Counselors have an ethical obligation to accept employment only when "they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience" for the jobs (ACA *Code of Ethics*, 2005, Standard C.2.c.). This standard also requires that counselors who hire other counselors employ only counselors who are qualified and competent. So, there is an ethical burden on those seeking employment to apply only for jobs they are competent to perform, and on those who hire to employ only counselors who are competent to perform the jobs.

## COMPETENCE AS AN ETHICAL AND LEGAL CONCEPT

The difference between law and ethics is that law demands a minimum level of practice from counselors, and ethics encourages counselors to approach the ideal in their level of practice. Competency is a parallel concept in that external forces require counselors to demonstrate minimum competency for professionals, whereas an internal force demands that counselors strive for ideal practice. For example, state licensure boards set the *minimum* requirements that counselors must meet to practice in that state, and counseling graduate programs require *minimum* levels of performance in order for students to be granted a degree. On the other hand, counselors are constantly striving to attain *maximum* knowledge and skills, and national voluntary credentialing organizations such as the National Board for Certified Counselors (NBCC) certify counselors who have distinguished themselves beyond the minimum in the field.

So, as we discuss competence in this chapter, keep in mind that competency is not an *either/or* concept. Rather, competency is a complex construct with many possible levels along a continuum.

Competency in counseling involves both ethical and legal considerations. From an ethical perspective, the most salient moral principle is *nonmaleficence*: Do no harm. Incompetence is often a major factor in causing harm to clients. Counselors rarely intend to harm their clients, but harm *can* occur if counselors are not knowledgeable, skillful, and capable.

The most basic ethical standard related to competence in the ACA *Code of Ethics* (2005) is that counselors "practice only within the boundaries of their competence" (Standard C.2.a.). How can a counselor determine just where these boundaries lie? It is difficult to answer this question because counseling is an exceptionally broad profession. Just as attorneys and physicians could never be competent to practice in every area within law and medicine, counselors could never be competent to offer counseling services in all areas of practice or to everyone who seeks their

services (Barnett & Johnson, 2010). A counselor who is qualified and experienced in counseling children might not be competent to provide counseling services to a geriatric population. Expertise in counseling basically healthy clients who are having difficulty coping with life transitions does not qualify a counselor to counsel clients who suffer from severe, clinical depression. Counselors who are very skilled at providing professional services to individuals who are seriously mentally ill may not be competent to provide developmental counseling services in an elementary school. Competence in individual counseling does not necessarily translate into competence to lead a particular type of counseling group or to counsel families.

Competence is also a legal issue, because society expects professionals to be competent and holds them to this standard through licensing boards and the courts. Legal issues relating to competence include state licensure and the law of malpractice. Counselor incompetence is the second most frequently reported area of ethical complaints (after dual relationships with clients), according to one survey of state counselor licensure boards (Neukrug, Millikin, & Walden, 2001). When a client is harmed, the counselor could be sued for malpractice and be held legally responsible in a court of law. Many lawsuits brought by plaintiffs alleging that they were harmed as clients focus on competence.

In this chapter, we first explore methods of developing and assessing competence to *enter* the counseling profession. Next, we focus on ways to *maintain* competence during one's professional career. Finally, we address issues that arise when a counselor's competence is *questionable* or is called into question. These issues include malpractice, one of the most frightening of all legal issues for counselors. Considerations in counseling individuals who may be dangerous to themselves or others are discussed in this chapter because they constitute the most obvious areas of negligence and malpractice. When clients attempt or complete suicide, or perpetrate violence on others, the work of counselors often is reviewed to determine whether the counselors of these clients should have known that their clients were at risk. The issues of counselor stress, burnout, and impairment are also explored in this chapter.

## COUNSELOR PREPARATION ISSUES

Competence is based on "education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (ACA *Code of Ethics*, 2005, Standard C.2.a.). To be competent, counselors are also expected to "gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population" (Standard C.2.a.). Counselor preparation is obviously a basic component in developing competence to counsel; the process of becoming competent to enter professional practice begins with university counselor preparation programs. Measuring a student's competency as a counselor has proven to be a difficult process (Erikson & McAuliffe, 2003).

The initial responsibility for producing competent practitioners lies with those who do the preparation—counselor educators and supervisors. During the period of time when prospective counselors are working toward their master's degrees and are working under supervision toward licensure, the responsibility for ensuring an acceptable level of competence rests with counselor educators and supervisors. These professionals have an ethical obligation to protect the public by acting as "gatekeepers" for the profession (Dufrene & Henderson, 2009; Henderson, 2010).

Counselor educators must select and admit individuals to graduate programs who are likely to succeed at developing the skills, knowledge, and characteristics needed to become effective counselors (Erikson & McAuliffe, 2006). Academic ability is one important factor. Selection criteria typically include grade-point averages and scores on standardized tests such as the Graduate Record

Examination (GRE) or Miller Analogies Test (MAT). It is entirely possible, however, for a student to have strong intellectual abilities and still not possess the personal characteristics needed to be a “therapeutic person.” Personal characteristics such as openness to new ideas, flexibility, cooperativeness, being open to feedback, awareness of one’s impact on others, ability to deal with conflict, ability to express feelings, and acceptance of personal responsibility have been identified as necessary for effective performance as a counselor (Baldo, Softas-Nall, & Shaw, 1997; Frame & Stevens-Smith, 1995; McAdams, Foster, & Ward 2007). Additionally, a tolerance for ambiguity and a willingness to explore one’s own biases, values, and personal issues have been shown to be related to the ability to develop effective therapeutic relationships. Although these characteristics are difficult to measure, most counselor preparation programs rely on a personal interview, written essay, or other subjective criteria in selecting candidates for admission.

Once candidates have been selected and admitted into a graduate program, the next question that arises is, “What does a master’s degree program need to include in order to produce competent counselors?” CACREP has developed standards for preparing counselors, and the Council on Rehabilitation Education (CORE) has set forth similar standards for rehabilitation counselors. CACREP and CORE accredit preparation programs that have undergone a rigorous review, so it can be reasonably assumed that graduates of approved programs possess certain competencies (Herlihy & Corey, 2006). It should be noted, however, that the majority of counselor preparation programs are not CACREP or CORE accredited (Schweiger, Henderson, McCaskill, Clawson, & Collins, 2011), and that many competent counselors are educated in programs of sound quality that have not sought this accreditation. Another approach to ensuring adequacy of preparation programs is regional accreditation of universities. Regional accrediting agencies have set the minimal standard for universities in the United States. If a university is accredited by a regional accrediting agency, there is an assumption it is legitimate. The ACA *Code of Ethics* requires that “Counselors clearly state the accreditation status of their degree programs at the time the degree was earned” (Standard C.4.e.). Counselors should not explicitly state or imply that the university that granted their degree was regionally accredited if it was not at the time their degree was granted.

Although these approaches to ensuring quality of counselor preparation are both necessary and helpful, the reality remains that successful graduation from an accredited program does not guarantee competence (Kitzrow, 2002). Much depends on the individual student’s motivation and ability to learn, the quality of instruction, the competencies of the faculty members, the breadth and extent of supervised experience in counseling clients that is provided by the program, and the quality of supervision received. In our own experience as counselor educators, we have found that most students who are about to graduate are keenly aware that they have only just begun to develop competence as practitioners. As a novice counselor, you need not be hobbled by a concern over your limitations and lack of experience. In most states, you will continue to be supervised closely and supported in your work as a counselor until you have been licensed for independent private practice. Nonetheless, a healthy awareness of your limitations can help you avoid exceeding your boundaries of competence in your eagerness to begin practicing your new profession (Gaubatz & Vera, 2006).

## **CREDENTIALING**

Credentialing is a “method of identifying individuals by occupational group” (Sweeney, 1995, p. 120). Two important types of credentialing that are found in counseling are certification, which takes various forms, and licensure. These credentials provide a tangible indicator of certain accomplishments



and, as such, they have implications for assessing the competence of the credential holder. Counselor credentials are discussed in this chapter with a focus on how credentials are related to determining counselor competence.

The terms *licensure*, *certification*, and *registration* have many different meanings but are sometimes used interchangeably, which causes a great deal of confusion. The strict use of the terms in governmental regulation of a profession is as follows: (a) *Licensure* refers to the most rigorous form of regulation in that only those who are licensed may practice the profession in a state; (b) *certification* is the term used when a title, such as “professional counselor,” can be used only by those who are certified, but anyone can practice the profession without being certified; and (c) *registration* is the form of governmental regulation in which members of a profession must “sign up” with the government if they practice the profession in the state, but anyone may sign the registry without a review of their credentials (Anderson & Swanson, 1994). National private organizations, such as the NBCC, offer national certification, which is a credential that is voluntary (not required by a government for practice). In addition, state departments of education require certification of school counselors employed in public school districts. In this chapter, we use the term *licensure* to refer to state regulation of a profession generally, and the term *certification* to refer to national voluntary credentials and state department certification of school counselors.

### Licensure

All 50 states, the District of Columbia, and Puerto Rico now license counselors (American Counseling Association, 2012), but that many exemptions to the licensure requirement exist. In some states, only the title *professional counselor* or *mental health counselor* is protected, but the practice of counseling is not restricted to those who are licensed.

Licensure is related to counselor competency in that it is the most powerful type of credentialing and is established by state law. When state legislators determine that the public’s best interests are best served by creating a license to practice a particular profession, the minimum standards for practice of that profession in that state are established through a political process. State governments would rather not be involved in regulating the practice of professions. Legislators agree to license a professional group only when it can be shown that members of the public (a) do not have the ability to determine who is competent to practice within a particular profession and (b) could be harmed by incompetent practitioners.

When a state legislature passes a statute that establishes counselor licensure or passes amendments to an existing licensure statute, part of that statute specifies the minimum standards for becoming licensed to practice in that state. When these bills or amendments are introduced, political pressures are put on politicians. Economists oppose counselor licensure, arguing that licensing of professions is self-serving, restricts entry into professions, and causes fees for services to rise unreasonably (Rottenberg, 1980). Organizations whose purpose it is to limit the role of government in citizens’ lives also oppose licensure statutes. They often are joined in their opposition by other mental health professionals (including psychologists, psychiatrists, and social workers) who do not want to see counselors licensed to provide mental health services because marketplace competition will increase. When these groups of related mental health professionals realize that a bill or amendment is going to be passed over their objection, they often demand very high standards for licensure to keep as few individuals as possible from being licensed. All these groups put political pressure on legislators to set the minimum standards for licensure very high.

On the other side, there are pressures to set the minimum standards very low. For instance, individuals who are already practicing counseling in a state when counselor licensure statutes are being considered or amended often lobby for statutes that include very low standards so that they will not lose their status and will be entitled to licenses. The U.S. Constitution requires that individuals who were practicing counseling in a state when a licensure statute is passed be automatically licensed. This process has been referred to as *grandparenting*.

As a result of these various political pressures, states now have differing standards. According to Harris (1997) and the ACA (2012), licensing statutes for counselors range from a low of 30 required graduate credits to a high of 60 credits. In addition, the number of required post-master's-degree supervised hours range from 2,250 to 4,000. Some statutes specify a significant number of required courses; others require fewer specific courses. Most state statutes require the same courses as those required by CACREP and NBCC, although some differences exist. Most states require a course in diagnosis of mental and emotional disorders, and some states have additional requirements such as a course in marriage and family counseling or a course in substance abuse counseling.

Although there is variation from state to state, all licensed counselors (except those who were grandparented) have completed at least a master's degree, have had post-master's supervised experience, and have successfully completed an examination or other form of screening. Thus, when clients select licensed professionals as their counselors, they can be assured that their counselors have demonstrated certain knowledge, skills, and abilities to the satisfaction of those professionals who evaluated them. Nonetheless, as is true of other approaches, there are limitations to what licensing can accomplish in terms of ensuring competence. Some writers have questioned whether there is evidence that licensure actually ensures general competence, protects consumers, or promotes higher standards of practice (Keith-Spiegel & Koocher, 1985; Pope & Vasquez, 2007). Others have pointed out that the licenses of mental health professionals are sometimes revoked for incompetent practice (e.g., Morris, 1984).

Corey, Corey, and Callanan (2011) have pointed out that the possession of a license does not ensure that practitioners will competently *do* what their license permits them to do. The counselor license is a generic one. This leaves it up to licensed counselors, as individuals, to discriminate between professional titles and the professional *functions* they are competent to perform. In addition, whereas licensure boards can restrict or terminate the practice of incompetent practitioners against whom they have received complaints, they are not in the business of monitoring the practices of counselors about whom they have received no complaints.

Clearly, licensing of counselors is an attempt to ensure competent practice. Government regulation may have a positive influence on competency within the counseling profession, but it falls short of accomplishing its objective of ensuring competence. In reality, the standards set for licensure are often the result of political compromises rather than of standards set by the profession for minimum competency.

### **Certification**

In addition to becoming licensed, counselors can offer evidence that supports their competence by becoming certified. Some types of certification are mandatory for practicing in certain settings and occur at the state level. For instance, public school counselors must be certified by the states in which they practice. There are also national, voluntary certifications, such as those offered by the NBCC. National Certified Counselors (NCC), like licensed counselors, have received preparation in specific content areas and clinical instruction, have had supervised counseling experience, and have passed an examination.



### Specialties

In addition to generic certification as an NCC, NBCC offers specialty certifications including school, mental health, and addictions counseling (NBCC, 2003). An affiliate of NBCC offers a specialty credential in supervision (Center for Credentialing and Education [CCE], 2008). Specialty certifications are another means of establishing a counselor's competence to work with certain types of clients, in certain settings, or in specialized areas of counseling. There are also a host of other, narrower specialty certifications offered by various groups in such areas as hypnotherapy, biofeedback, or sex therapy.

Specialty preparation is a controversial issue in counseling. Some have argued that only practitioners who have specialized preparation should be allowed to practice that specialty. Some have called for specialty *licensing* (Cottone, 1985), whereas others (Remley, 1995) strongly oppose specialty licensing. Remley has pointed out that the other major professions of medicine and law license professionals to practice their profession generally. Physicians and lawyers may practice any type of medicine or law. The only force that restrains them in limiting themselves to specialties is their own understanding that they must be competent in the professional services they render, and that no one can be competent in all areas. Specialty *accreditation* of counselor education programs is another approach that suggests that only certain counselors are qualified to practice in specified areas. This is the approach that is currently being taken (Sweeney, 1995).

There appears to be tension between proponents of two schools of thought regarding specialty preparation. Some counselors believe that establishing competence boundaries should be left up to individual professionals, who then would be accountable to licensure or certification boards if they exceeded those boundaries to the detriment of a client. Others believe that counselors should be prevented by licensure boards from practicing within specialty areas unless they have received specific preparation in the form of graduate courses or supervision. The issues of specialty preparation and specialty licensing and certification will likely be debated within the counseling profession for some time. Currently, however, the prevailing school of thought is that counselors who have proven their minimal preparation and are licensed can decide for themselves the boundaries of their competence and may practice in areas considered specialties without holding any specialty certifications. Nonetheless, counselors have an ethical responsibility to practice in specialty areas new to them only after they have obtained appropriate education, training, and supervised experience (Standard C.2.b.). They also must take steps to ensure the competence of their work while developing skills in new specialty areas (C.2.b.).

### MAINTAINING COMPETENCE

Once counselors have completed their formal education and are licensed or certified to practice, the burden of determining competence shifts away from counselor educators and supervisors and onto the counselors themselves. Counselors are autonomous professionals, responsible for monitoring their own effectiveness. The ACA *Code of Ethics* underscores this responsibility in Standard C.2.d., stating that "Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary." Even when counselors are employed in agencies or institutions, they are held individually accountable for practicing in an ethical and professional manner. One of the indicators of a profession, which distinguishes it from a semiprofession or a nonprofession, is that the members of the profession practice autonomously. In return for this privilege of independence, professionals must limit themselves to practicing within the areas in which they are competent. Professionals individually determine the limits of their competence and practice accordingly.

### Continuing Education

Although competence can certainly be enhanced by the skillful application on a day-to-day basis of the knowledge gained in a formal preparation program, experience alone is no guarantee against errors. Considering the constant contributions that new research makes to knowledge in the field, as well as significant, ongoing changes in the environment in which counseling is practiced, we doubt that a counselor could retain even a modicum of professional competence over a 30- or 40-year career without further education. For example, counselors must keep up with new knowledge related to issues such as treating depression (Paradise & Kirby, 2005) or counseling clients who are involved in self-injurious behaviors (Kress, 2003). The *Code of Ethics* states that counselors recognize the need for continuing education to maintain awareness of current scientific and professional information (Standard C.2.f.), and most counselor licensure and certification boards have established continuing education requirements for maintaining one's license. As Herlihy and Corey (2006) have noted, however, there are limits to what continuing education requirements can accomplish. "It is difficult to monitor the quality of continuing education offerings or their relevance to a particular counselor's needs. The number of clock hours obtained may have little relationship to how much the counselor has actually learned and integrated into practice" (p. 180).

Many other questions could be raised regarding what constitutes a legitimate effort to maintain competence. For instance, is attending a seminar commensurate with teaching one? Is writing an article for a professional journal an indicator of continuing competence? What is the relative value of reading books and scholarly articles about new techniques and theories? Can counselors who regularly but informally consult with colleagues about their cases be considered to be as diligent in working to maintain competence as counselors who attend formal seminars? There may be no way to objectively assess whether a counselor has maintained competence over time. External criteria such as continuing education credits earned are not sufficient to ensure continuing competence. Perhaps more important are counselors' own efforts, as autonomous professionals operating at the aspirational level of ethics, to remain aware of their own limitations, to recognize that these limitations can increase over time, and to seek to keep skills current by both formal and informal means (Keith-Spiegel & Koocher, 1985).

### Peer Review

Peer review is a convenient and cost-effective approach to monitoring competence that can be very effective (Truneckova, Viney, Maitland, & Seaborn, 2010). Peer review is a system by which mental health professionals assess one another's services. Granello et al. (2008) have argued that peer consultation or peer supervision should continue as a lifelong learning process, and we agree that peer review is useful for counselors at all levels of experience and offers many benefits to counselors. These benefits include enhanced self-awareness and a deeper understanding of the complexities of counseling (Granello et al., 2008); opportunities to discuss a wide variety of answers to clinical and professional questions (Barnett & Johnson, 2010); mutual support; objective feedback in dealing with countertransference issues; information on therapeutic techniques, new research, and referral sources; and help in dealing with difficult cases, stress, and the isolation often experienced by private practitioners. Ideally, peer consultation or supervision groups would meet on a regular, scheduled basis to discuss practice challenges and ethical issues, with a structured but flexible agenda determined by the needs of the members (Borders, 1991; Greenburg, Lewis, & Johnson, 1985). Independent private practitioners are expected to seek peer supervision (Standard C.2.d.), and this is a strategy we recommend

for counselors in all work settings. Several models have been developed for peer supervision that can be used by counseling practitioners (e.g., Benshoff & Paisley, 1996; Gottlieb, 2006; Remley, Benshoff, & Mowbray, 1987; Stoltenberg, McNeill, & Delworth, 1998; Truneckova, Viney, Maitland, & Seaborn, 2010).

### **Information Technologies**

The cyberspace phenomenon presents counselors with myriad opportunities for keeping current and improving their competence as practitioners. New information technologies are developing at such a rapid pace that any attempt we might make to describe them would be obsolete almost immediately. We can, however, highlight a few key resources. The counseling profession has established a solid presence on the Internet. This offers opportunities to access virtual libraries for researching the latest information on client problems and effective counseling techniques, as well as to collaborate and consult with other professionals around the world. Many of ACA's divisions, NBCC, and CACREP have home pages on the World Wide Web, so you can communicate quickly and directly with professional groups that are working to strengthen counseling as a profession. Videoconferencing on the Internet enables you and counselors everywhere to obtain further preparation and even supervision without having to travel great distances. You can subscribe to mailing lists that allow you to share experiences, ask questions, and exchange information and ideas.

These new technologies present many exciting opportunities, but they also have created problems related to ensuring competence of services. Some counselors have begun to provide direct counseling services over the Internet. The fact that counseling is taking place over the Internet before the profession has fully considered the ethical implications is cause for concern. The 2005 *ACA Code of Ethics* has addressed this issue, however, in Standard A.12., which has a number of provisions. With Internet counseling there is no reliable method of regulating the services offered, of ensuring the competence of the providers, or of protecting consumers from ill-advised Internet-based services (International Society for Mental Health Online, 2008; Peterson, Hautamaki, & Walton, 2007; Shaw & Shaw, 2006; Wilson, Jencius, & Duncan, 1997).

### **Making Referrals**

Standard A.11.b. of the *ACA Code of Ethics* requires that counselors make appropriate referrals when they determine an inability to be of professional assistance to clients. Ethical counselors recognize that they will need to refer a client when accepting or continuing to work with that client would exceed their boundaries of competence. Sometimes it can be difficult for counselors to acknowledge that they are not competent to provide professional services to every client who might request their help. There are many sources of temptation to accept clients who might be better served by a referral. These might include a reluctance to disappoint a valued source of referrals, financial pressures to increase your client load when business has been slow, or the ego-enhancing nature of requests from clients who hold exaggerated beliefs about your talents and abilities to help them. To succumb to these kinds of temptations would not be ethical and would not be in the clients' best interest.

An issue that has become the focus of much controversy is whether or not value conflicts between a counselor and client are an appropriate basis for referring a client. There have been lawsuits that involved counseling practitioners who refused, based on their religious beliefs, to counsel LGBT clients regarding their same-sex relationships. The court rulings in these cases

were based on interpretations of employment law and did not clarify the issue of values-based referrals. Other court cases, however, have involved counseling students who also refused, based on their religious values, to counsel LGBT clients. The students were dismissed from their training programs after they failed to comply with remediation plans that required them to develop competencies in counseling LGBT clients. These cases brought the issue of values-based referrals into bold relief. In *Ward v. Wilbanks et al.*, (2012) and in *Keeton v. Anderson-Wiley* (2011), the students appealed the dismissal decisions and based their appeal in part on the argument that they were ethically mandated to refer LGBT clients according to the standard in the *ACA Code of Ethics* that says counselors must refer a client when they “determine an inability to be of professional assistance” to that client (Standard A.11.a.). The counselor educators who dismissed the students argued that an inability to assist refers to lack of competence to work with a particular client, not an entire class of clients. The counselor educators also pointed to the standard in the *ACA Code of Ethics* that requires counselors to gain “skills pertinent to working with a diverse client population.” The question that seems to have emerged from all the court cases is whether it is ethical for a counselor to refer LGBT clients based on the counselor’s religious objections to homosexuality.

Another type of challenge is posed when counselors need to refer a client with whom they are already engaged in a counseling relationship. Despite the best efforts of counselors to accept only those clients whom they believe they can provide with competent services, the course of counseling is unpredictable. A client’s presenting problem may be well within the counselor’s scope of competence, and the counselor might in good faith begin working with that client, only to discover as therapy progresses that the client has unanticipated counseling needs. The case described in the following is an example.

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## 1 The Case of Marianne

Marianne, a Licensed Professional Counselor (LPC) in private practice, began working with Ellen, a young woman who came for counseling to deal with what at first appeared to be moderate anxiety. Ellen described herself as a perfectionist and sought counseling to learn to “stop being so hard on myself.” It was only after several counseling sessions that Ellen felt safe enough in the counseling relationship to reveal to Marianne that she was so fearful of becoming “fat” that she regularly engaged in self-induced vomiting after meals, abused laxatives, and exercised excessively. Marianne recognized these behaviors as symptoms of anorexia nervosa or bulimia nervosa (American Psychiatric Association, 2000), a problem area with which she had no experience.

- How should Marianne approach this situation with Ellen?
  - If Marianne decides to take workshops and do independent reading on treatment of individuals who have eating disorders, how will she know when she is competent to provide counseling services to clients like Ellen?
  - What if Marianne is able to find a suitable referral source but Ellen refuses, stating that she has complete faith in Marianne’s ability to help her?
  - What if Marianne practices in an isolated, rural community and a local referral resource or expert consultants or supervisors are not available?
-

**Discussion:** Marianne has an ethical obligation to either refer Ellen to a specialist or to another therapist who is competent to work with clients who suffer from eating disorders, or to ensure that she provides quality counseling services to Ellen by obtaining educational experiences and consultation, or supervision from experts.

If Marianne decides to refer, it might be difficult for her, after establishing rapport with Ellen, to tell Ellen she now needs to see a different counselor. Marianne will have to be firm in making the referral, and at the same time be sensitive to Ellen's concerns.

If Marianne decides to take workshops and do independent reading on the treatment of individuals who have eating disorders, she will need to consider a number of issues in determining whether she is competent to provide counseling services to clients like Ellen. There are no rules about how a counselor adds a new area of expertise. Marianne will have to decide for herself when she is competent in a new area. She should be ready to defend her new competence by providing evidence of how she developed it, should someone later challenge her regarding this competence.

If Marianne is able to find a suitable referral source, but Ellen refuses, Marianne will need to be firm in refusing to continue to work with Ellen. If Marianne has trouble being firm in a situation like this, she should seek clinical supervision for support in doing what has to be done.

If Marianne practices in an isolated, rural community and a local referral resource or expert consultants or supervisors are not available, there really is no absolutely correct way to proceed in a situation like this.

There are several options that Marianne might consider. She could develop a relationship with a local physician who could treat Ellen's physical issues at the same time Marianne counsels Ellen. She could enter into an Internet supervisory arrangement with a specialist in eating disorders and continue to counsel Ellen under that person's clinical supervision. She could investigate and find the closest and best treatment option available for Ellen, and inform Ellen that this is really her best option, despite travel hardships.

Marianne must invest the effort required to meet Ellen's needs. Without the needed competence or expert assistance, Marianne cannot in good conscience continue to counsel a client who may have an illness that can be life threatening. If Marianne suggests a referral, and Ellen rejects the referral, Marianne must consider Standard A.11.b. of the ACA *Code of Ethics*, which states that "If clients decline the suggested referrals, counselors should discontinue the relationship."

Other situations that might raise the question of referring a client are less clear-cut. As Corey et al. (2011) have noted, even the most experienced counselors will at times seriously wonder whether they have the personal and professional abilities to work with some of their clients. Difficulty in working with some clients does not, in itself, imply incompetence. In fact, counselors who refer all clients with whom they encounter difficulties will probably have few clients. Instead, counselors can extend their boundaries of competence through reading, participating in workshops and other professional development opportunities, consulting, co-counseling with colleagues who have expertise in a needed area, and working under supervision. The key is to keep a careful balance, referring when necessary and extending your areas of competency by keeping clients in other situations. Counselors can avoid stagnation and can continue to learn and grow as professionals by taking on clients who present new concerns and issues, thus extending their scope of competence.

In fact, it would be impossible to develop expertise in a new counseling specialty area without eventually accepting a client with an issue in that area. At the same time, care must be taken that clients are not harmed while the counselor is in the process of learning new skills and developing new competencies. You must make careful judgments regarding when to refer and when to keep new clients when you are preparing to provide services in a new area.

### **Diversity Considerations in Counseling Competence**

Recognizing diversity in our society and developing intercultural counseling competence are essential to ethical practice. When you think of your own future practice, keep in mind that if you are not trained and competent to work with culturally diverse clients, you might be practicing unethically if you attempt to provide services to these clients. Counselors have an ethical obligation to actively attempt to understand the diverse cultural backgrounds of their clients and to learn how their own cultural, racial, and ethnic identities have an impact on their values and beliefs about the counseling process. The 2005 *ACA Code of Ethics* has incorporated, throughout the document, provisions requiring counselors to be culturally competent. The Introduction to Section A states, “Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process.” Every section of the code reminds counselors of their duty to be aware of cultural differences in their counseling practices.

We believe that the standard that says counselors avoid entering or continuing counseling relationships if they “determine an inability to be of professional assistance to clients” (Standard A.11.b.) is related to situations in which counselors lack the skills or abilities to be of help to clients—not to situations in which counselors would want to discriminate inappropriately against a client.

Fortunately, the counseling profession’s attention to cultural diversity has increased dramatically in recent decades. There is an abundance of professional literature that can enhance counselor awareness and knowledge. The *Journal of Multicultural Counseling and Development*, the publication of the Association for Multicultural Counseling and Development (AMCD, an ACA division), contains excellent cutting-edge articles and has published the *Multicultural Competencies and Standards* (Arredondo et al., 1996). *Advocacy Competencies* have been developed as well. Diversity issues are addressed frequently in ACA publications that have a more general focus. The *Journal for Counseling & Development* regularly includes articles related to counseling clients from cultures that are different from a counselor’s own background. Numerous books on multicultural counseling and social justice and advocacy are now available, including several that can be purchased from the ACA bookstore at a discounted price for members.

At the same time, work remains to be done to improve counselor multicultural competence (Delphin & Rowe, 2008), although research has indicated that counselors as a group perceive themselves to be multiculturally competent (Holcomb-McCoy & Myers, 1999; Patureau-Hatchett, 2008). Holcomb-McCoy and Myers found that counselors perceive their multicultural preparation to have been less than adequate and that differences in self-perceived multicultural competence could be explained by whether a counselor is a member of an ethnic minority group. They suggested that the experience of being a member of an ethnic minority group, and interacting daily with members of the majority group, provides in vivo multicultural education. These findings underscore the need for White counselors to seek out experiences that will allow them to interact with those who are culturally different from themselves.

Counselors who work in urban and suburban settings are able to limit their scope of practice because they typically have numerous referral resources available to them. Counselors who practice in rural areas, however, do not enjoy this luxury and often practice as generalists out of sheer necessity (Welfel, 2010). The geographic location of their practice places extra demands on them



to increase their knowledge and skills in order to respond to the varied needs of their clientele. At the same time, they must practice diligence. They must weigh the risk of causing harm if they provide services to a client who presents problems or issues in which they are not adequately trained. Fortunately, maintaining competence is no longer as difficult as it was in the past now that opportunities to increase knowledge and skills are readily available through distance consultation and supervision, interactive webinars, and online continuing education courses.

## COUNSELOR INCOMPETENCE

### Distress, Burnout, and Impairment

Although the counseling profession has been slow to recognize the problem of impairment among its members, research and attention to the problem have increased in recent years. In 2003, ACA created a Taskforce on Counselor Wellness and Impairment. The Taskforce has organized and presented information on risk factors, assessment, wellness strategies, and resources, all of which can be accessed through the ACA's website ([www.counseling.org](http://www.counseling.org)). In a national survey of counselor wellness and impairment, Lawson (2007) found that counselors generally rated themselves high in wellness, but rated the wellness of their colleagues significantly lower. A substantial number of counselors who participated in the study (5 to 10%) had scores on an instrument that indicated they were at risk for burnout and compassion fatigue or vicarious traumatization. More recently, Lawson and Myers (2011) surveyed over 500 ACA members and found that counselors scored higher on the measure of wellness (Professional Quality of Life; ProQOL) than did populations previously studied, and had lower scores on compassion fatigue and burnout.

The terms *distressed*, *burned out*, and *impaired* have been used somewhat interchangeably in the counseling literature. However, these terms might be better viewed as ranging along a continuum from the least to the most serious in relation to their impact on competent professional performance.

Counseling can be stressful work, and this stress occasionally takes its toll on practitioners (Barnett, 2008). Ironically, the counseling relationship itself can be a source of stress. In other interpersonal relationships, such as friendships, there is give and take and a reciprocal meeting of needs. This balance does not exist in a counseling relationship. Counselors are experts in one-way caring (Skovholt, 2001) who make a *loan of the self* to the therapeutic relationship (Squyres, 1986), receive little in return, and sometimes doubt the effectiveness of counseling. Of counselors surveyed by Farber and Heifetz (1982), 74% saw *lack of therapeutic success* as the most stressful aspect of their work, and 55% felt depleted by the nonreciprocated attentiveness, giving, and responsibility that the therapeutic relationship demands. Stress can lead to distress, and most counselors probably could be described as *distressed* at some time during their professional lives. In fact, results of one survey indicated that 82% of psychotherapists had experienced at least one episode of psychic distress (Prochaska & Norcross, 1983). Distressed counselors may experience anxious and depressed moods, somatic complaints, lowered self-esteem, and feelings of helplessness, but they are not necessarily impaired in their professional functioning. They know at some subjective level that something is wrong, and distress is usually a transitory and temporary condition.

When distress remains unalleviated, however, it can lead to *burnout*, which has been described as "physical, emotional, and mental exhaustion brought on by involvement over prolonged periods with emotionally demanding situations and people" (Pine & Aronson, 1988). Burned-out counselors, exhausted and depleted, have little energy left for their clients. They tend to manifest negative attitudes toward self and work. Some writers have suggested that few counselors can expect

to stay immune from burnout, and even that burnout may be nearly inevitable after 10 years in the field (Grosch & Olsen, 1994; Kottler, 1993). Burnout is not so much a state or condition as it is a process that, if not corrected, can lead to impairment.

It would be rare for a counselor to never experience a frustrating week, a difficult client, an emotional overload, or occasional symptoms of burnout, yet counselors who are functioning well can put these experiences into perspective. *Impaired counselors*, by contrast, are unable to transcend periods of stress (Stadler, 1990b). Their therapeutic skills have diminished or deteriorated to the point that they are unable to perform their responsibilities appropriately (Emerson & Markos, 1996). The medical profession has described *impairment* as “the inability to deliver competent patient care” (Stadler, Willing, Eberhage, & Ward, 1988, p. 258). Substituting *client* for *patient*, this definition can be applied to counseling, and incompetence raises the risk that clients might be harmed. Impairment is often associated with alcohol and other drug abuse, and with the blurring of therapeutic boundaries that can lead to sexual exploitation of clients.

Why do some counselors become impaired, whereas others manage to bounce back from periods of distress or burnout? Sometimes *environmental factors* can play a key role. A counselor may experience the death of a loved one, divorce or desertion, rape, the severe physical illness of a family member, or other personal loss or trauma. These events can unbalance anyone’s emotional equilibrium. If the counselor takes time off work, goes for counseling, or in some other overt way takes control and works toward a return to full functioning, this type of impairment is usually transitory and need not be a cause for ongoing concern about the counselor’s competence (Emerson & Markos, 1996).

Sommer (2008) has pointed out that traumatic events occur more frequently than is generally recognized, and that there is a high likelihood that most counselors will work with traumatized clients. Human-created tragedies such as the 9/11 terrorist attacks and natural disasters such as Hurricane Katrina are examples of events that can put counselors at risk of experiencing *vicarious traumatization*, also known as compassion fatigue or secondary traumatic stress disorder. Counselors who fail to recognize the warning signs of vicarious traumatization in themselves may become less skilled and less able to be emotionally present with clients who have been traumatized. Thus, counselors have an ethical obligation to know about these hazards in advance and be prepared to deal with them (Sommer, 2008).

In other instances, *preexisting conditions* may put the counselor at risk. Some individuals enter the helping professions in order to work through their own unresolved problems. Personal difficulties that have led some counselors to enter the profession may be exacerbated by the practice of the profession. The practice of counseling can reactivate early experiences, open old wounds, and reawaken unresolved issues. Counselors with a history of addictions or a vulnerability to substance abuse seem to be predisposed to problems after entering the profession (Guy, 1987). Studies indicate that a significant number of impaired counselors experience alcoholism or other substance abuse problems (Deutsch, 1985; Thoreson, Nathan, Skorina, & Kilberg, 1983). Depression is also a common preexisting condition among impaired professionals; 57% of female psychologists who responded to one survey (Deutsch) reported that they had experienced more than one episode of depression. For these at-risk professionals, the connection between depression and suicide is a particular cause for concern. The death-by-suicide rate among female psychologists has been reported to be four times that of White women in general (Roeske, 1986). Glickhauf-Hughes and Mehlman (1996) contended that certain personality characteristics make counselors more vulnerable to impairment. These characteristics include parentification (a willingness to take responsibility for others), perfectionism, imposter feelings and self-doubt, and audience sensitivity (strong awareness of others’ feelings and responsiveness to them).

Stressful or traumatic events in a counselor’s personal or social life and preexisting conditions are not the only factors that can contribute to counselor impairment. Certain kinds of *clients* and *client problems* can promote counselor distress (Stadler, 2001). Working with suicidal clients

has been shown to take an emotional toll. The high relapse rate of clients with substance abuse problems can lead to counselor discouragement and cynicism about the sincerity of clients' desires to change. Certain client characteristics such as lack of empathy for others, manipulateness, and refusal to accept responsibility for one's behavior are often present in clients diagnosed with some personality disorders, sex offenders, and clients who abuse women or children. These characteristics can exacerbate the stress felt by counselors. As has been noted, counselors who work with victims of trauma and abuse are at increased risk for developing secondary posttraumatic stress symptomology. Having a practice that includes a large number of clients in managed care plans, with the accompanying demands for demonstrable, short-term results and often-burdensome paperwork can put counselors at greater risk for emotional exhaustion (Thompson, 1999).

The ACA *Code of Ethics* provides, in Standard C.2.g., clear guidance regarding counselors who believe they are impaired. This standard states that counselors are alert to signs of impairment resulting from their own physical, mental, or emotional problems. If they determine they are impaired, counselors must stop offering professional services to clients "when such impairment is likely to harm a client or others." Impaired counselors must seek assistance to address their problems. Further, Standard C.2.g. states that counselors assist their colleagues or supervisors in recognizing their own impairment. If counselors believe that their colleagues or supervisors may be harming their clients, counselors must *intervene as appropriate*. It might be difficult for counselors to assist their colleagues and supervisors in recognizing their own impairment. At what point would you decide that a colleague or supervisor was impaired? For example, how much social drinking is too much? Or, how many absences from work indicate impairment? Once you have formulated in your mind that a colleague or supervisor is impaired, how do you go about addressing the issue with him or her? Most individuals who are impaired go through an extended period of denial and probably would reject your input. In our opinion, this part of the *Code of Ethics* may be very difficult to comply with, especially if the counselor you believe is impaired is your supervisor, who has control and authority over you. Of course, you would need to intervene in some way to prevent harm to clients, but you should be very concerned that imminent harm will occur if you do not intervene and, if you do intervene, you must be prepared for a negative reaction. If you ever believe you need to confront a colleague or supervisor about your belief that he or she is impaired, this would be a good time to consult with other counselors or related professionals regarding your ethical obligations.

Ethical practice requires, first, that counselors be aware of warning signs of impairment. Some of the most common symptoms are presented in Figure 1.

Suzanne, the counselor in the following case example, is experiencing some of these symptoms.

1. Deterioration in personal relationships, including marital problems and family dysfunction
2. Becoming isolated and withdrawn from others
3. Feelings of disillusionment with the profession
4. Emotional distancing during counseling sessions
5. Alcohol and drug abuse
6. Changes in work habits such as increased tardiness and absenteeism
7. Moodiness, depression, and symptoms of anxiety
8. Procedural errors and sloppy record keeping

**FIGURE 1** Warning signs of professional impairment

## 2 The Case of Suzanne

Suzanne is an LPC who went to work at a community agency when she earned her master's degree. After 5 years at the agency, Suzanne resigned and opened a private practice on her own. Now, 8 months into this venture, she finds that she isn't sleeping well at night. She tosses and turns, worrying about whether she will be able to pay the monthly bills, and trying to think of new ways to market her practice. She misses the camaraderie she enjoyed with her colleagues at the agency and feels increasingly isolated. She has lost weight recently and is starting to have episodes of gastric distress. She realizes that she needs a break from the stresses of her work. However, because she feels trapped by her financial situation, she is taking on more clients during evening hours and on the weekends rather than taking time for self-care activities.

- What are some indicators that Suzanne is experiencing problems that might lead to impairment?
- If Suzanne does not change her behavior, what kinds of problems might you expect her to experience?
- If you were Suzanne's friend, what options might you suggest to her to relieve her distress?

**Discussion:** There are numerous indicators that Suzanne is experiencing problems that might lead to impairment: she isn't sleeping well at night, is worrying about whether she can pay her monthly bills and about finding ways to market her practice, misses her friends at her former work site, feels isolated, has lost weight recently, is having gastric distress, and has taken on more clients than she really wants to serve.

If Suzanne does not change her behavior, she is at risk for impairment. The quality of her counseling services to clients may decline. She may develop additional psychological problems or physical health problems, and may end up in a financial crisis.

If you were Suzanne's friend you might suggest that she try to find another job and close her practice after she does. Other suggestions might be that she find one or more other counselors in private practice to share her expenses and provide her with professional stimulation, join a peer support or supervision group, or seek counseling for burnout management.

Burnout and impairment can be prevented when individual counselors monitor their own vulnerabilities and are aware of the ethical ramifications of practicing when they are unable to function effectively (Witmer & Young, 1996). Many resources and strategies are available to counselors when they recognize that they need to make changes in their lives if they are to remain competent practitioners (Kottler & Schofield, 2001). Some of these are (a) seeking counseling for themselves; (b) seeking supervision, especially of their work with clients who are difficult and tend to drain their personal resources; (c) taking a break or vacation from practice; (d) joining a peer support group; (e) getting regular exercise, meditating, and taking time to enjoy hobbies; and (f) seeking support from family and friends. Attending to self-care is an ethical obligation that must be taken seriously; counselors cannot provide nourishment to clients if they do not nourish themselves (Corey et al., 2011; Culver, 2011; Patsiopoulos & Buchanan, 2011; Warren, Morgan, Morris, & Morris, 2010).

It is crucial that you develop self-monitoring skills so that you can stay psychologically and emotionally healthy as a counselor. Because graduate school is often stressful, now is a good time

to learn and practice these skills (Roach & Young, 2007). It will be helpful for you to know the symptoms of burnout, to familiarize yourself with various wellness models, and to periodically take the time to assess how you are managing the stressors in your life.

**DIVERSITY CONSIDERATIONS IN PREVENTION OF COUNSELOR STRESS, BURNOUT, AND IMPAIRMENT** The results of a study conducted by Myers, Mobley, and Booth (2003) on the wellness levels of counseling graduate students bode well for the future of the profession. These investigators found that counseling students scored higher than an adult norm group on the Wellness Evaluation of Lifestyle (WEL), and that doctoral students scored even higher than entry-level students.

There is cause for concern in differences that were found along cultural variables, however. Female students scored higher than male students on the measure of Gender Identity, and non-Caucasian students scored higher than Caucasian students on the measure of Cultural Identity. The researchers suggested that these findings may reflect greater awareness of gender and cultural issues on the part of persons who belong to historically oppressed groups in our society. Still, the fact that doctoral students scored higher than entry-level students on gender and cultural identity subscales may indicate that counselor preparation programs are succeeding at developing awareness of diversity issues among their students.

## MALPRACTICE

*Malpractice* involves professional misconduct or unreasonable lack of skill and has been defined as follows:

Failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them. It is any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct. (Black, 2004; p. 959)



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 6 and view the video clip entitled “A Counselor Is Sued for Malpractice,” which demonstrates what might happen in court when a counselor is sued for malpractice.

Although malpractice includes intentional wrongdoing, the role of incompetency, or unintentional wrongdoing of the professional involved in malpractice, is clear in this definition. “Unreasonable lack of skill” and “failure to exercise ... skill” are both indicators of incompetence that can form the basis of malpractice lawsuits against counselors. The concept of competency might be extended so that a counselor guilty of *professional misconduct*, *evil practice*, or *illegal or immoral conduct* also could be defined as incompetent.

Malpractice is a type of civil lawsuit that can be filed against professionals for practicing in a manner that leads to injury to a recipient of their services. Professionals have a legal obligation not to harm individuals who come to them for professional services. Although the law cannot restore people who have been injured to their former state of existence, it can require the person who harmed

them to compensate them financially for their damages. If clients believe they have been harmed by their counselors, they can file a malpractice lawsuit against the counselors. Counselors who are sued must then defend themselves against the lawsuit before a judge or jury. Although there is widespread belief that juries favor plaintiffs in professional malpractice suits against health professionals, evidence from a study of physicians has demonstrated that juries' findings follow what physicians themselves consider to be negligence, and probably even favor the professionals (Vidmar, 1995).

In order for a client plaintiff to prevail in a malpractice lawsuit against a counselor, the plaintiff must prove the following elements (Prosser, Wade, Schwartz, Kelly, & Partlett, 2005):

- The counselor had a duty to the client to use reasonable care in providing counseling services.
- The counselor failed to conform to the required duty of care.
- The client was injured.
- There was a reasonably close causal connection between the conduct of the counselor and the resulting injury (known as *proximate cause*).
- The client suffered an actual loss or was damaged.

Proximate cause is a difficult legal concept to understand. *Actual cause* means that a person actually caused the injury of another person. *Proximate cause* has to do with whether the individual would have been injured had it not been for the action or inaction of the other person. Cohen and Mariano (1982) explained that “an intervening cause which is independent of the negligence absolves the defending negligent actor of liability” (p. 121). In other words, just because professionals are negligent does not make them responsible for an injury. It must be proven that some other intervening event did not, in fact, cause the injury. Foreseeability is important in determinations of proximate cause (Cohen & Mariano, 1982). *Foreseeability* has to do with whether the professional knew or should have known that the professional's actions would result in a specific outcome.

Counselors have become increasingly concerned about being sued for malpractice. Although malpractice lawsuits against mental health professionals have increased dramatically over the past decade, the total number of these lawsuits is relatively small. Hogan (1979) concluded that few malpractice lawsuits are filed against counselors because it is difficult for plaintiffs to establish an adequate case. It is not easy to prove that a counselor deviated from accepted practices and that the counselor's act or negligence caused the harm that a client suffered.

It appears that mental health professionals continue to be sued most often because of sexual relationships with their clients. However, it is likely that the next leading cause of malpractice lawsuits against counselors revolves around situations in which clients attempt or complete suicide (McAdams & Foster, 2000; Roberts, Monferrari, & Yeager, 2008). Whether to have sex with clients is certainly under the control of a mental health professional. Predicting whether a client will attempt suicide, however, is scientifically impossible. Yet, counselors will be held accountable in courts if they fail to follow procedures endorsed by the profession when a client is at risk. Suicidal clients, potentially violent clients, and the duty to warn intended victims of client violence are discussed in the following sections, and guidelines for practice in these areas are offered.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 6 and view the video clip entitled “The Aftermath of a Client Suicide.” This situation demonstrates what a counselor might face in court if family members sue after a client has committed suicide.



## Suicidal Clients

When a client threatens to commit suicide, an ethical duty arises to protect the client from harm to self. The ethical standard that applies to clients who pose a danger to others applies to suicidal clients as well: Confidentiality requirements are waived when disclosure is necessary to protect clients or others from *serious and foreseeable harm* (Standard B.2.a.). Evaluating and managing suicide risk is one of the most stressful situations that you will encounter in your work (Corey et al., 2011). You must be prepared to take measures to prevent suicide attempts (Slaby, 1999), and a recent study by Ting, Sullivan, Boudreaux, Miller, and Camargo (2012) has shown that hospital emergency department admissions of suicidal patients is increasing, particularly among those who are ages 15–19. These prevention measures begin with a thorough risk assessment and then, depending on the level of danger, might include involving the client’s family or significant others, working with the client to arrange for voluntary hospitalization, or even initiating the process that leads to an involuntary commitment of the client. All of these interventions are disruptive and compromise the client’s confidentiality. Ethically (Standard B.2.d.), and legally under HIPAA (United States Department of Health and Human Services, 2008b), it is important to disclose only information you consider essential in order for someone else to help prevent a suicide attempt.

Similar to situations in which clients threaten harm to others, the counselor’s first responsibility is to determine that a particular client is in danger of attempting suicide. There is no sure way to determine this, but experts agree that individuals who commit suicide generally give cues to those around them (Capuzzi, 1994; Capuzzi & Golden, 1988; Curran, 1987; Davis, 1983; Hafen & Frandsen, 1986; Hussain & Vandiver, 1984; Jacobs, Brewer, & Klein-Benheim, 1999; Johnson & Maile, 1987; Laux, 2002; Myer, 2001; Rogers, 2001; Rogers, Lewis, & Subich, 2002; Schwartz, 2000; Schwartz & Cohen, 2001; Stanard, 2000). Day-Vines (2007) has alerted counselors to the soaring rates of suicide among African Americans in the United States, and information such as this must guide the day-to-day work of counselors when they assess clients for suicide potential. In most circumstances, a counselor’s determination of a client’s level of risk must be based on clinical observations, not on test results. If counselors were not prepared in their graduate programs to handle crises (Allen et al., 2002), they must overcome this deficit through independent reading, workshop attendance, post-master’s-degree course completion, and supervised practice (McGlothlin, Rainey, & Kindsvatter, 2005).

As noted earlier, determining that a client is at risk of committing suicide leads to actions that can be exceptionally disruptive to the client’s life. Just as counselors can be accused of malpractice for neglecting to take action to prevent harm when a client is determined to be suicidal, counselors also can be accused of wrongdoing if they overreact and precipitously take actions that violate a client’s privacy or freedom when there is no basis for doing so (Remley, Hermann, & Huey, 2003). As a result, counselors have a legal duty to evaluate accurately a client’s potential for suicide. Counselors can be held liable for overreacting and for underreacting. So, how should a determination be made as to whether a client is suicidal?

First, no matter where you work as a counselor, you are likely to provide services to individuals who might express suicidal thoughts (Hermann, 2001; O’Dwyer, 2012). Therefore, it is necessary for all counselors to know the warning signs that indicate that a particular person is at risk for committing suicide. An old legal case (*Bogust v. Iverson*, 1960) held that a college counselor was not a mental health professional and therefore had no duty to assess a client’s risk of suicide. Since then, however, counselors have established themselves as mental health professionals, and the law imposes on counselors practicing in all settings the responsibility of knowing how to accurately determine a client’s risk of suicide (Bursztajn, Gutheil, Hamm, & Brodsky, 1983; Drukteinis, 1985; Howell, 1988; Knuth, 1979; Perr, 1985). Courts generally have been reluctant to hold counselors

accountable for harm that results from clients who attempt or complete suicide, because the act is done by the client without the counselor being a party to it. Lake and Tribbensee (2002), however, in their discussion of liability of colleges and universities for the suicides of adult students, cautioned that current legal trends suggest that mental health professionals on college and university campuses may be held accountable more often in the future for adult student suicides.

There is much help available in the professional literature, including research studies and articles that provide information about warning signs of future suicidal behavior (Berman & Cohen-Sandler, 1982; Cantor, 1976; Daniel & Goldston, 2012; Meneese & Yutzenka, 1990; Sapyta et al. (2012); Sudak, Ford, & Rushforth, 1984). Today's counselors must know how to make assessments of a client's risk for suicide and must be able to defend their decisions at a later time (Linehan, Comtois, & Ward-Ciesielski, 2012).

The law does not require that counselors always be correct in making their assessments of suicide risk, but it is legally necessary that counselors make those assessments from an informed position, and that they fulfill their professional obligations to a client in a manner comparable to what other reasonable counselors operating in a similar situation would have done. Because of this standard of care to which counselors are held, the very best action you can take if you are unsure whether a client is at risk for a suicide attempt is to consult with other mental health professionals who are similar to you (Sommers-Flanagan, Sommers-Flanagan, & Lynch, 2001). The *ACA Code of Ethics* (Standard C.2.e.) advises counselors to consult when they have questions regarding their ethical obligations or professional practice. It also is important to look for consensus among your consultants and certainly to follow their advice in making your final decision about what to do in a particular case. Documenting your steps is essential (Boughner & Logan, 1999; Gutheil, 1999). In situations in which you have assessed a client's potential risk for suicide, it is essential that you document carefully, whether you determine that the client is currently not at risk for suicide or that the client may be at risk. Essential items to include in your documentation notes include the following:

- What precipitated your concern about the client (such as referral by another person, or something the client said or did)
- Questions you asked the client and his or her responses
- Individuals you consulted regarding the situation, what you said to them, and how they responded
- Interactions you had with any other persons regarding the situation, from the time you became concerned until you completed your work for the time being regarding the situation

When you make a decision that a client is a danger to self, you must take whatever steps are necessary to prevent the harm, and your actions must be the least intrusive to accomplish that result. Again, consulting with colleagues could be very helpful. Many counselors who have determined that a client may be at risk for suicide require that the client submit to an evaluation by a mental health professional who has expertise in suicide as a condition for continuing to provide counseling services for that individual. For example, you might demand that your client see a psychiatrist on the staff at the facility where you work, if that is an option. Or you might require your client to submit to a mental evaluation at a local hospital where psychiatric services are available. Of course there are other, less intrusive, options available, such as referring the client to a primary care physician if the client is in a health plan that requires that step before gaining access to a specialist, such as a psychiatrist. But you should choose a less intrusive option only if you are sure the client is not at imminent risk.

Because it is so difficult to decide what steps to take in a crisis situation, especially one in which a suicidal client's life may be in danger, we have provided an action plan to follow if you determine that an adult client may be at risk for suicide (see Figure 2). If your client is a minor,

If you determine that an adult client has exhibited some behaviors that are related to suicide, but currently does not appear to be at risk for committing suicide . . .

1. If you believe that an adult client may be thinking about suicide or if you have observed or have information that an adult client has exhibited some behaviors that might be interpreted as suicidal, but you do not consider the situation to be an emergency, summarize in your case notes the client's behavior that supports your concern. Do not write that you believe the client may be at risk for suicide. Instead, write that although you do not believe the client may be at risk for suicide, you believe a significant person in his or her life needs to be informed of the behaviors that concern you.
2. If you have consulted with colleagues, experts, or supervisors in reaching your position, document the consultations in your case notes.
3. Tell your client your concerns and, if appropriate, obtain an agreement from the client to inform a significant person in his or her life of your concerns. Tell the client to have that person contact you after being told.
4. If your client is not capable of telling the significant person, or for some other reason asking the client to inform the significant person does not seem like an appropriate course of action, explain to the client that you will be contacting a significant person to share your concern. If you are not in independent private practice, inform your supervisor of the actions you will be taking and follow any directives given.
5. Choose a significant person and inform him or her of the situation. A significant person might be your client's spouse, parent, adult child, other relative, domestic partner, dating partner, or close friend. Choose a person who lives with the client or who is in frequent contact with the client.
6. Document in your case notes all conversations with your client, client's significant person, and your supervisors.

If you determine that an adult client MAY BE seriously at risk for committing suicide ...

1. You are dealing with a very serious matter that requires immediate and decisive action. Make the determination that an adult client may be at risk for committing suicide only if the client has made a suicide gesture or attempt, has told you or someone else in a believable fashion that he or she plans to commit suicide, or has engaged in a pattern of behavior that the professional literature suggests is characteristic of a suicidal adult. Follow any agency policies that exist regarding managing suicidal adults. If you are not in an independent private practice, notify your supervisor of the situation and follow any directives given. If policies dictate or if your supervisor directs you to proceed differently from the following steps, follow the policies or the orders of your supervisor.
2. If you have consulted with colleagues, experts, or supervisors in reaching your position, document the consultations in your case notes.
3. Explain to your client that you will have to notify a significant person in his or her life so that the person can help.
4. Assure your client that you will continue to help and that you will disclose only the minimum information necessary to get assistance for the client. Try to calm the client, but do not minimize the seriousness of the situation. Explain what may happen in the next few hours, next few days, and long term.
5. Ensure that your client is not left alone and does not have any opportunity to harm self before turning the client over to the significant person.
6. Contact a significant person in your client's life and explain that you believe his or her relative, partner, or friend may be at risk for suicide. Give specific details that led to your concern. Insist that the significant person come to pick up the client immediately.
7. If a significant person cannot be found, make sure your client is under the supervision of a responsible person until a significant person is located.

**FIGURE 2** Steps to follow if you determine that your client may be at risk for suicide

8. If you cannot contact a significant person and if it is impossible to keep your adult client safe for an extended period of time, call an ambulance and have the client transported to a hospital that has psychiatric services. If you are not in an independent private practice, be sure to inform your supervisor and obtain permission and support for taking this action. If your supervisor directs you to take a different course of action, do so and document in your case notes what you were told and did. Give the ambulance attendant your contact information and offer to speak with the person at the hospital who will be conducting the evaluation, if requested to do so. Continue to attempt to contact the client's significant person.
9. When you talk to the significant person, ask that person to take possession and responsibility immediately for your client.
10. When the significant person arrives, explain that you believe that your client may be at risk for suicide, give specific details that led to your concern, instruct the significant person what to do next, and ask that a document be signed that acknowledges that the significant person has been informed of your concerns, has been given directions of steps to take next, and has agreed to take responsibility for your client.
11. Also, have the client sign a form giving you permission to disclose any information you have to mental health professionals who may evaluate or treat the client in the future. If the client refuses or is not capable of signing the form, ask the family member or significant person to sign on your client's behalf.
12. Explain to the significant person that he or she must ensure that your client is not left alone, does not have any opportunities to harm self, and is taken for an evaluation as soon as possible to determine whether the client is at risk for suicide.
13. If a significant person refuses to sign the document or communicates to you in some way that he or she will not take the situation seriously, call an ambulance and follow the steps in item 8.
14. As events occur, document in detail in your case notes all the events that transpired in relation to this situation. Be sure to date each entry and indicate the time you wrote it. Make several entries if necessary, and do not delay in writing details in your case notes.
15. When your client returns to you or your agency for services, obtain written permission from your client to contact the professional who determined that your client was not at risk for suicide, or was no longer at risk for suicide.
16. Contact your client's treating physician, psychologist, or mental health provider and explain that the client has returned to you or your agency for services. Ask the treating provider to summarize his or her evaluation and treatment of the client. Inquire as to whether the provider will continue to treat the client, and if so, the details of the planned treatment. Also ask the treating provider the types of counseling services he or she would like for you to provide to the client. Do not agree to provide any counseling services that your position does not allow you to provide. Ask the provider to tell you the circumstances in which you should return the client to him or her for further evaluation or treatment.
17. As soon as possible after you have talked to the provider, document in your case notes details of your conversation. Be sure to date the entry and indicate the time you wrote it.

**FIGURE 2** (continued)

you must always notify the parents or guardians (Capuzzi, 2002). The steps we have suggested are not the only options that counselors have. We are providing one possible way to manage potentially suicidal clients that hopefully will yield positive results.

If you work in an agency, school, hospital, or other setting, you must always follow procedures established by your employer. In many cases, counselors find that their employer does not have guidelines for how to manage potentially suicidal clients. If that is the case, you should consider following the guidelines in Figure 2 until such policies are adopted. In addition, you should

ask that guidelines be established for the welfare of clients and to protect the counselors who have to make decisions in difficult situations. If your administrative supervisor is present, you must follow his or her directives. The guidelines presented in Figure 2 could be adopted by your agency, or you could follow these, in the absence of any agency policies or directives from superiors.

As you can see from Figure 2, it is assumed that a client you refer for an evaluation will return to you for services. Even if a client is hospitalized, the hospitalization usually is only a few days in duration. Contacting and documenting your consultation with the mental health professional who determined that your client was not at risk for suicide, or was no longer at risk, are vital. You probably will counsel clients who have recently been at risk for suicide. In an interesting study, Paulson and Worth (2002) found that previously suicidal clients described these key therapeutic processes that helped them to overcome suicidal ideation and behaviors: (a) experiencing an affirming and validating relationship as a means of reconnection with others, (b) dealing with the intense emotions surrounding suicidal behavior, and (c) confronting and discarding negative patterns while establishing new, more positive behaviors.

### **Clients Who May Be at Risk for Harming Others**

Counselors are often responsible for violence prevention education (D'Andrea, 2004; Gintner, 2004; Smith & Sandhu, 2004). In addition, there will be situations in your counseling career when you must decide whether a particular client has the potential of harming another person, or perhaps even an individual's property. Making this decision is difficult, as there is no scientific basis for such decisions. If you do determine that a client is a danger to another person, then you must take the steps necessary to prevent harm (Gilbert, 2002; Hermann & Finn, 2002). This may include warning intended victims, whether or not their identity is known. In making these difficult decisions, it is essential to consult with other mental health professionals and to include supervisors to the extent possible.

What began as a legal requirement has now evolved into an ethical duty as well. Standard B.2.a. of the ACA *Code of Ethics* states that the counselor's confidentiality requirement "does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm." This particular exception to confidentiality has caused considerable confusion and consternation among helping professionals, not only because it involves breaching confidentiality but also because it demands that counselors be able to predict dangerousness. Human behavior is not always predictable, and counselors may find themselves caught on the horns of a dilemma, both ethically and legally, in determining whether to breach a client's confidentiality in order to prevent harm to the client or to others.

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## **3 The Case of Todd**

Todd is a counselor in a community mental health center. For the last 2 weeks he has been seeing a client named Bill, who is a junior in high school. Bill comes to center 1 day a week, walking from school to his sessions and then walking home afterward. This afternoon, Bill tells Todd that, after thinking about it for quite some time, he has decided to shoot the assistant principal at his school. Bill says that his father has a rifle collection in their home, and he has access to the guns and to ammunition. Bill explains that he plans to wait outside the assistant principal's home until he walks out in the morning and shoot him as he walks to his car. Because Bill is so calm as he relates all of this information, Todd asks Bill if he is serious. Bill smiles, laughs, and then says, "No, I was only kidding. I would never do anything like that." Because Todd doesn't know Bill very well, he is not

sure what to do next. Todd asks Bill to excuse him a minute and leaves his office to look for his supervisor. He discovers that his supervisor and all the other staff have left for the day. Todd returns to his office and finds Bill standing by a window, looking out with tears in his eyes.

- In these circumstances, what are Todd's options?
- What option would you choose if you were Todd?

**Discussion:** Todd has a number of options in this situation. He could (a) talk more with Bill and try to assess his potential for harming the assistant principal; (b) call Bill's mother or father and ask her or him to come to the center to pick Bill up, and tell the parents what Bill told him; (c) call the police and ask them to come over to talk with Bill; (d) or call the assistant principal and warn him of the threat against his life.

Todd's best option might be to talk further with Bill. If Todd determines that Bill was not serious, Todd should document what happened in his notes and explain why he reached the conclusion he reached.

Even if Todd determines that Bill might not have been serious, Todd should call Bill's parents and ask them to come over. He should get them to take responsibility for Bill's actions and the assistant principal's safety.

Research indicates that it is impossible to predict whether a particular person is going to harm someone else; yet the law and our ethical standards require counselors to determine whether a client is dangerous. How can this legal and ethical duty be fulfilled? First, it is important to learn as much as you can about the warning signs of persons who commit violent acts against others (Daniels, 2002; Haggard-Grann, 2007; Truscott & Evans, 2001). For example, it appears that the best predictor of violence is past violent behavior (Megargee, 1979; Meloy, 1987; Monahan, 1995; Mulvey & Lidz, 1995; Slovic & Monahan, 1995; Truscott, Evans, & Mansell, 1995). But you must be careful not to profile, or assume that a category of persons is prone to violence (Bailey, 2001). Special situations, such as those involving domestic partner violence (Lawson, 2001, 2003) or violence of persons with serious mental disorders, probably require deviations from the general guidelines offered in this chapter.

Once you have determined that a client is indeed dangerous and might harm another person, the law requires that you take whatever steps are necessary to prevent the harm, and further, that the steps you take be the least disruptive (Rice, 1993). You have choices that range from the least intrusive action (obtaining a promise from your client not to harm anyone else) to the most intrusive (having the client involuntarily committed to a psychiatric facility). There are numerous possibilities between these two extremes, such as notifying the client's family members and getting one of them to take responsibility for keeping the client under control, persuading the client to be voluntarily committed to a residential facility, notifying the police, or calling the client periodically. There certainly are no right formulas for action when you determine that your client is dangerous. If at all possible, consult with other mental health professionals and use their input in making your decision.

The guidelines in Figure 2 regarding managing potentially suicidal clients would work equally well in managing potentially violent clients. You would just need to add the determination of whether to warn intended victims, law enforcement authorities, or both.



**DUTY TO WARN INTENDED VICTIMS** Think about how you might react if you were counseling a client who made a threat to harm someone else (Burkemper, 2002). If you were to decide that the client was only venting anger and was not likely to act on the threat, and then later the client carried out the threat, you would have acted ethically in trusting your professional judgment and in preserving confidentiality and the counseling relationship. That would be little solace, however, if someone were killed or seriously injured. Also, the question might arise before an ethics committee or in a court as to whether you could have acted, or should have acted, to avert that harm. On the other hand, if you were to decide that the danger was in fact clear and imminent and you were to issue a warning, no harm would be done to a third party. If the client did not later attempt to harm the possible victim, however, you would have erred in labeling the client dangerous, and your actions probably will have destroyed the counseling relationship. You could be accused of misdiagnosis, defamation of character, or violating confidentiality (*Hopewell v. Adebimpe*, 1982). It is no wonder that counselors view these as no-win situations and might be tempted to simply avoid working with dangerous clients. Yet, it would be ethically questionable to close the doors of the counseling profession to a group of individuals who clearly need our help (Herlihy & Sheeley, 1988).

The duty to warn an identifiable or foreseeable victim of a dangerous client arose out of the landmark *Tarasoff v. Regents of University of California* (1976) court case, which established the following legal concept in California:

... when a psychotherapist *determines*, or pursuant to the standards of his profession *should determine*, that a patient presents a serious danger or violence to others, the therapist incurs an obligation to use reasonable care to protect the foreseeable victim from such danger. (McClarren, 1987, p. 273)

Although the Tarasoff doctrine has not been accepted or applied in every jurisdiction in the United States, counselors have chosen to incorporate it into the ACA *Code of Ethics* and generally assume that the concept is a national legal requirement. The only jurisdiction that has specifically rejected the Tarasoff duty to warn doctrine is Texas (*Thapar v. Zezulka*, 1999). In Texas, counselors do not have a duty to warn intended victims if their clients threaten to harm another person. As a result, if a mental health professional in Texas did warn an intended victim, the professional might potentially be liable to the client who made the threat for breach of confidentiality.

The facts in the *Tarasoff* case are important in understanding the duty that has been imposed on counselors. Prosenjit Poddar was a 26-year-old graduate student at the University of California at Berkeley. In the course of a session with his counselor, Poddar confided his intention to kill his girlfriend, Tatiana Tarasoff. His counselor was Dr. Lawrence Moore, a psychologist in the university counseling center. Because Moore believed that Poddar might be serious regarding his threat, Moore initiated proceedings to have Poddar committed for a psychiatric evaluation. Moore orally notified two campus police officers of his intentions to commit Poddar and then sent a letter to the police chief requesting assistance from the police department. The police took Poddar into custody, but released him when he promised not to contact Tarasoff. Poddar never went to see Moore again. Neither Moore nor the police notified Tarasoff of Poddar's threat. Two months later, Poddar stabbed and killed Tarasoff on the front porch of her parents' home. Tarasoff's parents sued Moore in a wrongful death action for not confining Poddar and not warning Tarasoff of the threat against her life.

Decisions subsequent to the *Tarasoff* case throughout the United States have interpreted the holding of the case differently. Many courts have limited its application to situations in which the victims are readily identifiable. Other courts, however, have extended the duty to all persons who are endangered by the patient's condition or threats (McClarren, 1987). In *Lipari v. Sears, Roebuck & Co.* (1980), a federal court held that a psychotherapist has a duty to warn and protect unknown

victims, as well as those who are readily identifiable. This case extended a counselor's duty to those persons who are foreseeably endangered by a client's conduct.

A Washington state court, following the *Lipari* decision, held that a psychiatrist could possibly be held responsible for injuries sustained by a traffic accident victim. The victim was hurt when a drug-abusing patient, released by the psychiatrist, ran a red light while under the influence of drugs (*Petersen v. State*, 1983). Two California cases expanded the *Tarasoff* doctrine by no longer requiring that a psychotherapist be able to readily identify the patient's victim (*Hedlund v. Superior Court of Orange County*, 1983; *Jablonski v. United States*, 1983).

In a Vermont case, the supreme court held that a mental health professional has a duty to take reasonable steps to protect a third party from threats of damage to property posed by a patient (*Peck v. Counseling Service of Addison County, Inc.*, 1985). In the *Peck* case, the court found that a counselor could be held responsible for property damage when a client burned down a barn. The client told the counselor he intended to do so, and the counselor did not warn the owners of the barn.

Originally, the *Tarasoff* holding imposed a duty to warn only if the victim was specifically identifiable. Subsequent decisions have extended that duty to include warning persons who are unknown, persons who are unintentionally injured by a patient, whole classes of persons of which the victim is a member, bystanders who might be injured by a patient's negligent act, and individuals whose property a client has threatened to destroy (McClarren, 1987). Fox (2010) has suggested, however, that contemporary courts are tending to limit a mental health practitioner's duty to protect third parties from potentially dangerous clients.

In a 2009 study, Pabian, Welfel, and Beebe found that 76.4% of the psychologists in four states were misinformed about their state laws regarding *Tarasoff*-type situations, believing that they had a legal duty to warn intended victims when they did not. Decision making for counselors around the *Tarasoff* legal requirements is complex. One thing is clear, however. Because of the *Tarasoff* case, when you determine that a client might harm an identifiable or foreseeable person, you must directly or indirectly warn that individual of the danger, except in Texas.

**CLIENTS WITH AIDS OR WHO ARE HIV POSITIVE** According to the Centers for Disease Control (2001) of the United States government, "The acquired immunodeficiency syndrome (AIDS) epidemic has had a substantial impact on the health and economy of many nations. Since the first AIDS cases were reported in the United States in June 1981, the number of cases and deaths among persons with AIDS increased rapidly during the 1980s followed by substantial declines in new cases and deaths in the late 1990s." In 2010, an estimated 47,129 people were first diagnosed with the HIV infection in the United States (Centers for Disease Control, 2012).

The advent of AIDS has placed mental health professionals in a quandary. Do counselors have an ethical duty to warn when a client is HIV positive or AIDS confirmed and could be putting others at risk through such behaviors as unprotected sex or needle sharing? According to Standard B.2.b., *Contagious, Life-Threatening Diseases*, of the *ACA Code of Ethics*, when a counselor receives information confirming that a client has a disease commonly known to be both communicable and life threatening, the counselor may be "justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease."

Note that, according to ethical guidelines, counselors are *justified* in disclosing, but are not necessarily *required* to disclose, information to an endangered third party. You will need to weigh a number of factors and determine your own stance regarding arguments that have been offered both for and against breaching confidentiality in working with AIDS or HIV positive clients. Due to medical advances, AIDS is no longer routinely fatal, which makes the applicability of this standard open to question. Some writers (Driscoll, 1992; Melton, 1991; Perry, 1989) have made some

compelling arguments in favor of maintaining confidentiality. Breaches of confidentiality are especially countertherapeutic when working with clients who have a high level of mistrust due to discrimination against them (for instance, gay men, prostitutes, and intravenous drug users). Exposure to HIV does not carry the same level of risk as a homicidal client who threatens to use a lethal weapon; not every exposure to HIV results in harm. Individuals who have consented to unsafe sex practices or sharing needles that could be contaminated must take responsibility for their own choices. If the client's confidentiality is compromised, the client is likely to discontinue counseling, and the problems that contribute to continuation of high-risk behavior (such as fear of abandonment and loss of control) will be exacerbated.

Other writers have argued for disclosure (Cohen, 1997; Erickson, 1993; Gray & Harding, 1988), pointing out that confidentiality is not an end in itself and that the need to protect someone who may be at risk of contracting a fatal disease creates a higher duty. They suggest that, with AIDS having reached epidemic proportions, mental health professionals have an obligation to do their part to protect the health and welfare of society at large when AIDS clients are putting others at risk. These writers also argue that, although it is an injustice that clients with AIDS suffer from discrimination, the protection of others must take precedence over the possibility of discrimination.

It is crucial that you use your clinical judgment in these cases and that you evaluate each AIDS confidentiality dilemma on a case-by-case basis (Harding, Gray, & Neal, 1993; Kain, 1989). To be in compliance with the ethical standards, it is imperative that you do not act hastily to breach confidentiality. First, you should ascertain that your client really does have AIDS or actually is HIV positive, as is required by the ACA *Code of Ethics* (2005; Standard B.2.b.). Often, a consultation with the client's physician is necessary. You should obtain your client's permission for such a consultation. Because AIDS/HIV-positive status is a medical condition, in many circumstances informing the client's physician of your concern about the client endangering others will transfer to the physician the obligation of protecting others.

If you believe you must take responsibility because a physician is not available, then you must determine whether your client has already informed the partner or other third party or is intending to do so in the immediate future. It is preferable that clients make their own disclosures, so you might continue to work with the client in exploring the client's willingness to assume this responsibility, or you might involve the partner in the counseling process.

In some jurisdictions, specific statutes have been passed that address the issue of AIDS and the duty to warn. When your clients who have AIDS or who are HIV positive refuse to disclose their condition to an endangered third party and you believe that you must do so, you must be aware of any applicable state laws that might restrict or guide your reporting options. Without a doubt, keeping abreast of legal and ethical obligations related to HIV/AIDS will continue to pose real challenges for counselors as more is learned about ways to transmit, prevent, and eventually, cure the disease.

To summarize, your work with clients who are dangerous to themselves or others will be fraught with ethical and legal complexities. It is important to keep up with the literature in this area and to familiarize yourself with guidelines for practice regarding the duty to warn, such as those offered by Costa and Altekruze (1994). Whenever possible, you should consult with fellow professionals (Standard C.2.e.) if you are in doubt about whether you have a duty to warn, protect, or report in a given situation.

### **A Hypothetical Malpractice Case**

To illustrate how a malpractice case might be considered against a counselor, we analyze a typical situation in which a counselor might be sued. Suppose that a teacher has come to Monica, a high

school counselor, with a concern about Mark, an 11th-grade student. Mark has written a paper for English class in which he discusses taking his life because he is upset about his parents' recent divorce. Monica calls Mark into her office and talks with him about the paper. She asks him if he has seriously considered taking his life. After a thorough discussion with Mark, Monica determines that he is not suicidal.

That same day, after school, Mark shoots and kills himself with his father's rifle. Mark's mother, Sheila, finds out about the teacher's referral and files a malpractice lawsuit against Monica, claiming that Monica's incompetence caused her son's death. Sheila's attorney probably would name as respondents in the lawsuit Monica individually, each of her direct supervisors up through the school superintendent, the school board, and any other individuals or groups who might be responsible for Monica's actions or failure to act. If Monica had her own independent professional liability insurance policy, her insurance company would hire a lawyer who would represent Monica individually in the case. If Monica did not have her own liability insurance policy, she probably would not be able to afford to pay an attorney to represent her. She would have to rely for her defense on the school system lawyers, who ultimately represent the school system, not her. The school system would have its lawyers, or the lawyers provided by the school system's liability insurance company, file a legal response to the case. Monica's lawyer, if she had one, and the school system lawyers would work together in defending the lawsuit.

Sheila's attorney, in presenting her case in court, would first have to prove that Monica owed a duty of reasonable care in providing counseling services to Mark. This would not be difficult to prove because Monica is a counselor in the school and called Mark in for a counseling session. When a counselor accepts a person as a client, the counselor then has a duty to provide the client with professional care that meets accepted standards within the profession. Counselors have a fiduciary relationship with clients, which is a relationship that fosters the highest level of trust and confidence (Anderson & Bertram, 2012). Clearly, Monica owed Mark a duty of care.

After establishing that a duty of care was owed to Mark, Sheila's attorney then would have to prove that Monica breached that duty and failed to conform to the required standard of care. Most experts would agree that counselors must assess whether a client is suicidal, even though studies have shown that it is impossible to scientifically predict suicidal behavior (Coleman & Shellow, 1992). If it is determined that the client is in danger, action must be taken to prevent the impending suicide (Ahia & Martin, 1993; Austin, Moline, & Williams, 1990). The question in this situation is whether Monica was reasonable in her assessment of Mark's risk. The only way to prove that Monica made an error in her professional judgment is for Sheila's attorney to bring in one or more expert witnesses who will testify that a competent counselor would not have done what Monica did or failed to do. The expert witnesses must compare the actions Monica took or did not take to the actions that a reasonable counselor with Monica's same background and preparation, practicing in the same locality, would have taken in the same set of circumstances. This is the legal standard of care to which counselors are held. Monica's attorney would arrange for a different set of experts to testify that Monica did act reasonably in this particular situation. The judge or jury would have to decide which expert witnesses to believe.

After offering evidence through expert witness testimony that Monica breached her duty of care, Sheila's attorney would have to prove that Mark was injured as a result of this breach. It would not be difficult to prove that harm occurred, because Mark killed himself.

Next, Sheila's attorney would have to prove that there was a close causal connection between what Monica did, or failed to do, and Mark's suicide. Sheila's attorney would have to prove that Monica knew or should have known that her actions would result in Mark's death. The attorney would

argue that Monica's failure to take action when Mark disclosed that he intended to commit suicide was the proximate cause of Mark's death because she failed to take actions that would prevent him from committing suicide. On the opposing side, Monica's attorney would argue that a number of other intervening factors led to Mark's suicide, and that a reasonable counselor would not and could not have predicted that Mark would take his life, given the circumstances in this situation. Further, Monica's attorney would argue that even if Monica did act negligently in this situation, Mark's suicide cannot be blamed on her failure to take action. Other factors *caused* his suicide—factors such as his father leaving his gun out so that Mark had access to it, no one being at home to supervise him after school, or his distress over his parents' contentious behavior during the divorce. The judge or jury would have to decide whether Monica's failure to act to prevent Mark's suicide was the proximate cause of his death, or whether other factors caused him to take his life.

If Sheila's attorney was successful in convincing the judge or jury that Monica was responsible for Mark's death, then the damage to Sheila, expressed in financial terms, would have to be determined. If a person is damaged with a financial loss, such as a loss in the stock market or investing in a deal that has no value, then it is easy to determine how much money the person needs to be *made whole again*. When a person has a physical injury, however, or loses a loved one through death, then it is very difficult to determine how much money it would take to compensate the person for the loss. In fact, these are losses that cannot be compensated with money, but the law requires that there be a financial compensation.

Damages in this situation would be determined by expert witness testimony on Mark's life expectancy, his earning potential, and the anticipated benefit of earnings that would go to his mother, Sheila. Because the loss of a life was involved in this situation, the damages could be hundreds of thousands or several million dollars. Judges or juries have wide discretion in setting the value in these kinds of cases.

If Sheila received a judgment in her favor, the school system's professional liability insurance carrier would most likely pay the judgment. Monica's professional liability carrier might be responsible for paying a portion of the judgment as well. Both the school's and Monica's insurance companies would pay the attorneys' fees and other costs of litigation, which could be as much as several hundred thousand dollars.

At this point, you probably are wondering how often lawsuits are based on client suicide and how often family members prevail and collect judgments. Although client suicide is not the only possible basis for a malpractice lawsuit against counselors, it is undoubtedly one of the most painful types of suits for both plaintiffs and defendants. In the following section, we review some actual cases related to client suicide.

### **Real Malpractice Cases**

In 1960, a college counselor was sued for the wrongful death of a student who had committed suicide. The student had seen the counselor in a professional capacity (*Bogust v. Iverson*). The holding in that case was that the college counselor was not a therapist and therefore had no duty to detect or prevent a suicide of a client. Since 1960, however, the counseling profession has evolved substantially, and counselors in all settings are considered mental health professionals. A similar case today would probably have a different result.

A case that is similar to *Bogust v. Iverson* and the hypothetical case of Monica was decided in Maryland in 1991. In *Eisel v. Board of Education of Montgomery County* (1991), Dorothy Jones and Deidre Morgan, school counselors at Sligo Middle School in Maryland (along with their school board, principal, and superintendent), were sued in a wrongful death action by Stephen Eisel, the father of Nicole Eisel. Nicole Eisel was a 13-year-old student at Sligo Middle School. Nicole and



another 13-year-old girl consummated an apparent murder–suicide pact on November 8, 1988. The complaint filed in the lawsuit was summarized in the case report:

The amended complaint avers that Nicole became involved in satanism, causing her to have an “obsessive interest in death and self-destruction.” During the week prior to the suicide, Nicole told several friends and fellow students that she intended to kill herself. Some of these friends reported Nicole’s intentions to their school counselor, Morgan, who relayed the information to Nicole’s school counselor, Jones. Morgan and Jones then questioned Nicole about the statements, but Nicole denied making them. Neither Morgan nor Jones notified Nicole’s parents or the school administration about Nicole’s alleged statements of intent. Information in the record suggests that the other party to the suicide pact shot Nicole before shooting herself. The murder–suicide took place on a school holiday in a public park at some distance from Sligo Middle School. (pp. 449–450)

Attorneys for the school board and its employees argued that school guidance counselors had no duty to recognize or prevent an adolescent’s suicide. A motion for summary judgment in favor of the school board and its employees was granted, which means that the court, without even hearing the evidence in the case, found that the counselors were not responsible. Eisel appealed to the Maryland Court of Appeals. The Court of Appeals reversed the summary judgment and required that the case go back to the trial court so that a judge or jury could determine whether the counselors would be held responsible for Nicole Eisel’s death.

In coming to this decision, the Maryland Court of Appeals held that “school counselors have a duty to use reasonable means to attempt to prevent a suicide when they are on notice of a child or adolescent student’s suicidal intent” (*Eisel v. Board of Education of Montgomery County*, 1991, p. 456). The decision noted that the counselors could have determined that Nicole was in danger of committing suicide even though she denied it when asked, that the school board had a policy requiring counselors to notify parents despite any confidentiality concerns, and that the school had a formal suicide prevention program in place. The decision stated, “the relationship of a school counselor and pupil is not devoid of therapeutic overtones” (p. 452). The appeals court did not decide that the two school counselors were responsible for Nicole Eisel’s suicide, but it did decide that a judge or jury could determine that the facts were such that they could be held responsible.

It is almost impossible to determine how many lawsuits of a particular nature are filed in court. Most lawsuits are settled without a judgment being rendered or are determined at the trial court level and are not appealed. Only cases that are appealed are reported in case books. From the cases that are appealed, however, it appears that very few lawsuits are filed against counselors due to client suicide, and few of those filed result in judgments against the counselors. Nonetheless, counselors certainly hope to avoid experiencing the double trauma of having a client commit suicide and being named as a defendant in a lawsuit resulting from that suicide. In fact, if you practice competently, the chances are good that you will never have to respond to a malpractice lawsuit.

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## Summary and Key Points

Counselor competence is an important concept, even though it is difficult to define from an ethical viewpoint and difficult to demonstrate in a court of law. It is best viewed as being based on performance and as existing along a continuum from gross negligence to maximum effectiveness. Some of the key

points regarding competence that are made in this chapter include the following:

- The law demands a minimum level of practice from counselors, whereas ethics encourages counselors to aspire to an ideal level of practice.



## Competence and Malpractice

- Counselors must practice within their boundaries of competence. It can be difficult to determine just where these boundaries lie.
- The development of competence begins with preparation and education, and the initial responsibility for producing competent practitioners rests with counselor educators and supervisors.
- Preparation standards established by accrediting bodies help to ensure that graduates of accredited programs possess certain competencies. Nonetheless, graduation from an accredited counselor education program does not guarantee competence.
- Licensure is a legal process that establishes minimum standards for a counselor to practice in a given state. Because licensure is a political process, counselor licensure requirements are not uniform across the states.
- It is questionable whether licensure actually accomplishes the goals of ensuring competence, protecting consumers, and promoting high standards of practice.
- Certification is another approach to attempting to ensure competence.
- Specialty preparation, licensure, and certification are controversial issues in the counseling field.
- Once counselors begin to practice, they are responsible for determining their own competence.
- Counselors are required to seek continuing education in order to maintain their competence. Peer review is an effective approach to monitoring competence.
- Many new information technologies exist and offer counselors resources for maintaining and increasing their competence.
- Counselors must know when and how to refer clients when they are not able to provide competent services to these clients.
- Counselors must exercise care while stretching their boundaries of competence to include client populations and concerns with which they have little or no experience.
- It is essential in today's society that counselors possess intercultural counseling competence.
- Counselors cannot claim they are unable to provide services for a client and refuse to see a client if their refusal is intended to discriminate against the client for unacceptable reasons.
- When counselors are experiencing distress, burnout, or impairment, they must take steps to protect clients from harm and to restore themselves to their full level of functioning.

Malpractice is the second major issue addressed in this chapter. Key points include the following:

- Malpractice lawsuits arise from claims of counselor incompetence. It is difficult to prove all five elements of malpractice that must be proved for a malpractice case to succeed.
- Some lawsuits have been filed against counselors for failing to prevent a client's suicide. Counselors are being held to a higher standard of care in these cases and must be able to assess a client's risk for suicide. Steps to follow in this process are included in the chapter.
- Counselors also have an obligation to take steps to prevent a client from harming others. The duty to warn and protect intended victims is extremely complex from both the ethical and the legal standpoints. Steps to follow in this process are included in the chapter.

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# Boundary Issues

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# Boundary Issues

## FOCUS QUESTIONS

1. Do you think that a sexual relationship between a counselor and a former client is ever acceptable? Why or why not?
2. What are the differences between a friendship and a counseling relationship?
3. What would you do if you found that you felt a strong sexual attraction to one of your clients?
4. How would you define the term “dual relationship”?

Perhaps no ethical and legal issue has caused more controversy among helping professionals than determining the appropriate boundaries of the therapeutic relationship. Boundary issues encompass a wide range of questions that counselors encounter on a daily basis. Following are just a few such questions: Is it ethically appropriate to accept a gift from a client? Is it permissible to enter into a bartering arrangement with a client who needs continued services but can no longer afford to pay the fee? Should I ever meet with a client outside the office? Hug a client? Accept a friend of a friend as a client? Attend a community event when a client will also be in attendance?

Although the term *boundary* is part of the everyday language of counseling, it has rarely been defined in the literature (Hermanson, 1997). A *boundary* can be conceptualized as a frame or membrane around the therapeutic dyad that defines a set of roles for the participants in the therapeutic relationship (Smith & Fitzpatrick, 1995). Viewed this way, boundaries help us understand the parameters of the relationship. Although counseling can involve a great deal of emotional intimacy, it is a professional relationship, and therefore, it has certain limits that might not apply to a personal relationship. To give just a few examples, there are limits on physical contact between counselor and client, on time and place for counseling (counseling generally takes place during regularly scheduled appointments and in a particular setting), on the amount and types of self-disclosure made by the counselor, and on the exchange of gifts. Katherine's (1991) definition of a boundary as

a “limit that promotes integrity” (p. 3) nicely captures the purpose of setting boundaries. Limits lend structure to the therapeutic relationship, which helps to create a safe space that is “unambiguous, consistent, and reliable” (Jordan & Marshall, 2010, p. 345). Boundaries exist to protect the welfare of clients who are in a vulnerable position in the relationship.

Boundary issues usually have been framed in the literature as questions of dual or multiple relationships. According to Herlihy and Corey (2006), dual or multiple relationships occur when helping professionals take on two or more roles simultaneously or sequentially with a help seeker. Stated another way, dual or multiple relationships occur whenever helping professionals have another, significantly different relationship with one of their clients, students, or supervisees. Dual relationships can involve combining the role of counselor with another professional relationship (such as teacher, minister, supervisor, employer, or business partner) (Smith & Smith, 2001) or combining the counselor role with a personal relationship (such as friend, relative, or lover).

Because the issues surrounding *dual relationships* or *multiple relationships* are so complex and sometimes confusing, and because dual relationships are not unethical per se, the 2005 ACA *Code of Ethics* does not use these terms. Instead, the code provides several standards under A.5. (Roles and Relationships with Clients). One of these standards states

Counselor-client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client. (Standard A.5.c.)

Note that the code of ethics does not prohibit *all* nonprofessional relationships. Rather, it cautions counselors to avoid nonprofessional relationships *except when the interaction is potentially beneficial to the client*. Except for sexual relationships with clients (which are universally agreed to be harmful to clients), how does one distinguish among nonprofessional relationships that might be acceptable and those that could cause harm to a client? What is it about boundary issues that makes them so complicated and difficult to resolve?



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 7 and view the video clip entitled “An Invitation to a Wedding.” In this situation, the counselor must decide whether to accept a social invitation made by a couple she has been counseling.

## THE COMPLEXITIES OF DUAL RELATIONSHIPS

Several characteristics of dual relationships make them problematic for counselors (Herlihy & Corey, 2006). First, *potential dual relationships can be difficult to recognize*. They can evolve in subtle ways. There is no *danger sign* that marks the point at which a professional relationship crosses the line into behavior that could lead to an inappropriate relationship. It is not difficult for a counselor, or a counselor educator or supervisor, to innocently enter into a form of extraprofessional relationship. A counselor might accept a client’s invitation to attend a special event that has meaning for the client. A counselor educator might find a friendship developing with a student whom the educator is mentoring. A supervisor might feel attracted to a supervisee and think about dating the supervisee as soon as the formal supervision is completed.

When dual relationships are sequential rather than simultaneous, it can be particularly difficult to foresee potential problems. Some of the questions with which conscientious professionals struggle are whether a former client can eventually become a friend, how a smooth transition can be made from a supervisory relationship to a collegial relationship once supervision is completed, and what factors need to be considered in determining whether a former therapeutic relationship can become a personal relationship of any kind.

A second complicating characteristic is that *the potential outcome of dual relating ranges along a wide continuum from extremely harmful to beneficial to clients*, as can be seen in the following two examples.

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## 1 The Case of Gerald

Dorothy, age 23, seeks counseling from Gerald, an LPC in private practice. Her goal is to work through issues related to the sexual abuse by her stepfather that she had endured when she was a child. After 2 months of counseling, Gerald initiates a sexual relationship with Dorothy. He rationalizes his behavior by telling himself that she can benefit from having a “healthy” sexual relationship. Dorothy feels guilty, confused, and isolated by this betrayal of her trust. She wants to end the sexual relationship but has become so dependent on Gerald that she feels trapped. She begins to have thoughts of suicide.

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## 2 The Case of Elizabeth

Fiona has been coming to see Elizabeth, her counselor, for nearly a year. Through counseling, Fiona has gained the self-esteem and confidence to return to college and complete the last four courses she needed in order to graduate. She asks Elizabeth to attend the graduation ceremony. She says that Elizabeth’s attendance would mean a great deal to her because she credits the counseling process for making it possible for her to achieve her goal. Elizabeth agrees to attend the ceremony.

- What are the differences between Gerald’s motivation and Elizabeth’s motivation to cross a boundary?
- What harm do you think might have resulted from Elizabeth attending Fiona’s graduation ceremony?

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**Discussion:** The first case illustrates the severe harm to a client that a sexual dual relationship can cause. Gerald’s behavior is exploitive, and he is causing harm by revictimizing his client. Gerald’s behavior is unethical, and in some jurisdictions it could be illegal as well.

Near the other end of the continuum are situations like Elizabeth’s in which a counselor chooses to engage in a form of dual relating in order to benefit a particular client. Elizabeth’s choice to attend the graduation ceremony probably has a low risk of causing harm. The *ACA Code of Ethics* (2005) specifically states in Standard A.5.d. that an example of a potentially beneficial interaction is “attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation).” Elizabeth would need to take the steps required in Standard A.5.d., which states: “the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client....”



Third, *with the exception of sexual dual relationships, there is very little consensus among mental health professionals regarding the propriety of dual relationships*. Boundary issues have been a “hot topic” that has generated over 1,500 books, articles, and scholarly works over the past 25 years (Pope & Keith-Spiegel, 2008). Historically, dual relationships were generally prohibited or discouraged, but the thinking of the profession has evolved during the twenty-first century. Prohibitions have been replaced by cautions and a recognition that some dual relating can actually be beneficial to clients (Corey, Corey, & Callanan, 2011). Nonetheless, there is still no consensus among professionals about this issue. You will need to give considered thought to developing your own stance toward boundary issues. Although the risks and benefits of nonprofessional or dual relationships are further discussed later in the chapter, we believe it may be helpful at this point to keep in mind Tomm’s (1993) caution that it is not dual relating in itself that creates an ethical problem. Rather, it is the counselor’s personal tendency to exploit clients or misuse power. Thus, simply avoiding dual relationships will not prevent exploitation. There are many ways that counselors can misuse their power and influence over clients even when they are not occupying more than one role with them.

Fourth, *our traditional ideas of the therapeutic frame are being challenged by developments in the profession and by new, innovative approaches to counseling*. One development is that there is greater cultural diversity among both clients and counselors in our increasingly multicultural society. We agree with Speight (2012), who suggested that cultural competence in counseling requires a different, broader understanding of therapeutic boundaries. She noted that many African Americans place high value on affective expression and sociability. Therefore, African American clients are likely to want counselors to “be real” in the counseling relationship, and they may react negatively to counselors who maintain distance and anonymity. Kertesz (2002) noted that in Latino cultures, where warm, close family and community bonds exist, dual relationships tend to be the norm rather than the exception. Sometimes, the shared experiences of being members of a marginalized group form a basis for establishing a counseling relationship. For instance, there is some evidence that LGBTQIQ counselors, some of whom specialize in counseling LGBTQIQ clients, encounter frequent and complicated multiple relationships due to the small size of these communities (Graham & Liddle, 2009). The participation of these counselors in social or political activities in the gay community may be the very reason the clients seek them out.

Other cultural factors can create “small-world” dilemmas. For instance, imagine a counselor who immigrated from Vietnam to a city in the United States 20 years ago. He has earned his master’s degree in counseling and continues to live and work in a section of the city where the population is primarily Vietnamese. Many residents of the area seek him out as a counselor because he speaks their native language and because they believe he will be able to understand their cultural values. Many of these prospective clients are people with whom he is acquainted or are even distant relatives. Would you expect this counselor to deny his services to these clients?

Some innovative approaches also are challenging the traditional boundaries that existed when counseling usually occurred in an office setting. For example, types of eco-therapy such as adventure-based counseling (Zur, 2007) and “walk and talk” therapy (McKinney, 2011) take place in outdoor settings that are less formal and less structured than in-the-office settings, which could easily lead to a relaxation of boundaries. As a result of all these changes, Jordan and Marshall (2010) have suggested that contemporary counseling practice requires a fluid and flexible frame that is more movable and dynamic than was once assumed.

The final characteristic that makes boundary issues so complicated is that *some dual relationships are unavoidable*. Although most of the literature regarding unavoidable dual relationships

has centered on rural practice, there are a number of situations in which counselors and their clients have shared social communities and in which overlapping roles are inherent. We discuss some of these situations in the following section.

### **“Small Worlds”**

As mentioned above, boundary issues in rural practice have been given a considerable amount of attention. Yet, it is important to recognize that there are other “small worlds” that can exist in a bounded environment or even in an urban environment. Counselors who work in the military face many of the same challenges as rural practitioners (Johnson, Ralph, & Johnson, 2005), as do those who are members of the deaf, religious, corrections and law enforcement, or addictions treatment communities (Glosoff, Corey, & Herlihy, 2006; Lazarus, 2006; Lazarus & Zur, 2002; Schank & Skovholt, 2006). Traditional boundaries do not even exist in some crisis counseling situations such as large-scale disasters. In the following subsections, we identify some of the boundary questions that can arise in rural, military, pastoral, and addictions counseling.

**RURAL COMMUNITIES** Counselors in isolated, rural communities or very small towns may find it impossible to avoid some overlap among roles (Erickson, 2001) and may find it much more difficult to maintain clear boundaries than counselors who practice in urban areas (Herlihy & Corey, 2008). Campbell and Gordon (2003) have argued that multiple relationships are inevitable in rural communities due to the limited number of mental health practitioners, access difficulties, characteristics of rural communities, and characteristics of counselors in these communities. Imagine a situation in which the local banker, beautician, auto mechanic, grocery store checkout clerk, and owner of the dry cleaners are all clients of a particular counselor who practices in a small town located a 2-hour drive from a major city. Would you expect that counselor to make a 4-hour round trip to receive all the routine services these clients provide, in order to avoid any possible overlapping of roles?

On the positive side, the fact that nearly every potential client will be an acquaintance of a rural practitioner may present an advantage to the counselor. Forester-Miller (2006) has suggested that familiarity and trust are necessary ingredients to be an effective counselor in rural areas. On the negative side, rural and small-community practitioners face the additional problem of dealing with the effects that overlapping relationships have on their own families (Schank & Skovholt, 2006). Consider the following scenario:

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### **3 The Case of Paula**

Marianne has been a client in counseling with Paula for several weeks. Marianne’s husband and Paula’s husband both serve on the advisory board for a charitable organization, and the two husbands begin to develop a friendship. They decide that they would like for their wives to meet and that the two couples should go out to dinner together.

- How should Paula respond when her husband suggests this social contact?
  - Do you think Marianne should tell her husband that Paula is her counselor and that she would not be comfortable in a social situation with Paula?
-

**Discussion:** There is no easy answer to the question of whether Paula should agree to a dinner engagement with her client and her client's husband. Paula will need to consider several factors: Does Marianne's husband know that she is in counseling? Does he know that Paula is her counselor? Is the marriage a relevant issue in counseling? Does Marianne have a high need for privacy? Would Paula feel uncomfortable in the situation if she went to dinner with the client and the client's husband?

An excellent solution to the problem would be for Marianne to tell her husband that she is in counseling with Paula. For now, however, Paula's best approach probably would be to postpone the decision without revealing to her husband her specific reason for doing so. Then, she can raise the issue with Marianne during their next session together. If Paula would not be uncomfortable with the two couples having dinner together, then she can be guided by her client's wishes on the matter.

Without question, counselors in rural and small-town practice face dual relationship and role-overlap dilemmas more frequently than do most other practitioners. Counselors in rural practice are aware that the usual "rules" are not always helpful and that they need to adapt creatively to situations as they occur (Corey et al., 2011).

**COUNSELING IN THE MILITARY** Counselors who work in the military may find themselves engaged in multiple relationships with clients on a daily basis. These multiple roles are often unavoidable and can be uncomfortable for both the client and the counselor. Johnson (in press) has described the conflicting roles that can exist when a counselor is *embedded* or deployed with a military unit. In this situation, counselors who are also commissioned officers have a legally binding senior-subordinate or subordinate-senior relationship with everyone in the population. Johnson has noted that the military is a rank-conscious culture in which it is difficult to fulfill multiple roles such as empathic counselor *and* superior officer, or mental health expert *and* direct subordinate. An additional complication is that counselors in embedded or isolated duty stations often cannot refer when role conflicts occur. The counselor may be the only available provider, expected to counsel all service members including personal friends, direct supervisors, and co-workers (Johnson, Ralph, & Johnson, 2005).

An additional type of role conflict can occur when a counselor is directed to perform a fitness-for-duty or security clearance evaluation on a service member who is also a client. The counseling relationship will almost certainly be jeopardized if the counselor determines that the service member is not fit for deployment or not a good risk for a security clearance.

Johnson (in press) has noted that military counselors are like rural counselors in that they find themselves in nonprofessional contact with many of their clients on a routine basis. "When deployed with a unit, the counselor will find him or herself eating, sleeping, and carrying out all the mundane tasks of life while (literally!) shoulder-to-shoulder with clients." Thus, military counselors need to be very comfortable with frequent boundary crossings and role blending.

**PASTORAL COUNSELING** Pastoral counselors have overlapping relationships with members of their congregations, and they face some unique boundary challenges (Haug, 1999; Lynch, 2002). Boundaries can be particularly difficult to maintain when pastors are expected to provide 24-hour

availability, when they often work without direct supervision or in isolation from peers, and when the power differential is exacerbated by the fact that they are idealized by their parishioners (Crisp-Han, Gabbard, & Martinez, 2011; Garland & Argueta, 2012). When Crisp-Han, Gabbard, and Martinez reviewed the cases of 70 pastors who had been referred for mental health treatment, they noted that clergy are expected to perform the multiple, overlapping roles of pastor, counselor, mediator, accountant, CEO, and friend. It appears that multiple relationships are an inevitable part of pastoral practice (Syme, 2003).

**ADDICTIONS COUNSELING** With the recognition of addictions counseling as an accredited specialty in the 2009 CACREP standards, addictions counselors may give increased attention to ethical issues in general and boundary issues in particular (Linton, 2012). At the present time, the education and credentialing of addictions counselors vary widely, and some counselors may not be receiving consistent training in how to manage boundary issues (Veach, 2006). There may also be disparities in how boundary questions are viewed by addictions counselors who are themselves in recovery and those who are not. Hollander, Bauer, Herlihy, and McCollum (2006) found that non-recovering board-certified substance abuse counselors were more likely than recovering counselors to find a variety of multiple relationship behaviors to be ethically problematic.

Some addictions counselors are members of the National Association of Alcoholism and Drug Counselors (NAADAC), which has its own code of ethics (NAADAC, revised 2011). The NAADAC standards regarding dual relationships differ from those found in the *ACA Code of Ethics*. The NAADAC code takes a more stringent stance, stating that “in rural settings and in small communities, dual relationships are evaluated and avoided as much as possible.” Strict adherence to this standard may be particularly difficult for the many substance abuse counselors who are themselves in recovery. What if there is only one 12-step program in the area where a counselor practices? Would you expect that counselor to jeopardize recovery by avoiding the meetings for fear a client might be in attendance?

## **RISKS AND BENEFITS OF DUAL/MULTIPLE RELATIONSHIPS**

As we have noted, most questions of dual or multiple relationships defy easy answers. Dual relationships can range along a continuum from extremely harmful to potentially beneficial to clients. Herlihy and Corey (2006) and Younggren and Gottlieb (2004) have suggested that counselors faced with decisions about potential dual relationships weigh the risks and benefits of entering into such relationships, exploring both the potential for harm and the possible benefits to the client. Potential risks and benefits are discussed in the following subsections.

### **The Potential for Harm**

Some writers have taken a cautious and conservative stance toward potential dual relationships. St. Germaine (1993) has reminded counselors that the potential for harm is always present in a dual relationship due to the loss of objectivity that accompanies that relationship. Bograd (1993) noted that the power differential between counselor and client makes it impossible for the client to give truly equal consent to an extraprofessional relationship. It is possible that counselors may unintentionally or unconsciously exploit or harm clients who are in a vulnerable position in the relationship. Pope and Vasquez (2007) cautioned that counselors who engage in dual relationships may rationalize their behavior in an attempt to evade their professional responsibility to find acceptable alternatives to dual relationships. Unfortunately, there has been little research conducted that

explores the impact of violations of nonsexual boundaries on client improvement in counseling (Mathews & Gerrity, 2002).

In determining the risk of harm in a nonprofessional relationship, Kitchener and Harding (1990) suggested that counselors should consider three factors: incompatible expectations, divergent responsibilities, and the power differential. First, the greater the incompatibility of expectations in a dual role, the greater the risk of harm. Second, the greater the divergence of the responsibilities associated with dual roles, the greater the potential for divided loyalties and loss of objectivity. Third, the greater the power differential between the two parties involved in a dual relationship, the greater the potential for exploitation of the individual in the less powerful position. We illustrate each of these factors in the following example:

Cora is the director of a university counseling center, and Eileen is a secretary in the center's main office. Eileen has been an excellent employee for many years, and Cora has come to count on her to help keep the center functioning smoothly. One day Cora comes out of her office and notices that Eileen's eyes are red and puffy and that she seems sad. When Cora expresses her concern, Eileen begins to cry. She tells Cora that she is having some personal problems and adds, "Can I just step into your office for a minute while I pull myself together?" Cora agrees to this request and they both go into Cora's office and close the door. Eileen begins to tell Cora about her personal problems. Cora listens as Eileen tells her story. After nearly an hour she suggests that Eileen might want to seek counseling. Eileen demurs, saying that she feels better now and thinks she can handle things.

Several weeks go by, during which time Eileen's work is not up to her usual high standards. She makes careless errors and forgets things. Cora calls her into her office twice to address this problem. Each time Cora spends about 30 minutes listening to Eileen's personal problems. At the end of each conversation, Eileen insists that she is "getting a grip on things." When the time comes for Cora to complete her quarterly evaluations of her counseling center staff, she gives Eileen a low rating on a number of the items on the form. When Eileen receives the evaluation, she is hurt and angry. She confronts Cora, saying, "How could you—of all people—do this to me! You know I'm a good employee but am just going through a rough time. You know what's going on in my life. I expected you to understand."

It is likely that Eileen's hurt and anger have resulted from the *incompatible expectations* she held for Cora. On the one hand, Cora has been a caring and sympathetic listener. Even though Cora did not intend to enter into a formal therapeutic relationship with Eileen, she has behaved as a counselor. Eileen has come to expect her to be understanding, accepting, and nonjudgmental while Eileen was working through her personal problems. Given this set of expectations, the evaluation feels like a punishment and a betrayal. On the other hand, she has been a secretary in the center for several years and is accustomed to receiving quarterly evaluations from her supervisor. As an employee, she realizes that her work has not been up to par, and in that role she would expect to receive a fair and accurate evaluation. Her expectations for Cora as a supervisor are incompatible with what she expects from Cora as a sympathetic listener and counselor.

Cora is faced with two *divergent responsibilities* in this situation. Because she has stepped into a counselor role, she needs to be accepting and supportive of Eileen, as well as patient, while Eileen works through her problems. As a supervisor, however, it is Cora's responsibility to evaluate her employees and to do so accurately. It is impossible for Cora to evaluate Eileen and be nonjudgmental at the same time.

Finally, there is a *power differential* in the relationship between Cora and Eileen. Cora is in a position of power because she is Eileen's supervisor who evaluates her work. Eileen is in a less powerful position as an employee and has made herself even more vulnerable by revealing

her personal problems. It is Cora's professional responsibility to avoid misusing her power and to ensure that the more vulnerable individual in the relationship is not harmed. Certain characteristics of the therapeutic relationship place counselors in a position of power over clients. When clients come for counseling, they are in an emotionally vulnerable state. In the counseling relationship, the counselor learns much about the client's innermost thoughts and feelings, while the client learns much less about the counselor. This unfortunate problematic situation between Cora and Eileen could have been avoided if Cora had not appeared to assume the role of counselor for Eileen. Counselors who are asked to counsel others with whom they have other relationships are put in a difficult situation, and it happens quite often. When persons with whom you have other relationships (relative, friend, employee, etc.) know that you are a counselor and ask you to counsel them, you need to be prepared to respond in both a caring and professionally appropriate manner. A good approach would be to acknowledge their distress and empathize with them, and then go on to state that you cannot function as their counselor because of your other relationship with them. Offer to help them locate a good counselor. If you then proceed to listen to their situation, it is wise to remind them periodically that you are listening as a relative, friend, or supervisor rather than as a counselor.

Of course, counselors never *intend* to exploit their clients. Cottone (2005) has urged counselors to think in terms of detriment or harm to clients, rather than in terms of potential exploitation. He notes that the word *exploitive* implies malicious intent, whereas the term *detrimental* focuses on outcome regardless of intent. His point is that counselors need to be held accountable for actions they take that cause harm to clients, regardless of intent.

### Potential Benefits to Clients

While some scholars have focused on the potential for harm and have urged counselors to avoid entering into dual relationships, other writers have argued persuasively that dual relationships can be helpful to clients if they are implemented thoughtfully and with care and integrity. Hedges (1993), presenting a psychoanalytic viewpoint, has argued that there is an essential dual relatedness in psychotherapy in that transference, countertransference, resistance, and interpretation all rest de facto on the existence of a dual relationship. Hedges urged counselors to remember that, viewed from this perspective, all beneficial aspects of counseling arise as a consequence of a dual relationship.

Greenspan (2002) described strict adherence to boundaries as a "distance model" that undermines the therapeutic relationship. In a similar vein, Tomm (1993) and Moleski and Kiselica (2005) have suggested that when counselors actively maintain interpersonal distance, they unnecessarily emphasize the power differential and promote an objectification of the therapeutic relationship. Tomm believed that dual relating invites greater authenticity and congruence from counselors and can actually improve their professional judgments because dual relationships make it more difficult for them to hide behind the protection of a professional mask.

Lazarus and Zur are perhaps the strongest voices among contemporary scholars who take the position that it can be extremely beneficial for counselors to engage in dual relationships with selected clients. Lazarus and Zur (2002) have noted that a power differential in a relationship is not necessarily associated with harm or exploitation. They point out that many hierarchical relationships (such as parent-child, teacher-student, and coach-athlete) flourish and contribute to an individual's growth and development. Zur (2007) has argued that rigid adherence to boundaries can actually weaken the therapeutic alliance, and that rigidity, aloofness, and distance are in direct conflict with therapist attributes known to be helpful to clients. Lazarus (2006) has asserted that counselors who selectively transcend certain boundaries actually may provide superior help. In



summing up the arguments in favor of flexible boundaries, Moleski and Kiselica (2005) concluded that dual relationships are “not always destined for disaster” (p. 7) and can in fact complement and enhance the counseling relationship.

### **Boundary Crossings Versus Boundary Violations**

At this point in your reading, you have a feel for some of the complexities of nonprofessional or dual relationships. You may be uncertain regarding your own stance toward some of the issues we have raised. If it is any comfort, many seasoned practitioners are also uncertain. Neukrug and Milliken (2011) surveyed a large sample of ACA members regarding a range of ethical behaviors. The respondents differed in their opinions about several dual relationship behaviors. Hugging a client was judged as ethical by 67% of counselors, while 33% thought this was unethical. Despite the existence of specific language in the *ACA Code of Ethics* that allows bartering in certain circumstances, 46.6% believed that bartering was unethical. There was nearly an even split in judgment regarding whether a counselor should sell to a client a product related to the counseling relationship (e.g., book, audiotape), with 47.6% deeming it ethical and 53.3% judging it to be unethical. Similar results were obtained on the question of whether it is ethical to become sexually involved with a client at least 5 years after the counseling relationship ended (42.9% ethical, 57.1% unethical). Obviously, experienced counselors disagree as to whether dual relationships with clients are ethical.

Compounding the confusion around nonsexual dual relationships with clients is the fact that counselors may engage in some behaviors with clients from time to time that have a *potential* for creating a dual relationship but are not in themselves dual relationships. These behaviors have been described as “boundary crossings” to distinguish them from ongoing dual relationships.

Several writers (Gabbard, 1995; Gutheil & Gabbard, 1993; Smith & Fitzpatrick, 1995) have attempted to distinguish between boundary crossings and boundary violations. A boundary crossing is a departure from a commonly accepted practice that occurs to benefit a client. In a crossing, the boundary is shifted to meet the needs of a particular client at a particular moment. By contrast, a violation is a serious breach that causes harm.

An example of a boundary crossing was given earlier in the chapter in the case example involving a counselor (Elizabeth) who decided to attend her client’s (Fiona’s) college graduation ceremony. This counselor’s behavior did not constitute an ongoing dual relationship, and arguably, it had the potential to enhance the therapeutic relationship. You should be aware, though, that not all counselors would agree with Elizabeth’s decision. As Barnett et al. (2007) have noted, one counselor’s intended crossing may be another counselor’s perceived violation. When Borys (1988) surveyed a large sample of mental health professionals regarding their beliefs about the ethics of certain boundary-crossing and dual relationship behaviors, she found very little agreement about most of the behaviors. We have adapted some of the survey items described in a later article (Borys & Pope, 1989) into a questionnaire (see Figure 1). We encourage you to complete the questionnaire and then discuss your responses with fellow class members or with colleagues. Think about the rationale you would offer for your responses, should a class member or colleague challenge your decisions.

One factor that the survey does not address, and that probably will influence your decisions regarding whether you are willing to engage in occasional boundary crossings in your practice, is that each client is unique. Some clients have generally clear interpersonal boundaries, and an occasional crossing during your relationship with them may have no further repercussions. Other clients present a real challenge to maintaining therapeutic boundaries. Clients with borderline personality traits or who have been diagnosed with the disorder, for example, may be adept manipulators who will try to draw their counselors into a “special” relationship (Gutheil, 1989; Simon, 1989). You will want to be very firm and consistent in maintaining the therapeutic frame with clients who have

# Boundary Issues

For each item below, place an X in the box that best represents your opinion.					
How ethical is it for a counselor to:	Never Ethical	Rarely Ethical	Sometimes Ethical	Usually Ethical	Always Ethical
1. Barter with a client for goods or services?					
2. Invite a client to a personal party or social event?					
3. Provide counseling to a friend who is in crisis?					
4. Accept a gift from a client if the gift is worth less than \$10?					
5. Accept a gift from a client if the gift is worth more than \$50?					
6. Accept a client's invitation to a special event?					
7. Go out for coffee with a client after a counseling session?					
8. Become friends with a client after termination of the counseling relationship?					
9. Give a home phone number to a client?					
10. Share personal experiences as a member of a self-help group when a client is in attendance?					
11. Occasionally hire a client to baby-sit?					

**FIGURE 1** Boundary issues survey of opinion

poor boundaries in other areas of their lives. Sonne (2005) has urged counselors to exercise extreme care in maintaining boundaries with clients who suffer from any psychological disorder (such as narcissistic personality disorder, delusional disorders, or dissociative disorders) that could impair their ability to understand or negotiate boundaries. Sonne also suggested that the depth of the client's social network outside the counseling relationship should be considered.

In general, from an ethical standpoint, occasional boundary crossings probably can be justified when there is benefit to the client and very little risk of harm. Counselors must take care, however, not to let these crossings become routine. As Herlihy and Corey (2006) have noted, "Interpersonal boundaries are not static and may be redefined over time as counselors and clients work closely together" (p. 11). These authors cautioned, however, that even seemingly innocent behaviors can, if they become part of a pattern of blurring the professional boundaries, lead to dual relationship entanglements with a real potential for harm. As small, well-intended relaxations of boundaries become more frequent in a therapeutic relationship or in a counselor's practice in general, it has been suggested (Gutheil & Gabbard, 1993; Pope, Sonne, & Holroyd, 1993; Sonne, 1994) that the "slippery slope phenomenon" may come into effect. That is, the gradual erosion of the boundaries of the professional relationship can take counselors down an insidious path toward serious ethical violations. As we discuss next, reasoning about boundary crossings from a legal perspective leads to similar conclusions.

## The Legal Perspective on Boundary Crossings

Counselors who are accused of wrongdoing for any reason may have their peers investigate complaints against them, or may even have to defend themselves in an ethics hearing or criminal court. Once you have been accused of having done something wrong, it is too late to undo any small indiscretions from your past. Often in the area of boundary issues, counselors will think, “Well, maybe just this one time it will be all right to ask my client to baby-sit for my daughter,” or “This client is particularly mature, so I’m sure we can have lunch together after our session today.”

Unfortunately, these small and seemingly insignificant boundary crossings can be the very evidence that causes an ethics panel, judge, or jury to find against you when you have been accused of having done something wrong. When people judging you consider the small boundary crossings that you have committed, they may come to the conclusion that you are incapable of understanding your profession’s prohibition against engaging in multiple relationships that are harmful to clients. Whether you have been falsely accused or even have been accused of something you wish you had not done, it is best if you have very few boundary crossings in your past.

## Specific Boundary Issues

In this section of the chapter, we explore some specific issues that are associated with nonsexual dual relationships and boundaries. These issues include bartering, social and business relationships with clients, accepting gifts from clients, the limits of counselor self-disclosure, and touching or hugging a client.

**BARTERING** Bartering with a client for goods or services is not prohibited by the ethical standards of the counseling profession, although it is discouraged as a routine practice. There is no consensus among counseling practitioners as to whether they consider bartering to be ethical. As noted earlier, counselors were divided in their opinion on this issue when surveyed by Neukrug and Milliken (2011). Counselors who enter into bartering arrangements with clients usually are motivated by a desire to provide services to clients whose financial resources are limited and who could not afford counseling without some sort of alternative arrangement for payment. This intention is admirable, and you may choose to enter into bartering agreements with clients from time to time in your professional career. However, you should be aware of the problems that are inherent in this practice.


One form of bartering involves the exchange of services. For example, a client might be a self-employed interior decorator who is having difficulty paying for continued counseling because his business has been slack lately. His counselor’s office suite needs new paint and wallpaper, so they agree to exchange counseling services for redecorating services. It is possible that an arrangement like this could work smoothly, but there are a number of potential pitfalls. For one thing, most services that clients can offer do not have monetary value equal to an hour of counseling (Kitchener & Harding, 1990). Unless clients can devote considerable time each week to holding up their end of the agreement, they are likely to fall further and further behind in the amount owed. They can become trapped in a kind of indentured servitude and come to feel resentful.

In addition to the question of quantity of bartered services, the issue of quality of services provided can be problematic. To take the example of the decorator, what if the counselor thinks the client is doing a sloppy and inferior job of painting and wallpapering the office suite? What if the redecorating work is excellent, but the decorator is not satisfied with the counseling services? Feelings of resentment that build up in the counselor or in the client are bound to have a negative effect on the counseling relationship.

Another form of bartering involves the exchange of goods for counseling services. For example, a client who is an artist might wish to pay for counseling services by giving the counselor an oil painting. The issues of quality that arise in bartering of services apply to this type of bartering as well. In addition, the issue of how many hours of counseling are equivalent to the value of the painting needs to be addressed. What criteria should be used to make such a determination?

In the *ACA Code of Ethics* (2005), a blanket prohibition against bartering is not made. Instead, the code offers guidelines for counselors to help them determine whether a potential bartering arrangement might be acceptable. The code states that counselors may participate in bartering only if three criteria are met: (a) the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, (b) the client requests it, and (c) such arrangements are an accepted practice among professionals in the community (Standard A.10.d.).

***Diversity Considerations in Bartering.*** If you establish your practice in a rural community, you may find that bartering is common among local physicians and other professionals. In such a setting, it would be acceptable for you to engage in bartering if your clients initiate the request and if you believe you and the client can work out fair and equitable terms of agreement. We believe it would also be wise for you to consider other alternatives to bartering with clients who cannot pay your full fee. Some of these alternatives might include using a sliding scale fee or providing a set amount of pro bono services.

 **SOCIAL RELATIONSHIPS WITH CLIENTS** Individuals who choose to become professional counselors do not cease to be members of their communities, nor are they expected to forgo their social lives in order to avoid all nonprofessional contacts with clients (Glosoff, 1997). As we noted earlier, some social contact with clients is difficult to avoid for counselors who share “small worlds” with their clients. Even when extraprofessional contacts with clients can be avoided with relative ease, however, counselors can find it tempting to develop social relationships and even friendships with their clients.

As Glosoff (1997) has noted, individuals ordinarily look to work as one setting where they can gratify certain psychological and social needs. For many people, their work environment is a place to meet others with whom they can socialize and form friendships. Choosing to become a counselor can limit these opportunities. Almost all counselors will have some clients who are likable and who would make nice friends, but a friendship and a therapeutic relationship cannot exist simultaneously. The therapeutic relationship is like a friendship in that it involves emotional intimacy, but it is different in a significant way. In a therapeutic relationship, the intimacy is one way. Friendships are coequal relationships in which personal disclosures, support, challenge, and other interpersonal dynamics are reciprocal. For a counselor to seek a friendship with a client would be to look for reciprocity in a relationship that is not, by its nature, reciprocal (Hill, 1990).

When counselors blend the roles of friend and counselor, they create a conflict of interest that compromises the objectivity needed for sound professional judgment (Pope & Vasquez, 2007). As professionals, counselors place the interests of their clients foremost, but the dual relationship creates a second set of interests—those of the counselor. For example, a counselor may be reluctant to confront a client who is also a friend, out of fear of jeopardizing the friendship.

Short of an ongoing friendship, there are many possibilities for more limited types of social contact with clients, and a counselor’s stance toward these contacts may depend on several factors. The counselor’s theoretical orientation might make a difference. Borys (1988) suggested that a psychodynamically oriented counselor might be quite strict about out-of-the-office social contacts

with clients, because psychodynamic theory stresses the importance of *maintaining the frame of counseling* and attention to transference and countertransference issues. In contrast, relationship-oriented counselors or those who espouse systems theory might be more willing to interact with clients outside the therapeutic setting. Another factor may be the nature of the social function. Of the respondents in Borys's study, only 33% thought it was never or only rarely ethical to accept a client's invitation to a special occasion, whereas 92% disapproved of inviting a client to a personal party.

Although there has been much debate in the literature, our opinion is that counselors have an ethical obligation to keep their professional and personal or social lives as separate as they reasonably can. Counselors should not get their social needs or personal needs for friendship met through interactions with their clients. ACA members surveyed by Neukrug and Milliken (2011) agreed with this opinion: 95.4% believed it was unethical to engage in a counseling relationship with a friend.

Counselors and clients do, however, meet each other in social contexts without prior planning on either person's part. Therefore, it is essential that counselors discuss with their clients how they might be affected by encountering the counselor outside the office and how these chance meetings should be handled.

A closely related issue that has also been debated in the literature is the question of post-termination friendships with clients. Counselors are often aware of clients' attributes that would make them desirable friends. Clients, for their part, may hope to continue the intimacy they felt and the caring attention they received during the therapeutic relationship. The code of ethics offers no guidance regarding post-termination friendships with clients, and there is no consensus among helping professionals regarding the advisability of such relationships.

Several risks in postcounseling friendships have been identified. Vasquez (1991) noted that many clients consider reentering counseling with their counselors, and that if a friendship develops this option is closed. Other writers have argued that therapeutic gains are jeopardized when a friendship follows a therapeutic relationship, because a post-termination friendship may disrupt a healthy resolution of transference issues (Gelso & Carter, 1985; Kitchener, 1992). The power differential that existed during the therapeutic relationship is not automatically negated when the counseling is terminated. As Salisbury and Kinnier (1996) have noted, "Unreciprocated knowledge of a former client's most sensitive weaknesses and most intimate secrets can render a client particularly vulnerable" (p. 495) in a friendship with a former counselor.

Despite these risks, there is some evidence that most counselors find the development of friendships with former clients to be ethically acceptable. Fully 70% of counselors surveyed by Salisbury and Kinnier (1996) believed that a postcounseling friendship with a client could be acceptable. Approximately one-third of them actually had engaged in this behavior. The fact that a substantial number of counselors condone or engage in a practice does not necessarily indicate that the practice is ethical, however. You should avoid a tendency to reflexively accept "prevalence" arguments as a justification for dual relationship behaviors (Pope & Vasquez, 2007).

There are a number of factors that you should consider before pursuing a friendship with a former client. These include the time that has passed since termination, transference and countertransference issues, the length and nature of the counseling, the client's issues and diagnosis, the circumstances of the termination, the client's freedom of choice, whether any exploitation might have occurred in the professional relationship, the client's ego strength and mental health, the possibility of reactivation of counseling, and whether any harm to the client's welfare can be foreseen (Akamatsu, 1988; Kitchener, 1992; Salisbury & Kinnier, 1996). It would be difficult to demonstrate that none of these factors were at play if a counselor were challenged by a licensing board or in court. As a general rule, we believe that counselors would be wise to avoid developing friendships with both current and former clients.

***Diversity Considerations in Social Relationships.*** Cautions against counseling friends or close acquaintances may present difficulties for counselors of color (Herlihy & Watson, 2003). The concern about dual relationships is not widely shared in the African American community, where helpers typically play multiple roles (Parham, 1997). Having a shared primary language with a counselor can be pivotal in the choices of some clients. For instance, there may be only one Spanish-speaking Latino counselor in an elementary school, and that counselor may know and socialize with the families of the Latino students. These students may seek out this counselor precisely because of this connection and because of the counselor's fluency in the language they speak at home.

**BUSINESS OR FINANCIAL RELATIONSHIPS WITH CLIENTS** Business and financial relationships with clients have received little focused attention in the literature, perhaps because the issues are much the same as those raised by personal and social dual relationships. For instance, counselors who work in rural settings may be more likely to have business-related encounters with clients. Schank and Skovholt (2006) described a situation in which a counselor took his car to a shop to be serviced. He thought the bill was rather high for the services performed, but was reluctant to question the charges when he realized that one of his clients had done the work. Of course, such unintended encounters can happen in urban and suburban practice. A counselor might have an electrical or plumbing problem at home, and have a client who is employed by the electric company or plumbing contractor show up to do the work. These occurrences, although awkward, might be resolved through an open discussion during the next counseling session.


Anderson and Kitchener (1996) asked counselors to describe critical incidents involving post-counseling relationships with clients. Business or financial relationships were second only to personal or friendship relationships in the frequency with which they were related. Their respondents identified two types of situations that could apply equally to relationships with current clients. The first involved the counselor paying for a client's expertise or assistance. Examples might include hiring a client or former client to perform clerical work or to cater a party at the counselor's home. The second involved a counselor and client joining areas of expertise to produce income, such as going into business together. It appears that counselors regard going into business with a current client as unethical; only 9% of respondents in Gibson and Pope's (1993) survey rated this behavior as ethical. When the question was one of going into business with a former client, however, the percentage who rated it as ethical rose to 46%.

Other types of dual relating that involve financial considerations occur when a counselor patronizes a client's place of business, or when a counselor sells goods (such as a relaxation tape or a book) to a client. In the former situation, the client could feel pressured to give the counselor a discount or some kind of special services. In the second instance, the client might feel coerced to buy the counselor's product. As was noted earlier, the counselors who responded to the Neukrug and Milliken survey (2011) were divided on the issue of selling a product to a client.

As is true of other types of dual relationships, counselors have differing viewpoints on business relationships with clients, and the same counselor might have differing views in different circumstances. For instance, Sonne (2005) has noted that the degree to which the business relationship is distinct from the counseling relationship could influence a counselor's decision making. Employing a client to work in one's home might be perceived quite differently from employing a client to work in a business in which the counselor has a financial interest but which is located in another town.

Although the practice of entering into business or financial relationships with clients needs further study, our own recommendation is that counselors should avoid entering into these relationships with current or former clients. Whenever a counselor is making a monetary profit from a secondary relationship with a client, that counselor's self-interest is clearly involved.



 **ACCEPTING GIFTS FROM CLIENTS** When clients offer gifts to their counselors—even small, token gifts—it can make counselors feel uncomfortable. They may be torn between wanting to decline the gift in order to keep the relationship within proper boundaries, yet wanting to accept the gift so that the client will not feel hurt or rejected. The best way to minimize such conflicts is to have a general policy that you do not accept gifts from clients and to include a statement to that effect in your informed consent document. This procedure will not completely solve all potential problems, however. Clients may vary in how they interpret the idea of a gift, or they may forget or choose to ignore that you have a policy. For your part, you probably will not want to interpret your own policy too rigidly. It is difficult to imagine an elementary school counselor refusing to accept a child client's offering of a handmade Valentine, for instance.

The 2005 ACA *Code of Ethics* has a standard on accepting gifts from clients. Standard 10.e. states, “Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client’s motivation for giving the gift, and the counselor’s motivation for wanting or declining the gift.”

It is certainly possible that a client may offer you a gift at some point. It is wise for you to think through how you plan to handle this event and use the criteria suggested in the *Code* to determine whether to accept or refuse a gift.

The monetary value of the gift is one obvious consideration. When you responded to the Boundary Issues Survey, did you answer the fourth item differently from how you answered the fifth? If so, a gift’s monetary value played some part in your decision-making process. Apparently, many mental health professionals would reason similarly. Over 88% of the counselors who responded to Neukrug and Milliken’s survey thought it was unethical to accept a gift from a client when the value of the gift is more than \$25.

It may be useful to consider the client’s motivation for offering the gift. A client might offer a small gift as a way of expressing appreciation. This seems different from a gift that the counselor perceives to be a form of manipulation or an attempt to buy loyalty or friendship. Sometimes a client’s need to offer gifts can become a useful therapeutic tool. For example, we know of a client who came to each of her first three sessions bringing a small home-baked item such as a brownie or a loaf of banana bread, saying that she had just finished baking and thought the counselor might like to sample the result. She was an excellent baker, and the counselor accepted the first two offerings with pleasure. When the client came to the third session with a treat, the counselor used this as an entree to exploring the client’s motivations. Through this exploration, the client became aware of her need to “make herself welcome” everywhere she went because she believed that she could not possibly be valued just for herself. This became a very productive session.

It may be equally useful to consider the counselor’s motivation for wanting to accept or decline the gift. For example, assume that your client has an extra ticket to a championship sports event and asks you to go along. You are a great sports fan and have been unable to get a ticket to the game. If you find yourself tempted to accept the ticket, keep in mind that you have a fiduciary relationship with your client and that you must not benefit from the relationship. It would also be useful to think about the implicit messages you would be sending to the client, who may think it is now acceptable to call you at home or invite you to future social functions. What if you are not really a sports fan but find yourself thinking that going to the game would be more enjoyable than sitting home alone? In this case, consider your obligation to avoid using clients to meet your own social needs. When you are determining whether to accept a gift from a client, your reasoning must be based on consideration for the client’s welfare.

Related to the issue of motivation is the nature or stage of the therapeutic relationship. A client might bring a small gift to a mutually agreed-on termination session as a way of saying “thank you” to the counselor. Accepting such a gift might not be problematic. By contrast, accepting a gift during the early stages of counseling before a stable therapeutic relationship has been established could set in motion a blurring of boundaries that could become problematic down the road.

***Diversity Considerations in Accepting Gifts.*** Cultural factors need to be considered, because gift giving has different meanings in different cultures. For instance, giving gifts is a common practice in many Asian communities as a means of showing gratitude and respect (Sue & Zane, 1987). Counselors responding from a European American perspective might politely refuse an offered gift without realizing the great insult and cultural meaning of their refusal for the client (Sue, 1997).

Counselors need to take care that their own discomfort at being presented with a gift does not overshadow their sensitivity to what the gift means to the client. Although there is a lack of research examining how accepting or refusing a gift may affect treatment of culturally diverse clients (Hoop, DiPasquale, Hernandez, & Weiss Roberts, 2008), we agree with Zur (2007), who urges that gifts should always be evaluated in the context within which they are offered.

**SELF-DISCLOSURE** The extent to which counselors engage in self-disclosure depends in large measure on their theoretical orientation and on their skill and comfort in using this technique. Psychodynamically oriented counselors, whose tradition includes Freud’s belief that the counselor should remain anonymous, are not likely to engage in much self-disclosure. Counselors who view the therapeutic relationship as more coequal, such as feminist counselors and existential counselors, place more value on self-disclosure. It appears that most counselors are comfortable with self-disclosure; nearly 87% of the ACA members surveyed by Neukrug and Milliken (2011) deemed self-disclosing to a client to be an ethical behavior.

As a technique, counselor self-disclosure can be a powerful intervention that can strengthen the therapeutic alliance. It is important that you learn the skill of self-disclosure and be able to articulate your rationale for using it in the counseling process. It is equally important that you understand self-disclosure as an ethical issue.

Counselor self-disclosures that are ethically appropriate are done for the client’s benefit within the context of the therapeutic process (Smith & Fitzpatrick, 1995). Self-disclosures are considered unethical when they are used to meet the counselor’s own needs for intimacy or understanding. It can be difficult for counselors to objectively gauge their motives when their own needs are involved. Pope and Keith-Spiegel (2008) have suggested that counselors who are considering self-disclosing to a client ask themselves two questions: Does this particular disclosure represent a significant departure from my usual practice? If so, why the change?

Counselors in independent private practice may be particularly vulnerable to using self-disclosure as a way to counter feelings of isolation (Glosoff, 1997). Self-disclosure, used improperly or excessively, can lead to a role reversal in which the client becomes the emotional caretaker of the counselor. Topics that are not considered appropriate for counselors to disclose are details of current stressors, personal fantasies or dreams, and their social or financial circumstances (Borys, 1988; Gutheil & Gabbard, 1993; Simon, 1991).

Self-disclosure has become an area of increasing ethical concern as more research has demonstrated that when treatment boundaries become blurred, they usually erode gradually over time. Simon (1991) found that inappropriate counselor self-disclosure, more than any other kind of boundary violation, is likely to precede counselor–client sexual intimacy.

Guidelines for distinguishing appropriate from inappropriate self-disclosure may seem fairly clear as you read about them, but judging what may benefit the client can be very difficult in practice (Smith & Fitzpatrick, 1995). Self-disclosure is a complex issue. You will need to think about whether to self-disclose, and how and when, in working with each of your clients. When you choose to self-disclose, your primary reason must be that you believe the disclosure will benefit the client. It is also important that you take cultural factors into consideration in your decision making.

***Diversity Considerations in Self-Disclosure.*** In some Asian cultures, self-disclosing to strangers (counselors) is considered a violation of familial and cultural values. Some Asian clients believe that personal matters are best discussed with intimate acquaintances or friends (Sue, 1997). Counselor self-disclosure might facilitate the establishment of the close personal relationship that these clients need in order to feel comfortable in sharing their concerns.

Studies have shown mixed results in determining the effects of counselor self-disclosure in counseling African American clients. However, one study provided some empirical support for greater counselor self-disclosure when working with African American clients, regardless of whether the counselor is African American or Caucasian (Cashwell, Shcherbakova, & Cashwell, 2003).

**PHYSICAL CONTACT WITH CLIENTS** The boundary question of whether counselors should touch or hug their clients is not easy to resolve. For certain clients, at certain times, a reassuring touch or a gentle hug can be facilitative. Yet, counselors who engage in these behaviors risk having their gestures misinterpreted as sexual advances or as violations of the client's personal space.

Smith and Fitzpatrick (1995) have noted that the issue of therapeutic touch has an interesting history. When *talk therapy* first began in the Freudian era, physical contact with clients was prohibited because of its presumed negative effect on transference and countertransference. Later, in the 1960s and 1970s, touching became an accepted practice within the human potential movement. One study (Holroyd & Brodsky, 1977) found that 30% of humanistic counselors, as compared to only 6% of psychodynamic counselors, believed that touching could be beneficial to clients. A decade later Pope, Tabachnick, and Keith-Spiegel (1987b) investigated the beliefs of mental health professionals regarding three types of physical contact. Their respondents believed that the most unethical type was kissing a client (with 85% stating that it was never or only rarely ethical), followed by hugging (with 44% disapproval), and finally by handshakes, which were deemed ethical by 94%. The beliefs of today's counselors seem to be quite similar to those reported by Pope et al. in 1987. Of the counselors who responded to the survey conducted by Neukrug and Milliken (2011), 87.5% judged it as unethical to kiss a client as a friendly gesture, and 33% rated hugging a client as unethical. Most (nearly 84%) thought it was acceptable to console a client through touch, such as placing a hand on the client's shoulder.

It appears to us that concerns about the consequences of physical contact with clients are driven more by legal than ethical concerns. Gutheil and Gabbard (1993) related a story of a therapist who was caught by surprise when a client suddenly hugged her on her way out at the end of the counseling session. The therapist felt somewhat uncomfortable about the incident, but left it undocumented and did not engage in further self-reflection. Some weeks later she received a letter from the client's attorney. Probably because such stories are not uncommon and are frightening, counselors usually are now trained to be cautious about making physical contact. They are often advised to hug a client only when the client requests it or, at the very least, when the counselor first secures the client's permission. Certainly, professional liability insurance carriers have become concerned that clients might bring suit against their counselors for even well-meaning instances of physical contact. Some applications for malpractice insurance directly ask the question, "Do

you ever touch a client beyond a routine handshake?" Counselors who answer "yes" must attach an explanation and run the risk of being deemed a risky applicant and having their application for insurance rejected.

***Diversity Considerations in Touching Clients.*** When you begin to practice as a counselor, you will need to determine your own stance toward physical contact with your clients. There are many factors that might be considered, such as the age of the client. Routinely hugging elementary school children is probably more acceptable than giving frequent hugs to adult clients. However, counselors who hug clients of the opposite sex run the risk of a sexual impropriety complaint if people report having seen them hugging their young clients. With teens and adults, you will want to assess the likelihood that the client may sexualize or misinterpret your touch. The client's diagnosis and history may also be relevant. For instance, hugging or touching a client who has been sexually abused generally is contraindicated.

Cultures vary widely with respect to the acceptability of touch. For example, people from some European countries routinely kiss each other on both cheeks as a way of greeting, and these clients might think you are cold and distant if you avoid physical contact with them.

The bottom line regarding the issue of therapeutic touch is that it is a matter of professional judgment. There are no definitive guidelines to be found in codes of ethics. In making your own determination about whether to touch a client, you will want to be clear about your motivations for doing so. Zur and Nordmarken (2010) have cautioned against avoiding touch simply out of fear of litigation. If you do use therapeutic touch in your practice, you must be able to demonstrate that touching has served the client's needs and not your own.

## **Ethical Decision Making**

Cultural factors are often important variables in ethical decision making regarding therapeutic boundaries. In this chapter, we have noted that bartering, gift giving, self-disclosure, and therapeutic touch are viewed differently in various cultures. Multiculturally sensitive counselors know that for many minority clients, the idea of seeking traditional counseling is foreign, and that these clients are often more comfortable turning to social support systems within their own community. They may be more likely to put their trust in healers who are a part of their culture such as shamans, folk healers, acupuncturists, or *cueranderos(as)*. Counselors who work with ethnic minority clients need to be flexible and willing to take on different roles, such as advocate, change agent, advisor, and facilitator of indigenous support systems if they are to effectively assist these clients. They need to balance their understanding of and adherence to their codes of ethics with their understanding of and sensitivity to the values and worldviews of minority clients.

Also, the counselor's own cultural background may contribute to his or her perspective on therapeutic boundaries: In some cultures it is considered polite and respectful to adhere strictly to boundaries of personal space and roles, while such behavior is considered rude and rejecting in other cultures. The counselor's religious affiliation is another potentially influencing factor; some religions support and encourage extended relationships among congregants and, as was noted earlier, some clients prefer to work with a counselor who shares their religious affiliation. The counselor's gender may make a difference, as female therapists tend to be more conservative than males in their ethical decision making around boundary issues (Sonne, 2005).

Several writers (Herlihy & Corey, 2006; Pope & Keith-Spiegel, 2008; Younggren, 2002) have offered decision-making models to assist counselors who are faced with potential dual or multiple relationships. These decision-making models have much in common. They suggest, as a first step, that the counselor should determine whether the potential dual relationship is necessary

and whether it is avoidable. Before embarking on or declining to participate in a dual relationship, counselors must judge whether the benefits outweigh the risks or whether the reverse is true. They need to consider the factors that create a potential for harm, including differences in the client's expectations of the counselor in the two roles, the counselor's divergent responsibilities in the two roles, and the power differential in their relationship. Pope and Keith-Spiegel suggested that counselors imagine what might be the best possible outcome and the worst possible outcome of crossing a boundary or engaging in a dual relationship.

If the counselor believes that the risk of harm to the client is greater than the potential benefits, the counselor should decline to enter the dual relationship and refer if needed. An explanation should be given so the client understands the rationale for not proceeding with the problematic part of the dual relationship.

If the counselor believes that the potential benefits to the client are great and the risk of harm is small, or if the potential dual relationship cannot be avoided, then the dual relationship can be initiated and the following safeguards put in place:

- Secure the client's informed consent to proceed with the dual relationship. The counselor and client should discuss the potential problems and benefits and reach an understanding regarding how they want to handle these problems if they arise. Younggren (2002) has recommended that the client sign an informed consent document, although he also cautions that clients can never give truly informed consent to something that poses a severe risk to them or that violates the prevailing standard of care. For example, even if a client were to sign a consent to enter into a sexual relationship with a counselor, the consent document would not assist the counselor, in either the ethical or legal arena, in a defense of the relationship.
- Seek consultation. Because one of the most intransigent problems in managing dual relationships is the counselor's loss of objectivity, it is important for the counselor to seek ongoing consultation for help in monitoring the relationship and the risk for harm.
- Engage in ongoing discussion with the client. Informed consent is not a one-time matter. The counselor can involve the client in a mutual, ongoing monitoring of the relationship and can discuss any potential problems that they might foresee and attempt to resolve any problems that do arise.
- Document and self-monitor. Although we have heard of instances in which counselors were advised to keep any mention of a dual relationship out of their case notes, we think this is unwise. If a dual relationship ever became an issue in a complaint proceeding before a licensure board or in a court of law, behavior that appears as if the counselor is trying to hide something will not be seen favorably by the parties adjudicating the complaint. It is much better for counselors to be able to demonstrate that they were aware of dualities, that they considered the risks and benefits for the client, and that they took steps to protect the client.
- Obtain supervision. If the risks in a dual relationship seem high, if the relationship is particularly complex, or if the counselor is concerned about the ability to assess the situation objectively, seeking consultation may not be sufficient. In these instances, counselors are wise to engage a fellow mental health professional in ongoing supervision of their work throughout the dual relationship.

In concluding this section of the chapter, we want to emphasize that boundary issues and dual relationships pose some complex and difficult questions to which there are no easy answers. Each client is unique, each counselor is unique, and each situation is unique and is constantly evolving (Pope & Keith-Spiegel, 2008). Counselors will struggle with boundary setting throughout their professional careers. In the absence of certainties, counselors must think carefully about

the consequences of their decisions, have a clear rationale for any boundary crossings, be open to discussing the issues with their clients who are equally affected by any decisions, and consult with colleagues.

## SEXUAL DUAL RELATIONSHIPS

The prohibition against sexual intimacies with help seekers is one of the oldest ethical mandates in the health care professions, predating even the Hippocratic oath. Nonetheless, ethics codes of mental health professions made no mention of this behavior until research began to demonstrate its prevalence and the harm done to clients (Pope & Vasquez, 2007). Although the problem of sexual relationships between counselors and their clients has existed for many decades, it remained unacknowledged in the professional literature through the 1970s. Counselor–client sexual intimacy was the “problem with no name” (Davidson, 1977) because helping professionals were reluctant to confront the issue. The reluctance was so pervasive that Pope (1988) concluded that helping professionals had engaged in “massive denial” (p. 222) of the problem. It was through the pioneering work of a few researchers, such as Gartrell and her colleagues (1987) in psychiatry, and Pope (1986, 1988) in psychology and counseling, that helping professionals were made aware that such violations were occurring, and in startling numbers.

Although the limitations of self-report data make it difficult to gauge how commonly counselor–client sexual intimacies actually occur, various studies indicate that approximately 7% of male counselors and 1.6% of female counselors reported sexual relationships with their current or former clients (Akamatsu, 1988; Borys, 1988; Holroyd & Brodsky, 1977; Pope & Bouhoutsos, 1986; Pope et al., 1993; Pope, Tabachnick, & Keith-Spiegel, 1987a; Salisbury & Kinnier, 1996; Thoreson, Shaughnessy, & Frazier, 1995; Thoreson, Shaughnessy, Heppner, & Cook, 1993). It is safe to state that these estimates are probably conservative. When Pope (1986) surveyed patients rather than counselors, as many as 20% of them reported having had sexual contact with their counselors. One hopeful note among these statistics was provided by Anderson and Kitchener (1996). They reviewed studies that had been conducted since 1977 and concluded that the frequency of sexual contact between counselors and current clients is decreasing.

### The Offending Mental Health Professional

Mental health professionals who engage in sex with their clients have not been well studied, but the male counselor/female client dyad clearly dominates. It appears that most offenders are repeat offenders. Holroyd and Brodsky (1977) found that 80% of psychologists who reported sexual contact also reported that they had been sexually intimate with more than one client. Pope and Bouhoutsos (1986) described several typical scenarios and rationalizations used by offending counselors:

- In a reversal of roles, the wants and needs of the counselor become the focus of the treatment.
- The counselor claims that sexual intimacy with the client is a valid treatment for sexual or other problems.
- The counselor fails to treat the emotional closeness that develops in counseling with professional attention and respect, claiming that the dual relationship “just got out of hand.”
- The counselor exploits the client’s desire for nonerotic physical contact (e.g., a need to be held).
- The counselor fails to acknowledge that the therapeutic relationship continues between sessions and outside the office.



- The counselor creates and exploits an extreme dependence on the part of the client.
- The counselor uses drugs as part of the seduction.
- The counselor uses threat or intimidation.

Although offending counselors do not fit a single profile, the portrait that emerges from the scant literature is one of a professionally isolated male counselor who is experiencing distress or crisis in his personal life (Simon, 1987; Smith & Fitzpatrick, 1995). He shares many characteristics with other impaired professionals, including professional burnout and a pattern of attempting to meet his own personal needs through his clients. Not all offenders will fit this description, however. Golden (1990) and Schoener and Gonsiorek (1988) described a wide range of professionals who become sexually involved with their clients. At one end of the range are those who are naive and uninformed about ethical standards. At the other extreme are professionals who suffer from sociopathic, narcissistic, or borderline personality disorders and the attendant inability to appreciate the impact of their behavior on others.

It is natural to feel compassion for those naive offenders who feel remorse for their behavior, but it is important to remember that ignorance is never a valid excuse, nor is blaming the client for being “seductive.” It is always the responsibility of the helping professional to ensure that sexual intimacies do not occur.

### **Harm to Clients**

It has been amply demonstrated that sexual relationships with counselors are extremely detrimental and sometimes even devastating to clients (Moleski & Kiselica, 2005). The harm is deep, lasting, and occasionally permanent. At least 90% of clients who have been sexually involved with a counselor are damaged by the relationship, according to their subsequent counselors (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983).

Pope (1988) suggested that clients are likely to suffer from *therapist–patient sex syndrome*, with reactions similar to those of victims of rape, spouse battering, incest, and posttraumatic stress disorder. He described a range of associated symptoms. Clients often experience a deep *ambivalence* toward the offending counselor. They are trapped between extreme dependency on and fear of separation from the counselor and a longing to escape from his power and influence. Like many victims of incest and battering, clients vacillate between wanting to flee from the abuser and wanting to cling to and protect him.

Clients often suffer from feelings of *guilt*, believing that they are to blame for the relationship. They may think that they did something to invite the counselor’s behavior. Although they may be deeply angry at the counselor, their rage remains suppressed due to the counselor’s continuing power, their feelings of ambivalence, and their sense of guilt. This guilt and rage, when turned inward, leads to an *increased risk of suicide*.

Because the offending counselor insists that the client keep their sexual relationship secret, clients feel *isolated*, alone, and cut off from the normal world of human experience. Not surprisingly, many victims manifest a profound *confusion* about their sexuality and about appropriate roles and interpersonal boundaries. When roles are reversed and the client becomes the counselor’s emotional caretaker, the client does not know where safe and appropriate boundaries lie.

Counseling involves a high degree of trust, and violation of that trust can have lifelong consequences. Clients’ *impaired ability to trust* often prevents them from seeking help from other counselors and may impair their ability to form other close relationships.

Finally, many clients display symptoms similar to those experienced by victims of post-traumatic stress disorder. These symptoms include difficulties with attention and concentration,

reexperiencing of overwhelming emotional reactions when they become involved with a sexual partner, and nightmares and flashbacks.

The harm to clients caused by sexual intimacies with their counselors is now well recognized. The ethical standards of all mental health providers' professional organizations, including the ACA *Code of Ethics* (2005), prohibit sexual relationships with clients. There are no credible voices in the profession arguing that sexual relationships with clients should be allowed.

The ACA *Code of Ethics* prohibits counselors from having sexual or romantic relationships with current clients, their romantic partners, or their family members (Standard A.5.a.). Romantic or sexual relationships with *former* clients (and their romantic partners or family members) are prohibited for at least 5 years following the last professional contact (Standard A.5.b.).

Typically, codes of ethics for mental health professionals prohibit sexual relationships with former clients for a minimum of 2 years. The ACA *Code of Ethics* (2005) has extended the sexual relationship prohibitions as described above. However, it is doubtful a court of law would do the same. Ethical standards reach for the ideal and legal standards define the minimally acceptable behavior society will tolerate from a professional counselor. A board of ethics might find a counselor in violation of the ethical code for having had a harmful romantic relationship with a former client's sister-in-law four years after the counseling relationship ended, but it is doubtful that a judge would find that the counselor had committed malpractice for the same behavior. Interestingly, lawyers are still debating whether it is acceptable for attorneys to have sexual relationships with their clients (Buckner & Sall, 2008).

### **Legal Consequences for Offending Counselors**

The harm caused to clients by sexual dual relationships is universally recognized and can have severe legal as well as ethical consequences. As Kaplan et al. (2009) have noted, the fact that sexual relationships with clients are the only exclusion contained in most professional liability insurance policies is an indication of just how harmful these relationships are. Most professional liability policies will provide an attorney to defend a counselor against an accusation of sexual improprieties with a client, but if the counselor is found guilty the insurance company will not pay for damages and will also expect to be reimbursed by the counselor for any legal fees incurred.

**CIVIL LAWSUITS** Because the impropriety of sexual intimacies with clients is universally recognized, clients who sue counselors for having been sexually involved with them have an excellent chance of winning their lawsuits, if the allegations are true. These lawsuits are civil, which means that one citizen has to sue another for action to be taken against a person who does something wrong.

Clients who were sexually victimized by their counselors and who are ashamed, uneducated, or lacking in self-confidence might choose not to file formal complaints or file civil lawsuits against their perpetrators. When that happens, counselors who violate our ethical standards and violate the rights of their clients are never held accountable. In fact, many believe that the lack of accountability encourages offending counselors to sexually violate other clients. When some counselors observe that others are getting away with having sexual relationships with clients, they may be inclined to do so as well.

Counselors who engage in sexual relationships with their clients may be sued on a number of grounds. Jorgenson (1995) has listed the following causes of action that victimized clients might allege in their lawsuits: malpractice, negligent infliction of emotional distress, battery, intentional infliction of emotional distress, fraudulent misrepresentation, breach of contract, breach of warranty, and spouse loss of consortium (love, companionship, and services). One of the elements a client

must prove in a malpractice suit is that a counselor behaved in a manner that breached the standard of care expected or required of counselors.

To encourage clients who are victimized by their mental health professionals to sue, some state legislatures have now passed laws that automatically make it negligence for certain categories of mental health professionals to have sexual relationships with their clients (e.g., Cal. Civ. Code sec. 43.93, West, 1993; Ill. Ann. State. Ch. 70, secs. 801–802, Smith-Hurd, 1992; Minn. Stat. Ann. Sec. 148A, West, 1993; Texas Senate Bill 210, engrossed May 22, 1993; Wis. Stat. Ann. Sec. 895.70(2), West, 1992). Those who sue must still prove they were harmed as a result of the sexual relationships, but harm can be emotional and financial as well as physical.

Some of these statutes have unusual and forceful components. For example, the Wisconsin statute (Wis. Stat. Ann. sec. 895.70(5), West, 1992) forbids accused mental health professionals from settling their cases without public disclosure. In other words, mental health professionals (or their professional liability insurance companies) who are sued by their clients for having engaged in sex with them cannot agree to an out-of-court settlement that is never reported to the public.

**CRIMINALIZATION OF SEX WITH CLIENTS** Our society has become so convinced that counselor–client sexual relationships are wrong that some states have now passed statutes that make it a crime for mental health professionals to engage in sex with their clients. Losing a civil lawsuit for having sex with a client can be distressing for counselors, but going to jail for the same thing is a much more dramatic result.

Between 1983 and 1992, 13 states enacted legislation that criminalized sexual relationships between mental health professionals and their clients. Kane (1995) reported that the following states had passed such statutes at the time the review was conducted: California, Colorado, Connecticut, Florida, Georgia, Iowa, Maine, Michigan, Minnesota, New Mexico, North Dakota, South Dakota, and Wisconsin. Each state statute varies in language, but the following professionals have been included in some of the laws: psychotherapists, counselors, marriage and family counselors, clergy, social workers, psychiatrists, and psychologists.

Some of these criminal statutes take unusually tough positions with mental health professionals. For example, the Colorado statute (Colo. Rev. Stat. secs. 12-43-708 [b & c], 1988) permits prosecutors to file injunctions that will put a mental health professional out of business even before the individual has been found guilty, if it can be proven that the professional presents a risk to clients by continuing to practice.

Roberts-Henry (1995), in giving a history of the passage of the Colorado statute, reported that the law was passed in 1988 over a great deal of objection from mental health professionals. Proponents had to compromise and exclude clergy from the bill before it could be passed. Roberts-Henry summarized the law as stating, in essence, that “any psychotherapist who perpetrates sexual penetration or intrusion on a client commits a felony” (p. 340). The law does not allow accused mental health professionals to use consent of the client as a defense.

Although Kane (1995) concluded that the laws criminalizing sexual relationships between mental health professionals and their clients have had a deterrent effect, it appears that they do not totally solve the problem. In Colorado, 8 years after the law had been passed, Roberts-Henry (1995) reported that victims were still treated poorly during the investigation process, and that many prosecutors were unwilling to proceed with cases because they did not understand abuse generally.

### **Postcounseling Sexual Relationships**

Ethical standards of the various mental health professions are divided on the issue of whether it is *ever* ethical for professionals to have sexual relationships with former clients. Social workers are

forbidden from ever having a sexual relationship with an individual after a professional relationship has been established (National Association of Social Workers, 1997). However, counselors (American Counseling Association [ACA], 2005) and psychologists (American Psychological Association [APA], 2002) have determined that after a set period of time following termination, sexual relationships may be permissible with former clients. ACA has set 5 years after termination as an acceptable period before a sexual relationship with a former client might be acceptable, while APA has set 2 years. The APA and ACA codes should not be interpreted as blanket permission to engage in post-termination sexual relationships. Counselors who consider entering into romantic or sexual relationships with former clients, even after several years have passed, still have an ethical responsibility to ensure that no harm is done. Not only do all the risk factors for post-termination friendships apply to post-termination sexual relationships, but because of the severity of potential harm, it is even more important to put safeguards in place. The ACA code states that before counselors engage in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members, even after 5 years, counselors must “demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client” (Standard A.5.b.).

Just as professional associations disagree about whether sexual relationships are acceptable after a waiting period, scholars are also divided on the issue. Although Friedman and Boumil (1995) have struggled with the arguments for and against the idea, Simon (1998) has recommended never having a sexual relationship with a former client. Apparently there is no consensus among counseling practitioners, either. In earlier studies that surveyed ACA members, 63.5% of male counselors believed sexual contact with former clients was unethical (Thoreson et al., 1993), and 45% of female counselors believed that this behavior was harmful and constituted misconduct (Thoreson, Shaughnessy, & Frazier, 1995). More recently, 57.1% of the ACA members surveyed by Neukrug and Milliken (2011) deemed it unethical to become sexually involved with a former client even after 5 years have passed since the professional relationship ended. As Herlihy and Corey (2006) noted, whether sexual relationships with former clients are ever acceptable probably will be a subject of continuing debate for some time to come. In our opinion, sexual relationships with former clients are not appropriate under any circumstances. The risk of harm is far too high; according to one study, 80% of clients who had begun sexual relationships with mental health professionals after counseling ended were found to have been harmed (Pope & Vetter, 1991).

### **Sexual Attraction to Clients**

Although the ACA *Code of Ethics* (2005) explicitly forbids sexual relationships with clients, it does not address more subtle ways that sexuality can become part of a counseling relationship. It is not at all unlikely that, at some point in your professional career, you will find that you are sexually attracted to a client. When this happens, it is natural to react with feelings of guilt or self-doubt. Sexual attraction to a client is not aberrant or unusual, however. Research indicates that 70% to 95% of mental health professionals have experienced attraction to at least one client (Bernsen, Tabachnick, & Pope, 1994; Pope, Keith-Spiegel, & Tabachnick, 1986). It is important to remember that *feeling* a sexual attraction to a client is not unethical. What is unethical is to *act* on that attraction.

When you feel a sexual attraction to a client, you have an ethical responsibility to acknowledge and deal with it appropriately. Some useful strategies include consulting with colleagues, carefully considering issues of client welfare, seeking supervision, and self-monitoring to ascertain whether you are feeling particularly needy or vulnerable. If your own needs and issues seem to be causing you to act in ways that are uncharacteristic of you, you will be wise to seek counseling for yourself to resolve those issues.

Sometimes, it will be the client who develops and expresses an attraction to the counselor. The counselor must handle such client disclosures with tact and work to ensure that the client understands that a dating or sexual relationship is not possible.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 7 and view the video clip entitled “A Sexual Attraction.” Consider your reactions to how the counselor in this scenario handled the situation.

### **Counseling Clients Who Have Been Abused by Previous Counselors**

In your practice, you should be prepared to counsel clients who report that they have been sexually exploited by a previous counselor. Welfel (2010), after reviewing prevalence studies, concluded that between 22% and 65% of mental health professionals have encountered such clients.

Counselors who provide services to individuals who have been sexually abused by mental health professionals are put in awkward positions. Most counselors feel obligated to take some action to bring attention to the wrongdoing of a fellow mental health professional. These counselors are afraid that if they do not take some action, more clients may be abused.

We caution you though, if you are ever put in this situation, to be respectful of your client's wishes in the matter. Clients must be willing not only to allege that a mental health professional has abused them, but they must also testify at formal hearings, will probably be cross-examined in a hostile and accusing manner, and must deal with the emotional strain of the process.

Your role, as a counselor, is to assist your client in meeting the counseling goals that the two of you establish together. If the client decides to proceed against the perpetrator in some manner, you can be very helpful in assisting the client deal with a very difficult situation.

It most likely will do no good for you to file an ethics complaint against another mental health professional if the victim refuses to participate. You would be violating your client's privacy if you disclosed the client's identity without his or her permission. In addition, most licensure boards, criminal prosecutors, or certification groups will not proceed in a case without a witness who was a victim.

Your role as a counselor is not to push your client toward accusing the mental health professional. You must guard against *intrusive advocacy* in your zeal to ensure that the wrong is redressed (Pope et al., 1993; Wohlberg, 1999). Rather, your job is to provide appropriate counseling services, to avoid imposing your own values, and to assist clients in meeting their personal goals.

It is important to be aware that clients who have been sexually exploited by a previous mental health professional tend to be especially vulnerable to revictimization when their counseling needs are not recognized and addressed. Counseling these clients requires sensitivity and expertise. If you undertake a counseling relationship with such a client, you should read the literature on the topic, get qualified supervision, and be prepared to have strong emotional reactions to the client's disclosures (Welfel, 2010).

To avoid becoming inappropriately involved if a client is trying to decide whether to accuse a former mental health professional of inappropriate sexual activity, you might consider referring the client to an advocacy group. There are many such groups that assist clients in making the initial decisions and then support them once the process begins. Biele and Barnhill (1995) and Schoener (1989) have listed such advocacy groups in their publications.

## Summary and Key Points

Therapeutic boundaries and dual relationships are among the most controversial of all ethical issues. A boundary can be conceptualized as a frame around the therapeutic relationship that defines the participants' roles in that relationship. Counselors enter into dual relationships whenever they take on two or more roles, simultaneously or sequentially, with their clients.

Codes of ethics discourage nonprofessional or dual relationships, except for those relationships that potentially could benefit a client. The only type of dual relationship that is absolutely forbidden is sexual intimacy with a current client or the client's romantic partner or family members, or with a former client, the client's romantic partner or family members for at least 5 years. There are a number of factors that counselors must consider when they are contemplating entering into a nonsexual dual relationship, to determine the potential for harm to the client.

Most counselors occasionally engage in boundary crossings, which are departures from usual practice that are made to benefit a particular client at a particular time. For instance, a counselor would not routinely meet all clients at out-of-the-office functions but might choose to attend a client's graduation or other special occasion. From a legal perspective, counselors who develop a pattern of frequent boundary crossings are at risk.

Several specific boundary issues were discussed in this chapter. These included bartering, social and business relationships with clients, post-termination friendships, accepting gifts from clients, counselor self-disclosure, and physical contact with clients. Throughout the discussion of these issues, multicultural considerations were highlighted. Guidelines for ethical decision making completed the first section of the chapter. Key points with respect to nonsexual dual relationships are as follows:

- Codes of ethics caution counselors to avoid those dual relationships that could impair professional judgment or increase the risk of harm to the client, but the ACA code also acknowledges that some nonprofessional relationships can potentially be beneficial.
- Factors that should be considered in assessing the risk of harm are incompatible expectations on the part of the client, divergent responsibilities on the part of the counselor, and the power differential between the two parties.
- Potential dual relationships can evolve in subtle ways and can be difficult to recognize, and possible outcomes range from beneficial to very harmful to the client.
- With the exception of sexual dual relationships, there is very little consensus among counselors regarding the propriety of various types of dual relationships, although the thinking of the profession seems to be evolving toward more flexibility in determining boundaries.
- Decisions about dual relationships require consideration of cultural variables.
- Some dual relationships are unavoidable, particularly when counselors practice in rural settings, the military, pastoral or addictions counseling, or other types of "small worlds."
- There are a number of counselor behaviors that do not by themselves constitute dual relationships but have the potential to create dual relationships. These behaviors can be termed *boundary crossings*.
- From both an ethical and a legal perspective, counselors are well advised to avoid developing a pattern of frequent boundary crossings with clients.
- Although bartering with a client for goods or services is fraught with potential problems, it is ethically permissible when the client requests it, when exploitation can be avoided, and when bartering is a common practice among professionals in the community.
- Although counselors may be tempted to develop social relationships or even friendships with current or former clients, counselors should not get their own social needs met through their interactions with clients.
- Business or financial relationships with clients should be avoided.



- Although counselors should be cautious about accepting gifts from their clients, there may be instances when accepting a gift is appropriate. There are a number of factors that counselors should consider when deciding whether to accept or refuse a gift from a client.
- Appropriate self-disclosure on the part of counselors is therapeutic, but when it is used inappropriately or excessively it can create a role reversal in which the client becomes the counselor's emotional caretaker.
- The issue of physical contact with clients is difficult to resolve and, again, there are many factors to consider. Today's legal climate tends to discourage counselors from the practice of therapeutic touch.
- Several ethical decision-making models are available to assist counselors in deciding what actions to take when faced with a potential dual relationship.

The second section of the chapter focused on sexual dual relationships. Sexual intimacies with

clients are probably the most harmful of all types of dual relationships. Although estimates of the prevalence of sexual relationships between counselors and their clients seem to vary, it is clear that male counselors are more frequent offenders than are female counselors. Pope has described the harm to clients as a "counselor-patient sex syndrome" that is similar to posttraumatic stress disorder. Legal consequences for offending counselors can be severe. They can be prosecuted in civil court and, in some states, in criminal court as well. Although there is universal agreement among mental health professionals that sexual intimacies with current clients are unethical, the question of posttermination sexual relationships is the subject of some debate. Counselors who provide services to clients who have been sexually abused by their former counselors face some difficult decisions. They must keep in mind that their role is to assist these clients in meeting goals that are chosen by the clients themselves.

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## Counseling Children and Vulnerable Adults

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# Counseling Children and Vulnerable Adults

## FOCUS QUESTIONS

1. How do you think legal and ethical requirements might come into conflict with each other when counseling minor clients?
2. Why do you think minors under the age of 18 in the United States are not able to assert their legal rights on their own, but instead are required to assert their legal rights in court through their parents or guardians?
3. How can a counselor determine whether an adolescent client's risk-taking behaviors present a sufficiently serious risk for harm to warrant breaching the minor's confidentiality?
4. What is your opinion of laws that make it a crime for a counselor to fail to report cases of suspected abuse of a child, elder, or vulnerable adult?

Legal and ethical requirements regarding counseling generally do not conflict with one another. Unfortunately, exceptions to this general rule occur when counselors provide professional services to minor clients or vulnerable adults. Counselors who counsel children and adolescents under the age of 18 or adults who do not have the legal capacity to care for themselves may be more likely than any other counselors to experience conflicts between what they consider to be their ethical or moral obligations and what the law dictates that they must do (Salo, 2006). These conflicts often concern confidentiality of client disclosures made during counseling sessions, or parents or guardians making decisions for dependent children or adult clients with which the clients do not agree. The legal perspective is that counselors are obligated to parents or guardians when counseling minor children. Yet, counselors believe that their primary ethical obligations are to their minor clients. This discrepancy between the legal and the ethical perspectives causes problems, especially in the area of privacy (Orton, 1997).

The *ACA Code of Ethics* offers very little guidance that is specific to counseling children (Corr & Balk, 2010); therefore, counselors must rely heavily on their professional judgment in dealing with ethical dilemmas involving minor clients. The numerous areas of conflict between ethical and legal requirements further complicate the work of the counselor. In this chapter, we explore these conflicts between law and ethics and suggest ways to resolve them. Because many of the same issues that arise

with minor clients also apply when counseling dependent or vulnerable adults, this chapter includes a discussion about working with these clients as well. Counselors who provide services to minors and to others who lack legal competency must pay attention to the legal rights of parents and guardians. Additionally, counselors who counsel clients who may be unable to protect themselves from harm, such as children and vulnerable adults, must take steps to prevent abuse or neglect of these clients.

## **COUNSELING MINOR CLIENTS**

Conflicts between law and ethics occasionally arise very clearly in situations where the client is a minor. One issue that causes tension between law and ethics is whether children should be allowed to enter into counseling relationships without parental knowledge or consent. Also, every child, regardless of age, has a moral right to privacy in the counseling relationship. From a philosophical viewpoint, many counselors would argue that children should have the same rights to confidentiality as adult clients. The legal rights to confidentiality and privilege of minors, however, are more limited. Basically, counselors have an ethical obligation of privacy to minor clients, and a legal obligation to the parents or legal guardians of those same minor clients to keep their children safe and to protect the privacy rights of the parents or guardians.

Counselors who provide counseling services to children must understand the legal rights of parents or guardians and appreciate their ethical obligations to children as well. Balancing these sometimes-competing interests can be quite challenging (Lazovsky, 2008). Counselors must contend with the issue of children's access to counseling and with situations in which children may object to their parents being given confidential information they disclosed in counseling sessions. In addition, counselors must decide who has the authority to give permission to disclose confidential information to third parties.

Counselors want to offer an appropriate degree of privacy to children whom they counsel (Isaacs & Stone, 2001). They want children to feel free to disclose aspects of their lives that trouble them, in an atmosphere of trust and confidentiality. It may be helpful for counselors to consider the following facts about children and privacy:

1. Younger children often do not have an understanding of confidentiality or a need for privacy, which is a socially learned concept. Young children may not be nearly as concerned about confidentiality as the counselor is (Huey, 1996) and may not need reassurances of confidentiality (Corr & Balk, 2010).
2. Preadolescents and adolescents may have a heightened desire for privacy that is appropriate to their developmental stage of growth.
3. Some children may not be concerned about their privacy. It is inappropriate to assume that children do not want their parents or guardians to know information they have told counselors.
4. Children sometimes tell an adult about their concerns hoping that the adult will act as an intermediary in telling their parents.
5. The reasoning capacity of children is limited, and they may not be able to make decisions that are in their own best interest because of their age.

Answers to confidentiality questions may vary, depending on the age of the client and on the setting in which the counseling takes place. Very young children are often not very concerned about confidentiality, whereas confidentiality concerns may be paramount for adolescent clients. According to Hendrix (1991), community mental health counselors tend to favor giving minors the same confidentiality rights that adults have, whereas school counselors (particularly those at the elementary school level) feel more oriented toward releasing information to parents.

## Legal Status and Rights of Minors

When the United States was established as a separate country in 1776, the government adopted the English common law as its legal foundation. The common law holds that minors must exercise through their parents any legal rights they may have and that minors have no legal standing to contract or bring lawsuits (Kramer, 1994).

The law with respect to minors has seen significant changes since the beginning of the nineteenth century. Before legal reforms, children were treated almost the same way as the property of their parents (especially the father), and the government seldom interfered with parents' control and authority over their children. In Massachusetts during the 1600s, children could be executed if found to be "stubborn and rebellious" (Kramer, 1994). Reforms have included laws that prohibit child labor, require compulsory school attendance, and, more recently, require professionals to report suspected child abuse.

It appears that the legal rights of children include the right to be supported by their parents and the right to not be abused or neglected. Today, even though minors have more governmental protection and are beginning to be recognized by courts as individuals with their own legal rights, the law still favors biological parents' rights over their children. The legal system in the United States usually requires that children assert any legal rights they have through their parents or guardians.

Due to their legal status in our society, children are not able to enter into contracts. Because the counseling relationship is contractual in nature, minors cannot legally agree on their own to be counseled. Thus, minors usually need parental consent before they can receive counseling services. Several exceptions to this requirement, however, have been created by statutes enacted by federal and state legislative bodies.

Clients who cannot comprehend what is being requested in a consent for disclosure or who are unable to make a rational decision are not able to give valid informed consent (Huey, 1996). As a general rule, the law stipulates that clients under the age of 18 are not adults and, therefore, are not competent to make fully informed, voluntary decisions (Davis & Mickelson, 1994). Although counselors may argue that many minor clients are developmentally capable of making these decisions for themselves, the law does not support this belief. The privacy rights of minor clients legally belong to their parents or guardians.

Several writers (Mnookin & Weisberg, 1995; Reppucci, Weithorn, Mulvey, & Monahan, 1984) have taken the position that some children should be able to exercise legal rights on their own, and they have advocated for making 14 the age at which children may legally give their informed consent for counseling or other health-related treatment. In all states (Phillis, 2011), this right is given to mature minors by statute—adolescents over a specified age (usually 16) who are able to understand the nature, risks, and benefits of counseling. Laws in some states allow minors themselves to give informed consent to counseling when there is an emergency situation, or when they need treatment for use of dangerous drugs, sexually transmitted diseases, pregnancy, or birth control (Lawrence & Robinson Kurpius, 2000). A number of states have enacted statutes that lower the legal age for obtaining counseling services, health treatment, or even abortions to an age lower than 18. Some federal laws and statutes also allow minors to consent specifically to counseling services at specified ages prior to age 18.

Phillis (2011) has brought attention to the issue of minors below the age of 18 engaging in sexual activity and choosing to become pregnant: "The emblematic 'coming of age' at sixteen instantly transforms a minor who was incapable of consent the day before into a sexually autonomous entity. Although ages may vary, every state has an age of consent law that vests in a minor the right to engage in sexual activity and to become pregnant without any parental involvement whatsoever.



Yet, in the majority of jurisdictions, a minor's right to independently consent to sex, become pregnant, and bear a child fails to be matched by a corresponding right to terminate her pregnancy without parental involvement" (p. 274).

Ehrlich (2003) completed a study of minors who had decided to have abortions without first obtaining parental consent and discovered that reasons the girls gave for avoiding parental consent were not because they were rebellious teenagers. Instead she found they "did not treat either the decision to abort or the decision to not involve their parents lightly. The stories they tell reflect the richness and intricacy of their lives and the depth of their feelings about becoming pregnant, the decision to abort, and their families. These teens spoke openly about abuse, loss, love, and their often poignant hopes for the future—a future that often included visions of motherhood" (p. 97). Stone (2002) has warned counselors to be careful to avoid advocating a particular position regarding abortion or assisting a minor in obtaining an abortion when counseling minors. Emancipated minors, who are under the age of 18 but live separately from their parents, manage their own finances, and have been adjudicated legally emancipated by a judge, can enter into a contract for counseling.

A new area of concern related to adolescent sexuality is the practice of "sexting," which involves sending sexual messages or images through text messaging. Luncelford (2011) observed that teenagers seem to be unaware of the potential for embarrassment and humiliation when these "sexts" are shared with unintended viewers or even posted on the Internet, despite the highly publicized suicides that have occurred. Although sending pornographic images of minors via the Internet is illegal, lawyers and judges are struggling to determine how to deal with a crime when the victim and perpetrator are the same person. From an ethical perspective, we believe counselors can play a vital role in teaching adolescents to consider the potential for harm involved in "sexting."

With so much variation in state and federal laws and regulations regarding minor clients and informed consent, it is essential for counselors who work with minor clients to know the relevant laws and regulations that apply in settings where they practice. It is important for administrators who supervise counselors to alert them when there are exceptions to the general legal principles that require parent or guardian consent for treatment of minors or give parents or guardians access to confidential information regarding the treatment of their children or wards.

When a minor is the client who will be receiving counseling services, the consent form indicate that a minor is the client and a legal parent or guardian is verifying that he or she consents to the counseling relationship. For therapeutic rather than legal purposes, counselors may also want to obtain the minor's signature on the form, depending on the minor's level of development and ability to understand the meaning of the document.

### **The Rights of Parents**

When the *ACA Code of Ethics* was revised in 1995, some statements were added that were intended to help counselors bring their ethical and legal obligations toward minors into closer alignment. The previous ACA ethical standards said that "when working with minors or persons who are unable to give consent, the member protects these clients' best interests" and that counselors could include parents or guardians in the counseling process as necessary (Standard B.3.). Huey (1996) described the difficulties that this wording seemed to have caused:

This reinforced the idea for some counselors that the best interest of the client was to protect from disclosure any information received because no mention was made of any ethical responsibilities to the parent or guardian. For other counselors, perhaps more in tune with liability issues, disclosing information to parents upon request was always considered to be in the minor client's best interest. It certainly was viewed by these counselors as being in their own best interest. (p. 242)

In the 2005 *ACA Code of Ethics*, several provisions were added that relate to including parents or guardians when counseling minor clients. The wording of Standard A.2.d. acknowledges the need to balance the rights of minor clients with the rights of their parents or guardians and to include minor clients in decision making, as appropriate. Additionally, Standard B.5.b. advises counselors to “respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law.”

The *ACA Code of Ethics* (2005) recognizes that it is often helpful to include parents and other family members when working with minor clients and reinforces the fact that parents can be valuable allies in the counseling process (Huey, 1996). Standard B.5.b., which encourages counselors to work to establish collaborative relationships with parents and guardians, allows counselors some latitude to use their professional judgment in determining whether and when to involve parents or guardians in the counseling process. Conflicts often can be avoided if counselors approach parents as allies in the counseling process, rather than as adversaries in a struggle over privacy.

Enzer (1985) has said that child psychiatrists are expected by their ethics code to inform children or seek their agreement to activities that affect them even though this is not required by law. Corey, Corey, and Callanan (2011) have suggested that counselors also have an ethical obligation to provide information to children and adolescents that will help these clients be active partners in their treatment. These authors pointed out that counselors demonstrate respect for client autonomy when they involve minor clients in defining counseling goals and choosing among treatment alternatives. Such an approach is supported by the 2005 *ACA Code of Ethics*. Standard A.2.b. advises counselors, when working with minors, to seek the assent of minor clients to services and include them in the decision-making process as appropriate. A cooperative approach might also help to minimize some of the reluctance or resentment that minor clients often feel when they are sent to a counselor by their parents, their teachers, or other adults in authority.

Counselors who work with minor clients need to respect parents' rights and responsibilities for their children, yet they also feel the need to honor the confidentiality rights of their clients. Counselors should understand that any time they decide to withhold information from a parent, they assume responsibility if that information later leads to injuries for the client. Examples of such potentially injurious information include minors disclosing that they are using controlled substances, engaging in sexual activity, breaking laws, or engaging in other risky behavior that their parents do not know about.

Parents or guardians probably have a legal right to know the contents of their children's counseling sessions, although a court may hold otherwise because of specific state or federal statutes or regulations, or due to legal precedent from case law in that jurisdiction. Of course, it would be complicated and expensive for parents to enforce their rights, but given the state of the law regarding parent and child relationships, they probably do have the right.

To avoid situations in which parents demand information and minor clients refuse to authorize counselors to provide it, it is wise to establish a thorough understanding with all parties regarding the issue of confidentiality before the counseling relationship is initiated. The use of written informed consent agreements among counselors, their minor clients, and the parents of minors would be helpful to avoid misunderstandings. Counselors must balance the ethical rights of clients to make choices, their capacity to give consent or assent to counseling, and the rights and responsibilities of parents or families to protect minor clients and make decisions on their behalf (A.2.d.).

### **Responding to Parents Who Demand Confidential Counseling Information**

Many professionals who counsel children report that they have never faced situations in which a parent or guardian demanded to know the contents of counseling sessions and the child felt strongly that the parent or guardian should not be told. Other counselors, however, have had to deal with

such situations (Mitchell, Disque, & Robertson, 2002). If you are ever presented with such a challenge and decide that the child's desire that the parent or guardian not be told is reasonable, we suggest you consider following these steps:

1. Discuss the inquiry with the minor and see if the minor is willing to disclose the content of the counseling session to the adult. Sometimes counselors are more concerned about privacy than a child is. If that doesn't work, go to step 2.
2. Try to persuade the adult that the child's best interests are not served by revealing the information. Attempt to educate the inquiring adult about the nature of the counseling relationship, and assure the adult that information will be given if the child is in danger. If that doesn't work, go to step 3.
3. Schedule a joint session with the adult and the minor. Assume the role of a mediator at this session. Hope that the adult's mind will be changed about wanting the information or that the minor will be willing to disclose enough information to satisfy the adult. If that doesn't work, choose step 4 or step 5.
4. Inform the child ahead of time and then disclose the content of the session to the inquiring adult. If the adult is not a parent or guardian, inform the parent or guardian before disclosing the information. Remember that the adult may have a legal right to the information.
5. Refuse to disclose the information to the inquiring adult. Secure approval from your direct administrator before doing this. Remember that the adult may have a legal right to the information.

**RIGHTS OF NONCUSTODIAL PARENTS** Counselors who provide services to children often counsel minors whose parents are separated, going through a divorce, or are divorced already. Special challenges for counselors occur when parents attempt to pull counselors into their custody disputes.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 9 and view the video clip entitled “A Counselor Testifies in a Custody Dispute.” This video demonstrates what could happen when a counselor has to testify in a child custody dispute.

A typical challenge presents itself when one parent wants the counselor to take his or her side in a court proceeding related to child custody. We recommend that counselors of children of divorce focus on their role of counseling the child and consulting with parents as necessary for the benefit of the child, avoiding in the process becoming embroiled in custody battles.

Counselors should refuse to support one parent over the other in a child custody controversy. The reasons are many: (a) the counselor must be able to maintain working relationships with both parents to be an effective counselor for the child; (b) counselors of children know very little about what goes on in a home or in a marriage, so it would be inappropriate for counselors to support one parent over the other; and (c) child custody evaluators, not the children's counselors, should be giving advice to judges related to custody matters. Counselors could be child custody evaluators, but they cannot serve in that role when they are a child's counselor as well.

If counselors of children are subpoenaed to court to testify in a child custody hearing after expressing their position that they do not want to become involved in that controversy, the

counselors must be careful how they conduct themselves in the legal proceedings. Any time counselors receive a subpoena, they should obtain legal advice. Generally, in child custody situations, one parent waives the privacy of the counselor–child relationship, so counselors must provide information through depositions or testimony in hearings or trials. When counselors are in such situations, they should answer any factual questions asked of them. If they are asked opinion questions, especially regarding the fitness of a parent, they should decline to give an opinion, maintaining that they do not have enough information to form a judgment on that matter, which is true. Counselors know only what is told to them. They do not have in-depth knowledge regarding the parents of their child clients.

Wilcoxon and Magnuson (1999) have argued that it usually is in the child's best interest to include the noncustodial parent in the counseling process. Children's counselors generally have a responsibility to provide requested information to noncustodial parents. Some states, however, do not require health care providers to provide noncustodial parents with information regarding the treatment of their children. If there is a controversy over whether a noncustodial parent should have information about the counseling of his or her child, counselors are advised to seek and follow legal advice that is based on the laws in their state.

### **Children at Risk for Harm to Self or Others**

As we have noted, a minor client's confidentiality might need to be breached due to parental demands. At other times, it will be the counselor who determines that parents or guardians must be given information that a child has disclosed in counseling sessions. If counselors determine that a child is at risk of harm (to self or others), they must inform the child's parents. School counselors must also consider whether they should report student risk-taking behaviors to an administrative superior (usually the school principal; Moyer, Sullivan, & Growcock, 2012). When a child client is at risk of suicide, a counselor's duty to notify the parents is clear. Much less clear are instances when children and adolescents engage in self-injuring behaviors (such as delicate cutting). Because there does seem to be a relationship between suicide and self-injury, counselors need to know how to assess for suicidal risk (Hoffman & Kress, 2010). Because deciding whether a child is at risk can be a difficult judgment to make, consultation with other counselors is recommended. If a counselor tells parents every time a child engages in any risky behavior, children will not be willing to disclose important information to that counselor. On the other hand, if a counselor decides not to inform a parent when a child is engaged in risky behavior, that counselor could be held legally accountable if the child is later harmed or harms someone else (Gilbert, 2002; Hermann & Finn, 2002; Hermann & Remley, 2000).

When such situations arise and counselors do have to inform parents or guardians of potential harm to their children or others, counselors should make efforts to maintain the counseling relationship with their child clients. Steps that might help in that regard would be having the children tell their parents themselves, telling parents with the children present, or at a minimum, informing the child before telling the parents. If you were Mary's counselor in the following case example, would you tell Mary's parents about her marijuana use?

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## **1 The Case of Benjamin**

Mary, age 14, reveals to Benjamin, her school counselor, that she once smoked marijuana with her friends on a weekend. She states that she has never tried any other drugs and insists that she knows

better than to “get hooked on marijuana or even try the hard stuff.” Mary also insists that the counselor must not tell her parents and that to do so would be a betrayal of her trust.

- What are the arguments for and against Benjamin informing Mary’s parents of her one-time marijuana use?
- What factors should Benjamin consider in making his decision?

**Discussion:** Of course, if Benjamin’s school system has a policy that parents must be informed in situations like this, he would be unwise to ignore the policy.

If no such policy exists, however, Benjamin must weigh the risks to Mary and to himself. How serious is the danger involved in the one-time use of marijuana? Is it better to honor the client’s wishes and not tell the parents in the hope of maintaining a trusting counseling relationship in which the problem can be further explored? Or is informing the parents a wiser choice?

Benjamin should consider several factors in making his decision. First, he should check out any values issues of his own that might be involved: Is his decision-making process being influenced by his own liberal attitudes toward marijuana use, for instance? What are the prevailing standards and attitudes in the community?

He should also consider factors such as the age and maturity of the student involved, his judgment about whether the parents’ response would harm the student if the parents were told, the student’s willingness to consider informing her parents in the near future, any applicable school policies, and any relevant ethical standards and laws.

If he decides that the parents must be informed, he should let the client know that he cannot keep this particular secret and try to negotiate a procedure for informing the parents that will be acceptable to her.

This case is an example of a situation that requires a counselor to make a judgment call about informing parents. There are no easy answers to these questions. Benjamin would be well advised to consult with other school counselors who are likely to have dealt with situations like this one.

### Release of Records

Ethically conscientious counselors work hard to respect the rights of minor clients to control access to personal information divulged during counseling, to the extent that this is possible. It is important to remember that confidentiality is not absolute for clients of any age. As has been noted, a legal consideration that limits the confidentiality of minors is that confidentiality and freedom of choice are both predicated on the ability of the client to give voluntary, informed consent.

Minor clients should have some control over the release of information that results from their choosing to engage in the counseling process (Huey, 1996). However, parents or guardians must exercise any legal rights children have up until they reach the age of 18 (unless a statute allows a younger age) or until the child is emancipated by a court of law. Parents do not have access to counseling case notes kept in the sole possession of the maker on demand under FERPA, but parents would have access to such notes under a subpoena or specific court order.

Generally, a parent or guardian has a legal right to assert the privilege that would belong to a minor. In some circumstances, however, courts have found that parents did not have the best

interests of the child in mind and have refused to allow the parents to assert a child's privilege (*People v. Lobaito*, 1984). Courts have also appointed a *guardian ad litem* to determine the best interests of a child related to privilege (*Nagle v. Hooks*, 1983).

### Confidentiality in School Counseling

Unless there is a federal or state statute to the contrary, school counselors do not have a legal obligation to obtain parental permission before counseling students. When parents enroll their children in school, they know or should know that their children will be participating in a number of obligatory and optional services, and one of those optional services is counseling in most schools. School systems or school principals who require counselors to obtain parental permission to counsel students are imposing that requirement because they feel it is an appropriate or *politically correct* thing to do, not because it is required by law. These administrators may be concerned that community support for the school and its counselors would be negatively affected if parents believed that the counselors were withholding information regarding the fact that their child is being counseled (Glosoff & Pate, 2002).



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 9 and view the video clip entitled “An Angry Parent.” In this situation, a school counselor has to decide how to proceed when a parent demands that counseling cease.

Because most counseling services are not required of all school students, however, parents who object to their child's participation in counseling probably have a right to do so. In extreme circumstances, school counselors should think about whether a child might be a victim of abuse or neglect when the parents object to their child's participation in counseling. However, counselors are cautioned to avoid jumping to the conclusion that parents or guardians have something to hide because they object to their child being counseled. Counselors should entertain the suspicion that a child might be at risk for abuse or neglect only if there is some compelling evidence that abuse is occurring.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 9 and view the video clip entitled “A Teacher Asks a School Counselor for Help.” In this situation, a school counselor is asked to reveal private information that a student has disclosed in counseling sessions.

School counselors routinely encounter situations that call on their professional judgment to decide whether student risk-taking behaviors are of sufficient intensity, frequency, and duration to warrant breaching a student's confidentiality (Moyer & Sullivan, 2008). After reviewing the approach that various federal court districts have taken in determining whether minors have a legal right to keep information, such as a pregnancy, secret from their parents, Gilbert (2007) concluded



that district court judges should take into account whether requiring disclosure to parents by health care providers would keep minors from seeking help. Prober (2005) has argued against school districts enacting requirements that school health personnel notify parents when minors report pregnancies to them so that students will continue to seek assistance from adults in the school environment. According to Prober (2005), such rules requiring mandatory reporting to parents are illegal and unconstitutional.

Results of one survey of school counselors (Isaacs & Stone, 1999) indicated that school counselors would breach confidentiality for the following issues: impending suicide or suicide pact, violent retaliation for victimization, use of crack cocaine, sexual intercourse with multiple partners when HIV positive, armed robbery, and signs of serious depression. Isaacs and Stone also found that the age of the child was the most significant variable that counselors considered in their decision making. Younger children were seen as more dependent and in need of protection, whereas high school students were viewed as being more capable of giving informed consent and making mature decisions. Moyer and Sullivan (2008) also surveyed school counselors to determine whether they would breach confidentiality to report risk-taking behaviors of student clients. They found that only one behavior (suicidal behavior) was perceived almost unanimously as posing an immediate threat, and that there was little consensus regarding a range of other risk-taking behaviors.

Many misunderstandings can be avoided if counselors take proactive steps to inform students, parents, and school personnel about confidentiality and its limits (Huss, Bryant, & Mulet, 2008; Keim & Cobia, 2010). Counselors in schools might consider publishing information about their services in the documents given to parents when they enroll their child in the school. A modified version of the information addressed to students might be published in student handbooks as well. Glosoff and Pate (2002) offered the reminder that there are many stakeholders in the school counseling program. They recommended that counselors conduct in-service programs for teachers and administrators, make presentations at PTA meetings, and visit classrooms early in the school year. All of these activities have the goal of educating interested parties about the role of the school counselor and the parameters of confidentiality.

### **Confidentiality in Working with Minors in Nonschool Settings**

The work setting of counselors often determines the types of confidentiality issues they encounter in working with minor clients (Salo, 2006). Counselors in private practice may encounter fewer issues around confidentiality because parents usually have given legal consent for the counselor to work with the client and because the number of people involved in the counseling process may be limited to the counselor, the minor client, and the parents or guardians.

By contrast, children who are being counseled in an inpatient facility will likely have been placed there by a parent or by children's protective services. These minors, regardless of their age, "will be deemed largely incapable of making crucial decisions for themselves" (Salo, 2006, p. 202), as the caregivers are assumed to be operating in the minor client's best interest. Parents may be consulted over the course of the minor client's stay in the facility, and treatment teams will also be involved in determining the treatment plans.

### **Confidentiality in Consultations**

Many counselors who provide services for children work in schools, treatment facilities, or social services agencies. Staff members often must consult with each other for the benefit of the children being served. It is important for counselors to educate other non-mental-health staff members that

they must keep confidential any personal information they learn about children as a result of their professional positions. If professionals disclose confidential information outside the institution and the reputations of parents or guardians are damaged, they could have the basis for a lawsuit.

School counselors, in particular, are in a precarious position because they have responsibilities as consultants to other educators. Because teachers and administrators may not have the same obligations to uphold student privacy, school counselors must constantly balance the potential benefits to a student of divulging private information to teachers or administrators during a consultation versus the potential harm that might be caused by sharing that information (Isaacs & Stone, 1999).

### **Reporting Suspected Child Abuse or Neglect**

Every state now has a statute that requires counselors and other professionals to report cases of suspected child abuse or neglect to a governmental agency (Jones, 1996; Kemp, 1998).

Although the *ACA Code of Ethics* (2005) does not specifically address child abuse reporting, we have seen that counselors do have a general ethical duty to protect vulnerable persons from harm (Standard B.2.a.). McEachern, Aluede, and Kenny (2008), for example, have discussed the responsibility of school counselors to include discussion of the problem of emotional abuse in their classroom guidance lessons. It appears that many mental health professionals do not routinely report child abuse or neglect and that confidentiality is the crucial variable that causes them to fail to make such reports (Corey et al., 2011; MacNair, 1992). Counselors may be reluctant to report for several reasons. These include their desire to avoid betraying a child's trust, fear that a child protective services investigation will be poorly handled, fear of retaliation from the alleged perpetrator, or hope of maintaining the counseling relationship with the family so that the abusing adults can be helped to learn more appropriate parenting skills. Conti (2011) has suggested that mental health professionals who are working with attorneys representing their counseling clients in a legal action should be exempt from making mandatory suspected child abuse reports. Conti's rationale for this suggestion is that lawyers are not allowed to make such reports because reporting would violate the attorney-client privilege. Nonetheless, in cases of child abuse or neglect, the need for absolute confidentiality in counseling has been determined by state legislators to be less important than the need to protect children.

**STATUTORY REQUIREMENTS** Because all states and U.S. jurisdictions now have mandatory reporting statutes of some type in the area of child abuse and neglect, and the statutes vary in their wording, it is vital for counselors to know the exact language of statutes that require them to make reports of suspected abuse or neglect. All states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have enacted statutes that require certain categories of professionals to report suspected child abuse or neglect (Child Welfare Information Gateway, 2010).

It is possible to find mandatory child abuse or neglect reporting statutes for each state and U.S. possession at the following website: [http://www.childwelfare.gov/systemwide/laws\\_policies/state](http://www.childwelfare.gov/systemwide/laws_policies/state).

Counselors must know which categories of professionals must make reports of suspected abuse or neglect and whether reports must be made only for suspected current abuse, or for suspected past abuse as well. Reporting statutes protect mandatory reporters from lawsuits that might be filed against them by those who have been reported, but sometimes only if the report is mandated by law. If reports of suspicions of past abuse are not mandated by law, then counselors making such reports may not be protected. Furthermore, if state statutes require that reports be made when the perpetrator is the child's caretaker and a report is made when the suspected perpetrator is not the

caretaker, again, counselors making such reports may not be protected. Where counselors work, their job titles, their licensing status, and other such factors may determine whether they are mandated by statute to make suspected abuse reports.

The protective clauses of mandatory abuse reporting laws protect counselors who make reports in *good faith*. In other words, as long as counselors sincerely believe that child abuse or neglect may have occurred or is occurring, they will be protected from lawsuits that might be filed against them by individuals who have been reported. This means that lawsuits against a counselor for defamation of character or some other type of tort would not prevail as long as the counselor genuinely believed that abuse or neglect might have occurred, even if it was later proven that no abuse or neglect had existed. In a 2011 New York case (*Cox v. Warwick Valley Central School District*), courts supported a middle school principal who was sued by parents after they were reported for suspected abuse in the course of suspending the student from school for submitting an essay in English class that included violence. Despite the ruling in *Cox*, if a counselor has been involved in a conflict on some other matter with a suspected perpetrator, it would be wise to ask another professional to gather evidence of the suspected abuse directly and make the report. Otherwise the suspected perpetrator might be able to convince others that the counselor made the report in *bad faith*: that the counselor knew that the report was untrue but made it to cause problems for the suspected perpetrator because of the previous conflict regarding another matter.

The language of the statute in your state tells you who must make an actual suspected child abuse or neglect report and where and how the report must be filed. In some states, counselors can fulfill their legal obligation by telling their supervisors that they suspect child abuse or neglect, and then it is the supervisors' legal obligation to file the report. In other states, the counselor who suspects child abuse or neglect has the legal obligation to personally file the report. Some statutes require oral reports only; others demand that written reports be filed; still others require reports to be filed within certain time frames. You are encouraged to locate and read carefully the mandatory child abuse and neglect reporting statutes in your jurisdiction, and then to ask for interpretations from an attorney if there is something you do not understand.

Important language in the statutes includes the following: (a) who must make the report to the governmental agency (the person with the suspicion or the supervisor); (b) when the report must be made (immediately, within 24 hours, 48 hours, or some other time frame); (c) whether the oral report must be followed by a written report; (d) what specific information is required when the report is made (such as age of the child, name and address of the child, specifics of cause of suspicion, name and address of parents); (e) whether past abuse must be reported; and (f) whether specific categories of suspected perpetrators must be reported (parents or guardians only, caretakers, siblings, other) while other categories of suspected perpetrators do not have to be reported. In situations where only specified categories of suspected perpetrators must be reported (for example, only caretakers must be reported), counselors may still report other categories of suspected perpetrators (such as neighbors or relatives).

Statutes vary in reporting requirements for past child abuse when the victim is no longer in danger. The statute may say specifically that past abuse must be reported, or that only currently abusive situations must be reported, or the statute may be silent on the issue. Laws are constantly changing with respect to reporting child abuse, and existing laws are being interpreted. For example, in May 2012 the Attorney General of the state of Texas issued an opinion that the state child abuse reporting statute does not require professionals to report abuse or neglect that occurred during the childhood of an adult client. Some statutes mandate that only suspected abuse by parents or guardians must be reported. However, all statutes allow nonmandated reports

to be made as well. Statutes that require only caretakers to be reported leave counselors in doubt as to whether to report issues such as sibling or peer (or even neighbor) child abuse (Phillips-Green, 2002). The problems associated with sibling abuse have been highlighted by Kiselica and Morrill-Richards (2007). In the event that more than one person suspects that abuse is occurring and that all of those involved are mandated reporters, the person making the report should indicate that the report is being made on behalf of others as well and ask that their names also be recorded as reporters.

Singley (1998) has argued that mandatory suspected child abuse reporters should be given civil good faith immunity for failing to report suspected abuse, just as they are given immunity in state statutes for good-faith reporting of suspected abuse. Singley has suggested that changing the laws would significantly reduce the number of unnecessary reports of suspected child abuse that are made out of fear of civil liability. At this point, however, mandated reporters can be sued by injured children or their parents if the mandated reporters fail to make reports of suspected abuse when they are required to do so by law.

**DETERMINING WHETHER A REPORT MUST BE MADE** The duty to report suspected physical, sexual, or emotional child abuse or neglect is a legal requirement (Mitchell & Rogers, 2003). This reporting obligation is clear, but counselors still must exercise clinical judgment in making a determination that a child has been or is currently being abused or neglected.

Before counselors determine that they have a legal obligation to file a report, they must form a clinical opinion that a possibility exists that a child has been or is being abused or neglected. Suspicion regarding abuse or neglect might arise as the result of something a counselor observes, such as seeing marks on a child, observing behavior that indicates abuse, or noticing something a child says in a counseling session. Also, clients may make verbal or written statements that they have been abused or that they have perpetrated abuse on others. If you are unsure whether you have enough information to form a suspicion that child abuse or neglect is involved, consult with colleagues.

Counselors must first exercise their judgment as to whether they suspect that abuse or neglect might be occurring or might have occurred in the past. Responsible counselors would consider the following factors in exercising their judgment: (a) the credibility of the alleged victim, (b) prevailing standards for discipline in the community, and (c) information that is known about the alleged victim and alleged perpetrator.

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## 2 The Case of Leslie

As a result of a play counseling session, Leslie, an elementary school counselor, has come to suspect that Arielle, a second-grader, is being physically abused by her father. Leslie realizes that the law in her state requires her to report the suspected abuse within 24 hours. Leslie is hesitant to do so, however, because her experience with the local child protective services agency is that it is ineffective in responding to such reports. Leslie fears that the agency social worker will visit Arielle's home but take no further immediate action. Her concern is that the father will escalate the abuse, placing Arielle in even greater danger.

- What should Leslie do when she believes following the dictates of the reporting abuse statute might endanger her child client?
  - What problems could occur if Leslie decides not to make a report?
-

**Discussion:** Even though Leslie believes filing a report might endanger Arielle, she should consider the importance of compliance with the law that requires her to report. Leslie should think about actions she might take to help ensure the child's safety. These might include enlisting the assistance of the child's mother or other relatives or teaching the child self-protection strategies.

She might also emphasize her concerns for the child's safety to the child protective services personnel and request that they take steps to protect the child. Leslie should document her contact with the agency and should inform her principal (or other immediate supervisor) of the situation.

She should talk with Arielle further after the report has been made to determine what happened thereafter. She should make additional reports if she believes the abuse has continued. If Leslie decides not to make a report and if Arielle is harmed by further abuse, and it is learned that Leslie knew about but did not report the abuse, Leslie could face legal repercussions. Leslie could also face disciplinary action by her school administrator.

Leslie would have to deal with her feelings, which could include regret and guilt, if Arielle were harmed when a different decision on Leslie's part might have prevented the harm.

**MAKING THE REPORT** In addition to adhering to statutory requirements in making mandatory suspected child abuse or neglect reports, counselors also must follow any procedures in effect in their employment setting. For example, a school district might require that a building principal be notified and a written report be filed before a report is made to state authorities, even when the counselor is mandated by law to make the report personally. Although school or agency policies cannot interfere with a counselor's obligation to make a report, policies can specify that school or agency administrators be notified simultaneously or after a report has been made. An employed counselor should always inform the supervisor before or immediately after making a report, even if supervisor notification is not required by policy.

It is important that counselors not forget their professional obligations to clients in fulfilling their legal obligations to make suspected child abuse or neglect reports (Remley & Fry, 1993). Child abuse or neglect reports are very disruptive to families. The lives of victims, perpetrators, and family members can be changed significantly when such reports are made. Although making a report of suspected child abuse or neglect may end your legal duties, your ethical and professional responsibilities as a counselor in the situation may continue for a long period of time after a mandatory report has been made.

Although most statutes allow suspected abuse reports to be made anonymously, professionals should give their names when they make reports. In addition, to protect themselves, reporters should always make a note to themselves indicating the date and time they made the oral report and the name of the person who took the report, along with a written summary of what was said when the report was made.

**AFTER A REPORT HAS BEEN MADE** The procedural aspects of making suspected child abuse or neglect reports are important from a legal perspective. However, counselors always must exercise their professional judgment before and after making such reports. Reporters should have several goals in mind, which include (a) maintaining, to the extent possible, any counseling relationship they have with the parties involved; (b) being concerned about the welfare of the alleged victim before and after the report (Remley & Fry, 1993); (c) helping the parties deal with the process that follows reports; and (d) fulfilling their statutory legal obligations.

After making a report, counselors must again exercise their professional judgment in determining whether to tell the alleged victim that a report has been made; whether to tell the alleged perpetrator; and how to interact with the alleged victim, parents or guardians, and the alleged perpetrator after the report has been made.

State agency personnel or police officers may contact the reporter after a report has been made to gather information. These individuals have investigatory powers and have a right to question witnesses. Agency personnel or police officers need to determine whether a child abuse or neglect report reflects actual abuse or neglect and the degree to which a child may be in danger (Kemp, 1998). Counselors should not discuss the case with unknown persons on the telephone. They should ask to see credentials of investigators, and they should be cooperative with state child protection agency investigators or police officers. Counselors may request that interviews be scheduled at times that are convenient for them. If investigators want to speak to alleged victims, the director of the agency or principal of the school should respond to such requests. Some states have specific statutory language that governs interviews with possible child abuse or neglect victims in school settings.

State agencies that investigate suspected abuse reports often are inundated with reports and may be understaffed. They must decide which cases are the most severe and usually pay particular attention to those situations. Whenever counselors are frustrated because they do not believe the state agency handles investigations properly or they believe children are put at risk after reports are made, they should report additional incidents and should request a meeting with governmental agency representatives to discuss the perceived problems.

### **School Violence**

A number of incidences of shootings and other acts of violence in schools have highlighted the need for school personnel to intervene to prevent students from causing harm to others (Hermann & Finn, 2002; Hermann & Remley, 2000; Sandhu, 2000). In response to the problem of widespread school violence, some school districts have created policies that require counselors to report students' destructive impulses or contemplation of illegal acts (Sandhu, 2000). These policies sometimes can put school counselors in a difficult position. If students, particularly adolescents, know that counselors will routinely be reporting any disclosures of their thoughts about hurting someone, they may decide not to reveal that information to their counselors. This, in turn, could reduce the opportunity to address the risk of violence (Welfel, 2010). School counselors need to work with administrators to ensure that school policies do not create a barrier to access to counseling services for students who are at risk for committing violent acts.

On a day-to-day level, school counselors also have an ethical obligation to work to prevent bullying (Espelage, Bosworth, & Simon, 2000; Hazler, 2001; Neufeld, 2002; Renshaw, 2001; Roberts & Morotti, 2000) and harassment of students by other students (King, Tribble, & Price, 1999). Counselors can address this duty through classroom guidance activities aimed at helping students understand the effects of bullying, intimidation, and harassment. A helpful resource in dealing with school violence is a guide to safe schools entitled *Early Warning, Timely Response* (ACA, 1998), which is available on the Internet.

### **Dual or Multiple Relationships**

Ethical dilemmas can be created by the job description and work environment of school counselors (Huey, 1996). School counselors play multiple roles, and there are inherent conflicts in some of these roles. Sometimes counselors are expected to serve, along with teachers, in duty assignments such as bathroom monitor, lunchroom supervisor, or chaperone at extracurricular events. If counselors



must carry out the disciplinary functions that accompany these duties, this will compromise their ability to function effectively as personal counselors with their students. It would be unreasonable to expect students to trust and confide in a counselor who assigned them to detention or reported their misbehavior to the principal.

School counselors sometimes voluntarily take on additional roles such as coach for an athletic team or club sponsor. Counselors can justifiably argue that these extra roles provide them with opportunities to know their student clients better outside the formal setting of the counselor's office. They should also be cognizant, however, that there is potential for misunderstandings and conflicts because these roles involve evaluation and supervision.

Occasionally, school policies exist that impinge on counselor effectiveness. If policies require counselors to inform parents about details of counseling sessions involving issues of birth control, pregnancy, abortion, sexually transmitted diseases, or other sensitive matters, some students will avoid discussing these issues with their counselors (Herlihy & Corey, 2006).

School counselors, especially those who work in small towns and rural communities, are likely to have friends who are teachers and friends who are parents. Both of these situations can lead to uncomfortable dual-role conflicts. Friendships between teachers and counselors seem inevitable, given their shared interest in children's welfare, their daily contacts, and the fact that some school counselors were teachers before they became counselors. Teachers are accustomed to the sharing that occurs among colleagues, and they value open communication with other school personnel regarding students with whom they all work. Counselors, on the other hand, come from a position of honoring the confidentiality of their child clients. This *clash of cultures* complicates the work of the school counselor (Welfel, 2010).

School counselors are equally likely to have friends who are parents, and it is possible that a friend's child might also be a student client of the counselor. In these instances, counselors must be careful to keep boundaries around the professional relationship with the child and the personal relationship with the child's parents. This can pose difficult challenges (Herlihy & Corey, 2006).

Finally, there is great potential for dual-role conflicts when counselors deal with child abuse. Counselors are required to report suspected abuse, yet their role is rarely limited to that of reporter. They are often asked to perform many other functions, including that of school system employee, court witness, liaison with social services, and counselor to the victim, perpetrator, or family (Remley & Fry, 1993). Because most children are left in their parents' custody after a report is made, the school counselor is likely to have the ongoing task of providing counseling for the child. Treatment of abuse victims is an intense and lengthy process that can strain a counselor's resources during a period when the counselor must also remain involved with the court system. The counselor will need to work with caseworkers from the children's protective services agency, with police and prosecutors, and perhaps with other attorneys. These simultaneous, multiple roles can severely test a counselor's ability to handle conflicting demands.

It is a challenge for caring counselors to maintain appropriate professional boundaries when they work with children who have been abused or who, for other reasons, are clearly in need of help. The counselor in the following case example is a case in point.

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### 3 The Case of Jeffrey

Jeffrey is a high school counselor who is well liked and respected by his student clients. He has a reputation among his students for being willing to go out of his way to help them. One morning at 2:00 A.M., 16-year-old Edmund, who is a member of one of the counseling groups that Jeffrey

conducts at school, shows up at Jeffrey's home. Edmund claims that he has been kicked out of the house by his parents and that he has nowhere else to go. It is raining, and Edmund is soaking wet. He begs Jeffrey to let him stay there for just one night and promises that he will call his parents in the morning.

- What would happen if Jeffrey were to allow Edmund to spend the night and later Edmund accused Jeffrey of making sexual advances toward him during the night he stayed at Jeffrey's home?
- What would be the wisest things for Jeffrey to say and do in this situation?

**Discussion:** If Jeffrey allowed Edmund to spend the night and later Edmund accused Jeffrey of making sexual advances toward him during the night, Jeffrey might face the following problems:

- Jeffrey would appear to have been unprofessional in allowing a student to spend the night with him.
- No matter what Jeffrey said or did in response to Edmund's claims, people would still wonder whether Edmund was telling the truth.
- Jeffrey might get fired from his job for allowing Edmund to spend the night with him.
- The school district probably would deny any responsibility for what happened that night because Jeffrey was at home and not on duty.

**Jeffrey should consider the following steps:**

- Jeffrey could take Edmund in and give him a towel to dry off with, and require Edmund to stay in the public parts of his home, such as a kitchen or front porch.
- He could call Edmund's parents and ask them to come and pick Edmund up, if Jeffrey determines that the parents are willing to do that. Other relatives, such as grandparents or aunts or uncles, might also be called to intervene.

If Jeffrey determines that he should not call the parents, he could call the police and ask them to come and pick Edmund up.

### **Diversity Considerations with Minors**

Working with children requires specialized knowledge and skills. Counselors who counsel minor clients must have a thorough understanding of child and adolescent development so that they can design interventions to match a child's developmental level (Lawrence & Robinson Kurpius, 2000). This knowledge base includes a solid grounding in gender role development, racial identity development, and the development of sexuality. Counselors must be careful not to impose their own values regarding gender, race or ethnicity, or sexual orientation onto minor clients, especially during adolescence when young people are forming their own unique identities.

Bemak and Chung (2007) have noted that school counselors are uniquely positioned to address the societal inequities and injustices that affect many poor students and students of color in U.S. schools. They have suggested that school counselors, serving as advocates for students, can play a significant role in reducing the academic achievement gap.

School counselors must be cognizant that female students and gay and lesbian students are likely to be subjected to sexual harassment and violence in the school environment. A solid body of

research indicates that gay and lesbian students experience high rates of verbal and physical assault (Comstock, 1991; McFarland & Dupuis, 2001; Pilkington & D'Augelli, 1995). Barber and Mobley (1999), Little (2001), and Welfel (2010) have offered several strategies that school counselors can employ when counseling gay youth. Welfel has suggested the use of inclusive, nonsexist language; challenging antigay and antifemale comments made by students and school personnel; educating students and staff about sexual harassment and homophobia; and having a repertoire of appropriate referral resources for students and families who need them. School counselors can serve as advocates for other stigmatized groups of students as well, including children who are HIV-positive, whose parents are imprisoned, who are grossly overweight, or who have experienced a family suicide (Corr & Balk, 2010; Lee, 2001).

In working with parents and families of child clients, it is important for school counselors to have an understanding of systems theories. Often, a child's behavioral, social, or academic problems are reflective of family dysfunction. Additionally, it is crucial for counselors to have an awareness of cultural differences in child-rearing practices. Some of the most complex and difficult situations that counselors encounter in their work with clients involve a convergence of the *duty to warn* exceptions to confidentiality and privilege with questions of counselor values and cultural diversity. An issue that can be particularly problematic in this regard is child abuse reporting.

In determining whether to make a report of child abuse, it is important to keep in mind that norms regarding acceptable child-rearing practices and punishment vary by culture (Fontes, 2002). The following case example illustrates this point.

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## 4 The Case of Tonya

Tonya, a Licensed Professional Counselor in a community counseling agency, has begun counseling the Hernandez family. The parents, Guillermo and Anabella, emigrated from Guatemala 6 years ago. They are experiencing some family conflict in their relationships with their three children, two teenage girls and a 7-year-old boy. Today, as Tonya is walking down the hallway to the reception area to greet the Hernandezes, she sees Guillermo grab the young boy roughly by the arm and slap him across the face. She is alarmed to see this abusive behavior and thinks she may have to report it to Child Protective Services.

- Do you believe that child-rearing practices that are acceptable in a subculture should be tolerated by the U.S. legal system?
  - What do you think Tonya should do in this situation?
- 

**Discussion:** Within the concept of *familismo*, family is a source of pride in Latino cultures, and it is very important for children to be well-behaved and represent the family well in public. When children misbehave publicly, Latino parents may respond immediately with physical punishment, which places them at greater risk for reports to child protection agencies. Knowing this information may make a difference in whether Tonya believes that what she saw was child abuse.

If Tonya believes, after considering cultural values, that what she saw Guillermo do (roughly grab his son by the arm and slap him in the face) constituted child abuse, she is legally obligated to make a report. She should explain to him that, by law, she has to make a report.

If Guillermo cannot understand or speak English very well, Tonya should obtain an interpreter. She should explain to him that although his behavior might be common and acceptable in his native country of Guatemala, it may not be acceptable by law in the United States.

She could explain to him how American parents might discipline their children in public in a way that is culturally acceptable here and help him understand how his behavior might be viewed by the majority culture. If she makes a report, she should explain to him what might happen after she does so, and she should make a sincere attempt to continue her counseling relationship with him and his family.

Counselors who provide professional services to culturally diverse populations of children and adolescents must continually examine their own values in determining the most appropriate actions when confronted with risk-taking behaviors. They must be clear about their own stances toward such issues as drug and alcohol use, premarital sex, abortion, and appropriate discipline, and be cognizant of community standards.

## **VULNERABLE ADULTS**

All of the issues related to minor clients apply equally to any adult clients who have been legally adjudicated mentally incompetent or who have had legal guardians appointed based on their diminished capacity. Just as counselors have an ethical and legal obligation to protect children when there is suspicion of abuse or neglect, they have a duty to protect adult clients who are vulnerable to maltreatment due to diminished capacity to protect themselves from harm. Adults who might be considered vulnerable include developmentally disabled, severely mentally ill, elderly, and physically disabled individuals. Many states now have laws requiring reports of suspected abuse or neglect of elderly persons, incompetent persons, or individuals who are dependent for any reason on others for their well-being.

### **Elder or Vulnerable Adult Maltreatment**

Numerically, the elderly are by far the largest group of adults who are vulnerable to abuse or neglect. Elder maltreatment is a growing but underrecognized problem in our society. The population of citizens over the age of 65 has grown twice as fast as all other age groups (Welfel, Danzinger, & Santoro, 2000), and by the year 2030, 1 in 5 Americans will be older than 65 (Administration on Aging, 2006).

Although many older adults continue to enjoy good health and function independently, beginning at age 75 the risk steadily increases for developing diseases and disorders that compromise functioning, including cognitive impairments. Older people who suffer from dementia, physical decline, or chronic diseases that limit their ability to live independently are at the greatest risk for maltreatment.

It is difficult to estimate the incidence of elder maltreatment because it so often goes unreported. It is possible that as few as 1 in 14 cases is reported (Quinn & Tomita, 1997). According to some estimates, it is likely that as many as 10 million older adults suffer abuse or neglect every year (Schwiebert, Myers, & Dice, 2000).

The National Center on Elder Abuse (2011) has estimated that about two-thirds of all elder abuse perpetrators are family members; most are the victim's adult child or spouse. According to the Center, abusers in many instances are financially dependent on the elder's resources and often have alcohol or drug problems.

Types of elder abuse identified by the National Center on Elder Abuse (1999) include the following: physical abuse; sexual abuse; emotional abuse; financial or material exploitation; neglect; abandonment; and self-neglect.

Clearly, there is a role for professional counselors both in prevention of maltreatment and in assisting victims to recover from its effects, which can include depression, posttraumatic stress symptomology, learned helplessness, and feelings of isolation, alienation, and mistrust.

Welfel et al. (2000) identified several forms of elder maltreatment. *Neglect*, defined as failure to provide essential physical or mental care for an older person, is the most common form. Neglect can be intentional or unintentional, or even self-inflicted. Self-neglect can occur when elderly people forget to take their medications or take them incorrectly, skip meals, use alcohol to self-medicate against depression or loneliness, or fail to maintain personal hygiene. Because self-neglect is often associated with depression (Quinn & Tomita, 1997), counselors are particularly well equipped to treat this problem.

Physical violence, another fairly common type of elder maltreatment, can take many forms, including slapping, pinching, withholding medication or overmedicating, misuse of physical restraints, and force feeding. Persons with dementia are particularly vulnerable to physical abuse by caregivers (Welfel et al., 2000). Psychological abuse, likewise, occurs in a variety of ways. Among the more frequently reported manifestations are verbal berating, threats to institutionalize the elder individual, and threats of abandonment, intimidation, or humiliation.

Financial exploitation is nearly as prevalent as psychological abuse, and it is estimated that there are 5 million cases of elder financial abuse each year (National Center on Elder Abuse [NCEA], 2008). This form of abuse occurs when someone (often a caretaker) misuses an older person's income or resources for his or her own personal gain. Abusers may deny elderly adults things to which they are entitled, steal their possessions or money, or coerce them into signing contracts that are not in their best interest.

The following case example illustrates a situation in which more than one form of elder abuse is present.

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## 5 The Case of Marjorie

Jerome is 89 years old and lives with his 58-year-old son, Tyler. Tyler is an accountant whose wife divorced him after many years of attempting to get him to kick his cocaine habit. Jerome suffers from mild dementia and is partially paralyzed as a result of a stroke. He needs assistance with bathing and dressing, but is able to get around the house using a walker. Tyler often leaves for work before Jerome awakens in the morning, so that Jerome is forced to spend the day unbathed and in his pajamas. It is not uncommon for Tyler to fail to come home after work because he is out looking to buy cocaine. On several such occasions, Jerome has burned himself while trying to cook his dinner. Tyler cashes Jerome's Social Security checks for him, but more often than not he spends the money to buy drugs. When Jerome tries to discuss these problems with his son, Tyler yells at him and threatens to put him into a nursing home. Jerome is so terrified by this possibility that he withdraws into silence.

Marjorie is a home visit counselor from the local mental health center. The first time she visits Jerome in his home, she is disturbed by his grooming and physical condition. Very reluctantly, Jerome tells Marjorie about some of Tyler's behaviors. Marjorie becomes even more concerned about Jerome's welfare.

- What should Marjorie say to Jerome?
  - What do you think Marjorie should do?
-

**Discussion:** Marjorie should inform Jerome that he does not have to endure the conditions in which he is living. She should assure him there are alternatives that he might find acceptable and explain to him what those alternatives are.

**Marjorie should consider taking the following actions:**

- If her state law requires counselors to report cases of suspected elder abuse, Marjorie should make the report.
- If there is no statutory requirement, then Marjorie should decide whether it is in Jerome's best interest to report the suspected abuse to authorities even though there is no legal requirement to do so.
- Marjorie should try to arrange an appointment with Tyler to determine whether she can be of assistance in helping him care for his father and perhaps persuade him to seek treatment for his drug addiction.

If you will be counseling older adults or families whose concerns including caretaking elderly relatives, you should be aware that elder abuse is difficult to detect. As is true in the case example just described, the perpetrator is usually a family member, and neither the victim nor members of the family want to reveal the problem. If you are alert to the possibility, however, you may find yourself confronted with the question of what to do when you suspect elder maltreatment. You must consider both your legal and your ethical obligations.

All states have enacted some form of legislation aimed at reducing elder maltreatment (Tatara, 1996). In many ways the laws are similar to child abuse reporting statutes, but they are different in that not every state mandates that professionals report suspected abuse to authorities. Another difference is that elder abuse reporting statutes usually allow older adults to refuse protective services if they do not want them (Welfel et al., 2000). To compound the problem, there is little uniformity across the states in elder abuse reporting statutes. Statutes vary with respect to age requirements for qualifying as *elderly*, types of abuse that are reportable, procedures for reporting, and whether counselors and other mental health professionals are considered to be mandated reporters. Obviously, you will need to learn the specific requirements of the relevant statutes in the state and community where you will be practicing.

All 50 states and District of Columbia have laws that authorize the provision of adult protective services in cases of elder abuse (National Center on Elder Abuse, 2011). The laws in states vary significantly. Variation exists according to the age at which a victim is eligible to receive protective services; the circumstances under which a victim is eligible to receive protective services; the definition of abuse; types of abuse, neglect, or exploitation that are covered; whether the abuse is considered criminal or civil; whether reporting is mandatory or voluntary; investigation responsibility and procedures; and remedies for abuse. Some state laws apply only to vulnerable citizens who are living alone or with family members. Other laws apply to individuals who are living in nursing homes or other long-term care facilities.

Information on specific state laws regarding elder and vulnerable adult abuse may be found at the following website: [http://www.ncea.aoa.gov/NCEARoot/Main\\_Site/Find\\_Help/APS/Analysis\\_State\\_Laws.aspx](http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/APS/Analysis_State_Laws.aspx).

The results of a National Council on the Elderly and Aging (NCEA)-commissioned study completed in 2000 indicated that of all 50 states, the District of Columbia, and the U.S. possessions, only 9 states had prosecuted someone for failing to report suspected elder abuse. A total of 472,813 elder



or adult suspected abuse reports were made, ranging from 108 from one state to 70,424 in another state. The most frequently occurring substantiated allegations of abuse or neglect included self-neglect (41.9%), followed by physical abuse (20.1%), and then caregiver neglect or abandonment (13.2%).

As an ethical obligation, reporting of elder maltreatment arises from the principles of non-maleficence and beneficence. When counselors suspect that a vulnerable person is being harmed in some way, they have a duty to intervene to prevent the harm from continuing and to promote client welfare. Welfel et al. (2000) offered the following guidelines for counselors faced with situations of elder maltreatment:

- Remember to consider the possibility of elder maltreatment when working with older clients who are dependent on family or others for their care.
- Interview family members separately to increase the likelihood of honest disclosures about the situation. Often, older adults feel intimidated by the presence of family members or embarrassed over the nature of the information.
- Provide an empathic and supportive environment in which clients will feel safe to reveal information that they may find shameful, humiliating, or acutely distressing. Ask nonjudgmental questions like, “Do you feel safe in your home?” or “Do you feel in control of your finances?”
- Focus on helping the older clients and their families or caregivers to improve the quality of care. Educate clients and families about the services available in their communities to assist them, such as advocacy groups and respite care facilities.
- Know the risk factors related to elder abuse. These include, for an older person, poor physical health, cognitive impairment, sufficient frailty to make independent living impossible, and a tendency to act disruptively. Risk factors for caregivers include a history of mental disorders, substance abuse problems, and a history of using violence to resolve conflict. Family characteristics that increase risk include social isolation and inadequate financial resources to assist with caregiving.

If, after careful exploration, you believe that you must make a report, you will want to try to accomplish this in a way that will not destroy the counseling relationship. You should involve the client in the reporting process, discuss thoroughly the logistical and emotional consequences of the report, report only essential information to preserve confidentiality to the extent possible, and follow up to ensure that needed services are being offered (Welfel et al., 2000).

### **Other Issues in Counseling Older Adults**

Schwiebert et al. (2000) identified two issues, in addition to abuse or neglect, that pose difficult ethical questions for counselors who work with older adults. When older adults have cognitive impairments, for example, questions regarding informed consent arise. If a client begins counseling during the early stages of a progressive deteriorating disease such as Alzheimer’s, at what point is that client no longer able to consent to continued counseling? Can the counselor continue to work with the client, or must the counselor wait until permission is granted by a legal guardian?

A second circumstance that can present agonizing dilemmas for counselors arises when clients have a terminal illness. Counselors are confronted with ethical and legal quandaries when these clients want to end their suffering by hastening their own deaths. Three new standards related to *End-of-Life Care for Terminally Ill Clients* appear in the 2005 *ACA Code of Ethics* (Standards A.9.a., A.9.b., & A.9.c.). These standards define the quality of care that should be provided to terminally ill clients, give counselors the option of whether to agree to counsel individuals “who wish to explore their end-of-life options,” and give counselors who know of a client’s decision to commit suicide the option “of breaking or not breaking confidentiality, depending on applicable laws and

the specific circumstances of the situation.” Although these new standards may be controversial, Bennett and Werth (2006) have concluded that the guidelines provide counselors with more latitude when counseling terminally ill clients who have a desire to die. Werth and Crow (2009) have offered the opinion that, due to the guidelines in the ACA *Code of Ethics*, counselors are in the safest ethical and legal position of all mental health professionals with respect to working with clients on end-of-life decision making. The issue of counseling terminally ill clients is discussed in some detail in the following section.

**END-OF-LIFE DECISIONS** Due in large part to the aging of the U.S. population and to continuing developments in life-saving and life-sustaining medical technology, death in our society now commonly occurs at an advanced age or after a prolonged illness. Thus, it is likely that increasing numbers of individuals will consider making a request for aid-in-dying through physician-assisted suicide (PAS). As a result, counselors will be called on more frequently to work with clients who are considering this action, and with their families and significant others (Herlihy & Watson, 2004).

At the present time, Oregon is the only state that has legalized PAS. In other states, PAS is a criminal act, or the law is ambiguous (Crawford, 1999). After reviewing the results of officially sanctioned physician-assisted suicide in Oregon and the Netherlands in the context of laws and statutes, Stern and DiFonzo (2007) concluded that there is still much to be learned about palliative care, societal beliefs about dying, and laws that eventually might be passed related to this topic. They believe that physicians need to take an unambiguous stand on physician-assisted suicide to avoid uninformed legislators enacting laws that are not in the best interests of those who are dying.

In 1997, the U.S. Supreme Court considered the legality of assisted suicide. The Court heard appeals to two Circuit Court decisions that had struck down criminal prohibitions against assisted suicide in the states of New York and Washington. The Court held unanimously in both cases that there is not a constitutional right to physician-assisted suicide, leaving it up to individual states to determine whether to allow the practice (Werth & Gordon, 2002). The ACA was the only major mental health professional organization to sign on to an *amicus curiae* (friend of the court) brief in support of the role of mental health professionals in helping terminally ill clients clarify their thoughts and feelings, explore alternatives, deal with grief and loss issues, and make their own choices regarding hastening their own deaths. The ACA, in its brief, was careful to state that its members do not promote any particular resolution of end-of-life issues. Nonetheless, the decision to join the brief was controversial, and the ACA Task Force on Revision of the *Code of Ethics* that was formed in 2002 was charged with making a recommendation regarding this issue.

Even though the ACA *Code of Ethics* was revised in 2005 to reflect support for a person's right to choose the time and manner of ending suffering caused by terminal illness, and support for counselor involvement in such decision making, you must decide for yourself whether you are able and willing to work with these clients. This will entail carefully examining your beliefs and values about living and dying, quality of life, and the right to die (Herlihy & Watson, 2004; Jamison, 1998). Do you believe that people have the right to hasten their own death? If so, in what circumstances? When they have a terminal illness? If so, must death be imminent? When their condition is not terminal but their lives are filled with pain and suffering and there is no hope for improvement? In some circumstances, such as when clinical depression is clouding a client's judgment or when a client is being pressured by others to consider PAS, you may need to invoke your duty to warn and protect that client.

You must also be aware of cultural issues, as some scholars have asserted that if PAS were legalized, it would have the greatest effect on the most vulnerable members of our society—those whose autonomy is already compromised by poverty, lack of access to quality medical care,

advanced age, or membership in a stigmatized group (New York State Task Force on Life and the Law, 1994). Thus, if you counsel terminally ill clients considering PAS, you will need to carefully self-monitor to guard against making assumptions based on the client's race, socioeconomic status, religious and spiritual beliefs, or age. Consider the following case example:

## 6 The Case of Karen

Weldon is a 73-year-old widower with a grown daughter. Karen is a counselor who works in a hospital, and her job is to counsel patients and families while they are hospitalized. Although Weldon has been diagnosed with terminal cancer, his doctors tell him that he might expect to live more than another year with further surgery and chemotherapy. Weldon wants to request physician-assisted suicide (PAS), stating that he doesn't want to die a lingering death or to consider hospice care. He adds that he doesn't want to be a burden to his daughter, who is a single mother and works long hours to support her two children. He insists that he would find it humiliating to be cared for by strangers in a hospice. He doesn't want to involve his daughter in his decision-making process because she would never accept the idea of a hastened death for him and because he wants her memories of him to be happy ones.

- How should Karen proceed in her counseling relationship with Weldon?
- Do you believe that other states should follow the example of Oregon and pass laws that permit physician-assisted suicide? Why or why not?

**Discussion:** Karen's first action should be to determine whether her state allows physician-assisted suicides. If they are allowed in her state, Karen should learn as much as possible about the requirements for a person to choose that option. If she feels competent to counsel Weldon regarding PAS, she can use her counseling skills to help him review his options and make his final decisions. Karen might assist Weldon by helping him to examine his motives for wanting PAS and to explore other alternatives. She also could work to facilitate an open dialog between him and his daughter.

### **Arguments for physician-assisted suicide laws include the following:**

- Persons should have a right to choose to die with dignity.
- It is inhumane to keep people alive when their quality of life has diminished beyond reason.
- Physicians have been assisting people with dying throughout history. It is time now to make it legal.

### **Arguments against such laws include the following:**

- It is impossible to know whether a person who wants to commit suicide is able to make such a choice.
- Vulnerable individuals would be at the mercy of others who might want them to die.
- Only God should decide when a person will die.

Counselors are well qualified to assist terminally ill clients with end-of-life decision making and may be called on more frequently to provide services, particularly if other states follow Oregon's example in enacting *death with dignity laws*. Bennett and Werth (2006) have advised

counselors who work with clients making end-of-life decisions to take several steps to ensure that clients receive quality care. First, counselors should determine whether they have the competency and training to work with such clients. Second, they should conduct a thorough assessment of the client, or refer the client to a competent provider. Third, it is wise to consult with other professionals. Finally, counselors should document carefully the assessment, consultations, and treatment options that were considered and chosen.

### **Diversity Considerations in Counseling Older Adults**

In working with older adults, counselors must guard against clinician age bias. Stereotyping and discrimination against older people appears to be a significant problem among mental health counselors. Danzinger and Welfel (2000) reviewed the research and found evidence that counselors are reluctant to work with older people, tend to view them as having poorer prognoses, and see them as being more set in their ways and less able to change. Clients who suffer from Alzheimer's disease or other cognitive impairments are as deserving of respect for their autonomy in decision making as are any other clients. When counseling with an older person, or a client with a pervasive developmental disability or severe mental illness, counselors must take care to avoid the paternalistic assumption that others (including the counselor) know what's best for the client.

### **Clients Who Have Been Declared Legally Incompetent**

All of the legal issues that apply to children and elderly persons also apply to individuals who have been declared incompetent by courts. Although very few individuals are declared by courts to be legally incompetent, adults who are developmentally disabled, critically ill, seriously injured, mentally ill, or elderly could be declared incompetent by a court. If such individuals are declared incompetent, the court appoints a legal guardian who has the same legal powers over the individual that a biological parent or a legal guardian would have over a child.

Counselors must be careful to distinguish between adult clients who have actually been declared incompetent and those who still maintain their legal rights, but who are dependent on others. Dependent adults maintain their legal rights until a court, upon a petition filed by some party, declares them incompetent and appoints a guardian.

The *ACA Code of Ethics* (2005) addresses the informed consent and confidentiality rights of clients who have been declared legally incompetent. Standard A.2.d. reminds counselors to seek the assent of clients to counseling services and to include them in the decision-making process to the extent feasible. Standard B.5.a. requires counselors to protect the confidentiality of clients who lack the capacity to give voluntary, informed consent.

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## **Summary and Key Points**

This chapter focuses on legal and ethical considerations in working with children and vulnerable adults. There are discrepancies between legal and ethical perspectives regarding certain issues in counseling minors, such as privacy and confidentiality rights. These discrepancies pose some difficult challenges for counselors. Many of the same issues that arise in working with minor clients also apply when providing services to vulnerable adults.

Some of the key points made in this chapter about counseling children include the following:

- Minor clients have an ethical right to privacy and confidentiality in the counseling relationship, but the privacy rights of minors legally belong to their parents or guardians.
- Counselors should not automatically assume that all minor clients do not want their parents

to know information they have shared with their counselors. The stance that minor clients take toward privacy will vary according to their age, developmental stage, and motivation for sharing information with the counselor.

- The ACA *Code of Ethics* (2005) allows counselors latitude to use their professional judgment in determining whether and when to involve parents or guardians in the counseling process.
- Generally, clients under the age of 18 are not considered legally competent to give informed consent to counseling, although there are exceptions to this rule.
- Parents or guardians probably have the legal right to know the contents of counseling sessions with their children.
- Noncustodial parents have certain rights and might be included in the counseling process if it is in a child's best interest.
- Counselors can follow a sequence of steps in resolving a situation in which a parent or guardian demands information and the minor client feels strongly that the information should not be divulged to the parent or guardian.
- When counselors determine that a minor client is at risk of harm to self or others, they must inform the client's parents or guardians. Determining when a minor client is sufficiently at risk to justify such a step is a difficult judgment to make. The counselor should make every effort to maintain the counseling relationship with the client.
- Although counselors who work in institutional settings often share information about clients for the benefit of clients being served, these counselors must take appropriate steps to maintain client confidentiality.
- Counseling is a contractual relationship into which minors cannot legally enter on their own. Nonetheless, school counselors do not have a legal obligation to obtain parent permission before counseling student clients. On the other hand, parents who object to their child's participation in counseling probably have the legal right to demand that services be discontinued.
- For legal purposes, informed consent to counsel a minor should be obtained from the parents.

As an ethical matter, the child client should be actively involved in giving consent and determining treatment goals and strategies.

- Counselors are required by law to report suspected child abuse or neglect. Counselors need to be very familiar with reporting requirements in the state where they practice, because statutes vary considerably from state to state.
- The reporting of suspected child abuse requires counselors to exercise their professional judgment before and after making a report. A host of factors need to be taken into consideration throughout the process.
- School violence has become an increasing concern that raises questions for counselors regarding reporting threats and how to prevent bullying and harassment of children.
- School counselors often play multiple roles. Conflicts can occur between the role of counselor and other roles such as bathroom or lunchroom monitor, coach or club sponsor, and friend to teachers and parents of student clients. Difficult challenges are posed by the need to maintain appropriate boundaries around dual professional roles or simultaneous personal and professional roles.

Counseling vulnerable adults and clients who have been legally declared incompetent was also addressed in this chapter. Key points included the following:

- Counselors have an ethical and legal obligation to protect adult clients who are vulnerable to abuse or neglect due to a diminished capacity to protect themselves.
- Elder abuse and neglect is an underreported but common problem in today's society.
- As the U.S. population ages, counselors will be confronted more often with requests to assist clients in their end-of-life decision making.
- All of the legal issues that apply to minor clients apply to individuals who have been declared by courts to be legally incompetent. Counselors need to be careful to distinguish between legally incompetent clients and clients who are dependent on others but who retain their legal rights.

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# Counseling Families and Groups

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# Counseling Families and Groups

## FOCUS QUESTIONS

1. How is confidentiality different when counseling couples, families, or groups, as opposed to counseling an individual client?
2. Why do you think marriage and family counselors end up embroiled in their clients' lawsuits so often?
3. What should counselors tell potential counseling group members to ensure adequate informed consent?

**E**thical and legal issues can be complex when counselors work with more than one client at a time, as they do in family counseling and group counseling. Many of the same issues apply as when counseling individuals, but they often are more complicated and difficult to resolve when more than one client is involved.

This chapter begins with a focus on counseling families. Ethical concerns that are particularly challenging when counseling families are competence, consent, confidentiality, competing interests (Koocher, 2008), protecting client welfare, and the potential for imposition of counselor values. These familiar topics are revisited from a family systems orientation. This first section also examines some special considerations that often arise in family counseling such as preserving a marriage versus facing divorce, child custody, family secrets, and ethical questions posed by domestic violence.

The second portion of the chapter focuses on group work. The issues of client welfare and informed consent, protecting clients from harm, privacy and confidentiality, dual relationships, counselor values, and counselor competence take on new dimensions when applied to group counseling. Additional ethical and legal rights and responsibilities must be addressed when conducting group counseling, such as freedom to exit a group, screening potential members, protecting confidentiality with minors in groups, and dealing with outside-of-group socializing among group members.

## FAMILY COUNSELING

Family counselors use a systems perspective in working with their clients. From this viewpoint, the family provides the context for understanding its individual members and their problems. Family counselors believe that actions taken by any family member will influence the other members and that their reactions in turn will have a reciprocal effect on the individual (Corey, Corey, & Callanan, 2011). Counselors often work with couples, parents and children, nuclear families, families of origin, extended families, and nontraditional families. Therefore, the first question that the counselor needs to answer is, “Who is the client?” Although family counselors see the entire family system as their client, the answer to this seemingly basic question is not that simple. If the counseling goals of one family member are different from or even antithetical to the wishes of another member, whose interests does the counselor serve? Family counselors need to consider their responsibilities to each of the parties involved in the counseling process (Fisher, 2009). Balancing the interests and fostering the well-being of everyone in the family is one of the most challenging ethical mandates for family counselors (Corey et al., 2011).

Sometimes counseling begins as individual work, and the family is included later. The ACA *Code of Ethics* (2005) encourages counselors to recognize that families are usually important forces in clients’ lives. They should enlist the support, understanding, and involvement of the client’s family and support network, when appropriate, with the client’s consent (Standard A.1.d.). When counseling begins with an individual client and then includes family members, to whom does the counselor have primary responsibility—the individual family member who originally sought counseling or the family as a whole? Standard A.5.e. states that when changing from individual to relationship or family counseling, or vice versa, counselors obtain informed consent from the client and “explain the right of the client to refuse services related to the change.” This standard further advises that clients must be fully informed of any anticipated consequences of counselor role changes. Therefore, when counselors begin counseling with an individual client and then change the focus to family counseling, they will need to revisit issues related to goals, informed consent, parameters of confidentiality, and treatment planning.

Problems can arise when these questions are not resolved at the beginning of the counseling relationship. Standard A.7. of the ACA *Code of Ethics* (2005) states that counselors clarify at the outset “which person or persons are clients and the nature of the relationships the counselor will have with each involved person.” The standard provides guidance in the event the counselor is called upon to perform conflicting roles and requires that, in such circumstances, “the counselor will clarify, adjust, or withdraw from roles appropriately.”

Additionally, “Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known” (Standard B.4.b.).

Because the law and the mental health profession have different perspectives on the family, the two are sometimes in conflict. Family counselors often view the family system as their client and treat the family, as opposed to treating individual members of a family. The law, on the other hand, always views family members as having separate and distinct rights and responsibilities that are individual in nature. To further complicate the situation, the law states that any minor or legally incompetent family member can exercise rights only through parents or legal guardians. This poses problems when one family member wants a family counselor to uphold confidentiality, and another family member demands that the counselor reveal in court conversations what took place during counseling sessions. A family counselor generally favors the family member who wants privacy, whereas the law usually favors the family member who wants the information revealed. This problem is discussed in greater depth later in this chapter.

## Informed Consent

When working with families, the issue of informed consent is complicated. The counselor must attempt to ensure that consent to counseling is given freely after clear and sufficient information has been provided and must also address the following questions:

- Who gives consent on behalf of the family?
- Who in the family is seeking counseling, and are there reluctant participants? Can family members who feel pressured to join in the counseling process give truly free consent?
- What happens when one of the adults in the family refuses to give consent for family counseling?
- How capable are potential participants, particularly children, of understanding what they are getting into?
- How can counselors adequately address the reality that there will be changes in the family system, as well as in individual members, as a result of counseling?

Obtaining informed consent from all members of a family sometimes is not possible. In marriage and family counseling, the desired procedure is to have all adults and legally competent family members give consent to counseling. A difficult situation arises if one such individual refuses to do so. Kenneth, the counselor in the following scenario, is faced with this situation.

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### 1 The Case of Kenneth

Kenneth is a private practitioner who is licensed as a professional counselor and as a marriage and family therapist. He receives a telephone call from Mr. Marquez, who wants to make an appointment for himself and his two children, ages 10 and 12. He states that he and his wife have been having serious marital difficulties, which are taking their toll on the children, who are beginning to act out both at home and at school. He adds that his wife is supportive of their wish to seek counseling but that she refuses to participate in the process because she believes the marital problems are entirely his fault.

- How do you think Kenneth should respond to this request from Mr. Marquez?
- If Kenneth begins counseling with Mr. Marquez and his two children, what issues should he keep in mind?

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**Discussion:** Kenneth might agree to see the family members who are willing to engage in counseling. If he does so, he should explain to Mr. Marquez the problems that exist when one family member is unwilling to participate. If Kenneth begins counseling with Mr. Marquez and his children, he will need to be careful to avoid allowing the three attending family members to blame the absent wife/mother for problems that are occurring in the family. He should, instead, keep the focus on helping Mr. Marquez and each child examine their own behavior and how it contributes positively and negatively to the family dynamics.

The issue of what to do about nonparticipating family members raises some difficult ethical questions. A controversial procedure used by some family counselors is to withhold services until all family members agree to participate in counseling. The problem with this practice is that

the counselor thereby cooperates with the resistant family member by keeping the rest of the family from receiving counseling. Willing family members are then put in an unfair position of being denied services (Haas & Alexander, 1981; Wilcoxon, Remley, Gladding, & Huber, 2007). Of course, coercion of reluctant family members would be unethical, but some family counselors are comfortable exerting some pressure on a resistant family member to participate in one or two sessions. These counselors hope that the resistance can be overcome when members see that they are not going to be scapegoated or blamed for the family's problems (Welfel, 2010). Other strategies that have been suggested include inviting the reluctant family member to attend one individual session to explain the counseling process and address any fears the person may have; referring the willing family members to individual counseling with other providers until the entire family is ready to enter into counseling; and sending the nonparticipating member a letter explaining the family counseling process and changes that might occur as a result of counseling (Wilcoxon & Fennel, 1983).

Another point of view is that when individual family members refuse to participate, counseling still should be made available for those who desire counseling. Counseling should also be made available to family members who are mandated by courts to attend counseling.

Although children cannot legally give informed consent, counselors are wise to involve them in the decision-making process. It is hard to imagine that family counseling would be successful if it included a resistant, resentful teenager who felt left out of the decision to engage in the process. Counselors must be able to communicate with adolescents and children in a way that enables them to understand their role in the family counseling process, and then request their consent to participate (Goldenberg & Goldenberg, 1996).

Just as counselors have an ethical obligation to alert individual clients to life changes that might occur as a result of counseling, family counselors must describe potential changes in family relationships as well as in adaptations that individual family members might make in conjunction with shifts in the family system (Herlihy & Corey, 2006). It can be very difficult to anticipate directions that these reciprocal changes might take, and it is possible that counseling outcomes viewed as desirable by one participant, such as a wife's decision to divorce, might be seen as disastrous by another participant (Wilcoxon et al., 2007). Nonetheless, family counselors have an obligation to explain that the family system will be the focus of the counseling process and that no one family member will be treated as the "identified patient" who is the source of the family's problems (Corey et al., 2011).

### **Client Welfare**

Family counseling gives priority to the good of the family and, thus, may not be in the best interests of an individual in the family. Ethical practice demands that family counselors make every effort to minimize the risks to individuals (Hare-Mustin, 1980). One way to accomplish this is to encourage family members to question how counseling relates to their needs and goals as well as to those of the family. This kind of discussion should take place as part of the informed consent process and throughout counseling, as needed.

Although family counselors may consider the family as a whole to be their client, the law would demand that all clients within a family group be able to rely on the counselor to act in a manner that furthers their best interest and protects them from harm. Legal problems might arise, for example, if a client in family counseling were financially harmed after a counselor encouraged the family to make decisions that excluded the family member from the financial support of the family.

The changing nature of families raises another legal concern for family counselors. Few families seeking counseling today consist of a biological mother and father, and their children. Instead,



families reflect a number of societal trends: single parents are raising children; a stepparent is in the family; single parents have partners to whom they are not married living with the family; close friends are intimately involved with the family; extended family members such as grandparents, adult siblings, uncles, aunts, or cousins reside with the family and may be responsible for raising the children; and gay and lesbian couples are raising children. Family counselors must keep in mind, when working with nontraditional families, that only biological parents or court-appointed guardians have legal rights of control and authority over children. Often, one or more biological parents who are not present in a family have legal rights that must be considered when family decisions regarding children are made.

One-third of the children in the United States live in some type of step parenting situation (Jones, 1996). Stepparents, nonmarried partners, grandparents, other relatives, and friends have no legal rights to confidential information or other privileges held by biological parents. In the event that a counselor wants a person other than a biological parent to have confidential information regarding a child client, a simple solution is to have a biological parent sign a form allowing the counselor to disclose information to the other person.

### **Risky Techniques**

Any time counselors use techniques that are out of the ordinary, they must ensure that clients are protected. If a client is harmed as a result of a nontraditional or unusual technique, the client or the counselor's colleagues could claim that the counselor was operating outside the scope of accepted practices in the field.

Family members often enter counseling feeling vulnerable and fragile, and they may relinquish some of their own authority and allow the counselor to be very influential (Manfrini, 2006). The ethical obligation to reduce client dependency and foster autonomy can be particularly problematic in marriage and family therapy because, in most marriage and family therapy approaches, the counselor is seen as an active and directive agent of change (Nichols & Schwartz, 2004; Wilcoxon et al., 2007). Family counselors sometimes become quite active in directing family members to take, or refrain from taking, certain actions. Directives given by counselors are sometimes called *prescriptions* (Carlson, Sperry, & Lewis, 1997). A professional who prescribes behavior must ensure that no one is harmed as a result of the directives.

One controversial technique used by some family counselors is known as paradoxical directives or interventions. The concept behind the technique is that if authorities instruct persons to do things that are against their best interests, they will defy the counselor and correct the behavior on their own (Goldenberg & Goldenberg, 1998). When paradoxical directives are used in the strategic family counseling model, according to Carlson et al. (1997), "The therapist assigns tasks in which success is based on the family defying instructions or following them to an extreme point and ultimately recoiling, thus producing change" (p. 63). As an example, assume that a teenage daughter is in an inappropriate role reversal situation with her parent. The parent is acting like a teenager, and the daughter is acting like a disapproving parent. The family counselor tells the daughter to work harder at correcting her parent's irresponsible behavior and to take on even more household responsibilities. In this situation, the counselor would hope that the daughter would recoil, defy the counselor's directive, and recognize that she was taking on a parenting role that was inappropriate for her.

Ethical concerns regarding this technique have been raised. One objection to paradoxical directives is that they are manipulative and deceptive. Even though the counselor may ultimately debrief the target of the intervention (the daughter in the previous example), the counselor delivers the intervention without revealing these intentions. Haley (1976) has argued that such a procedure



is a “benevolent lie,” but many writers question whether techniques that involve deception can ever be considered ethically permissible (Lakin, 1994; Welfel, 2010).

A second concern involves the risk of negative outcomes. Some applications of this technique that are potentially dangerous are (a) a parent who is overly strict is told to become more strict in disciplining the children, and (b) an employee who is frantically worried about not performing up to an employer’s expectations is told to be more concerned about pleasing the boss. In these two examples, it is clear how problems could manifest themselves. The parent could physically harm the children, and the employee could become so distressed as to lose the job.

Paradoxical techniques are not the only type of powerful intervention used in family counseling. Family sculpting also can have powerful and unpredictable effects. Other interventions that evoke strong feelings or uncover feelings that have been kept secret in the family can leave clients vulnerable to harm. As a result, family counselors must carefully consider the ramifications of such interventions (Welfel, 2010) and ensure that no one is harmed.

### **Family Violence**

Lawson (2003) has pointed out that 50% to 60% of couples seeking counseling services have reported at least one incident of violence in their relationship. In 1987, Arias, Samios, and O’Leary found that intimate partner violence (IPV) is more common in dating couples and among women about to be married than in married couples. In addition, men and women were almost equally violent toward one another in terms of frequency, as reported by Straus (1999) and Straus and Gelles (1992).

Some scholars, and feminist counselors in particular, have been critical of the idea of applying systems theory to abusive relationships. They note that 95% of victims of physical abuse are women, and they assert that blaming the relationship or relationship dynamics for the abuse is inexcusable. They believe strongly that the male abuser must be held responsible for his behavior.

Welfel (2010) has described the difficulties inherent in attempting to conduct family counseling with couples when abuse is occurring in their relationship. When one partner in a relationship is being abused by the other, the foundation for successful counseling is absent. The partner being abused cannot express feelings honestly in counseling sessions or risk behavior change. The perpetrator can evade personal responsibility when the problem is framed as a family issue. For these reasons, most writers recommend that family counselors see the partners individually, at least initially. Of course, some counselors believe that couples counseling is an appropriate approach when dealing with some physically abusive relationships. Haddock (2002) has addressed the need for counselors to be prepared to assess for partner abuse and provide counseling to the couple. There is no empirical evidence that one approach is more effective than the other.

Wilcoxon et al. (2007) have presented a thoughtful discussion of ethical dilemmas that counselors face when IPV is present in the relationship of a couple in counseling. For example, if counselors encourage the victim to leave or insist that the victim leave a violent relationship, are the counselors imposing their own values and infringing on the client’s right to autonomy in decision making? On the other hand, *not* encouraging a victim to leave a dangerous situation would seem to violate the moral principle of “do no harm.” We caution counselors not to encourage a victim to leave a violent relationship until a safety plan is in place to ensure that this individual does not come to further harm.

### **Privacy, Confidentiality, and Privileged Communication**

Challenges to confidentiality increase exponentially when counselors counsel more than one person at the same time (Kleist & Bitter, 2009). Counselors can guarantee confidentiality only on their own

parts. They must encourage confidentiality but make it clear that it cannot be guaranteed on the part of family members.

The legal counterpart to the ethic of confidentiality is privileged communication. The general rule regarding privileged communication is that privilege is waived if a third party is present (Knapp & VandeCreek, 1987). Most licensed counselors practice in jurisdictions where privilege exists between counselors and their clients, but where there is no specific guarantee of privilege for family situations. In these circumstances, clients who wish to bring family members into counseling sessions must be told that the privilege that normally would exist between the counselor and the client probably would be lost.

Some privilege statutes have been enacted more recently that specifically grant privilege to family members individually and to their counselor (Arthur & Swanson, 1993; Huber & Baruth, 1987; Kearney, 1984). In these situations, an individual client could prevent a counselor from being forced to testify as to what occurred in the sessions, but there is a question as to whether the client would be able to prevent other family members from testifying if they were inclined to do so. As a result, counselors who practice in states where privilege does exist in family counseling situations should assure clients that they would not willingly disclose information from their sessions, but should inform clients that other family members may not have the same obligation to keep the relationship confidential (Jacobs, Masson, & Harvill, 1998).

In *Perez v. City of Chicago* (2004), a federal court found that family members had a right to demand that their private information revealed in family counseling sessions be kept private even when a family member who was a party in a lawsuit had waived his privilege. The court noted that it would be very impractical for a counselor to redact information from family counseling notes to preserve the privacy of the family and therefore held that the family counseling records did not have to be produced in response to a subpoena. This is an unusual result, but it demonstrates how privacy rights unexpectedly will be preserved by courts.

Counselors who provide professional services for married persons are often confronted with a problem related to privileged communication and married couples. In a typical scenario, the couple comes to the counselor because they are experiencing problems in their marriage. In the course of the counseling relationship, a number of stressful topics are discussed and either the husband or the wife admits engaging in negative behaviors such as excessive drinking, infidelity, abusive behavior, or violent acts. Later, the couple decides to divorce. One of the parties wants the counselor to repeat in a legal deposition or hearing the admissions the other party made in the course of the counseling sessions. The other party, for obvious reasons, wants the counselor to keep the information confidential.

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## 2 The Case of Sanjeev

Sanjeev recently began counseling a couple, Margaret and Jason, who were having marital problems after 3 years of marriage. They have one child, a daughter who is 1 year old. During the first two sessions, Jason tearfully admitted to having had an extramarital affair with one of Margaret's good friends during their first year of marriage. The affair lasted 6 months. Margaret had suspected that Jason was romantically involved with her friend, but was not sure about it until Jason admitted it in the counseling session. Before the third counseling session occurred, Margaret told Jason

that she could no longer live with him because of his affair with her friend and that she was filing for divorce, alimony, and child support. Jason called and canceled the third session and reported to Sanjeev what Margaret had said to him.

Now, 1 year later, Margaret's attorney has subpoenaed Sanjeev to attend a deposition to discuss Jason's admission of the affair in the counseling session. Yesterday, Sanjeev received a call from Jason saying that he did not want Sanjeev to reveal what he had said in the counseling sessions because what he said was confidential and privileged.

- What should Sanjeev do now?
- If Sanjeev does attend the deposition, how should he respond to questions?

**Discussion:** Sanjeev should obtain legal advice immediately. An important question with which his attorney can help him is whether a statute exists in Sanjeev's state that extends privilege to family counseling situations. If there is such a statute, Sanjeev's attorney will tell him he cannot reveal confidential information at the deposition. If there is no statute, the law may require him to reveal what Jason said. Sanjeev's attorney will attempt to preserve Jason's privacy if Sanjeev asks the lawyer to do that. How Sanjeev conducts himself in the deposition depends on how his attorney has advised him. He should ask his attorney to accompany him to the deposition.

The situation described here occurs frequently. When counselors find themselves in such dilemmas, they must consult an attorney where they are employed or a private practice lawyer if they are private practitioners. If the counselor refuses to testify at a deposition after a subpoena has been issued, and the spouse who made the negative admissions has legally waived privilege under state law, the counselor could be held in contempt of court. If, on the other hand, the counselor does testify and the relationship with the spouse who made the negative admissions was privileged under state law, the counselor could be legally accountable to that person for violating the spouse's privacy. Reading the state statute on privilege is not sufficient because legal arguments could be made for and against disclosure whether or not a privilege statute exists and regardless of the wording in the statute. This is a situation in which counselors must seek legal counsel and must follow the advice of their attorneys. Of course, counselors should tell their attorneys whether they want to testify and their reasons for feeling that way. This will help the attorney review the situation from the counselor's perspective.

Confidentiality of records can be a problematic issue when counseling couples or families. Adams (2010) has raised the question of what happens to records when the original counseling relationship is altered, either by the addition of a spouse or partner to a previously individual counseling relationship or when a couple are seen separately as individuals for some but not all sessions. The *Ethical Code for the International Association for Marriage and Family Counseling* (2006) offers this guidance: "in situations involving multiple clients, couple and family counselors provide individual clients with parts of records related directly to them, protecting confidential information related to other clients who have not authorized release" (Standard A.13).

### **Family Secrets**

A confidentiality issue that emerges frequently in family counseling is how to deal with family secrets—information that one family member has shared with the counselor but has withheld from a

spouse, children, or other family members (Brendel & Nelson, 1999). There has been considerable debate over whether counselors should keep such revelations in confidence (Kuo, 2009; Margolin, 1982). One position is that secrets should be kept. A rationale for this stance is that the counselor, by agreeing to uphold the confidentiality of individual family members, will be more likely to obtain honest and complete information. This will help the counselor better understand family dynamics and conduct an accurate assessment.

A differing position is that counselors should refuse to keep secrets. In this view, secrets are seen as being counterproductive to the open and honest communication that is necessary for family counseling to be successful. Additionally, by refusing to keep secrets, the counselor can prevent triangulation. Triangulation is a kind of subgrouping created when the counselor and the family member with the secret collude in withholding information from the other family member(s). Some family counselors make it a policy to refuse to see family members individually to avoid becoming recipients of secrets (Dattilio, 2009).

Still others have argued a third, middle-ground position. They stress the need for flexibility and propose that counselors should exercise their professional judgment, divulging or maintaining a confidence in accordance with the greatest benefit for the family. They argue that the criterion should be the effect on therapeutic progress and family welfare.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 4 and view the video clip entitled “A Family Secret.” In this video, the wife shares a “secret” with the counselor and asks the counselor not to tell her husband.

One type of secret that has received a great deal of attention is marital infidelity. Snyder and Doss (2005) have suggested that conflicts of interest may be unavoidable for counselors, who must work to ensure that improvement in one spouse does not occur at the expense of the other. When one partner in a relationship discloses an affair that remains unknown to the other, effective counseling may be impossible (Whitman & Wagers, 2005). Counselors have several choices regarding how to deal with a disclosure of infidelity: they can inform the couple in the initial session that anything revealed outside of conjoint session becomes a part of the couple’s therapy; they can treat the information as confidential on a temporary basis but insist that the individual who committed the infidelity disclose to the partner; or they can keep the revelation confidential (Snyder & Doss, 2005).

The 2005 ACA *Code of Ethics* allows counselors some discretion in how to deal with family secrets. Standard B.4.b. states, “Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual’s right to confidentiality and any obligation to preserve the confidentiality of information known.” If you believe that no secrets should be allowed within the context of family counseling, you could include a policy in your disclosure statement that each individual gives permission to the counselor to disclose to other family members anything said in any interactions between family members and the counselor.

You should keep in mind that your promise to uphold confidentiality is not absolute. When securing informed consent from the family members, tell them that if you learn about activities going on in the family that put family members in danger (such as spouse battering, child abuse, or incest), you may need to take steps to prevent further harm. You must also let your family clients know that you must breach confidentiality when you are required by law to do so.

## Divorce and Child Custody

Because it appears that half the marriages in the United States end in divorce and 60% of second marriages fail (Jones, 1996), many children are affected by divorce. An increasing number of children are born in the United States today to parents who are not married. DeParle and Tarvernise (2012) have reported that the majority of children born to women under 30 in the United States are born to women who are not married. Fathers of children who are not married to the mothers of their children have the same legal responsibilities and rights as men who father children within marriages.

It is important for counselors to understand the nature of child custody so that they will not be tempted to involve themselves inappropriately in custody battles. The Children's Rights Council (2012) provides information regarding custody and parenting that is helpful to parents and those who help parents. Some basic information regarding custody is offered here to give you some sense of the difficulties involved in trying to make decisions regarding your role.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 8 and view the video clip entitled “A Counselor Is Caught in the Middle” to see what can happen when a divorcing couple make conflicting demands on their counselor.

Generally, a custody order by a court defines the nature of the rights and responsibilities of two parents who are separated or divorced, in relation to a child or children. Mnookin and Weisberg (1995) have distinguished between physical and legal custody, stating, “Legal custody carries with it the right and obligation to make long-range decisions involving education, religious training, discipline, medical care, and other matters of major significance concerning the child’s life and welfare” (p. 846). They also stated that when the parent who was not granted legal custody has physical possession of the child, that parent usually has the authority to make decisions concerning the child’s welfare.

The primary components of a custody order specifically define which parent has physical possession of a child at which times and orders child support payments when appropriate. Unless a parental right is specifically altered, modified, or terminated in a custody order, a parent maintains that right, even without the right to physical custody. As a result, noncustodial parents might have a right to receive correspondence that schools send to parents, to review their child’s school record, to contract for counseling for the child, to demand that a child discontinue counseling services, and to take other actions that a custodial parent would have a right to take.

Whether a child’s preferences will be considered in making custody decisions varies greatly from court to court. Appellate courts have done everything from allowing judges to base custody decisions entirely on the expressed preferences of the child to allowing judges to disregard those preferences entirely. Most judges will consider the wishes of a child regarding custody, particularly if the child is older (Kramer, 1994).

Mnookin and Weisberg (1995) described four forms of child custody: sole custody, split custody (one parent is awarded custody of some children, and the other parent receives custody of the remaining children), divided custody (each parent is awarded custody for part of the year), and joint custody. Awarding joint custody to both parents is a controversial practice, yet all but seven states in the United States have statutory provisions that allow joint custody as an option (Children’s

Rights Council, 2012). Some experts believe that joint custody is a positive concept in that it allows natural parents to participate equally in raising their children. Others believe that joint custody is usually detrimental to children because children suffer when parents disagree and no one seems to be in charge. A Nebraska court has said that joint custody is not favored and should be avoided (*Petrashak v. Petrashak*, 1989), while a court in Montana has determined that joint custody is in the best interests of a child (*In re marriage of Kovash*, 1993). Roy (2008) has reported that parenting plans have replaced legal primary and secondary parent status in Florida, following models that had been adopted already in Oregon and New Mexico.

It is difficult for nonlawyers to determine whether a parent has a legal right to possession of a child at any given moment. Parents often agree between themselves to modify the times that they have possession. Some custody orders even stipulate that the parties may mutually agree to modifications. If parents are in conflict over who should have possession of a child, counselors should insist that administrators, lawyers, or even the police become involved in resolving the dispute, rather than trying to resolve it themselves.

Courts sometimes, though rarely, issue an order terminating parental rights. This order severs the legal relationship between a child and the biological or legal parent. Custody and termination of parent rights orders vary greatly in their structure and language and must be drafted to comply with state law. Court orders should always be interpreted by attorneys if there is a question regarding their meaning.

When a divorce has been contentious and child custody has been disputed, parents sometimes make demands that put school counselors in an awkward position. The following scenario is a case in point.

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### 3 The Case of David

Mrs. Jones brings her 12-year-old daughter to school and enrolls her midyear. As she is enrolling her daughter, Mrs. Jones produces a legal document that she says gives her full legal custody of her daughter and terminates all of her husband's parental rights. She instructs David, the school counselor, that if her former husband inquires about his daughter, the school should give him no information and certainly should not allow him to see or pick up her daughter from the school.

- How should David respond to Mrs. Jones's request?
- What should the school officials do in this case?

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**Discussion:** David should not try to deal with this matter; he should refer Mrs. Jones to the school principal. The principal should read the court order to determine what the language actually says about Mrs. Jones's and her former husband's custody rights. If the language is unclear, the principal should ask the school district attorney to interpret it. The principal would also be wise to ask the lawyer how to handle the situation if the former husband shows up at the school and demands to see or take his daughter from school.

Generally, courts give custody preference to natural parents over others who have an interest in obtaining custody. If a caretaker who is not a biological parent wants to obtain custody over the objections of a natural parent, usually a court would have to find the natural parent unfit (Kramer, 1994).



### **Counselor Competence**

Marriage and family counseling is based on a theoretical perspective that is philosophically quite different from the foundations of individual counseling (Cottone, 1992). Thus, developing competence in marriage and family counseling requires more than the completion of one or two specialized courses (Warnke, 2001). The American Association of Marriage and Family Therapists (AAMFT) has established educational requirements that are quite extensive and include, in addition to academic training, supervised experience in working with couples and families, work in one's own family of origin, and personal therapy. Additionally, the AAMFT has adopted core competencies for family therapists (Perosa & Perosa, 2010). CACREP has also promulgated a set of core competencies that are considered necessary for counselors who hold themselves out as specialists in marriage and family counseling.

There is debate among helping professionals as to whether marriage and family counseling is a separate discipline or a specialty area of counseling. Marriage and family counselors in most states have succeeded in getting separate licensure bills passed that set them apart from licensed professional counselors. This diversity of opinion is reflected in the ethics arena. The AAMFT has a code of ethics, as does the International Association for Marriage and Family Counseling (IAMFC), which is a division of the ACA. We recommend that you familiarize yourself with both of these specialized codes for family counselors. They provide guidance more specific to working with couples and families than does the ACA code, which is focused primarily on individual counseling. For example, the AAMFT code (1991) explicitly states that counselors must clearly advise their clients that decisions on marital status are the responsibility of the client (Section 1.4). The ACA code does not address the issue of whether counselors can ethically advocate for the preservation of a marriage or for divorce.

We believe that counselors who are trained generically as professional counselors can appropriately include family counseling in their practices. Specific training in marriage and family counseling is recommended. Additional training could include specific coursework, supervised experience, and some personal work on understanding one's own family of origin issues. The potential for countertransference reactions intensifies when counselors have unresolved family of origin issues (Corey et al., 2011). The bottom line is that professional counselors must stay within the boundaries of their competence in providing services to couples and family clients.

### **Counselor Values**

The personal values of counselors undeniably have an influence on how they conduct individual counseling. The role of counselor values may be particularly critical in the practice of marriage and family counseling (Corey et al., 2011; Huber, 1994). Very few family counselors deliberately attempt to impose their own values on clients. Yet, it is impossible for counselors to avoid using their influence in subtle ways—sometimes without being aware that they are doing so. Marriage and family counseling often deals with some of the most value-laden issues in our society. Just a few examples are offered in Figure 1.

Counseling is never value-free, and all family counselors have their own definitions of healthy and dysfunctional families, effective and ineffective ways of communicating, and affirming and destructive relationships. As Welfel (2010) has so aptly pointed out, no therapeutic work could take place without these definitions. It is not unusual for couples and family clients to espouse values different from those of the counselor, and it is in these instances that counselors are the most challenged to avoid imposing their own agendas. To illustrate, as you read the following case example, try to be aware of the assumptions and values that have entered your thinking about the case.

- Cohabitation, marriage, and divorce
- Marital fidelity and extramarital affairs
- Parenting and disciplining of children
- Birth control, abortion, and adoption
- Relationships between couples of different races or cultures
- Gay and lesbian relationships
- Sex roles and gender roles
- Unorthodox sexual practices such as sadomasochism, partner swapping, or fetish arousal

**FIGURE 1** Value-laden issues in marriage and family counseling

#### 4 The Case of Charlotte

George and Victor are a homosexual couple who have sought counseling from Charlotte to help them decide whether to make a big change in their lives. A number of years ago, George was married and had a son with his wife. He has been divorced and in a committed relationship with Victor for 5 years. George has been thinking about seeking joint custody of his son, who is now 13 years old and with whom he has maintained a parental relationship, although his son has not lived with him. Victor is generally supportive of the idea but admits to some apprehension about having to help parent a teenage son, having to deal with George's ex-wife, and having to share George's affection and attention.

- What assumptions do you think Charlotte might hold that could influence how she works with George and Victor?
- What if you were George and Victor's counselor? Do you hold certain ideas about the morality of homosexuality? About how enduring homosexual and heterosexual relationships are likely to be? About what makes a "healthy" role model for a 13-year-old boy? About the impact that a homosexual or heterosexual partner's jealousy or possessiveness might have on child rearing?

**Discussion:** Charlotte might be assuming that gay men cannot parent effectively, that they would not be good role models for a teenage boy, or that homosexuality is morally wrong. It is important for counselors to give careful thought to their own values and assumptions around such issues so they are better prepared to counsel LGBTQIQ clients and less likely to impose their own values.

One issue of counselor values that has received increased attention in recent years is gender bias. Feminist counselors in particular have contended that family counselors are far from immune to the sex role stereotyping that exists in our society. When counselors do not challenge traditional assumptions about gender roles, they are likely to expect women to be the ones to change in counseling (Nixon, 1993). Counselors also may be vulnerable to certain other biases such as (a) placing less importance on the demands of a woman's career than on a man's, (b) encouraging couples to accept the belief that raising children is primarily the mother's responsibility, (c) seeing a woman's

extramarital affair as more serious than a man's, and (d) assuming that marriage is the best choice for a woman (Guterman, 1991; Margolin, 1982; Sekaran, 1986). On the other hand, feminists have been accused of having their own biases when they encourage counselors to help women define themselves rather than be defined by others, to set their own standards rather than try to meet the expectations of others, and to nurture themselves as much as they nurture others. Some have criticized feminist counselors for rejecting stereotypical but societally endorsed roles of men and women, even though many individuals have consciously chosen those roles.

Family counselors must work to achieve a balance with respect to gender and therapeutic change. They are likely to cause harm to both partners in a relationship if they urge change in gender-prescribed roles solely because they believe such changes are needed. Conversely, it is equally irresponsible to condone through silence emotional abuse or intimidation (Wendorf & Wendorf, 1992). Of course we are exposing our own biases when we suggest that some goals worth striving for, in your work with couples and families, might include the following: (a) practicing in a gender-aware manner; (b) being open to nontraditional roles and relationships; (c) helping family members identify ways that their views on gender roles may be contributing to their problems; and (d) continually monitoring your own behavior for unintended bias, such as looking more at the wife when discussing child rearing and more at the husband when discussing financial issues.

You probably have identified some of your values and assumptions as you reflected on the issues we have raised in this section. Over the course of your career as a counselor, you will inevitably encounter couple and family clients whose values, lifestyles, and choices are very different from your own. It will be important for you to be aware of your own values and biases and keep clearly in mind that it is not your role to decide how couples or families should change. You will be better able to make informed ethical decisions when you know your own values and understand and respect the values of the families with whom you are working.

## **GROUP COUNSELING**

Most of the ethical and legal issues that were discussed in relation to family counseling apply to group counseling as well. A primary difference between family counseling and group counseling is that group members usually do not know each other and do not have personal relationships with each other outside the group counseling environment.

This portion of the chapter addresses the issues of informed consent, screening, client welfare and protection from harm, privacy and confidentiality, dual relationships, socializing among members, counselor values, and competence as they pertain to group work. Included in the discussion are some ethical and legal considerations unique to group counseling, such as freedom to exit a group and screening potential members.

### **Informed Consent**

Potential members of a counseling group have the same rights to informed consent as do prospective clients who are seeking individual counseling. Because the group format differs in some significant ways from individual counseling, counselors need to address additional elements of informed consent for group participation, preferably in a pregroup interview. According to Corey (2008), elements that participants have a right to understand before they make a decision to join a group include the following:

- The purpose of the group, and its format, procedures, and ground rules
- The psychological risks involved in group participation

- What services can and cannot be provided within the group setting
- The division of responsibility between leader and participants
- The rights and responsibilities of group members
- Confidentiality and its limits
- Ways the group process may or may not be congruent with the participant's cultural values
- Freedom to leave the group if it does not turn out to be what a member wants or needs

The purpose of counseling is an issue that must be addressed in individual as well as group counseling, but clients in a group setting have less freedom to determine the topics or process of counseling. Typically, group leaders have already established a general theme or purpose for the group such as adjustment to divorce, assertiveness training, or succeeding in college. Therefore, the aim in discussing the group's purpose is to help prospective members determine whether their goals in seeking counseling have a reasonable chance of being met within a group context, and if so, whether the particular group is compatible with their goals and needs.

There are psychological risks involved in individual counseling as well as in group participation, but in group counseling the risks are increased because the group leader has less situational control over events. Therefore, informed consent must include a full discussion of this topic. Group pressure or coercion is one such risk that has received considerable attention from specialists in group work. Risks will be discussed further in a later section on client welfare.

Although group workers consider it an ethical imperative to give members the freedom to exit a group at any time during the life of the group, they have debated the delicate matter of how such an event should be handled. When a member drops out of a group, it can cause disruptions in the process for the remaining members. If they are concerned that they have said or done something to cause the departure, the trust and cohesion of the group will be affected. For this reason, many group leaders believe that members who are considering leaving the group should be encouraged to raise the matter in a group session rather than simply notify the leader of their decision to withdraw. Corey (2008) has stated that group members have a responsibility to the leaders and to other members to explain why they want to leave. The member who wants to exit the group may feel pressured or coerced to remain, however, rather than have to submit to such a process. The ethical question in these situations is whether the comfort and wishes of the individual member or of the group as a whole should take precedence.

Although clients in voluntary groups have the freedom to withdraw from participation, this freedom is abridged when counseling is court-ordered. Mandated clients need to be informed that prematurely exiting a group could place them in a compromised legal position, possibly including being remanded to jail (Herlihy & Flowers, 2010).

Both counselor and client must fulfill certain responsibilities in order for counseling to be successful. In a group setting, regular attendance and being on time for sessions are particularly important client responsibilities, because other members and the group as a unit are negatively affected when an individual does not meet these obligations. In individual counseling, clients can choose to share information they have discussed in sessions, but in group counseling they have a responsibility to maintain the confidences of other members. Taking interpersonal risks and giving feedback to others are further responsibilities that pertain to group counseling participants.

When group members are minors, obtaining informed consent raises some of the same issues that arise when working with minors individually. The Association for Specialists in Group Work (ASGW) recommends that the "appropriate" consent forms be obtained, but does not specify whether the minor or the parent has the right to make the decision for a minor to participate in a group. There are potential problems with either alternative. It is possible that parents might not give consent for

their children to participate in some groups, such as groups for children of alcoholics (COAs) or abused children. However, if parental consent is not sought and parents later are upset to learn that their child has been participating in such a group, this also could present problems.

### **Screening**

Leaders should secure informed consent of potential group members prior to implementing a counseling group. They should also screen potential members to determine whether any of them should be excluded (Hines & Fields, 2002; Ritchie & Huss, 2000). The *ACA Code of Ethics* (2005) requires that counselors screen prospective group participants and do their best to select members whose needs and goals are compatible with the goals of the group. Counselors should select members whose well-being will not be jeopardized by the group experience and who will not impede the group process (Standard A.8.a.). The primary criteria for inclusion should be whether potential members are likely to contribute to the group and whether they are likely to be compatible with each other.

Unless the group has a very specific purpose, it is much easier to decide whom to exclude than it is to decide whom to include. Prospective participants who generally should be excluded are those who are likely to dominate or monopolize group time, are hostile or aggressive in their style of interacting with others, are in a state of severe crisis, are suicidal, are lacking in ego strength, are acutely psychotic, and are highly suspicious or paranoid (Corey, 2008). Individuals diagnosed with certain personality disorders such as narcissistic or antisocial are considered poor candidates for group counseling (Yalom, 1995).

Generally, highly motivated clients who have interpersonal problems will profit most from a group experience (Yalom, 1995). Of course, the purpose of the group will be an important factor in determining whether prospective members will be included or excluded.

Some additional issues need to be considered when recruiting and screening minor clients for groups in school settings. If counselors solicit teachers for potential members for groups on topics such as children of divorce, COAs, or attention deficit hyperactivity disorder (ADHD) or disruptive classroom behaviors, they run the risk of labeling such students as well as violating their privacy. School counselors are advised not to give their groups a name that would label children or imply a diagnosis and to allow students to come see the counselor at their own discretion to discuss their interest in participating in a group (Ritchie & Huss, 2000).

### **Client Welfare and Protection from Harm**

Participating in a counseling group, like any catalyst for personal change, can pose psychological risks. Group counselors have an ethical responsibility to take precautions to protect group members “from physical, emotional, or psychological trauma” (*ACA Code of Ethics*, 2005, Standard A.8.b.). They need to have a solid understanding of the forces that operate in groups and how to mobilize those forces in a constructive manner (Corey, 2008). Four potential dangers to which group leaders need to be alert are scapegoating of members, the subjection of members to undue pressure, the misuse of confrontation, and injury resulting from group exercises or activities that involve physical contact.

Sometimes an individual member of a group is singled out as a scapegoat, and this person is made the object of the group’s frustration or hostility. When this happens, it is the responsibility of the group leader to take firm steps to stop this behavior.

The ASGW, in its *Ethical Guidelines for Group Counselors* (1989), states that it is essential for group counselors to differentiate between the “therapeutic pressure” that is part of any group and “undue pressure” that is not therapeutic. The *Guidelines* remind group counselors that the purpose of a group is to help members find their own answers rather than to be pressured into doing what

the group thinks is appropriate. Group counselors have an ethical responsibility to avoid coercing participants into changing in directions that are not chosen by the participants themselves, and to intervene when members use undue pressure or coercion.

Confrontation is a valuable and powerful tool in a group, but it can be misused by members who have not developed the skill of confronting constructively. When members are inappropriately confrontational, it is the group counselor's responsibility to intervene. It is critical that group counselors model appropriate confrontation.

Although the possibility of a group member physically harming another group member is remote, it could happen with some populations and in particular settings. Counselors who conduct group counseling sessions are expected to ensure the safety of members. Group members who have the potential for harming others either should be excluded from group sessions or should be monitored carefully.

Some group counseling approaches involve group members interacting with each other physically. The law of assault and battery requires that individuals not be touched or put in apprehension of being touched without their permission (Swenson, 1997). Counselors who use group exercises that involve touching should explain in their disclosure statements to clients that touching among members will take place. They should avoid touching that might be considered offensive or sexual, and they should not use any activity that might result in a physical injury.

### **Privacy and Confidentiality**

As noted earlier in the chapter, counselors can guarantee only their own behavior with respect to upholding confidentiality. Counselors must inform clients that they cannot guarantee confidentiality on the parts of group members. It is possible that counselors do not clearly understand how confidentiality promises in group work differ from those that can be offered in individual counseling. Of the ACA members surveyed by Neukrug and Milliken (2011), nearly 37% thought it was ethical to guarantee confidentiality for group members. According to the ASGW *Ethical Guidelines* (1989), group counselors define confidentiality clearly, explain why it is important, and discuss the difficulties involved in enforcement. The *Guidelines* offer several specific suggestions to assist group counselors in dealing with confidentiality in groups:

- Define the limits of confidentiality, and when working with minors, specify the particular limits that apply.
- Stress the importance of maintaining confidentiality before the group begins and at various times during the group.
- Set a norm of confidentiality.
- Provide members with examples of how confidentiality might be breached inadvertently.
- Inform members about the potential consequences of intentionally breaching confidentiality.
- Make participants in a mandatory group aware of any reporting procedures that are required.

### **Confidentiality with Minors**

The ethical and legal complexities of conducting groups with minors are highlighted when a group member discloses some risky behavior that his or her parents should know about. There is no answer as to how such situations should be handled. The counselors must assess each unique situation, given all that is known about the minor and his or her family and what is known about the risky activity in which the minor is involved. Consultation with other counselors before making a decision is always the best course of action for counselors.



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## 5 The Case of Shadiqua

Shadiqua, a high school counselor, is conducting a group for sophomore girls. The purpose of the group is to foster self-esteem and to help in making wise choices. During the fifth session, the topic is boyfriends and whether to “just say no” to sex. Megan, a 15-year-old, shares that she and her boyfriend are sexually active and that she thinks it’s okay because they are really in love. Megan adds that her parents “would kill” her boyfriend if they found out and would throw her out of the house.

- Do you think Megan’s parents must be notified? Or can Shadiqua keep Megan’s disclosure in confidence?
- If Shadiqua breaches Megan’s confidentiality, what are the risks to her relationship with Megan and with the group?

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**Discussion:** Because Megan is a minor, Shadiqua should talk privately with Megan to see if she can persuade Megan to tell her parents. Shadiqua can remind Megan that the limits of confidentiality had been discussed at the beginning and throughout the group, and she can remind Megan of those discussions. It is possible that, despite Shadiqua’s previous explanations of confidentiality limits, Megan and other group members will feel betrayed and the effectiveness of the group will be compromised.

Cases in which parents may need to be told information points up the importance, when working with minors, of discussing confidentiality and its limits before the group begins and throughout the life of the group. If counselors reiterate confidentiality limits whenever sensitive topics are broached during group sessions, they will have a better chance of avoiding such difficult dilemmas.

### Privileged Communication

Privileged communication may exist for relationships between counselors and clients in your jurisdiction, but this privilege generally is considered to be waived when you are counseling more than one person. A few privileged communications statutes grant privilege to individual group counseling members and their counselor (Arthur & Swanson, 1993; Huber & Baruth, 1987; Kearney, 1984). Read and understand provisions of the privileged communication statute in your state to determine whether group counseling situations are covered.

### Dual Relationships

Although dual relationships between counselors and their clients, including members of counseling groups, are generally to be avoided, relationships between group members and leaders will vary somewhat depending on context. When task groups are held within a work environment, for instance, casual contact between leaders and group members may be inevitable. In counseling groups, however, outside-of-group contact between leaders and individual members can be inappropriate and counterproductive for the group as a whole (Gladding, 2008).

If the group counselor has a personal or social relationship with one of the members, this can lead to charges of favoritism. The counselor might avoid confronting this member or might be reluctant to explore in group some interpersonal issues that are problematic in the social relationship with the member. Group counselors should not use group clients to meet their personal needs

for social relationships or friendships. The role of group counselors is to help members meet their goals, not to help counselors meet their own needs.

Just as group counselors should not develop friendships with group members, they should not admit friends or close acquaintances to counseling groups they are conducting. In the same way that preexisting personal relationships are problematic in a group context, prior professional relationships can cause difficulties. Some counselors make it a routine practice to form their groups largely from their former clients in individual counseling (Herlihy & Corey, 2006). This is not unethical, although there are potential problems. Members of a group who have been counseled individually and who are accustomed to having the counselor's full attention for the entire session may find it difficult to share their counselor with other group members. Additionally, members who are not former individual clients of the counselor may feel disadvantaged because they have not had the same opportunity to form a bond with their group counselor.

There are limits to counselor self-disclosure in group counseling as well as in individual counseling. As a group leader, you must monitor your self-disclosures so that you are aware of what you are saying and your rationale for sharing any personal information. Although it is not your role to use group time to work on your own issues, you can self-disclose appropriately in several ways. You can let members know that you are personally affected by what they are sharing, you can express your persistent reactions to members and offer feedback, and you can model appropriate and timely self-disclosure by expressing how you are affected in the moment by what is going on in the group (Herlihy & Corey, 2006).

### **Socializing Among Members**

Group work specialists have taken varying positions on the question of whether socializing among group members facilitates or hinders the group process. As is true of leader-member contact outside of group sessions, much depends on the context in which the group occurs. In 12-step groups, socializing among members outside the meetings is common, and one member might serve as another member's sponsor. In hospitals, schools, and other institutional settings, it is inevitable that members will encounter one another between sessions. Many group leaders avoid making strict rules about socializing and personal relationships among members because these rules are impossible to enforce (Jacobs, Harvill, & Masson, 1994).

Although the group counselor cannot control members' lives outside the group, there are some good reasons for discouraging the members from forming friendships or social relationships with each other during the group's duration. If cliques or subgroups form, this is detrimental to the group process. If some group members meet outside the group context and discuss matters that are best dealt with in group sessions, hidden agendas will develop and impede group progress. Members who meet outside the group in this way have a responsibility to bring information about their meetings into the group, but they may avoid doing so. Yalom (1995) has made the point that counseling groups teach people how to form intimate relationships but do not provide these relationships. Thus, group leaders have a responsibility to discuss with members the reasons why it is inadvisable for them to socialize between group sessions. If members recognize the pitfalls and understand the rationale for avoiding outside-of-group socializing, they are more likely to honor the counselor's request to refrain from this activity.

### **Counselor Competence**

Because many, if not most, counselors will conduct group work as part of their professional practices, training standards are written to ensure that counselors have adequate knowledge and experience in leading groups. CACREP (2009) requires that graduate programs in counseling include

training in group work that incorporates the study of group dynamics, group leadership, theories of group counseling, methods of group counseling, types of group work, and ethical considerations. The CACREP standards also require the development of group work skills under supervision as part of the requirements for practicum and internship training.

ASGW has published *Professional Standards for the Training of Group Workers* (1992) that describes two levels of competencies for group counseling. The first level specifies core knowledge and skill competencies that provide a foundation for specialized training. Areas of knowledge include awareness of personal strengths, weaknesses, and values; characteristics associated with typical stages of group development; facilitative and debilitative member roles and behaviors; therapeutic factors of a group; group and member evaluation; and ethical issues special to group work. Skill competencies include opening and closing group sessions, modeling appropriate behavior, self-disclosing appropriately, giving and receiving feedback, helping members attribute meaning to the group experience, helping members integrate and apply learnings, and demonstrating the ability to apply ethical standards in group practice.

According to ASGW (1992), after counselors in training have mastered the core knowledge and skills, they can develop a group work specialization in one or more of the following areas: (a) task facilitation groups, (b) psychoeducation groups, (c) counseling groups, and (d) psychotherapy groups. Developing competence in both the basic and the specialized levels of practice requires participation in planning and supervising small groups and clinical experience in leading groups under careful supervision.

Different groups require different leader competencies. For example, a counselor may be qualified to facilitate adolescent groups but be ill-prepared to conduct reminiscence groups for elderly residents of a nursing home. You will need to continually evaluate the match between the types of groups you are considering conducting and your level of training and experience. As you prepare to include group work in your professional practice, you will find that you need specific training and supervised experience for each type of group you intend to lead (Corey, 2008).

It is equally important that you continue to update and expand your skills and knowledge. As is true with all counseling specialties, counselors who work with groups need to continually update their knowledge and skills, particularly in new and emerging areas. Counselors who engage in group work are urged to familiarize themselves with ASGW's *Multicultural and Social Justice Competence Principles for Group Workers* (2012).

Lakin (1994) has expressed concern that many counselors fail to monitor their own competence in the wide range of group modalities and varied clientele to be served. Both continuing education and peer supervision can be useful in this regard. Gladding (2008) has suggested that peer supervision groups can be particularly helpful for increasing one's knowledge as well as one's awareness of even minor misjudgments in group leadership.

### **Diversity and Values Considerations in Group Counseling**

It is not at all unusual for value-laden issues—such as divorce, sexuality, religion, family of origin issues, and honesty versus deceit in relationships—to be brought into a group. Corey (2008) has noted that a group can be an ideal place for members to assess the degree to which their interpersonal behavior is consistent with their values, through receiving feedback from others. The group counselor's role in this process is to make the group a safe place where members can feel free to explore values issues that are troubling to them.

The ASGW *Best Practice Guidelines* (1998a) remind group counselors of the importance of sensitivity to cultural differences. It is crucial that you, as a group leader, are aware of how your own cultural background, attitudes, values, and beliefs influence the way you work with a group.

You must be alert to issues of oppression, sexism, and racism as you work with diverse group members. You should not impose your values on group members or operate as though all members share your worldview or cultural assumptions. If the group is based on values that are alien to some group members, the counselor is likely to encounter resistance from those members. You will want to understand and respect the roles of family and community, religion and spirituality, and ethnicity and culture in the lives of group members. It is also important for group counselors to develop skills for working with clients from other countries. Yakunina, Wiegold, and McCarthy (2010) have noted that groups can be very effective in helping foreign students deal with issues of acculturative stress, language difficulties, cultural misunderstandings, racial and ethnic discrimination, and loss of proximity to support systems such as family and friends.

Group counselors need to be prepared to address issues of social justice in their work with clients. Burnes and Ross (2010) have expressed concern that counselors are unprepared to address the impact of privilege and oppression on the group process. Counselors should seek out training to become more prepared, as groups can be very effective for empowerment at the systemic as well as the individual level (Hays, Arredondo, Gladding, & Toporek (2010). Ratts, Anthony, and Santos (2012) have offered a model for transforming traditional group work into a socially just framework.

Certain values are inherent in the group process, such as self-disclosure, risk-taking behaviors, communicating openly and directly, and increasing awareness and autonomy. Group counselors must be cognizant that some of these values may run counter to the values of group members. For example, striving for personal autonomy may be an alien concept for group members who come from certain cultures (Herlihy & Corey, 2006).

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## Summary and Key Points

When counselors work with multiple clients, as they do in family and group counseling, ethical and legal issues can be more complicated to resolve. Family counselors often work from a systems perspective that is quite different from the theoretical underpinnings of individual counseling. They view the entire family system, rather than its individual members, as their client.

Key points with respect to family counseling include the following:

- The issue of informed consent in family counseling presents some unique challenges, such as determining who in the family gives consent and how to deal with situations in which one family member is reluctant to participate or refuses to participate in the process.
- When one adult, legally competent individual in the family refuses to give consent for the family to participate, counseling cannot take place with all family members.
- Although reluctant family members cannot be forced or coerced into participating in family counseling, some family counselors encourage these resistant members to attend one or two sessions.
- Children cannot give legal informed consent; nonetheless, they should be included in the process.
- Counselors must be aware of legal questions created by the changing nature of families, particularly with respect to the rights of biological parents versus other family members who may wish to be involved in family counseling.
- Family counseling involves some powerful techniques. One such technique about which ethical concerns have been expressed is paradoxical directives. Such techniques must be used with caution so that no harm is caused.
- Whether family counseling should be avoided when there is ongoing abuse in the family should be carefully considered.

## Counseling Families and Groups

- Counselors must make it clear to family clients that there are special limits to confidentiality; counselors can guarantee confidentiality only on their own parts.
- Privileged communication generally is waived if a third party is present in the counseling situation.
- Some more recently enacted privileged communication statutes extend privilege to family clients and group member clients. Counselors should consult with an attorney regarding how to interpret these statutes.
- Family counselors take differing positions on how to handle the issue of family secrets.
- Divorce and child custody issues can be particularly problematic for counselors, and counselors should take care to avoid involving themselves inappropriately in custody disputes.
- Counselor values have a strong impact on how counselors conduct family counseling. Counselors must be vigilant so that they do not inadvertently impose their own values and assumptions, particularly regarding culture and gender roles.
- Developing competence in family counseling requires specialized coursework, supervised experience, and experience in the counselor's own family of origin work.

Group counseling is another modality that involves multiple clients. Ethical and legal issues have different implications in the group context than they do in individual counseling. Key points regarding group counseling include the following:

- Informed consent to participate in group counseling involves a number of issues in addition

to the standard elements of informed consent for individual counseling.

- Group leaders must balance the rights of the individual against the needs of the group when a member wants to exit the group prematurely.
- It is good practice to screen potential members of a group to exclude those who are unlikely to benefit from the experience, and to select those who are most likely to contribute to the group and be compatible with each other.
- Group counselors have a responsibility to protect group members from harm and to be alert to the dangers inherent in scapegoating, undue pressure, inappropriate confrontation, and injury resulting from activities that involve physical contact.
- As is true in family counseling, confidentiality is difficult to enforce in group settings, and counselors should make a special effort to ensure that group members understand the importance of confidentiality and how to avoid inadvertent breaches.
- Privileged communication may not exist in group counseling situations unless the state statute specifically extends privileged communication to group counselors and their clients individually.
- There are additional limitations to confidentiality when groups are composed of clients who are minors.
- Group counselors should make every effort to avoid dual relationships with members of their counseling groups.

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# Evaluation, Testing, and Diagnosis

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# Evaluation, Testing, and Diagnosis

## FOCUS QUESTIONS

1. Evaluation as an end in itself is a very different process from counseling. Why would a counselor want to be an evaluator?
2. To what degree do you believe counselors are competent to administer and interpret psychological tests?
3. The *DSM-IV-TR* system for diagnosis is based on pathology and the medical model of mental illness, whereas counseling is grounded in the wellness model. Why must counselors learn to diagnose clinical disorders?

Evaluating, assessing, testing, and diagnosing individuals are activities that are a critical part of the counseling process, but they are not counseling as it is usually conceptualized. Counseling most often involves face-to-face interviews between a counselor and client that are focused on the client's well-being and on assisting the client in personal decision making and problem solving. Personal interviews with individuals also may be included in an evaluation completed by a counselor. However, interviews in which persons are being evaluated have a different purpose than counseling interviews.

Because counselors may sometimes be evaluators, and because evaluators usually conduct personal interviews as part of the evaluation process, it is understandable that individuals may become confused about their interactions with evaluators. For example, a woman who goes to a counselor's office for an interview related to a child custody dispute may not understand that she is not entering into a counseling relationship, although the counselor may be asking questions about life events that are very upsetting. The purpose of a child custody evaluation is to report findings to a judge or jury about which parent may be best to have custody of a child, not to assist the person being evaluated in dealing with the stressors of the situation. Before counselors begin an evaluation interview, it is essential that they fully describe the difference between being counseled and being evaluated. Counselors must ensure that the individual understands this is not a counseling relationship and that the counselor may use any information gathered in the interview as the basis of a report

and opinion that will be given to a third party. These obligations are described in the ACA *Code of Ethics* (2005). Standard E.13.a. clarifies that “the primary obligation of counselors in providing forensic evaluations is to produce objective findings” to be used in reports or testimony. Standard E.13.b. requires counselors to inform in writing persons being evaluated *that the relationship is for the purposes of an evaluation and is not counseling in nature* and that the counselor obtain the written consent of persons being evaluated *unless a court orders evaluations to be conducted without the written consent of individuals being evaluated*.

What we have just described is a formal evaluation. There is another type of assessment that occurs within a counseling relationship. At the beginning of the counseling relationship with a client, a counselor must assess the circumstances of the client as part of the process of determining jointly with the client the goals of the relationship. Assessment is a collaborative process to which both the counselor and the client contribute with the aim of gaining a better understanding of the client’s problems. An accurate assessment of the problems, in turn, increases the likelihood that the problems will be resolved successfully in counseling. Counselors usually complete this preliminary step in the counseling process during the initial interview with a client. Sometimes, a more extensive assessment is needed, and counselors decide that formal evaluations are required.

The ethical and legal pitfalls in the areas of evaluation, assessment, interpretation, and diagnosis are numerous (Welfel, 2010), and an entire section (Section E) of the ACA *Code of Ethics* (2005) is devoted to this topic. We begin this chapter with a discussion of ethical requirements and related legal issues in evaluation and assessment generally. Then we focus on two types of assessment—testing and diagnosis. Multicultural issues in evaluation, assessment, testing, and diagnosis are examined along with other challenges.

## EVALUATION AND ASSESSMENT

### Objectivity in Evaluation

Evaluations can be simple or complex and might be completed by counselors or by other mental health professionals. When the counselor who is also going to treat the client completes an assessment, the sole purpose should be to gain information to allow the counselor and client to understand the problems and establish appropriate counseling goals. Dual roles should be avoided (ACA *Code of Ethics*, 2005, Standard E.13.c.). For example, a counselor who is providing individual counseling to a parent should never evaluate that parent in a child custody situation. Child custody evaluations require that unbiased and objective recommendations be made to a judge (Gould, 1998). An evaluator must be objective and dispassionate. Counselors always have the best interests of their clients in mind and, therefore, could not be objective evaluators if the findings might negatively affect their clients.

### Client Welfare and Informed Consent

When an assessment or evaluation is completed, the assessment itself is the end product. A counselor or any number of other individuals might then use the assessment report for purposes other than for counseling. As noted earlier, a personal interview of the person being evaluated is quite often a part of the process. Clients who are being assessed need to understand that the process is different from counseling, what the process entails, what the final product will be, and how and by whom the assessment is intended to be used (ACA *Code of Ethics*, 2005, Standards E.3.a. & E.13.b.).

Counselors have a responsibility to secure their clients’ informed consent to evaluation procedures. The client’s *written* informed consent should be secured before beginning a forensic evaluation (E.13.b.). Before counselors conduct any type of assessment, they need to explain its nature

and purposes in language that the client can understand, considering the client's personal or cultural context, the client's level of understanding of the results, and the impact of the results on the client (Standard E.3.a.). Their client disclosure forms should contain an explanation that an assessment is the initial step in a counseling relationship and gives information about the assessment process. The disclosure statement also sets forth information about the process that takes place when an assessment is being conducted by a mental health professional other than a client's counselor.

### **Competence in Evaluation**

Counselors have the education necessary to conduct certain types of evaluations. Some counselors have jobs in which they conduct evaluations on a regular basis, and some have private practices in which they conduct evaluations occasionally or exclusively. In order to conduct an evaluation, a counselor should have expertise in the area that is being evaluated and must be prepared to serve as an expert witness in court. According to the *ACA Code of Ethics* (2005), counselors utilize only those testing and assessment services for which they have been trained and are competent (Standard E.2.a.).

Counselors commonly conduct evaluations to determine the following:

- What type of custody arrangement would be in the best interests of a child
- The extent of an individual's disability and the potential for future employment
- Whether an individual has a substance abuse problem and, if so, the type of treatment that is needed
- Whether a person is at risk for abusing children in the future
- Whether a person is at risk for harming others
- Whether a person is at risk for suicide or other self-injurious behavior
- Whether a person has a diagnosable mental disorder
- Whether a person would perform well in a particular job

### **The Counselor as Expert Witness**

Counselors should avoid conducting evaluations that cast them in the role of expert witness unless they have agreed to do so. If your job requires that you conduct evaluations or if you complete evaluations in your private practice, you must be prepared to testify in court as an expert witness. There is a good chance that eventually you will be subpoenaed and ordered to explain and defend your conclusions and recommendations.

Counselors also should be certain that they understand the circumstances when an attorney appears to be referring a client for counseling. Such referrals may be attempted for legal purposes as well as for clinical reasons, in that attorneys may be seeking a counselor who would later be subpoenaed to repeat in court what the attorney's client has said in counseling sessions, or the attorney may simply want to demonstrate that the client has gone through the motions of seeking counseling. Counselors should ascertain whether a referral from an attorney is related to an existing or potential legal case and take this information into consideration when deciding whether to accept the client (Reid, 2010).

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## **1 The Case of April**

April has recently completed her master's degree in counseling and has taken a job in the probation and parole office at the local county courthouse. April's new supervisor has told April that her master's degree in counseling will be very helpful to her in her new position. April's job is to interview people

after they have been convicted of a crime to determine whether they are good candidates for probation or whether they should be put in jail or prison. April is told that good candidates for probation are those who have never committed crimes in the past or have had only minor violations, have a stable place to live, have jobs they have held for some period of time, and are truthful. April will look over the records of each convicted person, conduct an interview with that person, and then make a report to the judge, giving her opinion regarding whether the person is a good candidate for probation. In her first interview with Tom, who has been convicted of a crime, Tom tells April he is really glad to be able to talk to a counselor. Tom and April develop an easy rapport. In the course of the interview, Tom tells April about a number of crimes he has committed that did not show up on his criminal record and explains that he is about to lose his job because of absenteeism, has recently been evicted from his apartment, and doesn't know where he is going to live. In court 2 weeks later, April reports to the judge that, based on information she has gathered from Tom, she does not believe he is a good candidate for probation. Tom angrily tells the judge that April misled him into thinking she was his counselor and was trying to help him and now she has betrayed him by telling the judge private information. Tom's lawyer makes a motion to have April's recommendation stricken from the record because she has no experience conducting probation evaluations and misled his client.

- When April began her meeting with Tom, what should she have said or done to avoid this unfortunate situation?
- How should counselors react if a person they are evaluating indicates during an interview that he or she believes this is a counseling session, even though the counselors have explained that it is an evaluation interview?

**Discussion:** April should have carefully explained to Tom the purpose of the interview and ensured that he understood before beginning. She also should have given him a written document to sign that reiterated these explanations. When Tom stated that he was glad to be able to talk to a counselor, April should have interrupted the interview and again explained her role as an evaluator. She should call herself an "evaluator," "probation consultant," or other title, rather than "counselor." She also needs to explain to Tom that whatever he says could become a part of the report she is required to make and may be used in determining his probation decision.

An expert's testimony in court usually supports one side in a legal controversy and damages the other side. As a result, the attorney for the side that is damaged has a professional obligation to minimize the impact of the expert's testimony. The attorney will do this in one or more of the following ways: (a) object to the expert's credentials, arguing that the counselor is not expert enough to give an opinion in court; (b) attack the process the counselor used in completing the evaluation, claiming it was not adequate; (c) attempt to get the counselor to contradict statements, hoping that the judge or jury will give less credibility to a witness who is not consistent; and (d) offer another expert witness's testimony that contradicts the counselor's conclusions and recommendations, hoping the judge or jury will give more credibility to the other expert's testimony. Aggressive cross-examinations can be challenging and uncomfortable for counselors who testify in court as expert witnesses (Brodsky & Terrell, 2011).

Counselors who agree to provide expert testimony in the belief that judges, attorneys, and juries will listen respectfully to the counselor's opinions and be appreciative of their input are in

for a big surprise. Hagan (1997) has argued that all mental health expert testimony is a fraud. She has taken the point of view that mental health, as a science, is too inexact to allow its opinions as evidence. Ziskin (1995) has produced a three-volume set of texts designed to assist lawyers in discrediting the testimony of mental health expert witnesses.

Counselors who plan to serve as expert witnesses should take courses to prepare themselves, observe other experts testifying over a period of time, and read written materials (e.g., Becker, 1997; Gould, 1998; Stokes & Remley, 2001; Strasburger, 1998).

## TESTING

Although formal tests are only one type of assessment that counselors use, tests are particularly vulnerable to abuse (Welfel, 2010). There are a multitude of tests available. Perhaps at least partly for these reasons, the *ACA Code of Ethics* (2005) addresses testing in a number of ethical standards. Counselors use tests in various ways. Occasionally they may be involved in developing new tests, but more often they select existing tests, administer them, and interpret them for their clients.

### Developing and Publishing Tests

When counselors develop and publish testing instruments, they have an ethical obligation to use established scientific procedures, relevant standards, and current professional knowledge for test design (*ACA Code of Ethics*, 2005, Standard E.12.). To learn more about test development, consult the *Standards for Educational and Psychological Testing* (American Educational Research Association [AERA], 1999) that were developed jointly by AERA, the American Psychological Association (APA), and the National Council on Measurement in Education (NCME).

Designing, developing, validating, and marketing a new test requires specific knowledge and skills and is a complex and lengthy process. These factors undoubtedly deter many counseling practitioners from undertaking the task. Even if you are never involved in constructing a test, however, you should understand the ethical responsibilities of test producers. In essence, these responsibilities are to use the best scientific methods in devising their instruments and to have client welfare as the first priority (Welfel, 2010). Test producers must produce and market tests that have demonstrated validity and reliability and appropriate norms, as well as a manual that clearly explains how to use the test, the clientele for whom it is and is not suitable, and its strengths and limitations. They need to provide information that will help users interpret the results accurately.

There are some ethical considerations in marketing tests. Test publishers should make their tests available only to professionals who are qualified to use them. Typically, test publishers require those who wish to purchase their tests to state their degrees, licenses, graduate courses in testing, and training in the use of the specific test. If you ask to use tests as part of your graduate thesis or a research project, you probably will be required to supply the qualifications of your supervisor.

### Test Security

Counselors have both ethical and legal obligations to protect the security of tests from improper usage, copying, or dissemination (*ACA Code of Ethics*, 2005, Standard E.10.). Almost all tests depend on the user being unfamiliar with the test items. Therefore, counselors must keep testing materials safely locked away when not in use to prevent unauthorized users from gaining access to them. Of course, test security measures must also be carefully maintained when the test materials are accessed and stored on a computer.



## 2 The Case of Aaron

Kathleen has sought counseling from Aaron, a Licensed Professional Counselor. Her job situation is tentative because the company where she has worked for the past 12 years is downsizing. She is experiencing a number of somatic complaints related to anxiety along with a general feeling of apprehension. By the end of their second session together, Aaron believes that Kathleen may be experiencing depression as well as anxiety. Because her company's managed health care plan allows them only six sessions, he doesn't want to use precious time for assessment activities. He gives Kathleen a standardized depression scale and tells her to complete it at home.

- What do you think of Aaron's decision to let Kathleen complete the test at home?
- Can you identify any problems with this procedure?

**Discussion:** Aaron should not have allowed Kathleen to take the test home unless it was specifically designed to be self-administered (*ACA Code of Ethics*, 2005, Standard E.7.c.). Counselors have a responsibility to appropriately supervise the test-taking process. Any number of things could happen that would produce invalid results if Kathleen takes the test at home. She might misread or misunderstand the directions, exceed the time limits for completing the test, try to complete the test while watching TV or being otherwise distracted, or become alarmed by feelings evoked by the wording of some of the test items.

### Copyright Laws

A second problem related to test security occurs when counselors and other professionals break the law by violating copyrights of tests held by test authors and publishers (*ACA Code of Ethics*, 2005, Standard E.10.). Once a test has been created, the author (or publisher, if the author transfers the rights) owns the test for 75 years from the date of first publication or 100 years from its date of creation, whichever date expires first (Henn, 1991).

Tests that are published by commercial testing companies must be purchased. Materials include answer sheets, question booklets, report forms, manuals, and other items related to the test. Computer software of all types related to testing is copyrighted and may not be duplicated or used without permission of the publisher. Some commercial testing companies are aggressive in protecting their copyrights because their business profits are negatively affected by violations.

Some tests have never been published by the author or may have been published in a journal. Such tests are not available from a commercial testing company. However, permission must be obtained from the copyright holder before counselors can use the tests either to administer to clients or for research. In most situations, authors transfer their rights to the owners of journals when materials are published.

### Competence to Test

Counselors generally do not use testing as much as psychologists do in their practices. The preparation that master's-level counselors receive in testing usually includes the following: (a) a 3-credit assessment course, (b) some testing principles in a research class, (c) testing information in courses

such as career counseling and diagnosis of mental disorders, and (d) supervised practice of the use of tests in practicum and internship. Because of the limited use that counselors generally make of tests and the educational level of counselors in the area of testing, it is important both ethically and legally for counselors to administer and interpret only tests for which they are qualified by education, training, and experience (ACA *Code of Ethics*, 2005, Standard E.2.a.).

At first glance, testing procedures might seem to be fairly simple and straightforward. Test manuals give detailed step-by-step instructions for administration, and many tests can be scored and interpreted by a testing service. In reality, considerable knowledge and professional judgment are needed to select the right test for the intended purpose and clientele, to administer the test properly, and to interpret the findings to the client (ACA *Code of Ethics*, 2005, Standard E.2.c.). In order to select wisely, counselors must have a solid knowledge of the various tests that are available, what they measure, and their limitations. Anastasi (1988) has reminded counselors of their ethical responsibility to use *multiple criteria* for decision making. This means that counselors should never use a test as the sole criterion for making clinical or educational decisions. To illustrate this point, even if Aaron (the counselor in the previous case example) had asked his client to complete the depression scale in his presence, Aaron should not use only the client's score on the scale to determine whether a diagnosis of depression is warranted. Aaron should also consider his clinical impressions and the client's behavioral indicators, consult the diagnostic criteria for depression in the current edition of the *Diagnostic and Statistical Manual (DSM)*, and perhaps (with the client's permission) interview individuals who know the client well and have observed her general daily behaviors.

There is no absolute standard for adequate preparation to use particular tests. In addition, formal educational experiences such as for-credit courses and internships are not the only methods of training. Counselors could become proficient in testing through workshops, supervised practice, and independent study as well. The amount of training needed to develop proficiency varies greatly depending on the test. Developing competence to use complex personality tests such as the Minnesota Multiphasic Personality Inventory–2 requires extensive training (Pope, Butcher, & Sheelen, 1993). There are many tests, however, that counselors can learn to use through the instruction and supervised practice provided in a typical master's degree program. Competence to use a test always depends on the individual counselor's training and experience with the particular test.

Although assessment, including the use of various tests, has always been an integral component of the counseling process, the question of who is qualified to use assessment instruments remains a contentious battleground (Watson & Sheperis, 2010). For this reason an advocacy group, the National Fair Access Coalition on Testing (FACT), has been formed to protect counselors' rights to conduct assessment and testing (FACT, 2010). Counselor licensure laws now exist in all 50 states; however, some state laws either restrict counselors to certain testing activities or are ambiguous about whether counselors are qualified to make assessments.

For example, some states prohibit counselors from using projective tests, and at least one state statute requires licensed counselors to be further "privileged" to test (Louisiana Licensed Mental Counselor Licensing Act, 1999). Counselors should review their licensing statutes and regulations to determine whether there are any tests they cannot legally administer and interpret. If licensed counselors exceed their statutory authority to test, they could be accused and found guilty of practicing psychology without a license. This happened to a Licensed Professional Counselor in Louisiana (*State of Louisiana v. Atterberry*, 1995).

Counselors should regulate themselves in the practice of testing. This is the position taken by the ACA as is explained in the *Standards for Qualifications of Test Users* (ACA, 2003). Although counselors typically do not have extensive training in testing, many resources are available to assist

counselors in maintaining and increasing their competence to test. The website of the Association for Assessment in Counseling and Education (AACE; [www.theaaceonline.com](http://www.theaaceonline.com)), an ACA division, offers links to a variety of resources and testing documents. Two particularly useful documents are the *Code of Fair Testing Practices in Education* and the *Responsibilities of Users of Standardized Tests*. As the international counseling movement continues to grow, counselors who use tests in their work should familiarize themselves with the international guidelines for test use (International Test Commission, 2001).

### **Release of Testing Records**

Records of test results are the same as other counseling records. Counselors must ensure that testing records stored in computers are kept secure. A discussion of circumstances under which testing records of clients can be released to third parties was also included. Counselors who receive test results for clients they have been counseling should never transfer those records to another person. In the event that testing records received from another professional are requested or subpoenaed, counselors should refer the individual asking for the records to the professional who originally created them.

Counselors should not release test data to anyone who is not qualified to receive the information. The ACA (2005) *Code of Ethics* states that counselors should release test data *only to persons recognized by counselors as competent to interpret the data* (Standard E.4.). You may feel uncomfortable asking someone who requests test records to verify his or her qualifications, but releasing test data to unqualified individuals carries such a high risk to client welfare that counselors must stand firm on this point (Welfel, 2010). You also have an ethical obligation to ensure that testing records are transferred in a secure manner.

### **Providing Explanations to Clients**

Clients have the right to make an informed choice about whether they want to participate or refuse to engage in testing procedures (ACA *Code of Ethics*, 2005, Standard E.3.a.). They can also expect to receive an explanation of the results of any test they take (Standard E.1.b.).

Standard E.3.a. of the ACA *Code of Ethics* (2005) clearly indicates that informed consent applies to testing. Before counselors test, they must explain the nature and purposes of assessment and the specific use of the results in language that the client can understand. It is particularly important that clients understand what uses will be made of their test results. They have a right to know in advance if tests will be used as a factor in employment decisions, as a criterion for placement in a special educational program, as a device for screening potential members of a psychotherapy group, or as a means of making other decisions that will affect their lives.

The ACA *Code of Ethics* (2005) includes one other client right that must be attended to before testing takes place. Standard E.7.d. requires counselors to tell examinees what conditions produce the most favorable test results. For example, if being well rested has been shown to improve performance on a test, test takers need to be given that information.

After clients have participated in testing procedures, they have a right to receive feedback about the results (ACA *Code of Ethics*, 2005, Standard E.1.b.). Many standardized inventories are now computer scored, and counselors can receive results along with printouts that present a fairly extensive explanation of those results. What do you think of the way Louis, the counselor in the following case example, utilized the computer-scored and interpreted test results of his client?

### 3 The Case of Louis

Louis is a counselor in a university career counseling and placement center. Last week he began counseling Alicia, a freshman who sought his assistance in deciding which major to pursue. In their first session, he explored with Alicia her sense of being overwhelmed with so many interesting options. After the session ended, Alicia sat at a computer in the next room and completed a career interest inventory. Before his second session with Alicia, Louis obtains her computer-generated score report and interpretation. He reads it over, is impressed with its thoroughness, and decides to give it to her to read at home. He decides he would rather use their time together to explore some other issues she has mentioned, that seem to him to be related to her career indecisiveness.

- What are the problems with giving a client computer-generated test results without also providing an interpretation of the results?
- In what types of situations might you ethically use computer-based testing with clients?

**Discussion:** Although it is easy to understand Louis's reasoning, it would not be wise for him to follow his plan. Alicia might think the computer has given her "the answer" and may attribute too much power to the test results. Using computer-based testing with clients is not problematic so long as the counselor interprets the results to the client in person and puts the results in the context of other information about the client.

It is essential that counselors communicate test results and interpretations directly to their clients. Counselors appreciate commercial services that score and interpret psychological tests because the services save time and relieve them of the task of scoring the tests, but they should avoid over-reliance on them. Interpretations generated by commercial services cannot, by themselves, provide sufficient feedback to clients. They do not take into account the individual characteristics of the test taker and they may not generate enough alternative explanations of results (Matarazzo, 1986). Counselors must exercise their professional judgment and personal knowledge of the client in using reports provided by test interpretation services.

A face-to-face conversation with the client regarding test results can serve additional purposes. Clients sometimes view test results—particularly elaborate, computer-generated score reports—as being infallible. Counselors need to educate clients about the limitations of tests and to keep these limitations prominent in their own thinking. This will help them avoid any tendency to present results in absolute language. Additionally, a dialog with the client can shed light on any unclear or unexpected test results.

For some clients, taking a test is an anxiety-producing event, and they may worry until they see their results. Counselors should keep in mind that some clients have had negative experiences with test taking. Finally, feedback can have therapeutic value. Finn and Tonsager (1992) found that clients who received feedback on their Minnesota Multiphasic Personality Inventories (MMPI) found the feedback to be a positive experience and actually showed a reduction in symptoms.

In practice, counselors often struggle with the question of how much feedback or explanation of test results they should give their clients. They want to be thorough, without overwhelming

the client with detail. For many counselors, the pressures of time-limited counseling relationships imposed by managed care are also a factor. Welfel (2010) has suggested that the criteria for deciding how much time to devote to test interpretation should include the following: (a) clients' satisfaction that they understand the meaning and implications of the results, (b) the counselor's assessment that feedback has clarified any confusion or unclear results, (c) a mutual agreement about ways the test results should influence the counseling process, and (d) implications of releasing the findings to others if the client has agreed to such a release.

### **Diversity Issues in Testing**

Counselors must be cautious in using tests with culturally diverse clients. They must select tests carefully to avoid inappropriate testing that may lack appropriate psychometric properties for a particular client population (*ACA Code of Ethics*, 1995, Standard E.6.c.). It is important to be aware that many traditional assessment instruments have been developed by theorists and practitioners who are themselves lacking in diversity and multicultural training (Helms & Cook, 1999). Because many tests have been validated on mostly middle-class people of European extraction, special populations may not be represented in the norm group on which a test was standardized. Therefore, the test results may be less valid for them. When you use tests, you need to be knowledgeable about the characteristics of the norm group and recognize the limitations of the test with other populations.

The ethical standards require counselors to recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation. Especially when working with culturally diverse clients, test results must be placed in perspective with other relevant factors (*ACA Code of Ethics*, 2005, Standard E.8.).

No test is completely culture free. There is a considerable body of literature that provides examples of how assessment instruments have been misused with ethnic and racial minority clients, women, clients with limited English proficiency, the physically challenged, and other special populations (Herlihy & Watson, 2003). The use of educational and psychological tests, in the school setting in particular, has been challenged. There is evidence that these tests tend to discriminate against African American and Hispanic children (Walsh & Betz, 1995). Academic placement or advancement decisions should never be made on the basis of test data alone.

In addition to knowing about the norm groups on which tests are standardized, counselors should examine tests for content bias. When some items in a test refer to experiences that are not familiar to certain populations, the test is content biased. For example, an item on a test that refers to milking cows may make no sense to an urban child who lives in an impoverished socioeconomic environment. There is evidence that content bias of tests of cognitive abilities, in particular, is partly responsible for lower scores among cultural minorities (Lonner & Ibrahim, 1996). Disparities between the average scores of African American and White individuals on tests of intellectual ability are at least partly attributable to culture-specific variables associated with racial and ethnic minority group members' experiences (Axelson, 1993; Perry, Satiani, Henze, Mascher, & Helms, 2008).

Counselors must be alert to the passage of laws that affect testing practices. Two examples are the Education for All Handicapped Children Act (1975) and the Americans with Disabilities Act (1990). The Education for All Handicapped Children Act requires that tests be in a child's language and be appropriate for the intended use. It also requires that parents give their consent to testing and that they be given access to test protocols after testing has been completed. The Americans with Disabilities Act mandates that testing be appropriate for the individual being tested, that reasonable accommodations be made in testing, and that results may not be used to discriminate in employment choices for people with disabilities.

In summary, counselors must be alert to cultural bias in tests and in test interpretation, and must use caution in interpreting results with minority clients. Ethical practice requires counselors to understand how clients' cultures and worldviews can influence their performance on standardized tests and to place test results in perspective with other factors in evaluating these clients. A good resource for developing competence in assessment with culturally diverse clients is *The Handbook of Multicultural Assessment* (Suzuki & Ponterotto, 2007).

## DIAGNOSIS

Counselors are sometimes uncomfortable with the idea of diagnosing mental disorders. Diagnoses usually are made using the current edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which is published by the American Psychiatric Association and is the world's most widely used system for identifying and describing mental disorders (Gray, 2011). This system of diagnosis is based on the medical model of mental illness. In contrast to the medical model, counselors espouse a wellness model that focuses on client strengths rather than on simply ameliorating symptoms. Thus, there is an inherent philosophical conflict between the *DSM* system and the wellness orientation of counselors (Kress, Hoffman, & Eriksen, 2010).

A lively conversation has taken place in the professional literature regarding whether counselors, with their wellness perspective, should diagnose clients with clinical disorders using the *DSM* system (Ginter, 1999, 2001; Hohenshil, 1996; Ivey & Ivey, 1998; Smart & Smart, 1997). Hohenshil has suggested that the antidiagnostic position of some counselors arises from mistaken assumptions, including the following: Counselors counsel clients with less severe problems than clients who are counseled by other mental health professionals; because counselors focus on wellness, the pathology in the *DSM* is not helpful; and the client-centered relationships utilized by most counselors do not need *DSM* diagnoses for treatment planning. Gintner (2001) concluded that "ignorance of the *DSM* system is not congruent with current expectations concerning counseling practice" (p. 70). We agree that counselors in today's world, no matter where they work, must be knowledgeable of the current *Diagnostic and Statistical Manual (DSM)* and be able to converse with other mental health professionals regarding its contents.

When clients want to use their health insurance to help pay for mental health care, counselors usually must assign a diagnosis in order for their services to be reimbursable. Health insurance companies generally will not reimburse for counseling services unless a *DSM* diagnosis accompanies the insurance claim (Comer, 2007). Counselors want to serve their clients by helping them receive reimbursement for counseling services, yet their philosophical objections make them reluctant participants in diagnosis. Braun and Cox (2005) have warned that discomfort with diagnostic labeling can lead to problems. Some counselors may try to diagnose most or even all of their clients as having an adjustment disorder, which is the mildest and least stigmatizing type of disorder. Some might assign a more serious diagnosis than is clinically warranted so that a client can qualify for health insurance reimbursement. These practices of under-diagnosing, or *downcoding*, and over-diagnosing, or *upcoding*, are dishonest and inaccurate (Herlihy, Watson, & Patureau-Hatchett, 2008). Even more serious is the practice of deliberately changing a diagnosis for insurance reimbursement purposes. Research indicates that approximately 35% to 44% of mental health practitioners may be engaging in this behavior (Danzinger & Welfel, 2001; Tubbs & Pomerantz, 2001). Clients can be harmed by inappropriate diagnostic procedures, and the counselors are on shaky ground both ethically and legally. Standard E.5.a. of the *ACA Code of Ethics* (2005) states that "Counselors take special care to provide proper diagnosis of mental disorders."





**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 8 and view the video clip entitled “A Diagnostic Dilemma.” In this video, a counselor struggles to balance client needs against the demands of the client’s insurance company.

If you use the *DSM* system in your work as a counselor, it is vital that you use it appropriately. A first step is to clarify your own stance toward diagnosis. Diagnosis involves much more than assigning labels to clients. It is best conceptualized in context, as a part of the overall process of assessment that helps counselors understand their clients. Slick (1996) has likened the diagnostic process to working a jigsaw puzzle in that it involves putting together pieces of information about the client to build an overall picture of the person. The primary purpose of diagnosis is to facilitate effective treatment. The relationship between diagnosis and treatment is like a driving trip and a road map (Welfel, 2010). The diagnosis is a map that helps travelers develop a plan for reaching their destination. Diagnosis should point the way to treatment planning and to the selection of effective treatment strategies for identified disorders.

Diagnosis serves other important functions (Fong & Silien, 1999). First, an accurate diagnosis can help counselors make a prognosis or predict the course of a disorder. Second, the diagnostic system in mental health care was developed to facilitate communication among professionals (Kutchins & Kirk, 1987) and provides a common language and shared frame of reference for mental health professionals. Third, it helps counselors identify conditions that may require the attention of a physician, such as organic disorders or medical conditions that are contributing to psychological problems, so that a referral can be made. Finally, the diagnostic system provides a framework for research. Clinical outcome studies build our knowledge base regarding the effectiveness of various treatment approaches.

While keeping in mind all the useful functions of diagnosis, you should be aware of the risks involved, even when it is done honestly and accurately. For clients, learning their diagnosis can be a double-edged sword. It can be comforting for clients to learn that their condition has a name, that they are not alone in what they are experiencing, and that they are not “going crazy.” On the other hand, clients may feel embarrassed or ashamed of their diagnosis, or feel stigmatized by a diagnostic label and refuse treatment rather than have the diagnosis become part of their record. There is also a possibility that a diagnosis can lead to a self-fulfilling prophecy; for instance, a client who is diagnosed with depression may become even more deeply depressed. Counselors must be sensitive to the powerful effect that diagnosis can have on clients. Although the *ACA Code of Ethics* (2005) allows counselors to “refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others,” in most circumstances clients have access to their counseling records, including any diagnoses that counselors have rendered.

Diagnoses can affect not only clients’ feelings and self-concepts but also their lives in significant ways. Severe diagnoses can have harmful effects far into a client’s future, including having difficulty obtaining certain kinds of employment, having difficulty obtaining health insurance, or having their diagnosis used negatively in child custody proceedings (Overton & Medina, 2008). Under managed care, some diagnoses can “shadow a client’s life like hounds from hell” (Wylie, 1995, p. 32).

The process of diagnosing a client’s condition can have effects on the counselor as well as on the client. Studies have shown that the very availability of diagnostic labels can bias counselors in favor of using them, even when a client’s condition does not warrant a *DSM* diagnosis (Langer

& Abelson, 1974; Rosenhan, 1973). Particularly when a client's eligibility for health insurance coverage depends on a diagnosis, counselors may be tempted to "pathologize" behaviors that are developmentally normal. A rebellious adolescent might be diagnosed as having "oppositional defiant disorder" or "conduct disorder." A very shy young adult might be diagnosed as having an avoidant personality disorder. Welfel (2010) has cautioned counselors against jumping ahead to naming a problem before they have verified that one exists. Counselors who use diagnosis must take care to avoid losing sight of the uniqueness of each client. Even while using a system that is focused on mental disorders and pathology, they must maintain the wellness perspective that is unique to their profession. This can be a challenging task.

An additional challenge for counselors who have been trained in and have become proficient in using the DSM system is that a major revision of the manual is being developed. The *DSM-V* is scheduled to be published in 2014. The ACA offered input regarding proposed changes throughout the revision process, and the leadership has applauded some changes, such as reversing the pathologizing of normal bereavement, that have the effect of reducing the dissonance between the *DSM* and the wellness orientation of counselors. Nonetheless, as of June 2012, many of the proposed changes were controversial, both among counselors and within the psychiatric profession, and any revisions to the *DSM* system will remain grounded in the medical model. Nonetheless, we believe it has been important for ACA to offer input into the revisions as a means to work to establish the parity of professional counselors with other mental health professionals in the realm of diagnosis.

Some ethical issues that arise for counselors when they use diagnosis are securing the client's fully informed consent, working with physicians, and having the qualifications to diagnose. Multicultural considerations are also important in diagnosis. Following is a discussion of these issues as well as legal issues related to accurate diagnosis.

### **Informed Consent**

Some clients do not understand the stigma that might be associated with being diagnosed with an emotional or mental disorder. Others may be very concerned about the implications of diagnosis for their future employment or for health care insurability. Although it would be inappropriate to overemphasize the possibility that a client may be discriminated against in the future as a result of receiving a diagnosis, counselors do have a responsibility to raise the issue with clients. The challenge is to present a fully adequate explanation of the diagnostic process without deterring the client from continuing to seek counseling services (Kress et al., 2010).

When clients are participants in managed care plans, there is an increase in the information that needs to be discussed (Applebaum, 1993; Glosoff, 1998; Haas & Cummings, 1991). Clients must understand the impact that their insurance policy may have on the types and length of treatment that will be reimbursed. They must be aware that third-party payment might end before they believe they have met their counseling goals. They must also know what and how much information will be released to managed care companies, and they must give the counselor permission to release the information. The ACA *Code of Ethics* (2005) specifies that "Counselors disclose information to third-party payers only when clients have authorized such disclosure" (Standard B.3.d.).

So that clients cannot later claim that they did not even realize they might receive a diagnosis of an emotional or mental disorder, counselors should include a phrase regarding diagnosis in their client disclosure statement. We also recommend that, whenever possible, counselors should disclose to clients (or their parents or guardians) their diagnosis when the diagnosis is recorded. If an initial diagnosis is changed after the counseling process has begun as a result of a counselor's reassessment of the client's condition, of course this change should also be discussed with the client. Informed consent should be viewed as an ongoing process, not a one-time event. This may be

particularly important to remember with respect to diagnosis, as Grover (2005) has cautioned that some clients may not adequately understand, at the time of their initial consent, the full implications of being assigned a diagnosis and having it communicated to others.

### **Consulting with Physicians**

Because mental health is one dimension of health care, counselors have a responsibility to understand that some client behaviors or reported thoughts and feelings could have a physical basis. Counselors are wise to determine the physical condition of their clients when they begin the counseling process. Intake forms or interview protocols must ask clients whether they have any negative health conditions, and if so, the details regarding their treatment. Counselors must also know whether their clients are taking any medications and, if so, the purpose of the medications and the effects and side effects that the medications produce (King & Anderson, 2004). When clients have not had a physical exam in a long time, or if a possibility exists that a problem may be physical in nature, counselors should recommend that clients have a physical exam and ask the clients to report the results to them.

When clients have physical complaints that obviously might be related to medical problems (such as headaches, dizziness, or chest pains), counselors must insist that these clients have physical examinations as a condition to their continued mental health treatment. Mental health professionals who overlook or ignore the obvious need for a referral to a physician could be held negligent if a client's supposed mental condition later turned out to be caused by a physical problem.

The symptoms of some mental disorders can be alleviated by psychotropic medications. For example, several medications have been demonstrated to be effective in reducing symptoms of bipolar disorder (formerly called *manic depression*) in many sufferers. When counselors diagnose conditions that can be helped by taking medication, they must make clients aware of this option. Counselors can then refer clients who are willing to consider taking medication to a psychiatrist. With the client's permission, the counselor and psychiatrist can work cooperatively in assisting the client.

### **Qualifications to Diagnose**

An issue that has been controversial is whether counselors are qualified to diagnose mental disorders. Of course, counselors should not assign a diagnosis of an emotional or mental disorder unless they have had adequate training to do so (ACA *Code of Ethics*, 2005, Standard C.2.a.), but there is no absolute standard for determining adequate training. In terms of academic preparation, most contemporary programs that prepare counselors for clinical mental health or community agency practices require counselors to complete a course in diagnosis of emotional and mental disorders. Counselors should also have had supervised experiences in diagnosing as part of their practicum or internship in their master's degree programs, should continue to gain supervised experience in diagnosis while they are working toward their licenses, and should seek ongoing consultation and supervision of their diagnostic practices (Kress et al., 2010). Diagnostic criteria are updated periodically, and new research about effective treatments is appearing constantly, so counselors must continue to learn in order to stay current (Standard C.2.f.).

In some states, licensed counselors have been challenged and accused of practicing outside their scope of authority when they have diagnosed emotional and mental disorders. The following quotation from the *DSM-IV-TR* clearly states that counselors are users of this manual:

An official nomenclature must be applicable in a wide diversity of contexts; *DSM-IV* is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. (p. xv)

Accusing counselors of practicing outside their scope of authority when diagnosing emotional and mental disorders is an example of a “turf issue” that can pit counselors against other mental health professionals who have traditionally endorsed the medical model, such as psychiatrists, psychologists, and social workers. The issue is very important because if mental health professionals are unable to render diagnoses of emotional and mental disorders, health care providers and health insurance companies may refuse to employ them or may not reimburse their clients for mental health services they provide.

Counselors have responded to this problem by introducing legislation that amends the scope of practice in their state licensure statutes. The amendments specifically indicate that licensed counselors may diagnose and treat emotional and mental disorders. In states that do not have such specific language in their counselor licensure statutes, counselors still diagnose emotional and mental disorders. However, they must argue that doing so is part of the counseling process in general that is covered in other language in their counselor licensure statutes.

### Diversity Considerations in Diagnosis

Counselors must keep in mind whenever they are dealing with diagnosis that “mental disorders” are defined in a cultural context. Standard E.5.b. of the ACA *Code of Ethics* (2005) states, “Counselors recognize that culture affects the manner in which clients’ problems are defined. Clients’ socio-economic and cultural experiences are considered when diagnosing mental disorders.” Behaviors that may seem bizarre in one culture may be considered perfectly normal in another. The *DSM* system has long been criticized for pathologizing normal behaviors and for bias against women, members of ethnic and racial minority groups, geriatric populations, children, people living in poverty, and LGBT individuals (Rapp & Goscha, 2012; Zur & Nordmarken, 2010).

The *DSM* only *describes* mental disorders. It does not consider the etiology, or possible origin, of mental disorders. The manual does not ask clinicians to consider, for instance, why twice as many women as men are diagnosed with Major Depressive Disorder. Is it because women are more prone to depression than are men; because it is generally more acceptable in our society for women to express sadness and to ask for help for symptoms of depression; because women are more likely as an oppressed group to experience feelings of hopelessness and depression; or due to other reasons? Several studies have demonstrated gender bias against women among mental health professionals, including mental health counselors (Schwartz, Lent, & Geihlsler, 2011). These studies have been an outgrowth of a well-known study by Broverman and colleagues (Broverman, Broverman, Clarkson, Rosencrantz, & Vogel, 1970). These researchers found that mental health professionals used nearly identical adjectives to describe a “healthy male” and a “healthy adult” but a different set of adjectives to describe a “healthy female.”

Herlihy and Watson (2003) identified three ethical problems in the use of the *DSM* system with diverse clients. First, the *DSM* is based on the medical model of mental illness that defines problems as residing within the individual. Failure to consider social, political, economic, and cultural factors in clients’ lives does a disservice to clients whose problems originate in or are exacerbated by oppression, marginalization, and discrimination.

Second, the *DSM* system tends to pathologize the problems of racial and ethnic minority and women clients. A number of studies have demonstrated that members of minority groups tend to receive more severe diagnoses than members of the majority culture for the same symptoms. Studies have shown that African Americans are more likely to be diagnosed as suffering from schizophrenia (Neighbors, Trierweiler, Ford, & Muroff, 2003; Neighbors, Ford, Trierweiler, & Stillman, 2002; Pavkov, Lewis, & Lyons, 1989) and childhood disorders (Feisthamel & Schwaertz,

2009) than are Euro-Americans. Latinos/Latinas also are more likely to be diagnosed with psychotic illnesses (Manderscheid & Barrett, 1991).

Third, the *DSM* system tends to perpetuate a paternalistic approach to mental health care and thus to reinforce the societal oppression of women and minority clients. The medical, pharmaceutical, and psychotherapy industries profit tremendously from the treatment of mental disorders (Herlihy & Watson, 2003; Rave & Larsen, 1995). Women receive more prescriptions than do men in all classes of drugs and particularly psychotropic medications. The medical model mirrors the dominant/subordinate relationships between the authority who diagnoses and prescribes and women and minority culture clients who are the recipients of these services (Feisthamel & Schwartz, 2009; Rapp & Goscha, 2012). Counselors who strive to avoid replicating in the counseling relationship the inequities experienced by women and minority clients will reframe many symptoms as coping mechanisms and evidence of survival skills in an oppressive culture rather than as evidence of pathology.

The *ACA Code of Ethics* (2005) reflects the concern of counselors regarding historical and social prejudices in the diagnosis of pathology. Standard E.5.c. states that counselors recognize these prejudices that have led to the misdiagnosing and pathologizing of certain individuals and groups, as well as the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.

Counselors must be alert to the fact that Americans who are members of various minority groups will assign different cultural meanings to such traits as assertiveness, emotional expressiveness, and obedience. The *DSM-IV-TR* cautions mental health professionals that, if they are unfamiliar with the nuances of a client's cultural frame of reference, they may incorrectly judge as psychopathological the normal manifestations of behavior, beliefs, and experiences particular to that client's culture. This ethical responsibility is also addressed in the *ACA Code of Ethics* (2005).

Despite the problems inherent in the *DSM* system and despite the discomfort of many counselors in using this system, it would be impractical for counselors to refuse to participate in the *DSM* diagnostic process. Rather, counselors have an ethical responsibility to reframe their thinking about the *DSM* system in more culturally competent ways (Herlihy et al., 2008; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Counselors must be careful to maintain their wellness and holistic orientation and to avoid equating clients with their disorders through diagnostic labeling. For example, a client is never referred to as "a schizophrenic," but rather is described as an individual who suffers from schizophrenia (Dorre & Kinnier, 2006).

### **Legal Issues in Diagnosis**

Earlier in this section, we made the point that when counselors decide to render a diagnosis, the diagnosis must be accurate and honest despite any philosophical uneasiness or cognitive dissonance they may be experiencing. We noted that some mental health professionals record what they consider to be less serious disorders than what they believe the client has in an effort to avoid stigma for the client. At the other end of the spectrum, they sometimes assign diagnoses that are more serious than warranted so that their clients will receive third-party reimbursement for counseling services. These practices are not uncommon. Inappropriate use of a diagnostic category to obtain insurance reimbursement is the type of financial misconduct that is most frequently brought before ethics committees, licensing boards, and courts (Peterson, 1996).

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## **4 The Case of Charlotte**

Charlotte has been a counselor in a group private practice for 6 years. She shares office space with other counselors, but maintains her own separate private practice business. Most of the managed health care

companies for which Charlotte is an approved provider require her to identify an emotional or mental disorder before they will agree to reimburse her clients for her counseling services. Most companies require that Charlotte diagnose each client using the *DSM-IV-TR* with an Axis I clinical disorder. *Other Conditions That May Be a Focus of Clinical Attention*, sometimes called *V-Codes*, are not acceptable. Charlotte, having been educated from a wellness perspective of mental health, worries about labeling her clients negatively by diagnosing them with mental disorders. In reviewing the *DSM-IV-TR* Axis I clinical disorders, Charlotte has decided that *Adjustment Disorder* is the least objectionable and is least likely to distress her clients if she diagnoses them with it. Even though many of her clients do not meet the technical criteria for receiving a diagnosis of Adjustment Disorder, Charlotte uses that diagnosis anyway. About 80% of Charlotte's clients are diagnosed with Adjustment Disorder.

- Do you agree with Charlotte's diagnostic practices? Why or why not?
- How can a counselor with a wellness perspective justify diagnosing clients with *DSM-IV-TR* mental disorders?

**Discussion:** Charlotte's motives in diagnosing most of her clients with Adjustment Disorder are understandable, but her actions are not ethical and also constitute insurance fraud because she is lying to managed care companies in order to collect payments from them. She can be sued by the companies and charged with a crime by a prosecutor. Charlotte needs to make the effort to reconcile her wellness perspective with using the *DSM* system so that she diagnoses honestly and accurately. She should remember that rendering a diagnosis means that a counselor has identified the criteria for the diagnosis in the client at a given time.

Practices such as those Charlotte is using are classified as insurance fraud, which can expose counselors to both civil and criminal liability. A client could bring a civil malpractice suit against the counselor, and a prosecutor could bring criminal charges against the counselor based on the fraud. A client who was assigned a false diagnosis would have an excellent foundation for a successful malpractice suit against the counselor if the client later lost a job, was denied a license, or was denied a security clearance because of the false diagnosis. If it could be shown that a mental health professional knew or should have known that a client had a serious disorder but recorded a less serious disorder, and that the client received inadequate treatment that led to harm, or was denied health insurance reimbursement because of the false diagnosis, the mental health professional could be found to have committed malpractice. Obviously, you want to avoid ever having to face such a situation. It is crucial that you do not engage in the practice of assigning a diagnosis to fit insurance companies' criteria for reimbursement, even if you observe others doing it or even if you hear justifications for such fraudulent practices.

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## Summary and Key Points

This chapter discusses activities that are not counseling per se, but are an essential first step in the process of helping clients resolve their problems. Assessment is a collaborative process between counselor and client during which they work to

gain a better understanding of the client's problems. An accurate assessment then guides the treatment planning.

Testing and diagnosis are two specific types of assessment that are particularly vulnerable to ethical



and legal problems. Multicultural considerations are vital in both testing and diagnosis. Key points made in the chapter regarding evaluation and assessment include the following:

- Evaluations must be objective and for this reason counselors should avoid taking on dual roles such as counselor and child custody evaluator.
- Clients have a right to understand what an assessment process will involve, what its purposes are, and the uses to which it will be put.
- Counselors are competent to conduct many types of evaluation.
- When counselors conduct evaluations, they must be prepared to serve as expert witnesses in court.

Counselors may be involved in developing, selecting, administering, and interpreting various tests. Some key points with respect to testing include the following:

- Although counselors are unlikely to be very much involved in developing new tests, they must understand the ethical responsibilities of test producers.
- Test publishers must use the best scientific methods available in devising their instruments; keep client welfare foremost; and publish materials that describe the test's development, standardization, and instructions for use.
- Counselors are responsible for maintaining the security of tests that they use and for appropriately supervising the test-taking process.
- Counselors must be aware of copyright laws and must be careful not to violate such laws.
- Counselors are competent to administer and interpret many tests, but they should keep in mind that some tests require specific training in their use.
- In order to be competent in using a test, a counselor should have completed formal coursework and have had supervised experience in using the test.
- Other mental health professionals in some states have attempted to prohibit counselors from using certain kinds of tests.

- Counselors must use caution in releasing test records to third parties and should release the records only to those individuals who are qualified to receive them.
- Clients have the right to receive a full explanation of their test results.
- Counselors must be cautious in using tests with culturally diverse clients. Many tests have been shown to be culturally biased, and minority groups often are not represented in the norm groups on which the tests were standardized.
- Counselors must be knowledgeable about laws that affect testing practices.

Counselors are often uncomfortable with diagnosing mental disorders because the prevalent diagnostic system is based on the medical model. There are many good reasons for counselors to participate in diagnosis, however. Counselors who choose to participate need to clarify their own values with respect to diagnosis and its application within a wellness philosophy. Key points with respect to diagnosis include the following:

- Clients must understand the implications of any diagnosis that might be assigned to them.
- Counselors must be prepared to work cooperatively with physicians when clients may have a physical condition that is contributing to their mental or emotional problems or when they could benefit from taking medications for their condition.
- A controversial issue has been whether counselors are qualified to diagnose.
- Multicultural considerations are of paramount importance in diagnosis because all mental disorders occur in and are defined by a cultural context.
- Counselors must be alert to sources of bias against women and minority group members in the diagnostic process and must take care not to perpetuate historical and social prejudices in diagnosing pathology.
- Counselors are guilty of insurance fraud when they do not diagnose honestly and accurately, and they can be subject to both civil and criminal liability.

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# Professional Relationships, Private Practice, and Health Care Plans

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# Professional Relationships, Private Practice, and Health Care Plans

## FOCUS QUESTIONS

1. What types of interactions and relationships do counselors have with other mental health professionals who practice in their community?
2. What kind of help does a counselor need in order to set up a private practice?
3. How would you respond if you were a provider of counseling services for a managed care organization and you believed your client needed additional counseling sessions, but the case manager told you that no more counseling sessions would be provided?

## PROFESSIONAL RELATIONSHIPS

Counselors who practice in all settings interact regularly with other professionals (Edwards, Patterson, & Grauf-Grounds, 2001). Mental health professionals communicate and collaborate in several ways. They confer, consult, coordinate client care, engage in teamwork, and refer clients to each other (Glosoff, 2001). *Conferring*, the least structured of these types of communication, may be defined as an informal comparing of observations. For example, a school counselor might confer with a teacher to determine whether a child's classroom behavior has improved as a result of counseling for impulse control.

*Consulting* occurs when one professional solicits the opinion or advice of another professional. The consultation could focus on many possible issues, from determining the most efficacious treatment for a client's problem to resolving an ethical dilemma that the consultee may be facing.

*Coordination* of services usually refers to procedures put in place to ensure that all service providers are working from the same treatment plan and goals and are aware of each other's roles and functions in serving a client. For instance, a school counselor might work with the school psychologist, principal, school nurse, and teachers to implement and monitor a child's individualized educational plan (IEP).

*Teamwork*, the most structured form of collaboration, often takes place in inpatient settings where various professionals provide a range of services to a client such as individual counseling, group counseling, art therapy, medication monitoring, case management, and family therapy. Members of treatment teams tend to have formalized roles and responsibilities and work together over time (e.g., for the duration of a client's stay in a psychiatric hospital; Linville, Hertlein, & Lyness, 2007).

Finally, *referrals* occur when professionals determine that a type of expertise they do not possess is needed to assist a client. For example, a counselor might refer a client to a psychiatrist to assess whether psychotropic medication is indicated.

Counselors must be able to establish and maintain appropriate relationships with mental health and other professionals (such as physicians, law enforcement officials, and teachers) in order to render quality mental health services to their clients (ACA *Code of Ethics*, 2005, Section D). They must also be alert to ethical and legal considerations that relate to their interactions with other professionals.

Just as it is essential to establish appropriate personal boundaries with clients, students, and supervisees, it is equally important to establish appropriate boundaries with other professionals. Counselors must continually determine their precise role when they are interacting with other professionals. This role depends on the circumstances. Therefore, counselors must understand that they have many roles and responsibilities and often must clarify their position to others with whom they interact. Two examples may help to illustrate this point.

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**EXAMPLE ONE** A psychiatrist in private practice has diagnosed a patient as suffering from a mental disorder and has prescribed medication. The psychiatrist refers the person for counseling services to a counselor in private practice. In this situation, the psychiatrist and counselor function as co-equal partners in treating the individual. They consult and relate to each other in that fashion.

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**EXAMPLE TWO** A psychiatrist is employed as director of a public mental health center. The psychiatrist assigns a client to a staff counselor for treatment and specifies that the counselor should have five sessions with the client related to proper parenting skills development. The psychiatrist is the counselor's administrative supervisor, and the counselor is in the role of an employee carrying out the directives of a superior. Of course, the counselor has an obligation to exercise judgment in the case, but the dynamics between the two professionals will be much different from those in the first situation.

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The ethical and legal issues that are important to counselors as they interact with other professionals include the following: (a) employer/employee relationships, (b) confidential information, (c) referrals, and (d) respect for other professionals.

### **Employer/Employee Relationships**

Most counselors practice their profession as employees of agencies and entities such as schools, hospitals, mental health centers, and rehabilitation agencies. At some time in their careers, most counselors also supervise others in organizational settings, which requires them to function in the role of employer.

As a result, it is important that counselors understand the basic legal principles of employment law. Counselors also need to be prepared to address some of the tensions experienced by professionals who have obligations both to clients and to employers.

**COUNSELORS AS EMPLOYEES** When a counselor applies for, is offered, and accepts a job, the counselor then becomes an employee and must function within the legal framework that guarantees certain rights to employees and also imposes on them a number of obligations.

Employed counselors have a legal right guaranteed by the U.S. Constitution or federal statutes (Title VII of the Civil Rights Act of 1964; Age Discrimination in Employment Act of 1967; Title I of the Americans with Disabilities Act of 1990) to be free in the workplace of discrimination based on race, color, sex, religion, national origin, age, and disabilities (Belton & Avery, 1999). In some states or localities, discrimination based on other traits such as sexual orientation may be prohibited by statute as well. For example, in Florida, in addition to the federally protected categories of individuals, it is also illegal to discriminate in employment matters based on political affiliation or marital status (Fazio, 1997).

Also, employees do not have to submit to any supervisor's directive that constitutes a crime. If a directive is unethical, it might also be illegal. However, most ethical issues are debatable. Therefore, in order for a court to support a professional who refused to follow a supervisor's directive because the employee believed the directive was unethical, a directive probably would have to be clearly unethical and put clients at substantial risk.

Although a few employees have detailed contracts with their employers, most employees work without contracts. This means that they are employed at the pleasure of their employer and that the employer may terminate the arrangement at any point without giving a reason.

Originally, under the common law that the United States inherited from England, employees worked for employers under what is known as the *at will doctrine*. According to Perritt (1998), this concept held that employers could fire employees "at any time for a good reason, a bad reason, or for no reason at all" (p. 3). The pure at will doctrine has eroded over time in the United States; however, there is still a general concept in law that employees do not have a right to employment, and a presumption that employers have a right to dismiss employees without giving any reasons.

When employees who do not have employment contracts are fired, the legal burden is on them to prove that their dismissal was wrongful and should be overturned by a court (Perritt, 1998). There are three legal theories that might lead courts to conclude that a dismissal was wrongful: (a) the employer promised that the employee would have employment security, (b) the dismissal offends some important public policy, or (c) the termination was *unfair* or done *in bad faith*.

In many large businesses and governmental settings, policies and procedures exist that govern employer/employee relationships without contracts being signed. When such policies and procedures exist, they must be followed.

Labor unions generally negotiate employment contracts for their members. Unions provide leverage for employees that they would not normally have when disputes arise between employee and employer. If an employment contract has been negotiated either individually by an employee or by a union, then the exact terms of the contract will dictate the employer/employee relationship.

When disputes arise between employees and employers, the law generally favors the employer (Perritt, 1998). Individuals are not forced to work, and certainly they do not have to work for a particular employer. Because employees are free to resign from their jobs if they are dissatisfied, employers cannot be forced to comply with the preferences of an employee.

By accepting a job, an employee agrees to perform the tasks assigned. These tasks can be any that the employer wishes, unless there is an employment contract or internal policies and procedures to the contrary. If an employee refuses to carry out the directives of a supervisor, this constitutes insubordination, for which an employee can be legally dismissed. The only defenses to refusing to



carry out the directives of a supervisor would probably be that a directive (a) was in violation of an employment contract, (b) was in violation of internal policies or procedures, (c) illegally discriminated against a protected category of individuals, or (d) constituted a crime.

Many counselors who are also employees are concerned about being in a situation in which they believe they have an ethical obligation to act or refrain from acting, and their employer issues a directive to the contrary. The *ACA Code of Ethics* (2005) does not require counselors to “fall on their swords” and resign if they believe an organization demands actions that pose a conflict with the code. Instead, they should address their concerns directly with their employer and work toward change in the organization (Standards D.1.h. and H.2.c.). Standard D.1.h. provides a number of alternative actions for counselors who believe they are working for an employer who has inappropriate policies or practices, including “... referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.” Counselors should bear in mind, though, that licensure and certification boards accept ethical complaints only against individuals and will not accept complaints against organizations. Although counselors may be uncomfortable working in a conflictual situation, it is acceptable from both an ethical and a practical standpoint for them to secure employment elsewhere before resigning their position.

Most employers understand that licensure laws and codes of ethics guide the behavior of the professionals they employ, even though the employers may not be members of the same profession. Nonetheless, there are many disagreements among experts and professionals regarding what constitutes ethical and unethical behavior (Sperry, 2007). Most often, when disputes arise in ethical areas between professionals and their employers, it is because the parties disagree as to what is ethical and unethical.

Following are some examples of situations in which professionals and their employers might disagree about an ethical issue:

1. A physician believes that an operation would be in a patient’s best interest, but the health maintenance organization determines that a different, less expensive form of treatment is acceptable.
2. An attorney who is an associate in a law firm believes that a potential client has no chance of winning a lawsuit against a former employer because of the facts and the law. The attorney recommends that the firm decline to represent the potential client, but a senior partner directs the associate to take the case and to pursue it vigorously.
3. A psychologist who is employed by a prison believes that many of the inmates who are evaluated are in need of medical care due to their mental conditions. The supervisor, who is a psychiatrist, disagrees and says that the psychologist should just conclude that the inmates do not need medical care.

These situations illustrate that any professional who is employed could face problems of ethical decision making. The following case describes a counselor who has a disagreement with an employer regarding an ethical issue.

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## 1 The Case of Jason

Jason has been a counselor in a community mental health center for 2 years. A new director, Sofia, has been hired recently. Sofia holds a master’s degree in business, and she has never worked in a mental health facility before. Other counselors tell the director, Sofia, that Jason is an ineffective counselor, that he becomes inappropriately involved in the personal lives of clients, and that he does not follow center policies. Sofia wants to ensure that Jason is performing his job responsibilities

adequately. Therefore, she directs Jason to show her his case notes at the end of each day and to summarize his work with each of his clients. Jason refuses, based on his ethical requirement to keep his conversations with his clients confidential. Sofia fires Jason.

- If you had been advising Sofia regarding this problem situation with Jason, what would you have advised her to do differently?
- If you had been advising Jason regarding this situation, what would you have advised him to do differently?

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**Discussion:**

A better approach for the supervisor would have been to assign another, perhaps senior, mental health professional to supervise Jason's work for a period of time. On the other hand, Jason could have responded differently and perhaps saved his job. He could have engaged in a conversation with Sofia to determine why she was concerned about his job performance and could have presented his side of the story. He could have offered to be supervised by a senior counselor for a period of time to assure his supervisor of his competency.

He could have tried to accommodate his supervisor's concerns in some way and at the same time preserved the privacy of his clients. Trying to work with a supervisor is much better than defying the supervisor's order.

This situation describes a difficult problem for counselors and for those who supervise mental health professionals but are not mental health professionals themselves. Sofia, the counseling center director in this case example, certainly has an obligation to ensure that her employees are performing their jobs adequately. The director is legally responsible for the work of her employees. On the other hand, professionals have a confidentiality obligation to clients.

At some time in your professional career, you may be faced with a situation in which you and your employer disagree about what is ethical. We recommend that you take these steps if you believe your employer is forcing you to act in what you consider to be an unethical manner:

1. Avoid discussing the situation with coworkers in casual conversations or in staff meetings. Consult with outside experts and colleagues in a confidential manner regarding the issue, and ask them to keep your conversations confidential. If there is a consensus that the action is unethical, go to step 2. If time allows, a request could be made to the ACA Ethics Committee for an interpretation of the *ACA Code of Ethics* (2005). There is a formal process for requesting interpretations, and it takes a number of months to receive an interpretation. If experts and colleagues do not agree that the action is unethical, you could argue internally for change, but should follow the directives of your supervisor.
2. Schedule an appointment with your supervisor to discuss the matter. Tell your supervisor which provisions in the *ACA Code of Ethics* (2005) you believe are being violated and ask that you not be directed to act in what you consider to be an unethical manner. If your supervisor requests additional information or support for your position, offer to provide it to the extent possible.
3. If step 2 does not lead to a satisfactory resolution of the issue, you must decide whether to stay in the organization and work toward change or whether to look for a different job that does not force you to compromise your beliefs about your ethical obligations. If you decide to stay

in the organization, go to step 4. If you decide to leave, update your resume and begin your search. For practical purposes, if possible, keep your present job while you are searching. Many employers are suspicious that unemployed professionals may be poor employees, and many employers do not favor applicants who left previous jobs because of disputes with their employers.

4. Ask your supervisor to schedule a three-way appointment with you and his or her supervisor to discuss the situation. If your supervisor refuses, inform your supervisor that you are going to talk with his or her supervisor. Then, ask that supervisor directly for an appointment to discuss the matter.
5. If step 4 does not resolve the issue (and you still have your job), determine whether organizational policies could be created or changed that would resolve the dilemma in a manner that would be ethically acceptable to you. If so, suggest that a policy or procedures be created or changed following the procedure used to make suggestions within your organization (ACA *Code of Ethics*, 2005, Standard D.1.h.). To try to preserve your working relationship, inform your supervisor of your activities, if possible. Try to avoid the appearance that this issue is a struggle between you and your boss that one of you will win and the other will lose. Instead, present the issue as important to the organization and to your profession and advocate for change in a professional manner.

**COUNSELORS AS EMPLOYERS** Counselors who are in private practice or who own their own businesses naturally will hire employees from time to time to assist them with their work. In addition, counselors who become supervisors in the agencies in which they are employed become members of the management team and agents of their employer. Such supervisor–counselors function as employers as well.

The ACA *Code of Ethics* (2005) states that counselors “hire for professional counseling positions only individuals who are qualified and competent for those positions” (Standard C.2.c.). This standard suggests that counselors should not agree to hire in counseling positions individuals who are not qualified through education and experience. Standard D.1.f., which states, “Counselors select competent staff and assign responsibilities compatible with their skills and experience,” reinforces the concept that counselors who hire must ensure their employees are capable of providing quality counseling services.

Employed counselors should realize that they must assume the role of employer any time they have one or more persons who report to them administratively. Sometimes administrative lines within organizations are blurred. It is vital for counselors to clarify, if they are unsure, whether they are the supervisors for individuals with whom they work. Generally, a supervisor assigns work responsibilities to another employee and evaluates that person’s performance. In addition, supervisors generally make final decisions or final recommendations about whom to hire for positions that report to them. Supervisors also have significant influence and responsibility in disciplining and dismissing employees who report to them.

Employed counselors may have clerical or professional staff members who report to them. Employees want their supervisors to be clear in communicating expectations and directives. All counselors—whether they are in a supervisory, subordinate, or collegial relationship with employers and employees—have an ethical obligation to make expectations clear and to establish working agreements that are known to all parties.

Employees also want their supervisors to be fair and just in dealing with them. Counselors do not commit or condone practices that are inhumane, illegal, or unjustifiable in hiring or promotion. They do not discriminate on the basis of age, culture, disability, ethnicity, race, religion/spirituality, gender,

gender identity, sexual orientation, marital status/partnership, language preference, or socioeconomic status (*ACA Code of Ethics*, 2005, Standard C.5.).

It is very important that counselors who supervise others avoid favoritism or the appearance of favoritism among employees. Consider what could happen if a friendship or personal relationship developed between a supervisor and a supervisee. When the supervisor later disciplined or dismissed another employee or gave some type of benefit or promotion to the friend, the supervisor would be vulnerable to a complaint of favoritism, or perhaps even illegal discrimination.

As a result, it is recommended that counselors who supervise others maintain a personal distance between themselves and those they supervise. Organizational environments, however, often promote employee friendships through a friendly climate or social gatherings that sometimes even extend to family members. If a friendship or personal relationship does develop between a supervisor and employee, the counselor should be careful to avoid personal interactions with the employee at work and must self-monitor carefully to ensure that the employee is not being given favorable treatment. Consider the following case.

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## 2 The Case of Margaret

When Margaret was promoted to director of the local mental health center, one of the first personnel decisions she made was to hire one of her best friends, Beth, as a staff counselor. Margaret knew that Beth was an excellent counselor with many years of experience who would perform well as an employee for the center. Now, after a year, Beth has indeed performed her job in an exemplary manner. However, Beth is very focused on work and is highly productive in the work environment, and she has alienated most of the other employees at the center. They see her as unfriendly, abrupt in interpersonal communications, and self-centered. Margaret and Beth have maintained their friendship and frequently socialize together on the weekends. A unit supervisor has recently resigned, and Margaret must appoint someone to take his place. The two top candidates for the job are Beth and another staff counselor who is very popular among his peers. However, in Margaret's opinion, he is not as capable as an administrator. Margaret wants to promote Beth to the supervisory position, but she is worried that other staff members will be very upset with her if she does.

- What could Margaret have done to make this situation less difficult than it is?
  - Whom do you think Margaret should promote?
- 

### Discussion:

Perhaps Margaret should not have hired her best friend in the first place. However, once she did hire Beth, she should have ensured that her friendship with Beth was not evident in the workplace. If Margaret promotes Beth, surely most of her staff members will believe she is biased and promoted Beth because of their personal friendship. If Margaret promotes the other staff member instead of Beth, Margaret will worry that she is being unfair to Beth and to the organization. There is no easy solution to a problem like this. No matter what she decides, Margaret should work with Beth to help Beth improve her interpersonal relationships with other staff members. However, Margaret's attempt to do that may have a negative effect on her personal relationship with Beth. To avoid situations such as this, it is best to avoid personal relationships with supervisees, if possible.

Employed counselors who serve as administrative supervisors must thoroughly familiarize themselves with the policies and procedures of the organization and with the contract terms of anyone employed through either a personal or a union contract. It is essential that administrative supervisors follow, in detail, all written procedures. A common problem for administrative supervisors is having their decisions overturned either within the organization or by courts because they have failed to follow written procedures. Administrative supervisors who disapprove of organizational policies, organizational procedures, or contract clauses should work within proper channels to get them changed. Supervisors must follow such policies and procedures or contract clauses precisely while they are still in effect.

### **Confidential Information**

In the context of relationships with other professionals, counselors must often share information about clients that is confidential or even privileged. Sharing information with other professionals is an exception to confidentiality and privileged communication requirements. Consistent with informed consent requirements, counselors should inform clients in advance if they plan to share confidential information with other professionals.

It is best to obtain written permission from clients to transfer private information to others. Although written permission generally is not a legal requirement, the federal HIPAA law and state licensure laws or regulations for counselors could require that permission be in writing. Also, the *ACA Code of Ethics* (2005) requires that written permission be obtained to transfer records (Standard B.6.f.).

The *ACA Code of Ethics* (2005) also requires counselors to try to ensure that receivers of their records are sensitive to the confidential nature of the records (Standard B.6.f.). Counselors are not expected to conduct an investigation of the policies and procedures for maintaining confidentiality of every individual, agency, or institution that receives their records. What good practice dictates is that counselors ensure that the client's fully informed consent has been given to transfer the records and that they clearly mark as "confidential" any records that they send. Only information that is pertinent to the purpose of sharing records should be disclosed. The federal HIPAA law that applies to most counseling agencies has strict requirements in these areas.

### **Referrals**

The practice of making referrals to other professionals is associated with a number of ethical responsibilities. Because counselors have an obligation to practice only within the boundaries of their competence, they refer clients whom they are unable to assist (Standard A.11.b.). The concept that counselors should refer clients if they do not believe they are qualified or competent to serve them effectively has caused concern within the counseling profession. We believe this standard should not be interpreted in a way that would allow a counselor to refuse to counsel clients based on gender identity, sexual orientation, or any other basis that would constitute discrimination.

The responsibility to protect client welfare also may lead to a referral. Counselors are cautioned to avoid abandoning clients and "assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination" (Standard A.11.a.). Standard A.11.b. states that counselors "are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives." However, counselors should discontinue counseling relationships if referrals by clients are rejected (Section A.11.b.). Counselors recommend other service providers when they terminate a counseling relationship "when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling" (Standard A.11.c.). Finally, "when counselors refer clients to other practitioners, they ensure that appropriate clinical and administrative

processes are completed and open communication is maintained with both clients and practitioners” (Standard A.11.d.).

Counselors are prohibited from using their places of employment or institutional affiliation to recruit or gain clients for their private practice (Standard C.3.d.). The law regarding referrals is based on professionals’ fiduciary responsibilities to their clients. The law requires that professionals not do anything that would benefit themselves at the expense of a client or that would harm a client in any way (Ludes & Gilbert, 1998). Obviously, counselors would benefit if they referred clients to their own practice, which is why Standard C.3.d. exists.

Many counselors are concerned about the propriety of referring a client to a particular counselor. This practice is neither unethical nor illegal. There is a misperception among counselors that referrals to only one specified individual are wrong because many agencies, particularly agencies that are publicly funded, have policies either prohibiting referrals to specific practitioners altogether or requiring that counselors refer to a specified minimum number of individuals. Agencies have developed these policies in an attempt to avoid furthering the business interests of some mental health professionals to the detriment of other mental health professionals who practice in the community. To avoid complaints from professionals that others are being favored by the agency, many agencies adopt policies that require multiple referrals.

Ethical guidelines require counselors to be knowledgeable about referral resources so that they can “*suggest appropriate alternatives*” to clients (ACA *Code of Ethics*, 2005, Standard A.11.b.). Perhaps it is the use of the plural *alternatives* that has led some counselors to believe mistakenly that they must always provide clients with more than one referral source. The intent of this standard is to stress that counselors need to be familiar with the resources in their community that provide mental health and related services. If a counselor believes that a client would be well served by a referral to any of a number of other professionals, then it is good practice to give all these choices to the client. If a counselor believes that a client would be best served by a particular mental health professional whose specialty area matches the client’s needs, then the counselor should feel free to recommend that particular resource (unless agency or organizational rules require multiple referrals or no referrals to specific individuals).

Sometimes clients who seek counseling services are already being seen by another mental health professional. For example, a person who is receiving psychotropic medication from a psychiatrist might also seek counseling. In these instances, counselors should obtain client consent to contact and work with the other professional to establish collaborative professional relationships (ACA *Code of Ethics*, 2005, Standard A.3.).

Generally, a counselor would not be held accountable for the malpractice of a professional to whom an individual had been referred. However, if the counselor making the referral had some reason to know or should have known that a particular professional had a notoriously negative reputation in the professional community, then the counselor might be held accountable for harm suffered by the person who was referred.

### **Respecting Other Professionals**

The introduction to Section D of the ACA *Code of Ethics* (2005) emphasizes the importance of developing and maintaining positive, collaborative working relationships with other mental health professionals. The quality of services to clients is enhanced when counselors develop positive relationships and communication systems with colleagues. Thus, counselors have a responsibility to become knowledgeable about related mental health professionals and to be “respectful of approaches to counseling services that differ from their own” and “of traditions and practices of other professional groups with which they work” (Standard D.1.a.). They “work to develop and



strengthen interdisciplinary relations with colleagues from other disciplines to best serve clients” (Standard D.1.b.). A collaborative approach is particularly vital when counselors serve as members of interdisciplinary treatment teams that deliver multifaceted services to clients.

Counselors must be aware that their opinions regarding other professionals, particularly other mental health professionals, carry considerable weight with the general public. Counselors must be respectful of other professionals even if they personally have negative feelings about their approaches to practice. Our relationships with fellow mental health professionals should be based on respect, honesty, and fairness (Welfel, 2010). Counselors sometimes have philosophical and practical differences regarding therapeutic approaches, as well as turf wars, with other mental health professionals. A counselor and a psychologist might find themselves, on Monday, testifying at the state legislature on opposite sides of a mental health provider issue. On Tuesday, they might meet as members of a treatment team to work for the best interests of their shared clients. The key to managing such situations is to keep professional disagreements in the political and philosophical realms and to stringently avoid bringing them into our work with clients.

Glosoff (2001) raised an important point in noting that, when we focus on differences and disagreements, our attitude toward fellow mental health professionals tends to be one of tolerance rather than appreciation for how these differences can help us to better serve our clients. Rather than believing that our point of view is the only valid one, we need to keep in mind that interprofessional collaboration is an important resource for meeting the complex psychological, emotional, social, economic, physical, and spiritual needs of our clients. Counselors who have a strong professional identity and can clearly articulate their perspectives will be better able to establish and maintain collegial relationships with other mental health professionals (Glosoff, 2001).

From a legal perspective, counselors must be careful to avoid saying or writing comments that might damage the reputation of another professional. If counselors repeat rumors that are inaccurate, or purposefully make false oral or written statements, such actions could damage the reputations of other professionals, and those individuals could sue for libel or slander. *Libel* refers to false, defamatory, or malicious *written* statements; *slander* refers to such statements that are *spoken*. Generally, the law of libel and slander requires that persons who believe they were harmed by the words of another prove *special harm* (Robertson, Powers, & Anderson, 1989). Injured persons usually have to prove actual pecuniary loss, as opposed to humiliation or general harm to their reputations. However, accusing persons of being unfit for their profession falls under the category of libel or slander *per se*, which means that *special harm* does not have to be proven. Because professional reputation is so important to a career, it is assumed in law that persons are harmed if their reputation is damaged by lies or deceit.

Prosser, Wade, Schwartz, Kelly, and Partlett (2005) have listed the following defenses to accusations of libel or slander: truth, retraction, absolute privilege, and qualified privilege. If you were accused of defaming another person, you could argue that what you said or wrote was true. You also could publicly retract what you said or wrote. Judges have absolute privilege and cannot be sued for what they say in their official capacity. If you are defending yourself, you have a *qualified privilege* to repeat what you have heard if you must do so to protect yourself.

## PRIVATE PRACTICE

Many counselors-in-training idealize private practice and have a goal of owning their own independent counseling practice someday. They may not have considered that by owning a private practice they will be running a business and that opening a practice involves all the promises and pitfalls

of starting any small business. Most counselors do not have training or experience in business administration, so it is important that they consider many important issues before deciding whether to go into private practice. To see how you measure up to the Small Business Administration's ideas about running a business of your own, see Figure 1.

### **Taxes and Business Licenses**

If counselors generate any income at all outside of their salary, they are in business and have a private practice. Depending on the state statute and the nature of the services rendered, counselors may need to be licensed by their state counselor licensing board. In some states, a license is required

#### **ARE YOU READY?**

##### **Is Entrepreneurship For You?**

In business, there are no guarantees. There is simply no way to eliminate all the risks associated with starting a small business—but you can improve your chances of success with good planning, preparation, and insight. Start by evaluating your strengths and weaknesses as a potential owner and manager of a small business. Carefully consider each of the following questions.

##### **Are you a self-starter?**

It will be entirely up to you to develop projects, organize your time, and follow through on details.

##### **How well do you get along with different personalities?**

Business owners need to develop working relationships with a variety of people including customers, vendors, staff, bankers, and professionals such as lawyers, accountants, or consultants. Can you deal with a demanding client, an unreliable vendor, or a cranky receptionist if your business interests demand it?

##### **How good are you at making decisions?**

Small business owners are required to make decisions constantly—often quickly, independently, and under pressure.

##### **Do you have the physical and emotional stamina to run a business?**

Business ownership can be exciting, but it's also a lot of work. Can you face six or seven 12-hour work days every week?

##### **How well do you plan and organize?**

Research indicates that poor planning is responsible for most business failures. Good organization of financials, inventory, schedules, and production can help you avoid many pitfalls.

##### **Is your drive strong enough?**

Running a business can wear you down emotionally. Some business owners burn out quickly from having to carry all the responsibility for the success of their business on their own shoulders. Strong motivation will help you survive slowdowns and periods of burnout.

##### **How will the business affect your family?**

The first few years of business startup can be hard on family life. It's important for family members to know what to expect and for you to be able to trust that they will support you during this time. There also may be financial difficulties until the business becomes profitable, which could take months or years. You may have to adjust to a lower standard of living or put family assets at risk in the short term.

**FIGURE 1** Are you ready to start a private practice?

<http://www.sba.gov/starting-business/startup/areyouready.html> Reprinted by permission of the Small Business Administration, 409 Third Street, SW, Washington, DC 20416.

to provide counseling services in a private practice, while in other states, a license is optional. Also, in some states, counselors may conduct educational workshops, produce written professional products, and engage in other counseling-related activities that produce an income without being licensed. Whether a license in counseling is required depends entirely on the wording of the state counselor licensure statute.

Counselors who generate income outside of wages or salaries must file a separate federal income tax form for income produced from a business. In states that have income taxes, similar forms sometimes must be filed at the state level as well.

There are numerous federal, state, and local requirements that must be addressed when counselors open their private practices. Haynsworth (1986) has listed the following possible steps that a counselor might need to take:

- Obtain a federal tax identification number if there are any employees.
- In some states, obtain a professional license.
- Apply for and obtain a business license.
- Purchase worker's compensation insurance or unemployment compensation insurance.
- Obtain employee bonds if required.
- Purchase liability, property damage, or other types of insurance.
- Comply with a fictitious or assumed name statute.
- Fulfill other public filing requirements that may exist.

Counselors with businesses must purchase a business license from their local jurisdiction's office, which is usually located in a city hall or county courthouse (Alberty, 1989). Purchasing a business license involves listing a business address. In most jurisdictions, zoning laws prohibit or limit in some way clients (or customers) coming to a residence. So, if a residence is listed as the place of business, the counselor must indicate that no clients or customers come there for services. Each year, when a business license is renewed, counselors must report the amount of their gross income and pay a tax to the city or county. This tax is minimal until substantial income is generated. Although few jurisdictions actively pursue those who violate business license laws, violations could become important if a counselor were accused of wrongdoing at some point.

Counselors who generate income and fail to report it on federal and state income tax forms, or who fail to purchase and renew business licenses each year, are committing crimes. A number of counselors who are unaware of tax and business license requirements are in violation of these laws. Ignorance of legal requirements does not excuse those who violate them.

### **Business Form**

Businesses are structured in a number of ways. Most professional private practices are known in law as sole proprietorships. The individual professional owns the private practice and no other professional has a financial interest in it. This is the simplest form of business ownership and the one chosen by most private practitioners in counseling. In our opinion, it is usually the best option for counselors who engage in private practice.

The second most popular business form for counselors is a partnership. Generally, partnerships should be chosen only if a partnership is required to obtain financing for a new business or if there is a significant advantage in the commercial market for a partnership over a sole proprietorship.

Many counselors seem to choose partnerships because they are anxious about beginning a business venture on their own, or because they want the social benefits of affiliating with friends or colleagues. These are not good reasons for forming a partnership. There are many arguments against forming partnerships that should be carefully considered: (a) Total agreement on all business

decisions is required; (b) each partner is fully liable for the acts or omissions of the other partner; (c) there is a presumption of equality of partners regarding liabilities and profits; (d) personal assets are not protected from business debts; and (e) dissolutions of partnerships can be contentious and very expensive if problems cannot be resolved amicably, and one or more partners hire lawyers to represent their interests.

A corporation is a third possible business form. Generally, individuals are motivated to form corporations if the business involved is very risky and if the owner has substantial personal assets (Alberty, 1989). Most states have what is known as *professional corporations*, in which individual professionals essentially incorporate their individual private practices. Although professional corporations were very popular in the past, tax advantages have been reduced through legislation (Hamilton, 1990). Corporations are complicated and difficult to keep current, and as a result, professional corporations have fallen out of favor. However, according to Weil (1983), some individuals are still forming professional corporations, which still offer the following advantages: (a) accumulation of capital, (b) transferability of ownership, (c) flexible fiscal year, (d) employee benefits, (e) some reduction in liability, and (f) management structure.

A professional's primary motivation for choosing any type of corporate form for a private practice would be to protect personal assets in the event that the business failed or a judgment was rendered against it. A reason for not forming a corporation, however, is that adequate professional liability insurance can be purchased to avoid losing the business and personal assets because of a lawsuit or judgment. Other problems with corporations include the following: (a) they are very expensive to form, (b) meetings must be held periodically and annual reports must be filed or the corporation will cease to exist legally, (c) income is taxed to the corporation and is taxed again when it is distributed to owners, and (d) accountants and lawyers must be retained on a continuous basis to ensure that the corporation is functioning properly.

Some counselors choose to form nonprofit corporations as the basis of their practice. Essentially, counselors form a nonprofit corporation and then pay themselves a salary from the proceeds of the entity. Such corporations have favorable tax laws (Hamilton, 1990) and might be eligible for certain grants. The significant problem with nonprofit corporations is that the counselor does not own or control them. To qualify as a nonprofit corporation, the charter of the entity must include a board of directors. Although counselors might originally form boards that will support them as directors, it is possible that board members may begin to assert themselves or that replacement board members may not support the counselor. A nonprofit corporation board has the authority to remove the counselor as the director and to take over the business entity.

### **Fees for Services**

Counselors in private practice must set fees for their services, and they struggle with establishing their fee structures (Newlin, Adolph, & Kreber, 2004). They are in business, so they must generate enough income to cover their business expenses. In addition, if their private practice is their only source of income, they want to generate enough income above expenses to allow them to have a comfortable lifestyle. If their fees are too high, clients will go elsewhere for services. If their fees are too low, clients may not value the services they are receiving, or they may choose a practitioner who charges higher fees in the belief that the fee reflects the quality of services offered. Although most professionals seek to establish the highest fee that the market will tolerate, counselors, like lawyers, are in a fiduciary relationship with clients. Therefore, they must set fees within a framework of basic fairness (Smith & Mallen, 1989).

The *ACA Code of Ethics* (2005, Standard A.10.b.) states that in establishing fees, counselors should consider the *financial status of clients and locality*. The standard probably was intended

to encourage counselors to set fees that reflect the economy in the locality. However, it could be misinterpreted to mean that counselors should charge clients according to their ability to pay, which could result in serious legal problems for counselors in private practice. Legally, counselors and other professionals may set any fees that they wish for their services. They can even charge different clients different amounts for the same service as long as they do not discriminate based on constitutionally protected categories of persons. Standard A.10.b. also states, “In the event that the established fee structure is inappropriate for a client, counselors assist clients in attempting to find comparable services of acceptable cost.” If a potential client cannot afford to pay the fee you have established for your services in your private counseling practice, then you must help that client by providing him or her with referrals where counseling services may be free or available at rates below those you charge.

Some counselors establish the same *sliding scale* fee structure in their private practices that is used by counseling centers supported by public funds or private charitable funds. A sliding scale fee structure sets the fee for services based on objective criteria such as amount of income and size of family. With sliding scales, individuals with more income and less financial burden pay more for the same services than those with less income and more financial burden. Although a sliding scale seems more appropriate for a nonprofit agency than it does for a private practice from a business perspective, counselors in private practice could adopt this method, too. However, if counselors in private practice take clients who receive health insurance reimbursement for services, they must apply the sliding scale formula precisely for all clients, regardless of whether the client has health insurance that reimburses for the counselor’s services.

An important part of charging fees is the process of collecting them. Many counselors are uncomfortable taking money from their clients, but collecting fees is a necessary part of maintaining a successful private practice. Counselors who avoid the collection of fees probably should consider working in an agency where they do not have to collect client fees rather than operating a private practice.

The trend today is for all professionals to collect fees as services are rendered. In other words, counseling clients probably should be expected to pay for each session at the time the session is held. An exception, of course, would be clients whose payments will be made by another entity, such as an indemnity health insurance company, PPO, employee assistance program, or governmental agency. Counselors in private practice should develop clear policies regarding fee payment, and these policies should be spelled out specifically in the counselor’s disclosure statement. It is unwise to make any exceptions. If unanticipated problems arise regarding payment, it is best to address these problems immediately with the client (Knapp & VandeCreek, 2008).

Standard A.10.c. of the ACA *Code of Ethics* (2005) states, “If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.” Although this standard suggests that counselors do sue their clients for unpaid fees, we recommend against this practice. In the event that a counselor does allow a client to develop a large bill for services, the counselor should never threaten a client in any way if payment is not made, and certainly should never sue the client. If a counselor demanded payment from a former client for past services rendered, the former client could take the position that the services were inferior and could countersue or file a complaint with the counselor’s licensure board, certifying agency, or professional association (Smith & Mallen, 1989). In our opinion, it is better just to forget client bills that are never paid and, in the future, to avoid allowing any bills to develop.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 8 and view the video clip entitled “A Private Practitioner’s Financial Difficulties.” In this video, a counselor struggles with collecting fees from a client.

### **Attorney and Accountant Services**

Counselors who are employed can expect their employer to provide them with legal consultation when requested. Counselors in private practice must pay for the services of attorneys when they are needed. Employed counselors are not required to keep business financial records, but counselors in private practice must retain the services of an accountant on an ongoing basis.

As a counselor in private practice, you will need the services of attorneys for a variety of issues. Some of the more common situations are as follows:

- You are considering forming a partnership and must know the legal implications.
- You have been presented with a lease to sign for your office space, and you do not know much about leases.
- You receive a subpoena for a client’s records, and the client tells you not to release them.
- Staff members from a health insurance company notify you that they are denying claims made by one of your clients because they do not believe you rendered the services you said you provided.
- An investigator for a suspected child abuse case you reported is very aggressive in dealing with you.
- You and your partner have decided to dissolve a partnership, and your partner is being very unreasonable.

Legal issues arise regularly in a private practice, as this list illustrates. You will want to seek advice regarding identifying and establishing a relationship with an attorney.

Most counselors in private practice do not have the expertise or time to handle all the financial obligations of their business. As a counselor in private practice, you would be wise to retain an accountant or an accounting firm to perform the following tasks for you:

- Set up a system for recording income and expenses.
- Develop a retirement program for you and your employees.
- Handle your payroll, including deducting income taxes and social security payments.
- File annual tax returns for you.

The expenses for the services of attorneys and accountants are substantial and are a part of the overhead for a counselor’s private practice. Avoiding legal or financial advice because of the expense involved can lead to substantial problems later.

### **Professional Liability Insurance**

Professional liability insurance is essential for counselors in private practice. If a counselor’s private practice accumulates debts that exceed the assets of the practice, which could happen if a counselor were sued, a counselor’s personal assets might be taken. A counselor’s personal assets are always at risk when a private practice is opened. Even if the practice is incorporated, personal assets can sometimes be accessed in a lawsuit.



Therefore, it is essential that counselors purchase professional liability insurance for their practices. Counselors in private practice should purchase the best professional liability insurance available to them and should request the maximum coverage available. If possible, a policy should be purchased that pays for attorneys' fees and judgments, legal representation if an ethics complaint is filed against the counselor, claims made for actions that occurred during the time the policy was in effect, and claims against supervisees, partners, or employees.

Counselors in private practice also need insurance that covers injuries that might occur on their office premises (Schutz, 1990), acts or omissions by employees that they may be supervising, and any other claim that may arise as a result of their business. This type of insurance is relatively inexpensive.

### **Making the Transition**

Typically, counselors who go into private practice begin their professional careers by working in an agency or organization for several years to gain experience and to complete the hours of supervised practice required for licensure. Later, when they are considering going into private practice, they should assess their ability to handle financial uncertainties. These include an initial period of struggle that may last 3 to 5 years while the practice is getting established, financial losses incurred by cancellations and no-shows, and income that fluctuates from month to month. Personal stressors, such as isolation and dealing with suicidal clients, should also be given some thought. For counselors who can manage the stressors and who enjoy the independence that self-employment allows, private practice can be very rewarding.

A counselor who establishes a part-time private practice while employed as a counselor in an agency must be careful not to accept clients for a fee in the private practice who could receive the same services from the counselor in the employment setting (*ACA Code of Ethics*, 2005, Standard A.10.a.). If an agency does allow its counselors to accept agency clients in their private practices, then the standard says that clients are informed of other options in addition to being counseled by a staff member in his or her private practice.

An issue that seems to be emerging in the realm of private practice is restrictive covenants, usually called noncompetition agreements. A *noncompetition agreement* prohibits an employee from practicing the profession for a specified time or within a geographic region when the employee leaves the organization. Although these types of agreements have been common in professions like law, medicine, architecture, and dentistry, they present unique problems for counselors. Three issues that could have an effect on client welfare are informed consent, transfer of clients, and solicitation of clients (Wyatt & Daniels, 2000). Counselors who are planning to leave an employing agency need to inform clients regarding their choices. Will the client be transferred to another counselor within the agency, or can the client choose to follow the counselor to the counselor's private practice? If the client has the choice, the counselor must be careful not to exercise undue influence on the client's decision.

As you have seen after reading this section of the chapter, starting your own private practice is a complex process. Review Figure 2, which was provided by the Small Business Administration, to alert yourself to some common pitfalls. Most counselor preparation programs do not offer courses in establishing and maintaining private counseling practices (Green, Baskind, Mustian, Reed, & Taylor, 2007). As a result, counselors who plan to open private practices should attend workshops on the topic and read materials that have been developed to help them achieve success (Grodzki, 2000; Hunt, 2004; Rowell & Green, 2003; Truffo, 2007). The American Counseling Association (2012c; ACA) offers its members access to valuable and detailed private practice information provided by an experienced private practitioner, Anthony Centore. The information is one of the benefits of ACA membership.

Counselors in both private practice and in agency or other community settings must deal effectively with third-party payers, or health care insurance companies, if they are to serve the

### Why Small Businesses Fail

Success in business is never automatic. It isn't strictly based on luck—although a little never hurts. It depends primarily on the owner's foresight and organization. Even then, of course, there are no guarantees.

Starting a small business is always risky, and the chance of success is slim. According to the U.S. Small Business Administration, over 50% of small businesses fail in the first year, and 95% fail within the first 5 years.

In his text *Small Business Management*, Michael Ames gives the following reasons for small business failure:

1. Lack of experience
2. Insufficient capital (money)
3. Poor location
4. Poor inventory management
5. Overinvestment in fixed assets
6. Poor credit arrangements
7. Personal use of business funds
8. Unexpected growth

Gustav Berle adds two more reasons in *The Do It Yourself Business Book*:

9. Competition
10. Low sales

### More Reasons Why Small Businesses Fail

These figures aren't meant to scare you, but to prepare you for the rocky path ahead. Underestimating the difficulty of starting a business is one of the biggest obstacles entrepreneurs face. However, success can be yours if you are patient, willing to work hard, and take all the necessary steps.

### On the Upside

It's true that there are many reasons not to start your own business. But for the right person, the advantages of business ownership far outweigh the risks.

- You will be your own boss.
- Hard work and long hours directly benefit you rather than increase profits for someone else.
- Earning and growth potential are far greater.
- A new venture is as exciting as it is risky.
- Running a business provides endless challenge and opportunities for learning.

**FIGURE 2** Pitfalls in starting a private practice

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majority of clients who seek counseling services. In our observation, counselors in private practice struggle to a great extent with issues related to receiving reimbursement from third-party payers (Rowell & Green, 2003). In the following section, we discuss some realities of managed care that counselors need to understand.

## HEALTH CARE PLANS

In 2007, health care costs in the United States increased by 6.9%, double the rate of inflation. Total spending was \$7,600 per person. About 16% of the nation's income is spent each year on health care (National Coalition on Health Care, 2008). Health care plan assistance is a necessity for many

individuals who receive mental health services, because they could not afford the services without this help. It is important for counselors to have a basic understanding of how health care plans function, particularly in the area of providing mental health services.

In many countries, citizens pay taxes to the government, and the government then provides health care services for no cost. In the United States, individuals pay for health care plans because the federal government does not provide health care services and the cost of some of their health care needs could easily exceed the individual's financial resources. When people enter into contracts with health care companies, the health care plan agrees to provide them with health care in return for a premium they pay on a regular basis.

As a fringe benefit, employers in the United States often provide health care plans for their employees free of charge, or more commonly, they subsidize the cost of the plans for their employees. Individuals who are unemployed, who own their own businesses, or who work for employers who do not provide health care plans must purchase their own. Indigent persons or disabled individuals who cannot purchase their own insurance may receive health care assistance in the form of Medicaid (42 U.S.C. § 1396, 1982) from the government. Older persons receive Medicare from the federal government if they qualify due to having paid into Medicare when they were working.

Unfortunately, a number of persons in the United States have no health care plan at all. These individuals must pay for medical services as they are rendered to them, or they simply do not receive medical care. Howe (1999) has suggested that most of the people who do not have health care plans belong to the *working poor*. These are people who produce income that exceeds the eligibility limits for Medicaid, have jobs that do not provide health care plans as a fringe benefit, and cannot afford to purchase health care plans on their own. There are millions of individuals in the United States who do not have health care plans to assist them in paying for mental health services. In addition, many of the health care plans that people do have pay for no mental health services or for services that are extremely limited.

On March 23, 2010, the Affordable Care Act took effect in the United States and will be fully implemented in the year 2014 (Department of Health and Human Services, 2012). The goal of the Act is for every citizen in the country to have health care. Everyone will be required to have a health insurance plan by 2014 if they can afford one and if their religious beliefs allow health care, and those who do have a health care plan may be assessed. Many health care providers are concerned that mental health services will not be covered under the new federal plans to the same extent that physical health care services are provided (Flaskerud, 2009).

### **State Insurance Laws**

Each state or jurisdiction in the United States has different laws governing health care plan contracts that may be sold in that state. These laws require that health care plan companies offer certain health benefits to be allowed to sell plans in that state. In addition to benefits that are mandated by state law, health care companies can offer additional benefits as an incentive for individuals to purchase plans from them rather than from other companies.

A state may also mandate by statute which categories of professionals are eligible to render the health care services that are reimbursable. Physicians are always listed as acceptable providers of health care services. State legislation can require that other health care providers, such as chiropractors, nurses, or physical therapists, be eligible to provide health care services under all insurance plans sold in the state. This type of statute is called *freedom of choice* legislation. It allows consumers of health care services to choose the provider they prefer, rather than allowing health care companies to limit categories of approved providers, thereby excluding other providers.

In some states, freedom of choice statutes exist that require licensed counselors to be allowed to provide mental health services if those services are reimbursed by health care companies. In other states, where such legislation does not exist, health care companies can determine for themselves whether they will reimburse for services if they are rendered by licensed counselors.

In most circumstances, health care companies will voluntarily reimburse their plan members for the reimbursable mental health services of licensed counselors. If health care companies refuse to allow licensed counselors to provide mental health services to their plan holders and there is no statute in that state to the contrary, plan members or licensed counselors cannot force them to allow licensed counselors to be providers.

### **Types of Health Care Plans**

Health care companies offer many different types of plans to the public. The most common kinds available today include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and traditional indemnity health insurance policies. Of course, many other types of health care plans exist, such as exclusive provider organizations (EPOs; Carabillo, 1986), managed care organizations (MCOs), and individual practice associations (IPAs; Randall, 1994). Combinations of two or more types are occasionally formed, and sometimes what appears to be an HMO is called a PPO.

When individuals purchase health care plans from an HMO, they agree to go to the HMO for all their health care needs, and they agree to accept the provider of the health care services assigned to them by the HMO. Although most HMOs offer some flexibility in choosing providers within the organization, members cannot go outside the organization for their health care. HMOs hire providers of health care. Members do not pay for services and then get reimbursed. Instead, they receive health care services from the HMO for no fee or for co-payments that they have agreed to in their contracts.

Individuals who purchase health care plans from a PPO agree to go to providers who have been preapproved by the organization for all of their health care needs. PPO policy members can choose their providers, but only from the list of approved providers given to them by the PPO. PPOs do not hire providers of health care. The approved providers on their list usually are in private practice or work for a separate health care agency. PPO members pay for health care services and are then reimbursed by the PPO.

Indemnity insurance works in a similar fashion to PPOs, but individuals who purchase indemnity health insurance do not have to go to providers who have been preapproved by the organization. Policyholders can choose their health care provider, as long as the provider is in a category of providers that the insurance company recognizes. Persons insured by indemnity health insurance companies pay for services and are then reimbursed by the insurance company.

### **Managed Care**

Managed health care is a relatively new concept that has had a significant impact on mental health care services (Rupert & Baird, 2004). Basically, managed care means that people are not given all health care services that they want or that their provider wants for them. Instead, health plan members are given the services that the health care plan company has determined are appropriate and necessary. The idea is to lower the cost to the company for health care by *managing* the care provided.

These companies have policies regarding the type of care they will provide for preventive procedures or for various illnesses. They also use a procedure known as *utilization review*, in which

a physician or panel of physicians reviews requests for services from the treating service providers to determine whether the services will be allowed (*Wickline v. State of California*, 1986). If plan members or their providers want services that exceed those allowed under a managed care system, they must request exceptions from the company.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 8 and view the video clip entitled “Limits of Managed Care.” A client has reached the maximum number of sessions allowed by managed care in this video clip.

A controversy regarding managed care revolves around whether health care companies are indeed containing health care costs appropriately by eliminating unnecessary procedures and limiting allowable services, or they are simply increasing their profits at the expense of health care recipients. Many health care providers are dissatisfied with managed care systems because administrators make decisions about health care services that professionals believe they should make themselves. Two-thirds of the mental health counselors in one study stated that they believed managed care had had a negative impact on their counseling relationships (Danzinger & Welfel, 2001).

Most health care companies today limit the number of outpatient visits for mental health concerns that members are allowed each year. The idea of limiting counseling services to a set number of visits is objectionable to many mental health care providers. They would rather have health care companies allow clients as many visits as the professional believes are necessary to resolve a mental health concern. Of course, clients who are plan members could have more visits than their health care plan allows, but they would have to pay the fees themselves.

### Counselors as Service Providers

Some counselors or counseling agencies refuse to accept clients who intend to use their health care plan to assist with fees. The position of these counselors and agencies is that dealing with health care plans or insurance companies is too time consuming or is objectionable philosophically. The clients of such counselors and agencies are directly responsible for any fees charged for the services rendered to them. Of course, such clients must have the financial resources to be able to afford the services.

In contrast, many agencies that employ counselors require that they become providers for health care plans. In addition, most counselors in private practice find that they must become providers in order to have enough paying clients to maintain their businesses.

Becoming a provider for a PPO is not an easy process. Counselors must first determine which PPOs exist in their community and then apply to become a provider separately for each one. Sometimes the application process is difficult and time consuming. PPOs purposefully limit their lists of preferred providers. Not all eligible mental health professionals in the community will be accepted by a PPO. They can accept or reject any application they receive, as long as they do not illegally discriminate against a professional. In order to become a provider for a particular PPO, a counselor may have to apply many times over a long period. Despite these difficulties, counselors do seem to be succeeding at becoming providers—60% of the counselors in one study reported that they were approved providers for at least one managed care organization (Danzinger

& Welfel, 2001). Once a counselor has been accepted by a PPO as a provider, or when a counselor has accepted a client who has indemnity health insurance that will reimburse the client for the counselor's services, it is important that the counselor complete health plan forms in an appropriate and professional manner.

Most health care plans demand accountability from their providers. Plans may require counselors to submit detailed justifications for their diagnoses. In addition, most health care plans expect providers of mental health services to develop objective and measurable goals as a part of each client's treatment plan. Some plans even send auditors to providers' offices to determine whether the provider is offering a professional setting for rendering services, is keeping confidential information secure, is accessible to clients for services, and is keeping records appropriately. If providers do not comply with a health care plan's requirements, the plan has the option of removing them as providers. In fact, to avoid liability, health care plans must remove providers from their lists who are ineffective professionally (Corcoran, 1989).

It is vital for counselors to request detailed information from each health care plan for which they provide services regarding the plan's expectations from providers. Each plan is unique and requests different types of information in a multitude of formats. In order to maintain provider status, counselors must comply with the requirements of each health care plan. Counselors must be "accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others" (ACA *Code of Ethics*, 2005, Standard C.6.b.).

Counselors who serve as providers must be prepared to deal with a number of ethical and legal issues that are unique to managed care and other types of health plans (Lawless, Ginter, & Kelly, 1999). Trudeau, Russell, de la Mora, and Schmitz (2001) found that mental health professionals from various disciplines generally are dissatisfied with managed care programs. Issues with which counselors must contend in managed care environments include client privacy, proper diagnosis, informed consent, receiving payment for services, continuing treatment and denial of services, and avoiding fraud. Welfel (2010) has pointed out that counselors who work with managed care companies must deal with a conflict of interest in that they must avoid alienating the company from whom they need referrals and must be advocates for quality care for their clients at the same time.

### **Federal Health Care Plans**

Counselors have been politically active in each state to become recognized as mental health care providers by health care companies under state laws. Recently, counselors have also had a number of successes in being recognized as providers under federal health care plans.

The National Board of Certified Counselors (2012b) has summarized federal programs in which counselors have already been officially accepted as mental health care providers. These programs include the following: (1) TRICARE, the program in which active duty military personnel and their families receive health care services, issued regulations on December 27, 2011, granting independent practice authority to licensed counselors; (2) the Department of the Army signed a directive on July 26, 2011, authorizing Licensed Professional Counselors as Fully Functioning Army Substance Abuse Program Practitioners; (3) Medicare is being debated in Congress as part of the new universal health care act, and counselors are asking to be recognized as mental health providers; (4) counselors are asking to be recognized by the Indian Health Service as health care providers; and (5) Veterans Administration officials have been meeting with representatives from the counseling profession to hear reasons why counselors should be included in the trainee support program that provides funding for associated health professionals serving in VA facilities.



## Client Privacy

When clients contract with health care plans, they sign forms that give health care providers permission to provide information regarding their health care to their health care plan administrators. Clients, in the past, believed that they had to agree that service providers could release any information regarding their treatment that the administrators requested. However, the Health Insurance Portability and Accountability Act (HIPAA) has changed that situation significantly. Under HIPAA, insurance companies are limited in the types of information they may request, and they are not allowed to disallow claims if clients refuse to provide them with certain types of information, such as psychotherapy notes.

Many mental health professionals feel uneasy about providing detailed information regarding their clients' diagnoses and treatment to administrators who usually are not mental health professionals. Their discomfort is compounded by the fact that they have no control over what happens to the information after it is released to the provider (Danzinger & Welfel, 2001). Yet if counselors wish to be providers, they must provide this information. When counselors become providers for PPOs, they should request a copy of the privacy waivers that PPO members routinely sign. If a counselor is ever unsure about whether a client wants the counselor to provide information requested from a health care plan administrator, it would be best to ask the client to sign a waiver giving permission for the information to be sent.

In our opinion, it is fruitless for an individual counselor to challenge the idea that health care providers inappropriately invade the privacy of their clients. If a counselor believes that a health care plan policy should be changed, the counselor should communicate directly with a company representative regarding the policy. Counselors who believe that laws or regulations should be changed should work through the state or national counseling association to seek legislative changes. The ACA belongs to a coalition of mental health organizations working to influence national legislation. Glosoff (1998) has suggested that counselors might take additional steps, such as increasing their role in the decision-making processes of managed care companies and working with companies to establish clearly structured appeals processes. Knapp and VandeCreek (2008) have reminded counselors that they have an ethical obligation to advocate for clients by informing policy makers about problems with the present health care system.

## Diagnosis

Using the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)* creates conflicts for counselors who espouse a wellness or developmental orientation. Most managed care organizations require that mental health professionals assign a *DSM-IV-TR* diagnosis to their clients in order to qualify for reimbursement of services. Most companies limit in some way the diagnoses for which they will pay benefits. Some companies will not reimburse for V-code conditions, typical developmental transitions, exclusively Axis II diagnoses, adjustment disorders, or family or couples counseling.

Counselors are sometimes caught in a conflict because they want to promote client welfare by helping clients receive reimbursement and, at the same time, to provide accurate diagnoses. Given the choice between an honest diagnosis without insurance reimbursement and a deceptive diagnosis with third-party payment, some counselors may succumb to playing a game of "diagnosing for dollars" in which diagnoses are tied to the chance of being reimbursed by health care companies (Wylie, 1995). Rather than yield to these temptations, counselors can improve the chances that their treatment plans will be approved by assessing thoroughly, setting realistic treatment

goals, and complying with health care companies' recommended treatment protocols (Hoyt, 1995). Counselors are ethically obligated to "take special care to provide proper diagnosis of mental disorders" (ACA *Code of Ethics*, 2005, Standard E.5.a.).

### **Informed Consent**

Managed care can complicate informed consent procedures in several ways. Because managed care plans typically limit treatment options and the number of sessions for which they will reimburse, counselors must address these limitations with clients at the outset of the counseling relationship (Daniels, 2001). Additionally, counselors must be alert to whether contracts they may sign with managed care organizations include *gag* clauses stipulating that counselors cannot discuss with their clients alternative treatments that fall outside the boundaries of plan-approved services (Wineburgh, 1998). These clauses in contracts run contradictory to the principle of client autonomy and have been challenged in court (Danzinger & Welfel, 2001). Informed consent also includes ensuring that clients know what information their managed care organization requires the counselor to disclose, as well as the ramifications of any diagnosis that might be assigned (ACA *Code of Ethics*, 2005, Standard A.2.b.).

### **Receiving Payment for Services**

Most PPOs pay providers directly for services rendered to the PPOs' members. These fees are sent to providers after they have completed necessary forms that document the services rendered. This arrangement means that counselors often receive payment long after services have been rendered.

When counselors provide services to indemnity health insurance policyholders, counselors can handle payment in one of two ways. Counselors may require that the client pay for services as they are rendered and then file for reimbursement. Counselors may also allow clients to assign their reimbursement to the counselors so that the payment comes to the counselor from the insurance company. With either method, counselors must verify to the insurance company that they provided services for the client and must provide all the information regarding the services requested by the insurance company.

Usually, both PPOs and health insurance companies require clients to pay a portion of the professional's fees directly. This amount is called a *co-payment*. It is vital that counselors collect co-payments from clients when such payments are a requirement of the PPO or indemnity health insurance company.

After counselors have succeeded in becoming approved providers under managed care plans, they confront some ethical issues. Most managed care companies approve only brief mental health treatment as a cost containment measure. Thus, counselors must be prepared to provide brief therapy for many of their clients who want their health care plans to pay for services. Many counselors have not been trained in the brief therapies. Only recently have counselor training programs recognized the need to teach not only the traditional approaches but also the brief therapy models. Programs are just beginning to prepare students to meet the clinical and ethical challenges created by managed care. Therefore, practitioners whose training did not adequately prepare them must seek continuing education in the brief therapies and seek supervision and consultation while developing their competencies (Glosoff, 1998; ACA *Code of Ethics*, 2005, Standard C.2.b.).

Counselors who participate in managed care plans must be able to assess which clients will be well served in a time-limited context. They must be knowledgeable about referral resources for clients whose needs cannot be met under the limitations of their health care plans. Because counselors have an ethical obligation to be advocates for their clients (ACA *Code of Ethics*, 2005, Standard A.6.a.), they must also be skilled at appealing health care companies' decisions to deny reimbursement when clients need more sessions than their plan allows.

### Continuing Treatment and Denial of Services

Although counselors may do their best to accept clients who can be well served by time-limited therapy, inevitably there will be clients who will need more sessions than their health care plan allows or approves. In these situations, counselors may be caught between the need to uphold their ethical standards and their need to remain financially viable in private practice. They have ethical obligations to avoid abandoning clients (ACA *Code of Ethics*, 2005, Standard A.11.a), to ensure appropriate termination (Standard A.11.c.), and to help clients find alternative resources for continued treatment (Standard A.11.d.).

Christensen and Miller (2001) found that mental health professionals continually faced issues of abandonment when they had to terminate clients before they believed they should have. It is not ethical to discontinue counseling services for lack of payment when the client is in a state of crisis or emergency. In these situations, counselors must continue providing treatment until the emergency is resolved or appropriate alternative care can be arranged (Welfel, 2010). At the same time, counselors cannot be expected, except in emergency situations, to continue indefinitely to counsel clients without receiving payment for their services (Standard A.11.c.).

Lawsuits have been filed when patients suffered injuries after their health plans refused to cover services that were requested (*Wickline v. State of California*, 1986; *Wilson v. Blue Cross*, 1990). In these cases, the health plans argued that their denial of payment or reimbursement for services was not a denial of care. They argued that the treating health care provider had the final responsibility for appropriate care. The courts in these cases held that health plans could be held liable if they were negligent in denying health care services that were necessary to avoid a patient being injured. In *Wickline*, the court also found that the physician involved in the case should have protested the health plan's denial of care that he requested. It was the court's position that a health care provider is not liable if a health plan refuses to provide necessary care, but that the provider does have a responsibility to protest if the recommendation for care is not accepted.

Mental health services under managed care probably present more challenges to providers than do physical health care services. First, mental health care often is limited to levels that seem inappropriate to mental health care providers. For example, a health care plan may allow only five reimbursed counseling sessions a year; or worse, the plan may require that a member have a diagnosis of a serious mental or emotional disorder, while severely limiting the services that may be provided under the plan.

The court cases discussed previously provide a foundation for making some recommendations to counselors providing services to clients covered by managed health care companies. These recommendations will help you protect yourself from legal liability:

- If you believe that a client requires counseling services beyond what has been approved by a managed health care company, request the additional services on behalf of the client. If the request is denied, file a written protest or complaint with the company.
- Instruct the client regarding the right to appeal a decision that denies additional services (Hilliard, 1998).
- If the client is a danger to self or others or is in a crisis and cannot afford to pay for your services directly, continue providing services for the client until care can be transferred to another professional or to a facility that provides mental health care.

Anderson (2000), who is a counselor and also has been a managed care case manager, has offered suggestions to counselors about how to deal constructively with managed care companies. He has suggested that counselors avoid treating managed care case managers as the enemy, but instead establish a positive relationship with them for the benefit of clients. Anderson has recommended to

counselors that they emphasize good treatment plans in their practices, use proper code numbers in submitting claim forms, and use empirical research results to support exceptions to decisions that have been made.

### **Avoiding Fraud**

Counselors who complete the forms required by PPOs or health insurance companies must be careful to avoid fraudulent practices. Fraud occurs when counselors misrepresent to health care companies any facts regarding their services so their clients will receive payment or reimbursement for the counselors' services. If fraudulent practices are discovered, health care companies can file civil lawsuits to recover payments or reimbursements made inappropriately and can even cause prosecutors to file criminal charges against counselors, because fraud is a crime.

Mayfield (1996) found that many counselors do not know what constitutes health care fraud. It is possible for counselors to commit fraud without realizing they are doing so if they do not understand which practices are fraudulent. New counselors should be careful not to pattern their behavior after that of seasoned practitioners because some actions that mental health professionals have been taking for years are actually fraudulent. Substantial numbers of the mental health counselors surveyed by Danzinger and Welfel (2001) had changed or would change treatment plans based on managed care limitations (60%), had terminated or would terminate with clients before they were ready because of these limits (46%), and had changed or would change a client's diagnosis to receive additional reimbursement (44%).

We believe that counselors sometimes engage in health care fraud activities because they are motivated to help their clients receive mental health care services that are paid for or reimbursed by health plans. Counselors report inaccurate information to health care plans so that their clients will be able to begin or continue counseling. Unfortunately, counselors also benefit from fraudulent practices in that health plans pay for their services based on inaccurate information they have provided. Therefore, it appears to outside observers that counselors are being very self-serving when they give false information to health care plans. Consider the following situation:

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### **3 The Case of Danny**

Danny has just been licensed as a professional counselor and has decided to open a private practice. He knows from talking to other licensed counselors in his state that a few of the major PPOs and health insurance companies in the state do not pay or reimburse clients for the services of licensed counselors. Danny's good friend, Monique, is a licensed clinical psychologist. Monique's clients do receive payment or reimbursement for her services. Monique agrees to sublease office space to Danny for his private practice. In addition, Monique agrees to *sign off* on PPO and health insurance forms, indicating that she is the client's therapist, even though Danny is the one seeing the clients. Monique and Danny meet weekly and review each of Danny's cases to ensure that Monique is comfortable with his treatment of clients. All clients are told that Monique is supervising Danny. In exchange for Monique's assistance, Danny agrees to give Monique 25% of all fees he collects from PPO and health insurance clients.

- What is the major problem with this arrangement?
  - What do you think would happen if Monique indicated on the insurance forms that Danny provided the mental health services and that Monique supervised him in providing those services?
-

**Discussion:** This arrangement between Danny and Monique appears to be one that serves everyone's purposes well. Monique is helping out her friend and realizing extra income through subleasing her office space, supervising Danny, and receiving 25% of the PPO and health insurance client fees that Danny collects. Danny is able to see clients who normally would not be able to see him, because their health care plans will pay or reimburse as long as Monique continues to supervise him and sign off. Clients are pleased that their health care plans are paying for their counseling services. This may seem like a perfectly reasonable arrangement, and mental health practitioners have long been involved in these kinds of arrangements. The problem is that Monique and Danny are fraudulently misrepresenting their services to the PPOs and health insurance companies. Although it may seem unfair that health care plans do not reimburse licensed counselors for their services, health care plans in their state do have the right to refuse to pay for the services of licensed counselors. If a health care company discovers what they are doing, the company could sue Monique, Danny, and Danny's clients for fraud and perhaps collect all of the fees they paid out to them plus other damages. In addition, the company could request that the local prosecutor file criminal fraud charges against all the parties and might also file ethics complaints against Monique and Danny with their licensure boards.

Actually, there is nothing wrong with licensed counselors affiliating with other mental health professionals such as licensed psychologists or licensed physicians. If the counselor is going to provide the direct service to clients, then PPO and insurance forms must be completed to reflect the actual situation. For example, in the previous case example, no fraud would have been involved if Monique had indicated on forms that Danny, a licensed counselor, was providing the direct service, and she, the licensed psychologist, was supervising Danny's work. A PPO or health insurance company might have refused to pay or reimburse for services provided under such an arrangement (which it would have a legal right to do), but possibly payment or reimbursement would have been approved. Then, the entire arrangement between Danny and Monique would have been acceptable. There is nothing illegal or unethical about fee splitting under arrangements such as theirs as long as there are no misrepresentations to PPOs or health insurance companies.

Listed in the following section are a number of fraudulent practices in which mental health professionals sometimes engage that could lead to serious trouble. Counselors commit fraud when they report the following to PPOs or health insurance companies:

- An approved professional is providing direct services to a client, when the services actually are being provided by a counselor who is not approved for payment or reimbursement.
- A client has a *DSM-IV-TR* diagnosis that is approved for payment or reimbursement, when the counselor actually does not believe the diagnosis is accurate.
- The counselor's fee is a specified amount, when actually the counselor charges a sliding scale for clients without health care plans and charges the full fee only to clients who have health care plans that will pay or reimburse for mental health services.
- The counselor is seeing a client for individual counseling (which is reimbursable), when actually the counselor is providing couples, family, or group counseling (which is not reimbursable).
- The counselor is collecting a required co-payment from a client, when actually the counselor is waiving the co-payment.

- Counseling services were rendered on a specific date, when actually the client missed the session, but the counselor billed for the missed session anyway.
- The counselor may be a physician by signing forms in the space marked *physician's signature*, without noting that the counselor is a licensed counselor rather than a physician.
- The counselor is beginning a counseling relationship with a client for the first time, when actually they are involved in an ongoing counseling relationship, because health care providers often will not pay or reimburse for *preexisting conditions*.
- The client is requesting payment or reimbursement from only one health care plan, when the counselor knows that the client is requesting payment for the same services from two or more plans.

Counselors who are willing and properly trained to diagnose emotional and mental disorders have an ethical and legal obligation to diagnose according to accepted standards in the mental health field (*ACA Code of Ethics*, 2005, Standard E.5.a.). If a counselor determines that a client does not have a *DSM-IV-TR* disorder for which a health care plan will pay or reimburse, then the counselor must not assign such a disorder just to allow a client to obtain health care plan financial assistance.

### Changing Nature of Health Care Plans

We have summarized the current types of health care plans available and the issues they raise for mental health providers. Health care plans have changed substantially over the past decade and are expected to continue to change as legislators and the public discuss and change health care delivery systems in the United States. It is important for counselors who provide services for clients with health care plans to constantly monitor changes in the health care industry. What may be an acceptable practice today may be prohibited tomorrow.

### Diversity Considerations

As we noted earlier in the chapter, a large number of people in our society do not have health care insurance. Unfortunately, many of these individuals are the very people who can ill afford to pay out of pocket for mental health care services. Wilcoxon, Magnuson, and Norem (2008) have urged counselors to confront the business paradigm of the health care industry and have suggested that counselors should advocate for changing corporate approaches to client care that further disadvantage those who already are disadvantaged in our society. Counselors in private practice grapple with conflicts between their desire to assist these individuals and their need to generate sufficient income to maintain their practices. Private practitioners are encouraged to provide some *pro bono* service; that is, service for which there is little or no financial return (*ACA Code of Ethics*, 2005, Section A Introduction). Knapp and VandeCreek (2008) have pointed out, though, that decisions about *pro bono* and reduced cost services should be made only after careful consideration of possible ramifications. For example, will the client devalue the worth of the services if the services are free?

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## 4 The Case of Isabelle

Isabelle has been in private practice for 10 years. She has an office in an affluent part of town, and all of her clients have insurance that pays for her services or are wealthy enough to pay her from their personal funds. Isabelle feels some guilt, however, because she entered the counseling profession in order to be of help to individuals and to society. She also is aware that the *ACA Code of*



*Ethics* (2005) encourages counselors to provide some services *pro bono*. Isabelle is wondering how she should provide free services to some clients.

- If Isabelle decides to see some clients for free or at a reduced rate in her private practice, what problems might that cause?
- How else might Isabelle meet her *pro bono* obligations?

**Discussion:** If Isabelle were to accept some clients into her private practice who pay nothing, she would need to have clear criteria regarding how clients could qualify for the services. If her other clients were to somehow learn that she was serving some clients *pro bono* and if they did not understand how she came to that decision, they might feel resentful even if they can afford her full fee. Perhaps a better option for Isabelle to fulfill her *pro bono* obligation would be to volunteer her counseling services in a community agency for a period of time each week, or to provide free workshops in the community.

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## Summary and Key Points

This chapter focuses on three related topics—professional relationships, private practice, and health care plans. Counselors who practice in any settings interact regularly with other professionals and must conduct themselves in an ethically and legally appropriate manner. Although private practice is idealized by many counselors in training, private practice is a business that carries associated risks and requires knowledge of business practices.

Key points regarding professional relationships include the following:

- Counselors will take different roles depending on the circumstances of their interactions with other professionals.
- Because most counselors function at various times as employees and as employers, it is important that they understand the basic principles of employment law.
- Counselors as employees have the right to be free of discrimination in the workplace and to refuse to follow a supervisor's directive if it constitutes a crime.
- Counselors as employees do not have a right to employment and in all but limited circumstances can be dismissed from their jobs.
- Counselors and their employers sometimes disagree about what is ethical, and several steps can be taken to attempt to resolve these disagreements.
- Counselors as employers need to be clear about their roles and their expectations of those whose work they supervise.
- Counselors as employers should avoid close personal relationships or friendships with their employees.
- Counselors should obtain client permission and must work to preserve client confidentiality when transferring private information about clients.
- Although counselors cannot make referrals in ways that might benefit the counselors themselves, they may make referrals to other professionals as dictated by client welfare or the policies of their employers.
- Relationships between counselors and other mental health professionals are characterized by respect, honesty, and fairness.
- Counselors must avoid making statements about other professionals that could be libelous or slanderous.

Private practice is a business. Counselors who wish to start their own practices need to understand certain aspects of business practice. Key points regarding private practice include the following:

- Counselors who wish to start their own practices must be knowledgeable about taxes and business licenses, and about the various forms of businesses including sole proprietorships, partnerships, and corporations.
- Private practitioners must set fees that are reasonable by community standards.
- Counselors must understand the appropriate and inappropriate uses of a sliding scale fee.
- Counselors should collect payment at the time they render their services.
- Counselors in private practice need the services of attorneys and accountants to assist them in managing their businesses.
- It is vitally important that counselors carry adequate professional liability insurance.
- Private practice is not for every counselor. The risks and benefits must be carefully weighed before a decision to enter private practice is made.

Most individuals today have some type of health insurance that is paid for or subsidized by

their employers or by the government. There are several types of insurance plans that raise complex issues for counselors who wish to become approved providers of mental health services. Key points regarding health insurance include the following:

- Each state in the United States has different laws that govern which health care plan contracts may be sold in that state.
- There are a number of types of health care plans, including HMOs, PPOs, and traditional indemnity plans.
- Managed care has been a controversial development that has had a significant impact on mental health care services.
- With some perseverance, counselors often can become providers for managed care companies.
- Ethical and legal issues raised by managed care and other types of health plans include maintaining client privacy, rendering appropriate diagnoses, ensuring informed consent of clients, receiving payment for services, continuing treatment after benefits end, problems caused by denial of services, avoiding insurance fraud, and meeting the needs of individuals who do not have mental health insurance.



# Supervision and Consultation

## FOCUS QUESTIONS

1. How are counseling, supervision, and consultation similar? How are they different from each other?
2. What would you do if you believed your clinical supervisor was not competent to provide you with quality supervision services?
3. As a beginning counselor, in what circumstances do you think you might seek consultation? In what circumstances do you think others might come to you for consultation?

**T**his chapter discusses legal, ethical, and professional issues that occur in supervision and consultation. During your career as a counselor, you will almost certainly be involved in each of these activities, in both the learner or help-seeker role (as supervisee or consultee) and the expert or help-provider role (as supervisor or consultant).

*Supervision* has been practiced for as long as counseling and psychotherapy have been in existence. Only in recent years, however, has supervision been given much attention as a process that is distinct from education, counseling, and consultation. The term *supervision* can involve a number of processes, ranging from one counselor having direct control and authority over another to a counselor simply giving input to a colleague involving a specific case. Bernard and Goodyear (2009) have defined clinical supervision as an intervention provided by a senior or experienced member of a profession to a junior or aspiring member or members of that same profession. Supervision also has been described as an attachment process that involves the development of a bond or working alliance that is gradually loosened as the end of supervision nears (Nelson, Oliver, Reeve, & McNichols, 2010). Clinical supervision involves multiple roles, including teacher, mentor, coach, evaluator, adviser, and consultant. Supervision also involves multiple responsibilities. Supervisors usually are responsible not only for the welfare of their supervisees but also, in an indirect way, for the welfare of the clients served by their supervisees. Additionally, a supervisor may have an obligation to the agency or other setting where the supervised practice occurs to ensure that

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## Supervision and Consultation

quality services are provided. Finally, supervisors, like counselor educators, may serve as gatekeepers to the profession.

*Consultation*, like supervision, involves a tripartite relationship among at least three parties: the consultant, the consultee, and the consultee's client or client system. Consultation has become increasingly common among mental health professionals in community agencies, schools, and other settings (Dinkmeyer, Carlson, & Dinkmeyer, 1994; Dougherty, 2009). Dougherty's (2009) definition of consultation is widely accepted. He describes consultation as

a process in which a human services professional assists a consultee with a work-related (or caretaking-related) problem with a client system, with the goal of helping both the consultee and the client system in some specified way. (p. 11)

Counselors frequently are the recipients of services from consultants, and they often function in the role of consultant themselves. When consulting, they apply their professional expertise to the questions, needs, or concerns of those who have sought their services.

Many of the issues regarding counselor education are equally pertinent to supervision and consultation. In this chapter, we discuss them as they apply to the specific triad involved (supervisor–supervisee–client or consultant–consultee–client or client system).

## SUPERVISION

The professional literature in mental health supervision recognizes that there are two basic types of supervision for counselors—administrative and clinical (Borders & Leddick, 1987). Administrative supervision occurs when direct-line administrators give direction, or supervision, to counselors who are their employees. Clinical supervision, on the other hand, is the process whereby the work of counselors is reviewed by other mental health professionals, usually with the goal of increasing the counselors' effectiveness. Within counselor education programs, supervision has the dual purpose of monitoring the services provided by counselors-in-training and monitoring the welfare of clients who are receiving services from these trainees (*ACA Code of Ethics*, 2005, Standard F.1.a.).

The purpose of administrative supervision is to ensure that counselors who are employed are performing their jobs appropriately. Curtis and Sherlock (2006) have identified and discussed managerial skills needed by counselors who serve in leadership and administrative roles. Administrative supervisors usually have direct control and authority over those who are being supervised. Generally, the purpose of clinical supervision is to help counselors increase their skills and ensure that they are serving their clients appropriately. Clinical supervisors usually have no direct control and authority over the counselors they supervise, unless they happen to be the counselors' administrative supervisor as well. Counselors who are receiving clinical supervision often are completing field experiences for their graduate program, or postmaster's supervised experience for state licensure or national certification (Magnuson, Norem, & Wilcoxon, 2000). In some instances, an administrative supervisor also serves as a counselor's clinical supervisor, and this arrangement has positive aspects and usually is not problematic (Tromski-Klingshirn & Davis, 2007). Most of our discussion in this chapter focuses on clinical supervision rather than an administrative supervision. Keep in mind, though, that the law treats the relationships differently because the purposes of the two types of supervision generally are quite different. When there is a legal question regarding supervision, the issue of whether the supervisor has direct control and authority is important.

### **Fair Evaluation**

Fair evaluation in supervision has to do with supervisee rights. Legal due process rights derive from the Fourteenth Amendment to the U.S. Constitution. Supervisees who work in public institutions and those who work in private organizations that have policies stipulating due process rights can expect to be protected from unfair or arbitrary decisions that affect them negatively. According to Bernard and Goodyear (2009), the most blatant violations of supervisees' fair evaluation rights occur when a supervisee is given a negative final evaluation or is dismissed from an internship or job without having been given warning that performance was inadequate along with reasonable opportunity to improve.

What this means for supervisors is that they need to provide supervisees with ongoing feedback, periodic evaluation, and opportunities to correct their deficiencies. When evaluation is negative, the changes that the supervisee must make should be communicated in specific, behavioral terms. Bernard and Goodyear (2009) have suggested that supervisees should be given a specific description of what constitutes inadequate performance, what behaviors constitute improvement, and what degree of improvement is expected. The *ACA Code of Ethics* (2005) contains some provisions to ensure that supervisee rights are protected when supervisors believe that supervisee limitations are impeding performance. Supervisors assist supervisees in securing remedial assistance when needed, seek consultation and document their decisions to dismiss or refer supervisees for assistance, and ensure that supervisees are aware of options available to them to address such decisions (Standard F.5.b.).

Counselors who supervise sometimes create problems because they are uncomfortable with evaluation and avoid giving clear feedback to a supervisee about deficiencies they observe. Supervisees will then be justifiably upset and angry when they receive a negative final evaluation or when the supervisor declines to endorse them for licensure or another professional credential. Supervisors should provide formative as well as summative feedback to supervisees. Formative feedback is designed to help supervisees improve their skills, whereas summative feedback serves the purpose of evaluating the performance of supervisees. Evaluation needs to be ongoing (*ACA Code of Ethics*, 2005, Standard F.5.a.) and given both orally and in writing.

### **Informed Consent**

Informed consent for supervision should be obtained both from the client and from the supervisee. *Clients* of supervisees need to know that their counselor is working under supervision and understand what this supervision will mean for them. For instance, will their sessions be observed, or audio- or videotaped? Who will be involved in supervision? Will supervision be conducted by just one person, or will the client's case be discussed with a supervision group? What does this all mean in terms of the client's confidentiality? These questions need to be clearly addressed with clients, and their written consent should be obtained before clients agree to enter into the counseling relationship. Best practice requires that counselors provide clients with specific information regarding supervisory relationships.

Clients have the right to be aware that their counselors are working under supervision, and they have the right to know the supervisee's qualifications to provide counseling services (*ACA Code of Ethics*, 2005, Standard F.1.b.). Sometimes counselors who are being supervised will minimize the need for supervision and gloss over the details of the arrangement in an attempt to make themselves and their clients more comfortable. As a counselor working under supervision, you may be concerned that your clients will not believe you are competent to provide services and may not develop trust and confidence in you. These concerns should not inhibit you from fully informing



your clients about supervision, however. If a client expresses reservations about a third party being privy to sensitive information that might be shared, a solution might be to arrange for the client to meet the supervisor face-to-face and raise any concerns directly with the supervisor. If some clients refuse to allow you to tape sessions or discuss their cases during supervision sessions and your supervisor requires the opportunity to supervise your counseling sessions with these clients, you may have to terminate your relationship with the clients and transfer them to another counselor.

Just as the supervisee has a responsibility to secure the client's informed consent, the supervisor is obligated to ensure that the *supervisee* understands and consents to the conditions of supervision. Several writers (Borders & Leddick, 1987; Cohen, 1979; McCarthy et al., 1995) have suggested points that should be discussed between the supervisor and the supervisee before they enter into a formal working relationship. These points are included in Figure 1. The *ACA Code of Ethics* (2005) also addresses informed consent for supervision, requiring supervisors to incorporate

- **Purposes of supervision.** The purposes of supervision are varied. The goal of a supervision arrangement could be to foster the supervisee's professional development and protect the welfare of clients while a supervisee is in the process of developing the competence to work independently. Although an important benefit of supervision could be that the supervisee accrues the supervised hours to fulfill requirements for an internship or licensure, simply acquiring a certain number of hours is not the purpose of supervision. When a supervisor and supervisee undertake their relationship with the intent of having the supervisor "sign off" on the required hours, there is little chance that supervision will be a growth-producing experience for the supervisee.
- **The logistics of supervision.** An understanding should be reached regarding how frequently the supervisor and supervisee will meet, where they will meet, and for how long. If the supervisee is under the direct control and authority of the supervisor in a work setting, the supervisee should know how to contact the supervisor, who to contact in case of an emergency, and what to do if the supervisor or the designee is unavailable. Supervisors and supervisees should discuss the various forms of documentation required by licensing boards, or in the case of student interns, by the university and the internship site, and who will be responsible for completing the paperwork.
- **Information about the supervisor.** Supervisees need to know that their supervisors are qualified by training, experience, or credentials to provide them with competent supervision. Supervisors should provide prospective supervisees with information regarding their credentials. To help supervisors and supervisees determine whether there are any differences in perspective that might need to be negotiated, supervisors should explain their theoretical orientations and describe their supervisory styles to potential supervisees.
- **Expectations, roles, and responsibilities.** These should be made clear for each party in the relationship. For instance, is the supervisee expected to bring audio- or videotapes to the supervisory sessions, present cases for discussion, or prepare in some other specific way? If the supervisor is charging a fee, what are the arrangements for payment? What is the nature of the supervisory relationship, and how does it differ from a counseling relationship or a consulting relationship? What are the boundaries of the relationship?
- **Evaluation.** It is best practice to explain in detail to supervisees the processes and procedures for evaluating their performance.
- **Ethical and legal practice.** Supervisors should not simply assume that supervisees have been instructed and that they know all they need to know about legal and ethical issues. Supervisors protect themselves and safeguard the welfare of their supervisees and the supervisees' clients when they ascertain at outset of the supervisory relationship areas of ethical and legal practice in which the supervisee may need further instruction or clarification.

**FIGURE 1** Topics to be discussed before supervision begins



into their supervision the principles of informed consent and participation and inform supervisees of their policies and procedures and the mechanisms for due process appeal of their supervisory actions (Standard F.4.a.).

### **Supervision Agreements**

Written agreements are recommended for counselor–client relationships, and these agreements are also important for supervisory relationships. Generally, written agreements are not necessary in administrative supervision because such relationships are dictated by the job descriptions of both the supervisor and the supervisee. The types of supervisory arrangements in clinical supervision vary substantially among dyads. Whereas one clinical supervisor may require payment for services and weekly audiotapes of sessions, another clinical supervisor may not charge a fee and may prefer to observe sessions. A written agreement can articulate a supervisory relationship in detail to avoid later misunderstandings. It can also serve to formalize the relationship, educate the supervisee regarding the nature of supervision, provide a model of how to approach informed consent with clients, and provide security for both parties by structuring the relationship (McCarthy et al., 1995).

### **Supervisor Competence**

Being a competent counselor does not necessarily mean that one is also a competent supervisor (Muratori, 2001). In fact, being a skilled counseling practitioner is only one prerequisite for competence as a supervisor. It also requires specific training in the knowledge and skills involved in supervision. Licensure boards in some states (e.g., California, Ohio, Louisiana, Texas) now require those who supervise candidates to be not only trained and licensed as counselors but also approved by the boards as supervisors. The Center for Credentialing and Education (CCE, 2003), a National Board for Certified Counselors (NBCC) corporate affiliate, offers a national supervisory credential that may be used to verify one's expertise in supervision of counselors.

The ACA *Code of Ethics* (2005) states that “prior to offering clinical supervision services, counselors are trained in supervision methods and techniques” (Standard F.2.a.). The Association for Counselor Education and Supervision (ACES) *Standards for Counseling Supervisors* (1990) provide a detailed description of the characteristics and competencies of effective supervisors. Briefly, the standards that represent best practice (Storm, Todd, Sprenkle, & Morgan, 2001) state that competent supervisors have the following characteristics:

- They are effective counselors themselves.
- They have attitudes and traits consistent with the supervisory role, such as sensitivity to individual differences, motivation and commitment to supervision, and comfort with the authority inherent in the supervisory role.
- They are familiar with and can skillfully apply the ethical, legal, and regulatory dimensions of supervision.
- They understand the professional and personal nature of the supervisory relationship and the impact of supervision on the supervisee.

## Supervision and Consultation

- They understand the methods and techniques of supervision.
- They appreciate the process of counselor development and how it unfolds in supervision.
- They are skilled in case conceptualization and management.
- They can evaluate a supervisee's counseling performance fairly and accurately and provide feedback to facilitate growth.
- They are knowledgeable about oral and written reporting and recording.
- They have a solid grasp of the rapidly expanding body of theory and research concerning counseling and counselor supervision.

Supervisors must be cognizant of the need for continuing education. According to the ACA *Code of Ethics* (2005), clinical supervisors “regularly pursue continuing education activities including both counseling and supervision topics and skills (Standard F.2.a.). This task can be enormous for supervisors, as they need to keep current in their own specialty areas as well as be aware of advances that are being made in the general area of clinical supervision (Bernard & Goodyear, 2009). Research has demonstrated that experienced supervisors can benefit from competency training. The clinical supervisors who participated in a study by Tebes et al. (2011) reported significant increases in their perceived ability to manage supervisory relationships, manage supervisee job performance, and promote supervisee professional development.

Supervisees sometimes want to gain experience working in specialty areas or with client populations in which the supervisor has limited training or experience. In these cases, supervisors must decide whether they have the necessary skills to adequately supervise. Supervisors should be clear about the kinds of cases they would not supervise (such as substance abuse, genetic counseling, or sexual abuse), the kinds of settings that are outside their scope of expertise (e.g., an agency counselor who works with adults not feeling competent to supervise an elementary school counselor), and the kinds of cases they would supervise only when they are working under supervision themselves or in conjunction with a consultant. In fact, because supervision is such a complex and demanding responsibility, supervisors would be wise to have a consultant or consultation group with whom they meet regularly to monitor their performance. The ACES Ethical Guidelines for Counseling Supervisors (1993) recommend that supervisors be active participants in peer review and peer supervision procedures (Section 3.03).

### Confidentiality Concerns

When you are working as a counselor under supervision, you can expect your supervisor to inform you about client rights including the protection of client privacy and confidentiality in the counseling relationship (ACA *Code of Ethics*, 2005, Standard F.1.c.). You will need to provide your clients with disclosure information that informs them of how the supervision process influences the limits of confidentiality, and let them know who will have access to their records (F.1.c.). You will have access to sensitive information about clients that must be kept confidential. In some circumstances, this information may be privileged by statute. At the same time, you will be required to share information about your clients with your supervisor. As a general rule, sharing confidential and privileged information with professionals who have a need to know for professional purposes, such as supervision, is acceptable and does not destroy legal privilege (Cleary, 1984). You must know how to apply the general principles of confidentiality to your specific situation. If you are working in a community agency, the agency is likely to have policies and regulations regarding release of client information, and you must know and abide by these regulations.

What would happen if your site supervisor were to inappropriately disclose confidential or privileged information? Because you may have had no control over who would be your supervisor,

you probably would not be held accountable. Nonetheless, you do have a professional and legal responsibility to address concerns you may have regarding an untrustworthy supervisor. This can be extremely difficult, because you are in a vulnerable position. If you are a practicum student or intern in a counselor training program, you should bring your concern to the attention of your university supervisor, who will help you determine how to proceed. If possible, it is best for you to resolve the concern directly with the site supervisor involved. Counselors who have graduated from a training program and are working under supervision toward their licensure should also attempt first to resolve the concern directly with the supervisor. If this approach is not feasible or is unsuccessful, they should consult with their supervisor's administrative supervisor.

The use of new technologies in supervision is burgeoning, and supervisors are challenged to keep current with all the innovations. The use of videoconferencing as a means of providing supervision is increasing because of its time and cost efficiency (Jencius, Baltimore, & Getz, 2010). However, because even encryption-protected telecommunications systems are highly vulnerable to intrusion, supervisors need to carefully weigh the benefits of providing distance supervision against the potential threats to confidentiality (McAdams & Wyatt, 2010).

### **Supervisory Relationships**

Supervision occurs at multiple levels and involves a number of parties including a client, a counselor/supervisee, and one or more supervisors. Within a counselor training program, both a university supervisor and a site supervisor typically oversee the work of the student who is completing a field-based practicum or internship. An advanced doctoral student who is learning applied supervision might also provide some of the supervision, and this doctoral student supervisor will be supervised as well. When relationships involve clients, a supervisee, a university supervisor, a site supervisor, a supervisor who is a doctoral student, and the supervisor of the doctoral student supervisor, sorting out the roles and responsibilities can be a daunting task.

Supervision also occurs at the postmaster's level. The counselor licensure movement has produced another group of supervisors—those who work with licensure applicants (Borders, Cashwell, & Rotter, 1995). Obviously, there are multiple roles and relationships to consider in supervision.

All of the guidelines in the *ACA Code of Ethics* (2005) regarding nonprofessional relationships between counselor educators and students apply equally to the supervisory relationship. In addition, ACES has published a set of ethical guidelines for counseling supervisors (ACES, 1993). Boundaries in supervisory relationships must be carefully managed because supervisors have considerable power in the relationship. In their gatekeeping function, they hold the key to the supervisee's entrance into the profession. Their supervisees look to them as models of professional behavior. Additionally, because the supervisory relationship can involve a strong emotional connection, transference and countertransference reactions are common.

Supervision is a complex process that can be further complicated when supervisors have multiple roles with their supervisees, such as teacher, clinical supervisor, and administrative supervisor. In these instances, the ACES guidelines (1993) suggest that these roles be divided among several supervisors, if possible (Section 2.09).

In more general terms, both the *ACA Code of Ethics* (2005; Standard F.3.a.) and the ACES guidelines (1993; Section 2.10) caution supervisors to avoid nonprofessional relationships with supervisees that might compromise the supervisory relationship. Although supervisors will probably encounter their supervisees in social settings and community activities, such as workshops or meetings of professional associations, socializing or friendships with supervisees could make it difficult, if not impossible, for the supervisor to conduct an objective evaluation. Counselor educators and supervisors can be tempted to relax the boundaries as students near completion of their training

programs. As supervisees make the transition to becoming their supervisors' professional peers, their interactions take on an increasingly collegial tone. Nonetheless, supervisors must remember that their position requires them to evaluate their supervisees and perhaps recommend them for licensure or future employment.

Business relationships between supervisors and supervisees are ill-advised, although they may not be unusual. Slimp and Burian (1994) believe that it is not uncommon for interns in field placements to be hired as staff members' employees in roles ranging from house sitting or baby-sitting to assisting in research or consulting activities. These authors point out that transference issues, the power differential, and the intern's developmental needs all make it difficult for an intern to resist supervisors' requests for such services. If supervisors are not satisfied with the services, the quality of supervision is likely to be affected, and the supervisor's evaluation is likely to be influenced.

Supervisors play multiple roles. Three roles often discussed in the literature are teacher, counselor, and consultant. Sometimes supervisors function more like teachers, especially when they are working with beginning supervisees. Sometimes they function more like peers or consultants, usually with advanced supervisees. Although supervision is also similar to counseling, there are important differences. In counseling, the relationship sometimes *is* the intervention, whereas if supervision consisted only of the supervisory relationship, the supervisee would not learn new and needed skills. A second important difference is that counseling is nonjudgmental, whereas supervision always has an evaluative component (Goodyear, Arcinue, & Getzelman, 2001).

Just as counselor educators should not become counselors to their students, a supervisor should not establish a therapeutic relationship with a supervisee as a substitute for supervision. The ACES guidelines (1993) direct supervisors to address personal issues in supervision "only in terms of the impact of these issues on clients and on professional functioning" (Section 2.11). The distinctions between the therapeutic aspects of the supervisor's role and the role of the counselor are not always clear. Herlihy and Corey (2006) have argued that when supervisors are overly cautious in trying to avoid the counselor role, they may do their supervisees a disservice. Effective supervision includes a focus on the impact of the counselor on the counseling process, and when supervision focuses exclusively on client cases or problem-solving strategies for working with clients, opportunities for supervisee growth may be lost. Research studies have indicated the following: supervisees value and feel comfortable in sessions that focus on their personal issues (Sumerel & Borders, 1996); supervisees experience less role conflict when the emotional bond between supervisor and supervisee is strong (Ladany & Friedlander, 1995); and counselors prefer a supervisor who is collegial and relationship oriented over one who is task oriented (Usher & Borders, 1993). At the same time, a personal-issues focus should not slide beyond appropriate boundaries and become a therapeutic relationship. When supervisors become counselors to their supervisees, these dual relationships model inappropriate behaviors that the supervisees may later perpetuate in their counseling relationships or when they become supervisors themselves (Tyler & Tyler, 1994).

There is a delicate balance to be maintained in the supervisory relationship. In your work as a practicum student or intern, your own unresolved personal issues occasionally may be triggered by a client, and this may interfere with your counseling effectiveness. You can expect your supervisor to help you identify what is occurring and to understand the issues involved. Your supervisor might even suggest that you seek counseling to help resolve the issues, but the focus of your supervisory sessions should remain on your work and should not become personal therapy sessions for you. These guidelines are applicable to the situation in which Dr. Jones finds herself in the following scenario.

## 1 The Case of Dr. Jones

Dr. Jones has been supervising Marla's work as a practicum student. Marla has demonstrated very good skills thus far in her first semester of counseling real clients. Dr. Jones has just watched one of Marla's sessions from behind the one-way mirror at the practicum clinic and was surprised to see Marla falter midway through the session and continue to give a poor performance. After the session, Dr. Jones sits down with Marla for a supervision session and shares her surprise that Marla's counseling skills in the session had fallen so far short of her usual abilities. Marla responds by bursting into tears and stating that her personal life is falling apart and she is under incredible stress.

- How should Dr. Jones react to this situation?
- Why is it inappropriate for a clinical supervisor to provide professional counseling services to a supervisee?

**Discussion:** Dr. Jones certainly will want to be supportive and empathic toward Marla, but without slipping into a counselor role. Dr. Jones might use active listening skills to allow Marla to vent her feelings, discuss how Marla's personal problems are affecting her professional performance, and perhaps suggest that Marla seek counseling. If Dr. Jones were to provide counseling services to Marla, this would constitute an inappropriate dual relationship and would make it very difficult for both of them when the time comes for Dr. Jones to evaluate Marla's practicum performance.

**SEXUAL RELATIONSHIPS BETWEEN SUPERVISORS AND SUPERVISEES** There is clear consensus in the counseling profession regarding the impropriety of sexual dual relationships between supervisors and their supervisees. Both the ACA *Code of Ethics* (2005; Standard F.3.b.) and the ACES ethical guidelines (1993) state that sexual intimacies between supervisors and supervisees are unethical. Bowman, Hatley, and Bowman (1995) conducted a survey of faculty and graduate students in programs accredited by the Council on Accreditation of Counseling and Related Education Programs (CACREP), which included a scenario depicting a romantic relationship between a practicum student and the professor who was supervising her. All faculty and 99% of students believed this situation was unethical. Despite this belief system, sexual relationships still do occur in supervision. One survey (Miller & Larrabee, 1995) found that about 6% of female ACES members reported sexual experiences with educators or supervisors during their graduate training. Less than one-third of these encounters, however, were with supervisors.

Although sexual intimacies seem to occur in only a small percentage of relationships between supervisors and supervisees, it is probably much more common for feelings of sexual attraction to develop between them. When this happens, several actions could be taken to resolve the problem. It is important to remember that when sexual attraction takes place in a supervisory relationship, the supervisor has the obligation, as the person with the power in the relationship, to manage the attraction in an appropriate and ethical manner. The supervisee could be transferred to a different supervisor, if this could be done without having a negative impact on the supervisee's clients or the supervisee's professional growth. If circumstances prevent a transfer, the supervisory relationship should be carefully documented by both the supervisor and the supervisee. The supervisor

should, at a minimum, request regular consultation and obtain a second opinion when evaluating the supervisee's abilities. It would be prudent to involve another supervisor who would monitor the supervisory relationship.

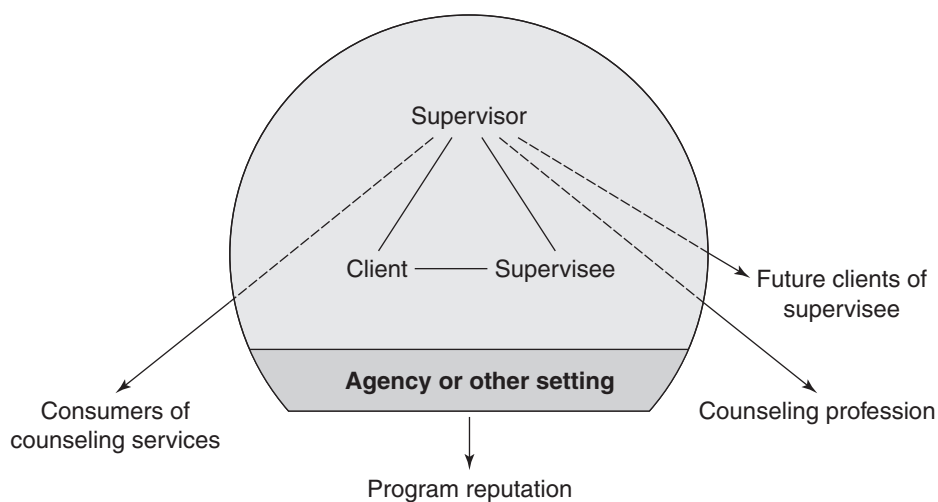
The manner in which issues of sexual attraction are handled by a supervisor can have a potent modeling effect for the supervisee. Feelings of sexual attraction to a client are likely to occur for the first time when counselors are still novices working under supervision. Therefore, supervisors must do more than admonish their supervisees to avoid sexual intimacies with clients. They must create an ethical climate for supervisee self-exploration (Bartell & Rubin, 1990). It is crucial that the supervisor develop a relationship of trust that encourages supervisees to honestly discuss their feelings of sexual attraction to a client without fear of being judged negatively.

### Accountability and Responsibility

Supervisors have a number of parties to whom they are directly and indirectly accountable. Although their primary responsibilities are to facilitate the growth of supervisees and to protect clients, they also have a larger scope of responsibility that includes parties who are indirectly involved.

The supervisor is indirectly responsible to the field setting in which the supervisee is working to ensure that clients who are served by the supervisee receive quality care. Community agencies, schools, hospitals, and other settings that accept and provide site supervision to practicum students and interns take on an additional responsibility that requires considerable time and effort. In return, university supervisors feel an obligation to ensure that these students make a positive contribution to the setting and do so in a professional manner.

Supervisors, like counselor educators, serve as gatekeepers to the profession. If supervisee incompetence is not addressed, the counseling program's reputation in the community will suffer, and the counseling profession itself will be diminished. Supervisors must not endorse supervisees for graduation from a training program or for a professional credential if the supervisees are not able to provide effective counseling services. In a broad sense, the supervisor functions to protect future consumers of counseling services. Figure 2 depicts the multiple layers of responsibility and accountability of supervisors.



**FIGURE 2** Multiple layers of supervisor responsibility



## Supervision and Consultation

Increased supervision is often prescribed as an intervention when supervisees are not making sufficient progress in their competency development (Henderson & Dufrene, 2011). After reviewing the literature, Nelson et al. (2010) concluded that a therapeutic supervisory stance is the most crucial variable in working with problematic supervisees. They emphasized the importance of creating a trusting relationship and safe environment before evaluating supervisee performance.

Supervisors are not only accountable for the work of their supervisees in an ethical and professional sense, but they can also be held legally liable for supervisee incompetence. This legal responsibility, which occurs under the principle of vicarious liability, will be discussed next.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 11 and view the video clip entitled “A Supervisor’s Responsibility.” This video depicts a supervisor’s dilemma when one of her supervisees has acted unethically.

### Vicarious Liability

The legal principle known as *respondeat superior*, or *vicarious liability*, holds that individuals who have control and authority over others will be held accountable for their negligence (Christie, Meeks, Pryor, & Sanders, 1997). Generally, an employer will be held accountable for the negligence of an employee who is acting within the scope of employment (*John R. v. Oakland Unified School District*, 1989; *Lisa M. v. Henry Mayo Newhall Memorial Hosp.*, 1995). *Respondeat superior*, a Latin term that means “let the master answer,” is the basis for an English legal concept known as *master/servant*. The legal reasoning has been that one who has the authority to direct the activities of another (the *master*) should be held accountable for the negligence of the person who has submitted to such authority (the *servant*). In the mental health arena, counselors who work for others or who volunteer their services, such as they usually do in an internship, would be the *servants*. The administrative supervisor would be the counselor’s *master*. From a practical standpoint, a person who has been injured by a servant (or employee) has a better chance of being compensated by a master (or employer) because masters tend to have more resources than servants.

The principle of vicarious liability was applied to the mental health professions in the famous *Tarasoff* case. In this case, a precedent was set for a mental health professional’s duty to warn potential victims of a violent client, and liability for the harm that was done was extended to the professional’s supervisor.

When a counselor who is under the control and authority of another person harms a third person, giving rise to a lawsuit, the amount of control that the counselor’s administrative and clinical supervisors have over the counselor probably will determine the degree to which each supervisor will be held responsible for the counselor’s negligence. For example, a counselor intern’s on-site supervisor who is physically present each day, assigns work to the intern, and monitors the counselor’s activities would most likely be held accountable by a court for the intern’s negligence. A court would be less likely to hold responsible a university supervisor who meets weekly for an hour with the intern and discusses issues brought to the supervisor’s attention by the intern. Of course, the liability of the supervisors would depend on the exact facts in the situation and the extent to

which the supervisors knew or should have known about the counselor's negligent acts. Lack of awareness of a supervisee's behaviors that caused harm to a client is not, in itself, an adequate legal defense for a supervisor. Borders and Leddick (1987) stated the following:

Ironically, if the supervisor is aware of the case, but makes an incorrect judgment regarding the case, the supervisor probably will not be found to be liable. The law does not ask the supervisor to be infallible, but rather, to be involved. (p. 55)

Obviously, supervision can be a risky undertaking. Snider (1985) has offered some guidelines for supervisors to help them reduce their likelihood of being named as a co-defendant in a malpractice lawsuit. These guidelines offer protection to supervisees as well. First, it is important to maintain a trusting relationship in which supervisees feel comfortable in sharing their doubts and concerns. Second, supervisors must keep up-to-date with legal issues that affect supervision and mental health practice in general. Third, supervisors must recognize the need for competent legal advice and ensure that an attorney is available to provide legal support. Finally, both supervisors and supervisees should carry liability insurance.

Supervisors are advised not only to document their supervisory sessions, because of the liability issues involved, but also to improve evaluation and to monitor client care. This documentation should include (a) meeting date and time, (b) a listing of cases discussed, (c) notes regarding client progress, (d) recommendations made to the supervisee, (e) issues to be followed up in future meetings, and (f) a plan for remediating any significant supervisee deficiencies that are identified (Harrar, VandeCreek, & Knapp, 1990; Welfel, 2010). Although documentation of supervisory sessions may constitute best practice, our observation is that not all supervisors actually take notes related to their supervision sessions.

### **Supervisor and Supervisee Rights and Responsibilities**

It should be evident from your reading thus far that supervision is a serious responsibility that is not undertaken lightly by your supervisor. For the process to facilitate your maximum professional growth, both you and your supervisor must understand your roles and responsibilities and work conscientiously to fulfill them.

You have the right to expect certain behaviors from your supervisor (Guest & Dooley, 1999). Your supervisor will work to ensure that you are aware of professional and ethical standards and legal responsibilities (ACA *Code of Ethics*, 2005, Standard F.4.b.). In accordance with the ACES guidelines (1993), you can expect your supervisor to provide you with regular face-to-face supervision (Section 2.07). If you are a student in a CACREP-accredited training program, you will receive a minimum of 1 hour per week of individual supervision and 1 1/2 hours per week of group supervision during your practicum and internship. Your supervisor may require you to bring audio- or videotapes to your supervisory sessions, or may even wish to have direct interaction with clients. Simply reviewing your case notes is not a viable alternative to these direct activities, although it may be a fairly common practice (Navin, Beamish, & Johanson, 1995).

You can expect supervisors to give you their full attention during your agreed-on supervision time. Your supervisory sessions should be reasonably free from interruptions, and your supervisor should not have taken on an excessive number of supervisees. Although some agencies have policies limiting the number of supervisees for whom their employees may be responsible, not all state licensure boards stipulate a maximum number of supervisees (Welfel, 2010). Your supervisor has a responsibility to ensure that you are able to contact him or her in emergencies or, if the supervisor is unavailable, to provide you with alternative on-call supervisors to assist you in handling crises (ACA *Code of Ethics*, 2005, Standard F.4.b.).

## Supervision and Consultation

You can expect your supervisor to thoroughly explain the supervision process to you and secure your informed consent, to possess the competencies described earlier in the chapter, to be skilled at managing the boundaries of the supervisory relationship, to provide you with ongoing feedback about your performance, and to safeguard the confidentiality of information exchanged.

For your part, it is important that you are open to receiving feedback and are willing to work to implement suggestions that will help you improve your effectiveness as a counselor. Although you may be hesitant at times to admit your uncertainties, confusion, or lack of knowledge about various aspects of your professional functioning, it is much better that you bring your concerns to your supervisory sessions and ask for assistance. Remember that supervision is a developmental process. Each time you master a new skill or add new knowledge and understanding to your repertoire, you become more competent to one day practice independently.

### Technology Issues in Supervision

Technologies have been infused extensively into the clinical supervision of counselors and have facilitated communication and improved the quality of supervision in myriad ways. Supervisees benefit from immediate, in-session learning when supervisors communicate feedback through bug-in-the-ear, phone-in, monitor text, computer-based live supervision, or other synchronous methods. E-mail, instant messaging (IM) and texting, and teleconferencing all have increased the ease and speed with which supervisee and supervisor can communicate with each other. Asynchronous video and digital video recording have made it possible for supervisors to review supervisees' counseling sessions without traveling to the site where the supervisee is working (Jencius, Baltimore, & Getz, 2010).

Cybersupervision, or distance supervision that uses various technologies, has the potential to revolutionize counselor supervision and is proving to be an effective means of providing supervision services (Chapman, Baker, Nassar-McMillan, & Gerler, 2011). Cybersupervision offers many benefits including lower costs to supervisees, flexibility in scheduling, supervision opportunities for those who live in isolated or rural communities, immediate access to a supervisor in crisis situations, and real-time supervision from experts on specific clinical issues (McAdams & Wyatt, 2010). Vaccaro and Lambie (2007) have noted that ethical issues must always be addressed in supervision, regardless of how it is delivered. These authors reviewed issues of confidentiality, liability, and technological competencies that arise in distance supervision. They reminded supervisors and supervisees that (a) they must be specifically trained in using the needed technologies, (b) measures must be taken to ensure the security of computer-based communications, (c) informed consent documents should explicitly discuss the limits of computer-based supervision, and (d) counselor education programs that use distance supervision should have adequate liability coverage and provide technical support. Problematic aspects of cybersupervision that remain to be addressed include the potential for miscommunications between supervisor and supervisee due to restricted nonverbal cues, and understanding the regulations that pertain to distance supervision. McAdams and Wyatt (2010) found that regulations were in place for technology-assisted distance supervision in 6 states and were under development or discussion in 18 states, but were prohibited as illegitimate activities in 19 states. Uneven regulation can make it difficult to determine whether distance supervision is acceptable when the supervisee and supervisor are communicating from different states.

### Diversity Considerations in Supervision

Addressing cultural diversity issues in supervision is essential to helping supervisees become multiculturally competent counselors (Ancis & Marshall, 2010; Colistra & Brown-Rice, 2011).

If supervisors are not attuned to diversity issues in supervision, they are likely to inadvertently reinforce the biased attitudes and behaviors of their supervisees. Supervisors must remain aware that their worldviews are likely to influence the therapeutic choices made by their supervisees (Brown & Landrum-Brown, 1995). Effective cross-cultural supervisors are aware of and address the role of multiculturalism/diversity in the client–supervisee and supervisor–supervisee relationships (ACA *Code of Ethics*, 2005, Section F.2.b.).

Research has shown that discussing diversity issues in supervision can increase supervisee satisfaction with supervision (Duan & Roehlke, 2001; Estrada, Frame, & Williams, 2004), increase supervisees' perceptions of their own multicultural competence (Toporek, Ortega-Villalobos, & Pope-Davis, 2004), and lead to more positive outcomes for clients (Ancis & Marshall, 2010). There is consensus that it is the responsibility of supervisors to initiate discussions of cultural differences with their supervisees (Bernard & Goodyear, 2009; Campbell, 2000; Corey, Haynes, Moulton, & Muratori, 2010). If the supervisor is silent on this issue, the supervisee will get the message that cultural diversity is a taboo subject in supervision.

It is likely that you will become a supervisor to at least one counselor or counselor trainee during your career. It is also likely that your supervisee will be culturally different from you in some ways. Although you may feel uncomfortable about broaching the issue of cultural differences with your supervisee, it is necessary to break the taboo about talking about racial, gender, or cultural differences (Corey et al., 2010). When you become a supervisor, it will be your responsibility to be aware of the complex ways in which culture and gender interact between client, counselor, and supervisor and present multiple challenges to communication and understanding (Nelson et al., 2006). Your initial supervisory sessions with your supervisees present opportunities to establish an open dialogue regarding multicultural issues.

Once the supervisory alliance is established, you can promote multicultural competence in your supervisees by incorporating multicultural case conceptualization into supervision. You can do this by helping your supervisees analyze the impact of their client's race or ethnicity, gender role socialization, social class, sexual orientation, and other salient cultural variables on the client's problems. It is also important that you promote culturally appropriate interventions, which may include teaching supervisees how to advocate for their clients.

A cultural variable that is often overlooked is that mental health professionals of different disciplines (including psychology, social work, marriage and family therapy, and psychiatry) often supervise someone with a different background, training, and theoretical orientation to practice. These differences must also be addressed at the outset of the supervisory relationship to avoid misunderstandings and conflicts (Campbell, 2000).

## CONSULTATION

Counselors must assume a variety of roles as they perform their work responsibilities, and each role demands different perspectives, attitudes, and behaviors. The professional role that counselors engage in at any given moment determines their behavior and, in many instances, their responsibilities to the individual with whom they are interacting. Consultant and consultee are two roles that counselors take on regularly.

Counselors regularly consult with others for the benefit of their clients and to further their knowledge of a particular area of counseling. Counselors use the following consultants: other mental health professionals when making clinical or ethical judgments; other professionals, such as physicians, social workers, nurses, and psychologists, who are also treating their client; family members, friends, and significant others in the clients' lives, for the benefit of clients; administrators in their

employment setting, regarding their job responsibilities or when seeking direction in difficult situations; and attorneys, when they have legal questions. The very best step a counselor can take when faced with a difficult ethical decision or with a legal question is to consult (Gottlieb, 2006; Knapp & VandeCreek, 2006). Consulting with peers and other mental health professionals is best for ethical dilemmas. Consulting with supervisors and attorneys is necessary for legal problems.

Counselors also find themselves in the role of consultant in a number of situations. A fellow counselor may be having difficulty making a clinical or ethical decision. Another professional who is treating one of their clients may request a consultation. In all of these examples, the consultation takes place between two individuals (a consultant and a consultee) for the benefit of a third person (a client). These consultation relationships are not formalized and generally are limited to a single discussion or a brief series of discussions. We will refer to this type of consultation as *peer consultation*. By contrast, counselors sometimes function as consultants to organizations such as businesses, agencies, or schools. These consultation relationships are usually more long term and are formalized in some manner, often through a contract. This type of consultation is known as *organizational consultation*. Both peer and organizational consultations are primarily aimed at work-related concerns as opposed to the consultee's personal problems.

### **Accountability**

In most situations, consultants do not have control and authority over the person who is receiving the benefit of their consultation. Consultants essentially are giving advice. Once individuals receive advice from a consultant, they are free to accept or ignore the advice they have been given. When consultants have no control over the actions taken by individuals who have received their advice, they cannot be held accountable legally for an individual's negligence even if they give inaccurate or wrong information or give bad advice.

Exceptions exist when a consultant is a counselor's administrative or clinical supervisor. As explained earlier in the chapter, a supervisor who has control over a counselor's actions probably has some degree of legal liability for the negligence of the counselor. Also, it is possible that an individual who retains a consultant may have a legal cause of action based on contract principles against a consultant who gives wrong or poor advice that the consultee relies on.

Counselors who are asked to consult with colleagues sometimes are concerned about whether they might be held responsible for advice they give as consultants. This is the case with Allison in the following scenario.

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## **2 The Case of Allison**

Raymond, a counselor in a mental health center, approaches Allison, another counselor at the center who has no administrative authority over him, and asks her to consult with him regarding a client with whom he is having some difficulty. As Raymond describes his work with the client, Allison has a hunch that the client may have borderline personality traits that Raymond has not recognized. She is hesitant to enter into a consultation with him, however, because she knows that clients diagnosed with borderline personality disorder can be difficult to counsel. Allison wonders to herself, "What if Raymond doesn't do an adequate job in working with this client? If I give him advice, can I be held accountable?"

- What do you think Allison should do?
  - If Allison does agree to consult with Raymond, how can she be helpful to him in working with his client?
-

**Discussion:** Allison should realize that Raymond will make the final decisions regarding how to counsel his client, and he will be responsible for his actions. A consultant who has no administrative authority over another counselor cannot be held accountable for what the counselor/consultee ultimately does. Allison should listen carefully to Raymond's concerns, and she might choose to give him her best advice depending on how she understands the situation. She will need to set boundaries to maintain her consultant role. She should not meet with the client herself to evaluate the client, and to avoid taking on a supervisory role, she should not meet regularly with Raymond regarding his counseling of the client.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 11 and view the video clip entitled “A Request for Consultation,” which depicts a challenging situation for a consultant.

After you have begun your counseling practice and you need to consult, you should choose consultants carefully with the understanding that you, as the individual who is seeking advice, will be held accountable. You should choose consultants who are knowledgeable, trustworthy, and reputable.

### **Power**

Although consultants generally have no legal accountability for the actions of their consultees, it is important to remember that the power, or ability to influence, is not evenly distributed in consulting relationships. Because the consultant is viewed as an expert, there is a potential for misuse or abuse of power. Even if the power differential is more perceived than real, consultants may have considerable influence on the outcome and process of a consultation. Therefore, consultants have an ethical responsibility to avoid misusing their power (Simpson & Glowiak, 2012).

### **Consultation Contracts**

In organizational consulting and in some other situations, consultants enter into long-term agreements with others to provide advice in a particular manner. A clinical supervisor who provides supervision over a 2-year period for a counselor who is gathering experience for licensure or certification is also a consultant. Just as a supervision agreement is recommended for supervisory relationships, a written contract is recommended for counselors who consult.

The following recommendations have been offered for contracts that are prepared by consultants:

- Clearly specify the work to be completed by the consultant.
- Describe in detail any work products expected from the consultant.
- Establish a time frame for the completion of the work.
- Establish lines of authority and the person to whom the consultant is responsible.
- Describe the compensation plan for the consultant and the method of payment.
- Specify any special agreements or contingency plans agreed on by the parties (Remley, 1993).



Counselors who take on consulting roles need to understand the legal principles involved in accountability and contracts and to fulfill those roles in an ethical manner. Unlike counselors who function as supervisors (who have the ACES ethical guidelines [1993] to assist them), consultants are at somewhat of a disadvantage. There is no code of ethics specifically for consultants, and the *ACA Code of Ethics* (2005) contains few standards (Standards B.8a.-c., and D.2.a.-d.) that address consultation directly. This paucity of ethical standards, along with the fact that not all counselors are adequately trained in consultation (Brown, 1993; Newman, 1993), raises some cause for concern that counselors may not be well prepared to resolve the ethical dilemmas they encounter when they are functioning as consultants. Writers in the field of consultation (Dougherty, 2009; Newman, 1993) have identified several ethical issues that consultants frequently face. These include (a) consultant competence; (b) consultee rights, including due process and confidentiality; (c) the consulting relationship; and (d) the influence of culture and values on the consulting process.

### **Consultant Competence**

Competence to provide services is an important ethical issue in consultation, just as it is in counseling and supervision. Before counselors agree to enter into a consultation relationship, they must assess whether their personal and professional competence is adequate for the task (Dougherty, 2009). When you become an experienced counselor and are asked to consult with peers, you should ask for a description of the potential consultee's problem and then determine whether you possess the expertise needed to be of assistance. For example, if you have worked for several years in a clinic that specializes in treating individuals with eating disorders, you will probably feel confident that you can serve as a consultant to a high school counselor who is wondering whether one of her student clients suffers from anorexia. By contrast, assume that you are approached by another counselor in the clinic where you work. She tells you that she needs a consultation because she is concerned that one of her teenage clients' parents might sue her for malpractice. This colleague has a legal problem, and you should refer her to the clinic supervisor. Being asked to consult is always a compliment, but you should not always agree to such a request. Gottlieb (2006) has suggested several questions that counselors might ask themselves before making a decision whether to consult, including the following: Am I qualified? Can I be objective with this colleague? Are there any potential conflicts of interest? Do I have the time to give this request the attention it deserves?

When counselors are asked to perform organizational consultation, they should present their professional qualifications clearly to avoid misrepresenting themselves. Before entering into an agreement to provide services, they should ensure that they have the resources and competencies to provide the needed assistance (*ACA Code of Ethics*, 2005, Standard D.2.a.). It is essential that consultants know their own limitations, and they should make an appropriate referral when they are unable to provide the requested services (Standard D.2.a.). The ability to carefully self-monitor one's own boundaries of competence is particularly critical because so few counselors have received formal training in consultation. Organizational consultation can be particularly complex because multiple parties are involved, both directly and indirectly. Because this can complicate the ethical and legal considerations, it is important that the consultant clarify who is the client before agreeing to enter into the consultative relationship (Fuqua, Newman, Simpson, & Choi, 2012).

Welfel (2010) has stated that counselors tend to make the same mistake regarding competence to consult as they make regarding competence to supervise—they assume that counseling skills are sufficient. She cautions counselors that when they present themselves as skilled consultants, they must be prepared to demonstrate the sources of their knowledge and to be ethically responsible for any harm their interventions might cause. Without a contract, consultants may not

be legally responsible for the outcomes of interventions they suggest, but they do have a professional and ethical obligation to carefully consider the implications of actions that may be taken based on their advice.

### **Safeguarding Consultee and Client Rights**

Due to the triadic nature of consultation, the client does not employ the consultant or sometimes even know that a consultant is involved. Welfel (2010) reminds counselors who consult to be attuned to the ramifications of their work for these rather invisible participants. Newman (1993) has raised a similar caution, noting that consultants must be sensitive to the effects of their work on all parties involved and to avoid situations in which their work could be used to the detriment of clients or client systems. The following scenario illustrates such an event.

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## **3 The Case of Jerry**

Jerry was hired by an administrator in a large organization to conduct a series of conflict resolution workshops with an employee group. Part of the agreement was that Jerry would conduct a pre- and post-assessment of the participants' conflict resolution skills to assess what they had learned. Jerry included the results of these assessments in his final report to the administrator. Later, the administrator used this information as one basis for determining which of the employees would be let go when the organization downsized.

- How did Jerry err as a consultant? How did the organization administrator err?
- What do you think Jerry can do to ensure that such problems do not occur again in his work as a consultant?

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**Discussion:** Jerry violated the privacy of the employees when he provided the administrator with their specific scores. It appears that he failed to clarify with the administrator exactly what his role as consultant would entail and what would be contained in the report. The administrator erred by using the information Jerry inappropriately gave him to make management decisions. He violated the trust of his employees by using that information. In the future, Jerry should develop a clear and detailed contract with any organization before he agrees to serve as a consultant to that organization.

The scenario above raises two crucial ethical issues—informed consent and confidentiality. Obviously, Jerry failed to negotiate how his report would be used by the administrator who hired him. The unfortunate outcome could have been avoided if Jerry had adhered to his ethical obligation to develop with his consultee “a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected” (ACA *Code of Ethics*, 2005, Standard D.2.b.).

Informed consent is an important consultee right that also extends to clients and client systems involved. In peer consultation, informed consent is a relatively straightforward matter. It is sound ethical practice for counselors to inform a client that they plan to consult about the client's case, explain their rationale, and obtain consent to proceed. Standard D.2.d. of the ACA *Code of Ethics* (2005) advises counselors functioning as consultants to review, both verbally and in writing, “the rights and responsibilities of both counselors and consultees.” They should use clear

language in informing all parties involved about the purpose of the consultation, costs, potential risks and benefits, and limits of confidentiality (D.2.d.).

Informed consent is much more complicated in organizational consulting. Often, administrators or executives hire consultants and make decisions about the work they want the consultant to do. Employee-clients may have little or no input into this decision, and the consultation process will be negatively affected if they feel coerced to participate. Therefore, consultants must be sensitive to the hierarchical nature of organizations and work skillfully with all the parties involved to make consent as informed and voluntary as possible (Welfel, 2010). Consultants must discuss the goals and purposes of the consultation, potential benefits and risks, and desired outcomes with those who will be affected by the consultation. Dougherty (2009) suggests that consultants should mentally put themselves in the consultees' position and ask themselves what they would like to know at the outset. Consultants must also remember that informed consent is an ongoing process, so these issues may need to be revisited periodically.

The *ACA Code of Ethics* (2005) offers these guidelines for protecting confidentiality in consultation: (a) agreement is sought among all parties regarding each individual's rights to confidentiality, each individual's obligation to preserve the confidentiality of information, and the limits of confidentiality; (b) information is discussed for professional purposes only with persons clearly concerned with the case; (c) reports present data that are germane to the purposes of the consultation; (d) every effort is made to protect client identity and avoid undue invasion of privacy; and (e) counselors do not identify a client, other person, or organization unless they have obtained prior consent or the disclosure cannot be avoided (Standards B.8.a., B.8.b., and B.8.c.). In peer consultations, confidentiality issues are not particularly difficult to manage. It is usually possible for a counselor to consult without revealing the identity of the client who is the subject of the consultation. Even if the consultant were to ascertain the client's identity, the consultant understands the professional obligation to keep information confidential.

In organizational consulting, it is important that those who participate in the process have a clear understanding of the limits of confidentiality. Consultants have an ethical responsibility to ensure that the participants understand what information will be gathered, how it will be used, with whom it will be shared, and for what purpose (Simpson & Glowiak, 2012). Managing confidentiality is particularly complicated when consultation is aimed at organizational change (Newman, 1993). If disgruntled employees share information about their boss with the consultant, will the consultant keep their disclosures confidential? Dougherty (2009) has suggested that employing the concept of anonymity—sharing the information but protecting its source—might be a useful strategy in such situations. He also suggests that complex questions about confidentiality should be posed at the outset of consultation, consensus on the answers reached, and the consensus publicized.

### **The Consultation Relationship**

Because the consultant–consultee–client relationship is very complex, consultants must be particularly careful to maintain appropriate boundaries. Because counseling, supervision, and consultation are alike in several ways and there is some role overlap, it can be easy for counselors to confuse these activities with each other. Similarities and differences are outlined below.

*Consultation* and *counseling* are similar in that both usually are voluntary in nature and each is a temporary process aimed at assisting the help seeker to function independently, without the helper, in the future. Both counseling and consultation are collaborative relationships, but they are not relationships between equals. In each relationship one participant is assumed to have greater expertise that can be brought to bear on the problem. Consultation and counseling are different in that counseling is a dyadic relationship in which a direct service is provided to a client, whereas

## Supervision and Consultation

consultation involves a triadic relationship in which an indirect service is provided to someone who works directly with a client. Counseling generally focuses on personal problems, while consultation focuses on work-related problems.

*Consultation* and *supervision* are similar in that both relationships are tripartite; the person who provides assistance to the client does so indirectly through a third party (the consultee or the supervisee). In both relationships, the goal is to increase the help seeker's skills and ability to function independently. They are different in that supervision is not always voluntary, and in a supervisory relationship the person in the help-seeker role may not be free to decline the helper's advice or recommendations without penalty. Supervision is a hierarchical relationship, whereas consultation is a collaborative relationship: Consultants have no direct authority over the help seeker. Also, supervision is generally ongoing or long-term, while peer consultation is usually temporary and of brief duration.

The focus of the consultation relationship should be on work-related problems, not on the personal problems of the consultee. As is the case in supervisory relationships, there is a fine line to be drawn, and it can be difficult to distinguish between professional concerns and personal issues. For example, assume you are a school counselor who has been approached by a teacher who wants help in dealing with a difficult student. During the consultation, the teacher says, "You're helping me see that the student's behavior isn't all that much out of line. If I weren't in the midst of a painful divorce, he wouldn't be getting under my skin this way." You must be careful to avoid converting the consultation into a counseling relationship that centers on the teacher's personal problems.

Dual relationships in consultation create conflicts of interest as well as role conflicts. The two most common dual roles in consultation are combining the role of consultant with that of counselor or supervisor (Dougherty, 2009). The blurring of boundaries that leads consultants into the counselor role often occurs when a consultant determines that the basis for a work-related concern resides more in the consultee than in the client. In these instances, the consultant should refer the consultee for assistance.

When a consultant has supervisory or administrative experience, it can be easy to incorporate supervision into a consulting relationship. This is inappropriate because consultation is essentially a peer relationship, whereas supervision involves evaluation and a power differential. Dougherty (2009) has noted that the use of supervision in consultation allows the consultant to build an illegitimate power base, creates potential conflicts of interest, and violates the consultation contract. Dual relationships in consultation should be avoided.

Freedom of choice is the final important relationship issue to consider in consultation. Consultees should feel comfortable that they have the freedom to do whatever they choose to do with the consultant's recommendations. Freedom of choice is diminished when a dependency on the consultant is created. Standard D.2c. of the *ACA Code of Ethics* (2005) states that "the consulting relationship is one in which consultee adaptability and growth toward self-direction are consistently encouraged and cultivated." Consultants must avoid coercing, pressuring, or manipulating consultees into taking actions that the consultant might advocate. Having a clear understanding at the outset about the parameters of the relationship can help prevent later problems caused by blurred boundaries.

### **The Role of Values and Diversity in Consultation**

Consultants, like counselors, must be aware of the ways in which their values and worldviews influence the process and outcomes of their work. As Newman (1993) has stated, "To ignore or deny the central role of values in the practice of consultation is naive at best, and from an ethical perspective, dangerous" (p. 151). The consultant, consultee, and client or members of the client system all

have values formed by their life experiences, and these values will have a mutual influence in the consulting process. Therefore, consultants must possess a reflective understanding of their values and how they influence the process of consultation and make a commitment not to impose them on consultees (Dougherty, 2009). Additionally, consultants must understand diverse worldviews and be aware of differences in reasoning and communication patterns. They must be aware of how their own culture and gender affect their work as consultants.

Value conflicts may be inevitable in organizational consulting, because the process involves multiple parties who have diverse and often competing interests and priorities. Conflicts can occur in peer consultations as well, particularly when the consultant and consultee have differing worldviews. For example, Pete, a Native American counselor, has asked Judy, a traditionally trained Anglo counselor, to consult with him regarding a client with whom he is working. Pete believes that the client would be well served by bringing members of the client's family into the counseling process. Judy disagrees, believing that this would diminish the client's autonomy and violate the client's confidentiality. In this case, the consultant and consultee have very different ideas, formed by their worldviews, regarding how the client can best be helped. Judy is operating from Euro-American notions of individualism and autonomy. For Pete, including the client's family would be consistent with the tradition of honoring the wisdom of tribal elders, which is part of his cultural background. Consultants must be honest with themselves in determining whether they can be objective enough to work with a consultee whose values or worldviews differ significantly from their own.

Increasingly, consultants are providing their services during crisis and disaster situations. Consultants need knowledge and skills that are unique to these situations, including how to conduct a lethality assessment, familiarity with organizational crisis policies and procedures, crisis intervention skills, and knowledge of how to develop a disaster plan (Corey, Corey, & Callanan, 2011). Dougherty has cautioned consultants to remain sensitive to the acute vulnerability of people who are experiencing a crisis or disaster (2009).

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## Summary and Key Points

Supervision and consultation are two types of tripartite relationships that involve complex ethical considerations. Legal issues in supervision and consultation have to do primarily with fair evaluation, accountability, and contracts. Supervision is an intervention that an experienced member of a profession provides to a novice member of that profession. Consultation is a process in which a counselor assists a consultee with a work-related problem related to a client or client system.

Key points regarding supervision include the following:

- There are two types of supervision—administrative and clinical—that differ in the amount of control or authority that the supervisor has over the supervisee.
- Supervisors must be sensitive to the due process rights of their supervisees, especially with respect to the obligation to provide ongoing feedback and evaluation of supervisee performance.
- Informed consent for supervision must be obtained from both the client and the supervisee.
- Points that should be discussed between a supervisor and a supervisee before they enter into a working relationship include the purposes of supervision; the logistics of supervision; information about the supervisor's qualifications and supervisory style; the expectations, roles, and responsibilities of both parties; evaluation; and ethical and legal practice.

## Supervision and Consultation

- Written supervision agreements are recommended in order to avoid misunderstandings and to articulate the nature of the supervisory relationship.
- The major components of supervisor competence have been described in the *ACES Standards for Counseling Supervisors* (1990). Supervisors must possess the competencies described in this document, to be aware of the need for continuing education in supervision, to develop cross-cultural supervision skills, and to self-monitor the boundaries of their competence.
- The requirements to keep client information confidential in counseling relationships apply equally to supervision relationships.
- Boundaries in the supervisory relationship must be managed carefully. Supervisors should not engage in close personal or social relationships with their supervisees, nor should they enter into business relationships with them or establish a counseling relationship as a substitute for supervision. Of course, sexual intimacies between supervisors and supervisees are unethical.
- Supervisors have a large scope of responsibility and a number of parties to whom they are accountable. Under the legal principle of *vicarious liability*, to the extent that supervisors have direct control and authority over their supervisees, they may be held liable for their negligence.
- Both the supervisor and the supervisee have certain rights and responsibilities in the relationship. It is crucial that both parties understand these rights and responsibilities in order

for supervision to work in facilitating supervisee growth while protecting client welfare.

Counselors frequently take on the roles of consultant and consultee. Two types of consultation discussed in this chapter are peer consultation and organizational consultation. Key points regarding consultation include the following:

- Because consultants generally do not have direct control and authority over those who receive their services, they cannot be held accountable legally for the negligence of the consultee.
- When counselors enter into long-term agreements to provide consultation services, they should negotiate a written contract for the services.
- Consultants must be aware of the ways in which their values and their cultural backgrounds influence the consulting process and outcomes.
- Counselors must ensure that they have the needed competencies before they agree to take on a consulting role with a peer or with an organization.
- Consultants must take care to safeguard the informed consent and confidentiality rights of consultees and clients.
- Consultation focuses on work-related problems, not on the personal problems of the consultee. Maintaining this work-related focus, avoiding the dual relationship problems that are created by blending consultation with counseling or supervision, and ensuring consultee freedom of choice are all important consultant obligations.





# Professional Writing, Conducting Research, and Publishing

## FOCUS QUESTIONS

1. What is plagiarism and why do you think so many college students get into trouble because they plagiarize?
2. Which issues do you think are the most important in ethical standards for counselors who conduct research?
3. Why do you think the U.S. government has required universities and other organizations that conduct research to establish Institutional Review Boards that review research proposals to ensure that human subjects are protected from harm?

**T**his chapter explores ethical and legal issues involved when counseling graduate students, counselors, or counselor educators engage in the scholarly activities of professional writing, research, and publication.

Issues of academic integrity arise in many situations. Students in counselor preparation programs are expected to perform in an honest manner as they write term papers, complete course assignments, take tests, and prepare tapes of counseling sessions during practicum and internship. Counseling supervisees are required to report to their supervisors in an accurate manner counseling-related tasks they perform. Professors who teach and supervise counseling students and supervisees expect information to be reported to them in an honest fashion.

Wester (2007, 2011) has noted that little has been written about research integrity in counseling and has called upon professional counselors who conduct research to better inform themselves regarding their ethical obligations. If you are a full-time counseling practitioner or a master's-level graduate student, you may be thinking that a discussion of research or scholarship has only minimal relevance to what you do or intend to do. It is true that counseling practitioners, traditionally, have not engaged in research or even read much research (Tracey, 1991). Even today, counselors tend to view research and publication as activities that are performed by their professors, by doctoral-level graduate students, or by counselors whose employment depends on governmental or private funding sources that demand research to show that grant or contract

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dollars are well spent. You should be aware, however, that current economic and societal trends are challenging the assumptions that practitioners do not need to involve themselves in research activities (Welfel, 2010).

Counselors in schools and agencies are experiencing increased demands for accountability (Eschenauer & Chen-Hayes, 2005; Gysbers, 2004). More and more, counselors are being required to demonstrate that they are making a difference in the lives of children and adults (Erford et al., 2011). They are being asked to show that their services are having an effect on societal concerns such as school shootings, teen suicide, school failure and dropping out, unemployment, and the spread of sexually transmitted diseases (Lancaster, Balkin, Garcia, & Valarezo, 2011). Managed care companies are demanding accountability from counselors as well. They are requiring counselors whose services they are reimbursing to demonstrate that their treatments are effective with the clients served. Although Sexton (2001) has suggested that *best practice* in counseling must be *evidence based*, Ray et al. (2011) found in a review of articles from 1998 to 2007 in American Counseling Association division-affiliated journals that only 6% of counseling research articles explored effectiveness of counseling interventions. In recent years, articles focused on evidence and best practice (Choate & Gintner, 2011; Miller, Short, Garland, & Clark, 2010; Whiston, Tai, Rahadja, & Eder, 2011) are appearing more frequently. External pressures suggest that more counselors will be involved in conducting research and disseminating the results in the future (Crane & Law, 2002). Perhaps this involvement will help to close the gap between what researchers discover and the way in which counselors practice (Murray, 2009).

Many practicing counselors collect data and write reports. In addition, doctoral-level counseling graduate students and university counselor educators are heavily involved in research. Davis, Wester, and King (2008) have found that questionable research practices do exist within the counseling profession. This chapter highlights some of the important ethical, legal, and professional issues in writing, conducting research, and publishing.

## PROFESSIONAL WRITING

Writing often is a significant part of the professional activities of counselors. Counselors in all settings are required to create a multitude of documents, including notes from client sessions, evaluations of clients, reports regarding counseling programs, correspondence among counseling staff members, and letters to individuals outside the setting where counselors work.

Graduate students in counselor preparation programs write many term papers and reports that are submitted to professors. The general principles regarding academic integrity apply to the writing activities of counseling graduate students, practicing counselors, supervisors, and counselor educators alike. The following discussion, however, is intended primarily to assist graduate students, whom we often see struggle with the needs to avoid plagiarism and to master APA style.

Some scholars have studied motivation to engage in academic dishonesty. Williams, Craig, and Paulhus (2010) conducted a series of three studies in an effort to predict academic dishonesty and to better understand why students cheat. In past studies (Cizek, 1999; Stern & Havlicek, 1986), two-thirds of students surveyed have reported cheating, and in a more recent study (Robinson, Amburgey, Swank, & Faulker, 2004), up to 80% reported having been academically dishonest. A number of research studies have suggested that cheating might be predicted based on gender, subject matter being studied, ethnicity, or personality traits, but those findings are inconclusive. The three studies reported by Williams et al. (2010) concluded that the only significant predictor of student cheating was what they termed *psychopathy*, but not necessarily at clinical levels. They defined *psychopathy* as characterized by the four key features of erratic lifestyle, manipulation, cal-

lousness, and antisocial tendencies, and they found that students who displayed psychopathy were more likely to report having engaged in cheating behaviors.

A popular belief is that technology and the Internet have changed the way in which students define academic dishonesty, especially plagiarism (Lee, 2011). Gabriel (2010) reported that scholars and professors around the United States are saying that many students do not believe that lifting the writing of others and claiming it as their own is wrong for a number of reasons. Many students note that Web pages often do not include author information; some see much information on the Web as *common knowledge*; many have downloaded music (perhaps illegally) without even a thought that doing so might be wrong or illegal; and some argue that the ideas of originality and author ownership are outmoded in today's technological world. In addition, digital technology makes copying and pasting written information from the Internet very easy (Isaacs, 2011).

Although it is understood why modern students may believe that plagiarism is acceptable, the ACA *Code of Ethics* (2005) specifically prohibits plagiarism; most universities have strict honor codes or academic rules that prohibit plagiarism; and copyright laws in the United States provide legal protections of original works by authors. One major problem in dealing with the issue of plagiarism is that many students (and many professors as well) are not sure of exactly what constitutes plagiarism. Teaching students about plagiarism and giving them strategies for avoiding it are important tasks to address the problem (Elander, Pittam, Lusher, Fox, & Payne, 2010).

According to Standard G.5.b. of the ACA *Code of Ethics* (2005), counselors must not plagiarize, which is defined as presenting another person's work as one's own. This language in the ACA code is parallel with the language used in the *Publication Manual* of the American Psychological Association (APA, 2010), which states that "Researchers do not claim the words and ideas of another as their own; they give credit where credit is due" (p. 15). The manual gives the following instructions: "Quotation marks should be used to indicate the exact words of another. *Each time* you paraphrase another author (i.e., summarize a passage or rearrange the order of a sentence and change some of the words), you need to credit the source in the text" (p. 15). The manual also says, "The key element of this principle is that authors do not present the work of another as if it were their own work. This can extend to ideas as well as written words" (p. 16). Universities and legal authorities impose severe sanctions for plagiarism.

In universities, students found guilty of plagiarism could be given a failing grade on an assignment, issued an academic warning, suspended, or even expelled. In courts of law, those who plagiarize might have to pay monetary damages to the original author for having stolen his or her ideas or words.

A number of websites exist today where professors or editors of journals or texts may enter what has been written by someone else and check to see if the phrases, sentences, paragraphs, or passages are plagiarized (Lee, 2011). Examples of such websites include [www.turnitin.com](http://www.turnitin.com); [plagiarismchecker.com](http://plagiarismchecker.com); [articlechecker.com](http://articlechecker.com); [plagiarismdetect.com](http://plagiarismdetect.com); and [doccop.com](http://doccop.com). The existence of these websites is testimony to the fact that many academics are aggressive about exposing individuals who plagiarize, with some demanding that they be punished. Our position is that, generally, punishment should not be the first alternative considered when plagiarism is detected. Rather, the offender should be educated regarding the inappropriateness of plagiarizing. However, individuals who repeatedly plagiarize and purposefully steal the ideas and writing of others should not be allowed to continue to do so.

A helpful tutorial on plagiarism that students can access is provided by Indiana University, and many other universities and organizations have provided guidelines to writers for avoiding plagiarism (Empire State College, 2011; Fowler, 2003; Office of Research Integrity, 2011; Roig, 2009; The Writing Place, 2005). The tips for avoiding plagiarism in Figure 1 were created from their suggestions.

- It is acceptable and common in academic writing to use ideas, direct quotations, or paraphrased information from others. The key is to always give credit to other authors when you do that.
- Always give a citation to another author's work when you quote or paraphrase what the other author has said.
- Generally, in academic writing, paraphrasing is valued more highly than using direct quotations. Usually, direct quotations should be used when it is impossible to communicate what another writer has said without using his or her exact words. It is always essential to give credit to other authors when paraphrasing what they have said.
- When introducing the ideas of another author, use phrases such as "According to Smith, ...", "Jones said ...", or "In his 1987 study, Robinson found ...."
- Always put quotation marks around direct words, phrases, sentences, or excerpts when another author's direct words are quoted.
- If you paraphrase information from another author, look back over what you have written and what the other author wrote to ensure that you have not used any exact phrases used by the other author. If it is important to use exact phrases from another author, put those phrases in quotation marks.
- Read examples of good paraphrasing and poor paraphrasing so you can understand how to paraphrase appropriately.
- You do not have to give a source for information that is considered *common knowledge*. For example, it is generally agreed that Christopher Columbus discovered America in 1492, that the boiling point of water is 100 degrees Celsius, and that Mark Twain wrote *Huckleberry Finn*. As a result of common knowledge, you do not have to attribute such generally accepted information to a source. However, if some other person has given a unique interpretation to common knowledge facts, then you would have to give that person credit for his or her unique perspective. If you are in doubt as to whether a particular piece of information is common knowledge, it is always a good idea to provide a citation to an authority who has stated the knowledge.
- If one author quotes another, it is always best to find the original author's statement rather than rely on the second author's interpretation of what the first author said. If you do quote one author's quotation of another, make it clear in your writing that is what you are doing.
- All instances of plagiarism are unacceptable, even if they are unintentional, small, or seemingly unimportant.

**FIGURE 1** Tips for Avoiding Plagiarism

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## 1 The Case of Sylvia

Sylvia is a first-year master's-degree student in a counselor education program. She was required to write a term paper in her counseling theories course. While she was collecting information to put in her paper, she kept a careful record of the APA citations of texts, text chapters, and professional journal articles she read. Each time she read a professional source, she jotted down notes about what she had read so she could include the information in her term paper. Occasionally, she wrote down direct quotes from an author and put quotation marks around the materials and indicated the page number where the quote appeared when she did so.

Unfortunately, at one point Sylvia forgot to put quote marks around a few sentences that were a direct quote and she later thought she had written the information herself. So, she copied the sentences into her term paper, thinking they expressed thoughts she had created herself.



Sylvia's theories course professor, Dr. Adams, routinely submitted all student papers to an Internet service that checked for plagiarism. The sentences Sylvia had written in her paper were identified as direct quotes from an article Sylvia had cited in her paper, but Sylvia had not attributed the quotes to the author of the article.

Dr. Adams recently had dealt with several other instances of serious plagiarism in her classes, so she submitted Sylvia's paper and evidence of Sylvia's plagiarism to the Office of Judicial Affairs at her university and filed a formal complaint alleging that Sylvia had plagiarized.

- What other actions could Dr. Adams have taken?
- Do you think Sylvia should be punished for having plagiarized?

**Discussion:** The actions described in this case study are clearly an example of a situation in which a student who plagiarized should be educated rather than punished. Dr. Adams could have met with Sylvia, showed Sylvia the evidence of her plagiarism, and asked Sylvia to explain what had happened. Dr. Adams would have then learned of Sylvia's mistake and could have helped Sylvia avoid similar mistakes in the future. An extended ordeal with the university's Office of Judicial Affairs could have been avoided if Dr. Adams had taken the time to meet and talk with Sylvia.

Proper citation of sources is essential to avoid plagiarism. Generally, professors require graduate students to write their research papers and to cite using APA style. The sixth edition of the *APA Publications Manual* (APA, 2010) is an indispensable resource, and further assistance can be accessed at <http://www.apastyle.org/>. Purdue University also has established several websites to assist students with professional writing; these can be found by typing "Purdue Owl" into a search engine.

## CONDUCTING RESEARCH

### Research Roles

Conducting research in an ethical manner is essential (Wester, 2011). Perhaps the first question that should be addressed in a discussion of research procedures is this: Who conducts a research study, and who is responsible for ensuring that it is carried out in an ethical and legally appropriate manner? The American Psychological Association (APA, 1982) has described several roles in research. The first is the *principal investigator*, who conceptualizes, designs, and plans the study. If the principal investigator carries out the research alone, of course, the ethical and legal responsibilities fall to this one individual.

More often, though, the principal investigator has one or more persons who assist in the data collection, statistical analysis, or other components of the research study. In these instances, a second role is that of *research assistant*. In academia, students often play this role when they assist their professors with research. When this is the case, both the principal investigator and the research assistant(s) are responsible for proper behavior, but the principal investigator, as the supervisor, has the ultimate responsibility for any breaches of ethics or law that might occur.

A third role is that of *research supervisor*. This person advises and oversees the research of someone else. In an academic setting, this typically would be a professor who supervises

the doctoral dissertation or master's thesis research of a student. These relationships are based on mutual respect and are more co-equal because graduate students are knowledgeable researchers who have been trained in research procedures and in ethics.

A discussion of roles raises the issue of potential dual relationships. Professors who supervise thesis or dissertation research often have other relationships with the students involved. They may be simultaneously supervising students' clinical work in an internship, teaching them in formal courses, mentoring them toward their transition into the world of work, co-presenting with them at professional conferences, interacting with them as peers at meetings of local professional organizations, and writing letters of recommendation for their future employment. Most of these roles have an evaluative component, thus giving the professor considerable power over the student who is conducting the research.

Because of this power differential and the resultant potential for exploitation, counselor educators must attend carefully to ethical issues when they involve their students as research subjects or research assistants. Students' participation as research subjects should be voluntary. Certainly, professors should not require students to participate in their research as part of the student's grade or evaluation. Beyond that minimal requirement, they also must realize that students can feel pressured or even coerced to serve as subjects for professors' research.

When students volunteer or are asked to serve as research assistants, a full discussion must take place before the students agree to participate. In this discussion, the counselor educator should provide (a) assurance that there will be no penalty to students who decline to participate, (b) a clarification of expectations regarding who will do which parts of the work, (c) a time line for completion of the various tasks, (d) an agreement about the type of acknowledgment that the students will receive when the research is published (including whether they will be listed as co-authors), and (e) an agreement about the process that will be followed if any problems or misunderstandings should occur.

## Research Design

The overarching goal of all counseling research is, in a global sense, to identify interventions that will facilitate positive changes in clients and in their lives (Szymanski & Parker, 2001). Research studies must be rigorously and carefully designed. Researchers must remain aware that voluntary research participants are providing a valuable service and should "take reasonable precautions to avoid causing disruptions in the lives of research participants" (*ACA Code of Ethics*, 2005, Standard G.1.f.). In giving quantitative researchers advice, Trusty (2011) has emphasized the importance of researchers knowing the literature thoroughly and conducting pilot studies before beginning a research project.

Even when research is of high quality, experimental design raises some ethical considerations. Some researchers use a control group that does not receive the potential benefits of the treatment being investigated. If a delay in receiving treatment increases subject discomfort, or if the emotional conditions of control group members deteriorate while they are participating in the study, client welfare is at issue. The conundrum is that whether the experimental treatment is indeed beneficial cannot be known without conducting the study. One way to reduce risk to control group participants is to compare the experimental treatment with other treatments known to be effective, if such an option is available and viable. If the experimental treatment is found to be effective, the researcher has an ethical obligation to offer it to control group participants as soon as possible after the experiment is completed.

The ethical issues discussed thus far apply to quantitative research, which was once the predominant method of conducting research in the social sciences. A relatively recent development



in counseling research is the burgeoning of qualitative research (Hays & Wood, 2011). Unlike quantitative research—which uses statistics to control, explain, and predict—qualitative research uses words to create rich descriptions to understand the experiences of people who have *lived* a particular phenomenon. Qualitative research is particularly well suited to the counseling field (Hunt, 2011). As Paisley (1997) has stated:

As counseling comes of age as a discipline and as we as counselors acknowledge the diversity of our experience and our different ways of knowing, we must also come to a place where we can honor both empirical data and the power of personal narrative. (p. 4)

**DIVERSITY CONSIDERATIONS IN RESEARCH DESIGN** Designing research studies in counseling is an incredibly challenging process. Being sensitive to diversity issues means taking into consideration the complexity of variables involved in research with human beings. Contextual variables include client characteristics (such as gender, race or ethnicity, age, socioeconomic status, attitudes and values, and worldviews), counselor variables (including all of the same individual characteristics that apply to clients, plus training, experience, and theoretical orientation), and counseling process variables (interactional and reciprocal aspects of counseling; Szymanski & Parker, 2001). It is impossible to control for all these factors, yet any variance needs to be explained.

To give just a few examples of the importance of contextual variables, researchers should not generalize their results to populations not represented in their sample. If a study's participants were only men, the researcher cannot make generalizations to both genders. If the participants were primarily White and middle class, the researcher must acknowledge the limitations of the study with respect to race, ethnicity, and socioeconomic status.

The ACA *Code of Ethics* (2005) notes that “counselors are sensitive to incorporating research procedures that take into account cultural considerations” (Standard G.1.g.). Several difficulties present themselves in conducting research with ethnic minority groups and women (Kurasaki, Sue, Chun, & Gee, 2000). First, counseling practices based on Western theories or treatment modalities may be culturally inappropriate for some members of minority groups. Thus, studies that measure the effectiveness of traditional approaches may not produce valid results with minority research participants. Second, researchers often have difficulty finding an appropriate sample to study, due to the small size of some minority populations and the unwillingness of some groups (such as illegal immigrants) to become research participants. Third, because race or ethnicity and gender are closely linked to other variables such as socioeconomic status, researchers must account for these other variables before attributing any differences to race or gender. Finally, many standardized tests have questionable validity when used with minority group research participants. Despite all these obstacles, however, a growing body of culture-sensitive research (e.g., Arenas & Paz Sandin, 2009; Nagayama-Hall, 2001; Ojeda, Flores, Meza, & Morales, 2011; Smith, 2010) is making contributions to our understanding.

### **Protecting Research Participants from Harm**

In every research project that involves human subjects, there is some risk to the participants. Although counseling research rarely poses physical risks, there may be psychological risks because participation can cause discomfort, stress, anxiety, or distress. The ACA ethical standards (ACA *Code of Ethics*, 2005) remind counselors who conduct research that they are responsible for the participants' welfare and should “take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects” to the participants (Standard G.1.d.). Risks to participants must be minimized to the extent possible. Three ways to accomplish this goal are to (a) ensure that

participation is voluntary, (b) secure participants' informed consent, and (c) protect the confidentiality of participants.

**VOLUNTARY PARTICIPATION** Ethical standards encourage researchers to make participation in their research voluntary. There should be no penalty for declining to participate or withdrawing from participation (ACA *Code of Ethics*, 2005, Standard G.2.d.). Involuntary participation should be avoided if possible.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 10 and view the video clip entitled “Voluntary or Coerced Participation?” In this situation, issues are raised regarding proper procedures when professors involve their students in their research studies.

## 2 The Case of Clay

Clay is a counselor educator interested in conducting a research study related to older students' success in college. He plans to study whether individual counseling of older college students helps them succeed academically. At his university, there is a program for at-risk students whose grade point averages were below 2.0 the previous semester. To continue at the university, these students must participate in an at-risk student program that requires them to attend study skills classes and meet with an academic support group each week. The director of the program has agreed to allow Clay to include as participants in the study all students in the program who are above the age of 40. The director has offered to tell these students that participating in Clay's study is a requirement of the at-risk program. Clay is wondering whether it would be ethical for the director to require students to participate in his study.

- Do you think requiring the students to participate would be ethical? Why or why not?
- What might Clay do to ensure that students who participate in his study are not harmed in any way?

**Discussion:** Such an arrangement is not unethical. Although it is best if participation in a study is voluntary, researchers do not always have to study only those who volunteer to participate. Clay should inform participants that they can discontinue participation at any time they wish, and he should follow up with any students who drop out to determine whether they need assistance for any reason.

Researchers must be particularly careful to protect the rights of subjects who may not be participating voluntarily or who may be vulnerable to abuse, such as prisoners, hospital patients, residents of institutions, or individuals who are not competent to give consent. Children should be given the opportunity to assent to participation, although legally their parents or guardians must give informed consent (Welfel, 2010).

**INFORMED CONSENT** The ACA (*ACA Code of Ethics*, 2005) ethical standards go into great detail regarding what informed consent for research should entail (Standard G.2.a.). Participants have a right to receive a full explanation of the following, in language that they understand:

- The purpose of the research and procedures to be followed. Researchers must explain to participants what they will be expected to do and how long it will take.
- Any procedures that are experimental or relatively untried.
- Discomforts and risks involved.
- Benefits or changes in individuals or organizations that might be expected. There are many possible benefits, but basically, they can be considered to be external, such as money, or internal, such as learning something new or making a contribution to science (Wilkinson & McNeil, 1996).
- Appropriate alternative procedures that might be advantageous for participants.
- Their right to have their questions answered regarding the procedures.
- Any limitations on confidentiality. For example, if a participant showed signs of suicidal ideation, confidentiality concerns would be secondary to concerns for ensuring the person's safety.
- The audiences that most likely will read the research findings.
- Their freedom to withdraw their consent and discontinue their participation at any time.

A troublesome issue in informed consent is that of concealment or deception. There can be some very good reasons for researchers to withhold certain information from participants. For example, if participants know the goals of the study, their desire to perform in socially desirable and helpful ways can skew the data. Some measure of concealment can often be justified.

Deception is a more difficult matter. Researchers should be cautious about deliberately misinforming participants about the purpose of the study. Section G.2.b. of the *ACA Code of Ethics* (2005) states that counselors do not conduct research involving deception “unless alternative procedures are not feasible and the prospective value of the research justifies the deception.” If deception is used, the researcher is obligated to give participants an explanation as soon as possible. The ethical guidelines for psychologists are even more explicit about deception. They specify that researchers never deceive participants about significant aspects that would affect their willingness to participate, such as physical risks, discomfort, or unpleasant emotional experiences. Additionally, any deception must be explained to participants as early as feasible, preferably at the conclusion of their participation but not later than at the conclusion of the research. During the explanation, the researcher is obligated to try to correct any misperceptions that participants may have (*APA Ethical Principles of Psychologists and Code of Conduct*, 2002).

**CONFIDENTIALITY** The third consideration in minimizing risks to research participants is confidentiality. Information obtained about research participants during the course of a study must be kept confidential (*ACA Code of Ethics*, 2005, Standard G.2.e.). Researchers can ensure confidentiality in several ways. During data collection or in scoring protocols, a coding system rather than participants' names can be used. Any material collected (such as written reports, test scores, or audiotaped interviews) that includes identifying information about participants must be securely kept in a locked file or in computer files protected by passwords to which only the investigators and their assistants have access.

The *ACA Code of Ethics* also addresses relationships between researchers and research participants when research involves intensive or extended interactions (Standard G.3.). The code states that nonprofessional relationships between researchers and participants generally should be avoided

(Standard G.3.a.) unless such relationships are potentially beneficial to the research participants (Standard G.3.d.), that sexual or romantic relationships are prohibited (Standard G.3.b.), and that research participants are not sexually harassed (Standard G.3.c.).

When results are reported, participants' names are not used. The *ACA Code of Ethics* (2005) requires that the identity of research participants be disguised unless participants have specifically authorized otherwise (Standard G.4.d.). When reporting case studies or other descriptive information about research participants, all identifying details are disguised. Information is never disclosed to a third party without the prior consent of the participant, unless an exception to confidentiality (such as danger to self or others) applies. The bottom line is that people who participate in research studies have a right to expect to have their anonymity or confidentiality protected.

Institutional policies often require researchers to guarantee anonymity to participants when their informed consent is obtained. Once a researcher has guaranteed that a participant's identity will not be revealed, the researcher must take care to avoid disclosure (Wilkinson & McNeil, 1996). If a lawsuit were filed claiming damages for disclosure of a research participant's identity, courts probably would try to determine whether the researcher had made reasonable efforts to ensure anonymity after promising to do so. Careless disclosure of research participants' identities could cause legal problems for those who engage in counseling research.

Welfel (2010) has raised an ethical concern about research that does not involve the actual participation of clients but instead reviews client records. Securing the informed consent of the clients may seem unnecessary because they are not put at risk or inconvenienced, but it would be ethically questionable to proceed on such an assumption. Unless the clients were told when they entered counseling that their records would be utilized in a research study, Welfel believes that the researcher should attempt to contact the clients and request their permission to review the records. If this is not feasible, the counselors who produced the records might eliminate any identifying data from the records before giving the researcher access to them. Other researchers would argue that it would not be necessary to obtain consent from former clients to collect data from records as long as the researcher did not disclose the names of clients to others and did not identify the clients in reporting the study's results.

### **Institutional Review Boards**

Many of the ethical mandates regarding the protection of research participants are legal requirements as well. The National Research Act of 1974 requires institutions that receive any federal funds to establish committees to review research proposals to ensure that human participants are protected (Maloney, 1984). National Research Act of 1974 Regulations have been developed with specific requirements for researchers (45 Code of Federal Regulations 46). The penalty for violation of the requirements would be removal of federal funds from the institution, which would be devastating for both public and private institutions because almost all receive substantial federal support.

Universities and other research institutions have Institutional Review Boards (IRBs) that approve and oversee research involving human subjects. All investigators connected with an institution must have their research approved by an IRB, also sometimes called a *Human Subjects Committee*. This applies to graduate students who conduct research as well as to faculty. IRBs, which have considerable power, typically require researchers to submit detailed proposals describing informed consent procedures, the voluntary nature of participation, and the protection of confidentiality of information collected (Welfel, 2010). If you plan to conduct research during your graduate studies, your university will have a standard protocol for submitting your proposed research to its IRB. You will need to obtain this protocol, complete it carefully, and have it reviewed by your

major professor before you begin your research study. If you are collecting data from more than one source (e.g., students at several universities), you may be required to obtain approval from all of the IRBs. When you apply for approval to conduct a research project, you must guarantee to the IRB that you will take a number of steps to protect human participants. If you fail to do the things you have promised, you could be held legally accountable by the institution and by any participant who was harmed.

## Reporting Results

Once researchers have collected and analyzed the data from a study, they have four additional ethical obligations. According to the ACA *Code of Ethics* (2005), they need to honor their commitments to research participants (Standard G.2.g.), explain the nature of the study to remove any misconceptions (Standard G.2.h.), report their results honestly and accurately (Standards G.4.a., G.4.b., & G.4.c.), and make available sufficient original research data to qualified professionals who may wish to replicate their study (Standard G.4.e.).

### Commitments to Participants

When researchers make a commitment to research participants before their participation in the project, then those commitments must be honored after the project is completed (ACA *Code of Ethics*, 2005, Standard G.2.g.). Often researchers offer to give participants feedback regarding the study after the research project has ended. In research parlance, the process of providing feedback is sometimes called *debriefing*. Some evidence seems to suggest that providing feedback may be a frequently neglected commitment. McConnell and Kerbs (1993) found that more than 30% of researchers failed to provide participants with the feedback they had promised. When this happens, the participants not only are left hanging with respect to the particular study but also are likely to be less enthusiastic about participating in future research studies.

According to Standard G.2.h. of the ACA *Code of Ethics* (2005), “counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research.” In situations in which withholding such information is justified, counselors “take reasonable measures to avoid causing harm.” Occasionally, a researcher will withhold information about the purpose of the study out of concern that disclosure would invalidate the results.

If you plan to conduct research, you must consider (a) when you will offer to give feedback to your participants, (b) how you will give it, and (c) what you will tell them. In terms of timing, if you offer to give feedback, it should be given as soon as is feasible after the data are collected. You must also decide how much information you want to share about such aspects as the research purpose, hypotheses or research questions, the sample, and the contribution you hope the study will make. Carmen, the graduate student in the following case example, needs some help in deciding how to provide feedback.

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## 3 The Case of Carmen

Carmen, a doctoral student in a counselor education program, is designing her dissertation study, which involves surveying Licensed Professional Counselors regarding their attitudes toward counseling men who batter. She intends to send her potential participants a survey, along with a cover letter explaining her study that also includes informed consent information. Carmen plans to utilize an on-line survey service to collect her data. She wants to protect participant confidentiality, so she plans to ask recipients to return the survey anonymously. She wants to offer to provide participants

with a summary of her study's results, but is unsure how to obtain their names and addresses without compromising their confidentiality. She asks her dissertation director for advice.

- What suggestions might her dissertation advisor offer?
- Why do you think participants should be provided with a summary of the study once it is completed, if they want one?

**Discussion:** Most on-line survey services allow for respondents to ask for feedback in such a way that their identity is not tied to their survey responses. Carmen's dissertation advisor might instead suggest that Carmen ask participants who want to receive the results summary to send her their names and addresses via e-mail. Of course, Carmen will need to follow up and send the summary to those who request it, and do so in a timely manner. Another option would be to publish the results in the newsletter of the LPC board, which all participants receive. A third option might be for Carmen to inform participants that the results will be posted on a website URL given to them.

Participants need to be provided with a summary of the study, if they want one, for the following reasons:

- It is respectful, after asking individuals to participate, to give them the results at a later date.
- Participants have a right to know the outcome of a study in which they have participated.

Individuals who receive follow-up information might be more willing to participate in studies in the future.

### Honest and Accurate Reporting of Results

Counselors are responsible for reporting research accurately and in a manner that minimizes the possibility that results will be misleading. They are prohibited from engaging in fraudulent research, distorting or misrepresenting data, or deliberately biasing their results (*ACA Code of Ethics*, 2005, Standard G.4.a.).

Unfortunately, these practices may not be uncommon (Swenson, 1997). In the academic setting, pressures to *publish or perish* can be strong for assistant professors who are nearing their tenure decisions. Sometimes doctoral students, having become emotionally invested in producing a study with significant results, are tempted to ignore contrary findings or manipulate data to fit their expectations. The push for productivity can also be strong in research environments where continued funding depends on demonstrating that grant funds are being well spent. Miller and Hersen's (1992) text on research fraud cites numerous examples of the kinds of research misconduct that occur when a researcher's self-interest takes precedence over ethical standards.



**Note:** Go to MyHelpingLab and select the Ethical, Legal, and Professional Issues module from the Video Lab. Then select Module 8 and view the video clip entitled "Fudging the Results." This video demonstrates what counselors might do when they experience pressure to produce research results.



ACA ethical standards (ACA *Code of Ethics*, 2005) provide some specific guidance regarding the full and accurate reporting of research results. First, ethical counselors do not ignore findings that run contrary to their hopes or expectations. They explicitly mention all known variables and conditions that may have affected the outcome of a study or the interpretation of data (Standard G.4.a.). They also provide a thorough discussion of the limitations of their data and alternative hypotheses (Standard G.4.a.). Finally, they must communicate the results of any research judged to be of professional value, even if it reflects unfavorably on institutions, programs, services, prevailing opinions, or vested interests (Standard G.4.b.).

### **Cooperating with Other Researchers**

The ultimate aim of research in counseling is to improve the practice of the profession. As a body of evidence accumulates about the effectiveness of a counseling process or treatment strategy, it will be more widely applied, and more clients will be better served. Replication studies are one vital process through which this goal is accomplished. Thus, counselors have an ethical duty to “make available sufficient original research data to qualified professionals who may wish to replicate the study” (ACA *Code of Ethics*, 2005, Standard G.4.e.).

What this means for you, as a researcher, is that you have an obligation to keep your raw data for a number of years so that other researchers can have access to it. As Welfel (2010) has pointed out, this is not such an onerous duty now that voluminous data can be stored on computer disks. If you receive a request for your data, you would be wise to follow the dictates of the APA *Ethical Principles* (2012), which require you to release the data when “other competent professionals ... seek to verify the substantive claims through reanalysis and ... intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release” (Section 8.14).

## **PUBLICATIONS**

Ethical issues related to publication include giving credit to others for their work and following appropriate procedures for submitting work for publication consideration. Giving credit to others is a legal as well as an ethical issue. Other legal issues that are important to counselors who engage in all types of scholarly activities include observing copyright laws, signing contracts, and reporting income derived from research, presentations, or publications.

### **Giving Credit to Contributors**

Earlier we mentioned the pressure to *publish or perish* that can exist among university faculty. This pressure can affect the behavior of professors and can also have a negative impact on their students.

The practice of evaluating professors for tenure, promotion, and merit pay increases based largely on their records of scholarly publications has fostered an atmosphere that is more competitive and self-interested than would be ideal. Sometimes counselor educators who are outstanding teachers are denied tenure for lack of sufficient publications and are forced to leave their university positions, to the dismay of their students and the professors themselves. Others are challenged to uphold their scholarly integrity under reward systems that give more credit for sole authorship than for cooperative research endeavors, for being listed as first author on a publication, and for producing publications in quantity with little consideration for quality. These factors, although they do not excuse inappropriate behavior, probably do contribute to such practices among professors as

publishing student work under their own names or usurping first authorship for work that was more the student's than their own.

The *ACA Code of Ethics* (2005) addresses these practices in several ways. First, in publishing, counselors are familiar with and give recognition to previous work on a research topic and give full credit to those who deserve the credit (Standard G.5.a.). Second, they must give credit through "joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly" to their work, in accordance with such contributions (Standard G.5.d.). Third, guidelines exist for determining the order and types of acknowledgment to be given when more than one person has contributed to research (Moore & Griffin, 2007). The principal contributor is listed first, whereas minor technical or professional contributions are acknowledged in notes or introductory statements (Standard G.5.d.). A student is listed as the principal author on an article that is substantially based on the student's course paper, project, dissertation, or thesis (Standard G.5.f.). This standard arose because students sometimes have felt taken advantage of by their professors.

It is important for you to be familiar with these guidelines if you are involved or are planning to be involved in research activities during your graduate studies. The professor with whom you are collaborating or whom you are assisting should have a conversation with you before you begin the research endeavor regarding the work you will do and the type of acknowledgment you will receive. If you will be contributing substantially to the project, your professor should discuss with you and any other coauthors the order in which names will appear, because the first author listed is generally assumed to have contributed the most to a collaborative project, and the last author listed is assumed to have contributed the least. The order of names should be open to negotiation throughout the project, and all authors must be in agreement by the time the product is published. If your professor does not offer to have a discussion with you about these matters, you should feel free to request it. In a study that included over 1,000 participants, Welfare and Sackett (2011) surveyed doctoral students and faculty members in education-related disciplines regarding how they made decisions related to journal article authorship. They found that respondents believed authorship decisions should be made before beginning work together and evaluated throughout the project. In addition, respondents indicated that doctoral students should initiate authorship discussions to the same degree as faculty members do. However, the results indicated that faculty members usually decided independently who received credit for authoring manuscripts. To what extent do you think proper procedures were followed in the next case scenario?

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## 4 The Case of Singh

Singh, a master's student in a counselor education program, wrote a term paper for Dr. Martinez' class that greatly impressed the professor. Dr. Martinez suggested to Singh that his paper could be published, with some modifications. Singh, although flattered and excited, admitted to Dr. Martinez that he didn't know anything about how to get published. The professor offered to help him. They met and established an agenda that described the needed additional research and revisions to the manuscript, divided the workload equally between them, and established time lines and a meeting schedule. They completed their task and submitted the manuscript for publication, with Singh listed as the senior (first named) author.

- Do you think it was appropriate that the professor was listed as a co-author of the article?
  - How would you feel if one of your professors offered to help you publish a paper you had written?
-

**Discussion:** If the professor's contributions were substantial enough that they might eventually lead to the paper's publication, the professor being listed as an author is warranted.

The paper will look much different when it is submitted for publication than it did when the student wrote it. The differences will be a result of the professor's advice.

Usually, students are excited when a professor offers to help them publish a paper they have written and are pleased to list their professor as a co-author.

The process followed by Singh and Dr. Martinez seems to have met ethical guidelines. You will see, when you read the following section, that Singh may have several more time-consuming tasks to perform before his manuscript is published.

We turn now to the legal arena as it applies to the issue of giving credit to others. One source of litigation involves conflicts among multiple authors of scholarly work. Because individuals legally own the ideas that are reflected in written materials, multiple authors may argue over who owns which ideas.

Counselors who contribute to a scholarly work have legal rights regarding that work. When more than one person is involved, each author has some independent legal rights and some legal rights that require full agreement of all the involved authors (Leaffer, 1989). Each joint author has the full right to use the work or to allow others to reproduce it. However, agreement among all the joint authors is required to grant exclusive rights to the work or to transfer ownership rights of the work to a non-author. Authors must agree on an equitable manner of sharing income derived from the product as well.

Financial compensation for written works usually occurs in conjunction with a contract signed by the author(s) and a publisher. The terms of such contracts vary substantially and should always specify the amount of compensation that will be paid to each author individually.

Problems occur in multiple authorship of scholarly works when counselors do not discuss issues such as percentage of ownership, order of listing of author names, and other joint authorship matters. If one of the authors believes that he or she has not received adequate recognition or financial compensation, the individual may have legal ownership rights that could be pursued.

### **Submitting Work for Publication Consideration**

The primary ethical standard regarding the process of submitting work for publication has to do with duplicate submission. Counselors should submit their manuscripts for publication consideration to only one journal at a time (*ACA Code of Ethics*, 2005, Standard G.5.g.). Other fields (such as law) allow multiple submissions of a manuscript to several refereed journals at one time, so the social sciences rule requiring submission to only one journal at a time can be frustrating for authors. Because the time that elapses between the original submission and the publication of a manuscript can be lengthy, there is always concern that the material will be outdated by the time it is published or that someone else may publish something similar in the interim. There is no alternative to this system, however. Turnaround time from submission to publication is improving in refereed journals due to advances in the use of technology.

If you conduct research with your professors, you will experience the frustrations of *the waiting game*. It is likely that you will need to rewrite and resubmit your manuscript, maybe more than once; or it may be rejected by the first journal to which you have submitted it. You and your professor will then need to rewrite it and submit it to another journal. This process takes many months, at

best, and can take years. Patience is a necessary virtue if you intend to be active in conducting and publishing research.

The *ACA Code of Ethics* (2005) includes a lengthy standard (G.5.h.) to guide the activities of counselors who serve as editorial board members of refereed journals or who review manuscripts written by others. The new standard contains the following language:

Counselors who review materials submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors use care to make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and use care to avoid personal biases.

This standard was added to address questionable activities by some reviewers. Unfortunately, situations have occurred in which reviewers have stolen ideas from authors and used them as their own before the author's ideas were published, have been biased in their reviews of materials, have been dilatory in completing reviews, and have agreed to review materials that they were not qualified to comment upon. Fortunately, these negative practices are unusual. With the addition of this standard to the *ACA Code of Ethics* (2005), reviewers can now be required to defend actions they have taken that may appear to be inappropriate.

### Copyright Laws

Counselors involved in research, presentations, or publishing need to be aware of basic legal principles involving copyright. Essentially, a copyright acknowledges legally that individuals *own* ideas once they have created them.

Authors of original written materials have a copyright immediately when the documents are produced (General Revision of the Copyright Law). Materials do not have to be registered with the U.S. Copyright Office to be protected from infringement. However, individuals who do register their materials might qualify for an award of attorney's fees and substantial statutory damages if someone *steals* their ideas (Patry, 1986).

Authors who wish to announce that they are protective of their work usually insert at the end of the document either the symbol © or the letters *Copr.* followed by the year of first publication, with the author's name listed underneath (Carroll, 1994). The © symbol indicates that authors are aware that their work is protected legally, but does not necessarily indicate that the work has been registered (Henn, 1991).

Most written materials are legally protected from the time they are created until 50 years after the author's death. In the case of multiple authors, the copyright lasts until 50 years after the death of the last author. Copyright protection of tests, corporate products, or anonymous works lasts for 75 years from the date of first publication or 100 years from its date of creation, whichever date expires first.

When authors publish their work in a text or journal, they often assign or transfer their copyright to the publisher. As a result, a publisher, rather than the authors themselves, may own a copyright to a particular written work. The fact that a publication may no longer be available for purchase, or may be *out of print*, does not affect the author's or publisher's legal copyright protection. Permission to reproduce the work must still be obtained from the copyright owner.

Some publishers have become rather aggressive in protecting their copyrighted materials. Publishers sell for a profit the materials they produce, so they are naturally concerned when individuals duplicate their published materials and they lose income as a result. Cases against businesses

that duplicate materials (Henn, 1991) have demonstrated that some publishers will bring lawsuits to protect their copyrighted materials.

Counselors who are involved in scholarly activities generally do not register their written materials with the U.S. Copyright Office because of the time and expense involved. However, when you produce materials that are unique, have a potential for a high commercial value, or might be susceptible to being illegally duplicated, you may wish to consider paying the required fees and registering them.

Counselors also must ensure that they do not infringe on the legal rights of others by duplicating protected materials without permission. Before duplicating any material, you should obtain permission from the copyright owner, either the author or the publisher (Johnson & Roark, 1996), and give credit to the author of the material. Most duplicating businesses, university printing operations, and publishers are familiar with the process of obtaining permission to duplicate copyrighted materials.

The extent to which individuals can use the copyrighted work of others is sometimes difficult to determine. The Reporters Committee for Freedom of the Press (2008) has developed guidelines to assist individuals in avoiding copyright infringement, which can be found at <http://www.rcfp.org/handbook/c10p06.html>.

## **Contracts**

Counselors who engage in scholarly activities sometimes enter into contracts with publishers, entities that fund research projects, or organizations that pay for presentations. Generally, when there are no financial dealings involved, such as pay, honoraria, or reimbursement of expenses, no contract is signed by the parties. When counselors benefit in some way financially from the scholarly activity in which they are engaged, a contract often is signed by all of the parties involved. Letters of agreement that are signed by two parties usually are legal contracts as well.

The legal assumption made when a contract is signed by two or more parties is that the written contract represents an agreement reached among the individuals involved after they have carefully considered all the options and after open negotiations have occurred. Another important assumption regarding contracts is that the written document covers all the issues that were important to the parties. These two assumptions generally are not true when counselors sign contracts related to their scholarly work, and this can cause problems for counselors at a later time.

The reality is that counselors generally sign, without questioning, contracts that are presented to them by the entities with whom they will be working. Most entities that contract with counselors for services use preprinted contract forms that usually have been prepared by the attorneys representing the entities. They are the result of years of experience in contracting with authors, presenters, and researchers. Specific terms are filled on blank lines. Attorneys who prepare contract forms naturally include terms that are favorable to their clients. As a result, such contract forms protect the rights of the entities who are buying the counselors' services, but do not favor the counselors who will be signing them.

A further reality is that most counselors who produce scholarly works and who contract with entities for their services do not believe they have the financial resources to have contracts reviewed by their own attorneys. In addition, counselors may not have a favorable position in the negotiations process. The entities contracting with them can often go to other counselors for the same services if they cause problems in the negotiations process. These entities may be unwilling to alter their contract form for one individual.

The result is that most counselors engaged in writing, presenting, or conducting research usually sign the contract presented to them and hope for the best. Sometimes the only area that can be successfully negotiated with preprinted contracts is the amount of compensation or reimbursement. Most counselors sign very few contracts and have neither the position nor the resources to

do anything more than read contracts presented to them, ask for clarification of terms they do not understand, negotiate basic financial matters, and finally sign them.

Of course, counselors who have unique credentials or talents have more negotiating power and can be more aggressive in the contract negotiations process. If substantial compensation is involved or if the publications could have a significant impact on their careers, they probably should hire an attorney to either negotiate contracts for them or at least advise them as they negotiate contracts for themselves. Beren and Bunnin (1983) have developed a guide for authors that includes advice on locating attorneys who specialize in publications law.

When a counselor is employed and the contract for a research project is between the institution and the funding entity, the contract usually is negotiated directly between the institution's representatives and the funding entity. A counselor may apply for external funding, but the contract goes to the counselor's employer.

When counselors receive funding that is external to their institution, it is important that they comply with the terms of their funding contract. The person who applies for a grant and receives the funding usually is responsible for ensuring that the money is spent properly.

The funded project's manager must sign all expenditure authorizations. Occasionally project managers engage in fraudulent practices that can lead to civil and criminal charges against them. Diverting project funds to other purposes, falsifying reimbursement requests, and failing to follow required bidding for service procedures are some of the fraudulent practices that may cause problems.

### Reporting Income

When counselors receive any payment for their services, they must report it for income tax purposes. It does not matter whether the payment is called a fee, charge, payment, or even an honorarium. It is considered income by the Internal Revenue Service and must be reported.

In fact, counselors who receive income for their scholarly activities are in *private practice* and should conform to all of the legal requirements for private practices. A city or county business license should be purchased, and professional liability insurance should be secured.

Generally, the type of practice can be listed as *consultant*, and counselors are not required to be licensed as mental health professionals by their state to engage in many types of scholarly activities, such as writing, presenting workshops, or conducting research. State laws should be consulted to determine whether a license is required.

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## Summary and Key Points

This chapter deals with ethical and legal considerations that are important for counselors who write, who conduct research, and who report their findings in scholarly publications.

All counselors write when they are graduate students and later when they practice professionally. Additionally, counselors who are professors and supervisors often must evaluate the writing of other counselors. There are ethical and legal implications

regarding the writing activities of counselors, especially about plagiarism.

Some key points regarding writing include the following:

- Counselors in training must write many papers during their academic programs. Counselors in practice write reports, case notes, and other documents related to their jobs.



- Counselor educators and counselors who have jobs in research often write scholarly papers as well.
- Researchers have found that the majority of students admit to cheating or academic dishonesty.
- Some have suggested that students today, because of the technological world we live in, are more comfortable incorporating the ideas of work of others as their own because it is so easy to cut and paste information from the Web and because there is less respect for original creative works among young people.
- Plagiarism is prohibited by ethical codes and laws in the United States.
- The American Psychological Association (APA, 2010) *Publication Manual* specifies that plagiarism is unacceptable and explains that plagiarism occurs when individuals present the work of others as their own.
- Counselors who plagiarize are punished by universities and in courts of law.
- Guidelines have been developed to assist counselors to avoid plagiarism.

Due to current demands for accountability of counselors in all settings, more counselors than ever before will probably be involved in conducting research and publishing their findings. The process of conducting research involves understanding the various roles that are involved, knowing how to design good studies, and protecting participants from harm. The process of reporting the results entails giving feedback to participants, reporting honestly and accurately, and cooperating with other researchers.

Some key points regarding research include the following:

- The principal investigator conceptualizes, designs, and plans a research study and has the primary responsibility for seeing that ethical and legal requirements are followed.
- Students sometimes serve as research assistants when they help with a professor's research project.
- The professor who supervises the master's thesis or doctoral dissertation of a graduate student is the research supervisor who shares

ethical and legal responsibilities with the student investigator.

- Counselor educators must carefully manage dual roles with their students who are involved with them in research projects.
- Poorly designed research is actually unethical because it wastes the time of participants and erodes the esteem in which research is generally held.
- Researchers must attend to the rights of control group members as well as the needs of participants in an experimental group.
- Good research pays attention to issues of cultural diversity.
- Participating in a research study involves some level of risk to human participants; therefore, they must be protected from harm.
- Ways to protect participants are to ensure that their participation is voluntary, secure their fully informed consent to participate, and protect their confidentiality.
- Proposed research studies must be approved by Institutional Review Boards, which are quite rigorous in evaluating research that involves human subjects.
- After a study is completed, researchers must debrief or give feedback to everyone who participated in the study.
- Despite the existence of many pressures to publish, counselors must report the results of their studies with complete honesty and accuracy.
- Researchers are required to keep their raw data and make them available to other researchers who might want to replicate the study.

There are both ethical and legal issues related to writing and publishing. One ethical issue is knowing the procedures for submitting one's work for publication. Legal issues include observing copyright laws, signing contracts, and reporting income. The issue of giving credit to others who have contributed to a research study has both ethical and legal dimensions. Some key points regarding publications include the following:

- Pressures to "publish or perish" that exist in academia can make it challenging for counselor educators to uphold their scholarly integrity.

### Professional Writing, Conducting Research, and Publishing

- When publishing research, authors must give credit to all others who have contributed to the study, in accordance with their level of contribution.
- Counselors who produce scholarly works have legal rights regarding those works; when problems occur, they are usually due to multiple authorship.
- Counselors must not submit manuscripts for publication consideration to more than one social sciences journal at a time.
- Counselors must know the basic principles of copyright law.
- Counselors generally are not very adept at understanding contracts, although they may enter into contracts with publishers, entities that fund research, and organizations that pay them for giving presentations.
- All income received for scholarly activities must be reported to the Internal Revenue Service.



# Resolving Legal and Ethical Issues

## FOCUS QUESTIONS

1. How do you think you would react if you were a licensed counselor and received a registered letter from your licensure board informing you that you had been accused of professional incompetence by a former client?
2. Do you think it is wise to avoid telling anyone if you receive notification of a complaint against you? Why or why not?
3. In what circumstances do you think you would report another counselor for unethical behavior?

**Y**ou probably are familiar with the process of ethical and legal decision making. A process for ethical decision making helps you identify key points to consider when you are faced with an ethical dilemma. Reasoning through a dilemma before taking action to resolve it can prevent later problems, such as being accused of improper or unethical behavior. This chapter, by contrast, focuses on how to deal with suspicions or accusations of unethical or illegal conduct when they do occur.

You may also have a process for identifying legal issues when they arise and ways to request legal advice as an employee or as a counselor in private practice. It is one thing to understand rationally how to recognize legal issues and obtain legal advice, but it is quite another thing to feel the distress of dealing with legal issues when they actually arise.

## LEGAL AND ETHICAL DECISION MAKING

This chapter is aimed at helping you deal with situations that directly involve you in ethical and legal challenges that come before ethics committees, licensure or certification boards, and courts of law. After legal and ethical decision making are briefly reviewed, two kinds of situations are addressed: (a) what to do when you are accused of unethical or illegal behavior, and (b) what to do if you suspect that a professional colleague is behaving unethically or illegally. The chapter concludes by suggesting some guidelines for avoiding ethical and legal problems and maintaining your professional vitality.

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### **Personal Legal Decision Making**

It is impossible for counselors to understand all aspects of the law. As a result, you must rely on the advice of attorneys from time to time as you practice. You must make every effort to fully explain a situation to your legal advisors and educate them, to the extent possible, regarding the counseling process and the counseling profession. You can then follow the legal advice you have been given without worrying about whether it is correct. Of course, you should raise questions if you believe you are being given incorrect advice, but you can rely on the advice you have been given. Lawyers are required to stand behind the advice they render. You can sue your lawyers if you are harmed as a result of relying on their incorrect advice. An attorney who has represented mental health professionals when they were sued (Gould, 1998), has stated that the best advice he can give to those who are involved in litigation and are trying to protect themselves from attacks is to listen to their lawyer and do what the lawyer says.

Most legal issues faced by counselors involve acting as witnesses in litigation concerning other people. Unless you are being sued for malpractice or have had a complaint of improper conduct filed against you, it is important to remember that you are not being accused of wrongdoing. Reporting what you know in legal proceedings can be a simple matter if you have been advised by your attorney. It is important to avoid getting emotionally involved in your client's lawsuits or in legal proceedings that affect others. If you lose your objectivity and professional distance, it is easy to get inappropriately involved in legal matters that do not affect you directly.

### **Personal Ethical Decision Making**

No doubt it has become evident to you in your studies that ethical questions rarely have a single, clearly correct answer (Koocher & Keith-Spiegel, 2008). Codes of ethics can be helpful, and certainly they should be consulted. Remember, though, that ethics codes are written in general terms and cannot completely resolve most of the complex ethical dilemmas that arise in practice (Williams, 2001). Often, counselors' ethical problems are existential dilemmas. The decisions they make when attempting to resolve an ethical issue become the right decisions only because they were taken. It is impossible to guarantee in advance that actions, no matter how carefully considered, will have the desired outcome.

Ethical decision making is a complex process, even in the abstract. It can be even more difficult if you must make a decision when you are unsure about the ethics of your behavior or you suspect that a colleague is behaving unethically. Of course, when you have an ethical question, you should consult with fellow counselors, just as counselors who have a legal question should consult with an attorney. As was noted in the previous section, when a counselor asks an attorney for advice, the attorney becomes responsible for the advice given. In a parallel fashion, sometimes a counselor with an ethical question will have a clinical supervisor to whom the responsibility for decisions can be passed. Often, though, this option will not be available. When you have an ethical question, you can—and should—consult with colleagues, but the consultants are not responsible for your decisions or actions. Although an attorney can help you defend your actions later before an ethics committee or a licensing board, if that becomes necessary, an attorney cannot advise you about an ethical dilemma. You must decide.

## **RESPONDING TO ACCUSATIONS OF UNETHICAL OR ILLEGAL BEHAVIOR**

Neukrug, Milliken, and Walden (2001) asked counselor licensure boards throughout the United States about ethical complaints that had been made against licensees. When the data were collected in 1999, 45 states and the District of Columbia had boards that licensed counselors. Four boards

were too new to have processed complaints. Of the remaining 41 boards, 34 (83%) responded. Four of the 34 were not empowered to receive or process ethical complaints against licensees. The 30 remaining boards had received a total of 2,325 complaints in the previous 5 years. Of the 2,325, a total of 1,307 were identified by type of complaint. Of the categorized complaints received by these boards, 24% were for inappropriate dual relationships; 17% were for incompetence; 8% were for practicing without a license or misrepresentation of qualifications; 7% were for having a sexual relationship with a client; 5% were for breach of confidentiality; 4% were for inappropriate fee assessments; 1% were for failure to obtain informed consent; and 1% were for failure to report abuse. This information demonstrates that counselors have complaints filed against them for a variety of reasons, although the probability of being investigated by a licensure board is not great. However, five times more mental health professionals have licensure board complaints filed against them than have been the target of malpractice lawsuits (Zur, 2011).

Individuals react in various ways to accusations of unethical or illegal behavior. Emotions such as fear, panic, and anger are common. It is natural to have a strong reaction, but you must keep your emotions under control so that you can handle the situation effectively. Chauvin and Remley (1996) recommend that you seek personal support by expressing your emotions regarding the accusation to clinical supervisors, family members, friends, or your personal counselor. However, you should avoid talking to them about the facts of the situation.

Despite the denial, embarrassment, or distress you may feel, you should immediately report any threatened or completed accusation of professional misconduct to your immediate administrative supervisor, if you are employed in an agency or institution, and to your personal professional liability insurance carrier. If you fail to notify your insurance company, you could jeopardize the policy's providing legal representation for you or paying off possible judgments. When you tell your supervisor about the accusation, you should ask the supervisor to keep the information confidential and not discuss it with anyone other than the administrative supervisor or the organization's attorney.

In reality, it is not unusual for counselors to be threatened with ethics complaints or malpractice lawsuits. Counselors engage in many activities that could result in ethics claims against them. They must report cases of suspected child abuse, vulnerable adult abuse, or elder abuse, and they often counsel individuals who are embroiled in legal conflicts with others. Sometimes counselors must take actions their clients do not wish them to take, such as informing family members, over a client's objection, if the client is at risk for suicide. As a result, individuals occasionally are angry with counselors and make threats. Diesen (2008) created a new term, *justice obsession syndrome*, to describe individuals who believe that the most important thing in life is to get justice in a personal situation where they firmly believe that an injustice has occurred. An obsession occurs, according to Diesen, when the importance of retribution is out of proportion to the circumstances. At some point in your counseling practice, you may have a client who feels *wronged* as a result of what has transpired in counseling sessions with you and becomes obsessed with seeking justice for the perceived wrong. As with other syndromes, the chances of having such a client are not strong, but this type of behavior by clients has been known to occur.

Some counselors serve as child custody evaluators. There is always a disappointed—and often angry—parent when a child custody recommendation is made to a judge. Some parents who are upset file ethics complaints against child custody evaluators, accusing them of being biased and unfair.

A counselor who is dealing with an angry client should respond directly to the person making the threat, if that is possible. If you can calm the person down and listen to the concerns, you might be able to resolve the problem immediately or through additional conversations. You should be careful, though, not to admit to wrongdoing and not to say anything you would not want repeated or to repeat yourself under oath in a courtroom later. We advise caution on your part if a client you are



counseling has a history of filing lawsuits against other people for any reason. Clients who sue other people may be more inclined to sue their counselors as well. Once a formal complaint or lawsuit has been filed, it is unwise to contact a client and try to talk him or her into withdrawing the complaint (O'Mahony, 2011).

### Informal Complaints

The Introduction to Section H of the ACA *Code of Ethics* (2005) states, "Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct." This introduction also states, "Counselors incorporate ethical practice into their daily professional work."

Although we hope that you will always do your best to practice within the bounds of professional ethics, even the well-intended counselor occasionally can make mistakes or be accused of wrongdoing, even if no mistake has been made. A fellow counselor might directly observe you do or say something that raises cause for concern, or the concern might have come to your colleague's attention through the report of a client, fellow mental health professional, supervisee, or student. It is important to take the concern seriously, make yourself available to meet and discuss the concern, listen and respond genuinely and nondefensively, and take responsibility for your error if you have made one (Williams, 2001). If the concern can be resolved informally in this way, it is to everyone's advantage.

### Formal Complaints

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#### 1 The Case of Lee

Lee has been licensed by her state board as a counselor for 4 years and is employed as a counselor in a community counseling center. Much to her dismay, Lee received a registered letter at work today informing her that a former client, David, has filed an ethics complaint against her with the licensure board, claiming that he was harmed because Lee is an incompetent counselor. David claims that Lee counseled him for 8 months for depression, during which time she sent him to a psychiatrist for anti-depressant medication. David found out recently that he has a brain tumor, which his neurosurgeon has told him causes people to be depressed. David claims that if Lee were competent, she would have advised him to have a physical examination and that the brain tumor would have been discovered earlier. Lee immediately advised her supervisor at the counseling center and called and reported the complaint to her professional liability insurance carrier. After she faxed a copy of the complaint to her insurance carrier, she received a call from an agent telling her that the insurance company wanted Lee to see a local lawyer who would represent Lee. Lee has never heard of the lawyer.

- How should Lee respond to her insurance carrier?
  - When Lee meets with her lawyer, how should she conduct herself?
- 

**Discussion:** Lee should ask her insurance carrier how that lawyer was selected. Usually, lawyers are chosen who have expertise in defending mental health professionals or other professionals in ethics complaints before licensure boards. Insurance companies generally select the best lawyers in the area to represent those they insure.



Lee should agree to meet with the lawyer who has been suggested by the insurance company and accept that lawyer to represent her, unless there is some compelling reason not to. If Lee does not like the suggested lawyer, she can ask the insurance carrier to hire another lawyer whom she prefers, and usually the insurance carrier will agree to do that if the alternative lawyer has expertise in defending suits against mental health professionals.

When Lee meets with her lawyer, she should bring copies of all relevant records with her to the meeting. She should also construct a chronological listing of her relationship with the complaining client that is factual and detailed and bring a copy of that document to give to the lawyer.

Lee should tell the lawyer everything she knows about the situation, even if she is concerned that perhaps she used bad judgment or did some things wrong. The lawyer has a privileged relationship with Lee and cannot tell anyone else what Lee has disclosed. The lawyer needs to know all details (including negative ones) in order to craft an appropriate defense for her.

If you receive notice from a licensure or certification board or from a professional association ethics committee that you have been accused of unprofessional conduct, you need immediate legal counsel (Zur, 2011). The professional liability insurance policy offered to members of ACA provides legal counsel to policyholders who have complaints filed against them. Generally, other professional liability insurance companies provide the same benefit to counselors that they insure. Counselors are advised to make sure the professional liability insurance policy they purchase includes legal representation in the event a formal complaint is filed against them with their licensure board (Zur, 2011). Some policies do not include that benefit and are not the best professional liability insurance options.

Licensure boards, professional association ethics committees, and counselor certification boards have adopted procedures for processing complaints against those who are licensed or certified by their boards or who are members of their association. Each set of procedures is different; however, they have many common steps. The general process that boards and committees use in processing complaints is summarized in the following (Chauvin & Remley, 1996):

- Generally, investigations and the processing of complaints are confidential.
- First, a board will determine whether it has jurisdiction over the counselor against whom the complaint is being made. If the board does not have jurisdiction, it notifies the person making the complaint that it does not have jurisdiction and the case is closed. If the individual is licensed or certified by the board (or is an applicant for a license or certification), then the board generally has jurisdiction.
- Once jurisdiction has been established, the board determines whether the counselor may have violated the board's code of ethics, if the allegations against the counselor are true. If the action (or inaction) of the counselor would not have constituted a violation, the case is closed. When the allegation, if true, might be a violation of the board's code of ethics, the board then begins an investigation of the complaint.
- Investigations might range from actions that are as expensive and complicated as sending investigators to talk to witnesses or the accused counselor, to actions as simple as asking written questions of the accuser or the accused.
- Often, if a violation is found, informal negotiations between the board and accused counselor occur. A settlement of the matter may be reached on a voluntary basis that satisfies both parties.

- If a settlement is not offered by the board or is refused by the counselor, a hearing is generally held. Members of the board (or their designees) sit as a jury. A representative of the board prosecutes the case, and the accused counselor, or the counselor's representative, defends. Usually witnesses are called to testify, including the accuser. Accused counselors usually are allowed to be represented by legal counsel at these hearings.
- After the hearing, the board determines whether the counselor violated the code of ethics. If violations are found, the board may impose sanctions. Sanctions vary but could include a written reprimand only; probation; suspension; or revocation of a license, certification, or association membership.
- If the counselor who has been found in violation of the code of ethics is not satisfied with the result, the counselor can appeal. Usually, there are internal appeals in which the board reviews the case again. Once the internal appeals are exhausted, in most states the counselor can sue the board in a court of law if the counselor believes the treatment was unfair.

If you receive official notice that a malpractice lawsuit has been filed against you, of course, you must notify your employer and your professional liability insurance carrier immediately.

An emotional response to being accused of wrongdoing is natural. It may help to keep in mind that many formal complaints and lawsuits filed against mental health professionals are either dismissed or result in a finding in favor of the professional (Anderson & Swanson, 1994). In a study of complaints against rehabilitation counselors over a 9-year period, Saunders, Barros-Bailey, Rudman, Dew, and Garcia (2007) found that only 71 of the 113 complaints filed accusing rehabilitation counselors of unethical conduct were accepted for investigation. Actions or sanctions were taken against the counselors in only 36 of the 71 cases. It may also be helpful to know that severe sanctions against counselors are rarely imposed by the ACA Ethics Committee; for example, only two members were expelled from the association between 1996 and 2000 (Williams, 2001). In most formal complaint or lawsuit situations, the individuals being accused wish they had done or said some things differently. This is natural as well. To avoid making mistakes that might be detrimental to your case, Chauvin and Remley (1996) and Herlihy and Corey (2006) have advised that you take the steps in Figure 1 if you are accused or sued.

## **WHEN YOU SUSPECT A COLLEAGUE IS ACTING UNETHICALLY OR ILLEGALLY**

### **Unethical Behavior**

The primary purpose of the *ACA Code of Ethics* (2005) is to guide our own behavior, not to judge the behavior of others. However, we cannot turn our heads and ignore unethical behavior on the part of others, particularly if such behavior is substantially harming others or has the potential of causing substantial harm. It is each counselor's responsibility to society and to the profession to address in an appropriate manner the behavior of other mental health professionals that appears to be unethical. Generally, mental health professionals have been reluctant to confront the unethical behavior of a colleague (Lowman, 2006). The role of *policeperson* can be very uncomfortable and runs contrary to who we are as counselors and to our commitment to accepting and helping others rather than judging and punishing them. Nonetheless, we must recognize that unless we police our own profession, the courts will step in and do it for us. Even more importantly, Herlihy and Corey (2006) have asserted:

public confidence in a profession is based in large measure on the extent to which the public believes that the profession holds its members accountable to acceptable standards of behavior. A public perception that members of a profession "protect their own," and close ranks to protect an unethical

- Maintain composure and respond at all times in a professional and unemotional manner.
- Notify your employer and professional liability insurance carrier immediately.
- Once you have a lawyer, follow the lawyer's advice precisely.
- Respond carefully to the charges. Remember that the members of the board or committee who will be deciding the outcome of the complaint do not know you and will base their decision only on material they have received. Write your response as deliberately and dispassionately as you can, and address each of the specific charges that have been made. For instance, if you have been accused of misapplying a technique, you should submit case notes or other records that show how you deliberated and decided to use the technique, how you were trained to use it, when you consulted about it, and any other steps you took to prevent harm to the client. Do not submit any responses until your attorney has reviewed them.
- Do not agree to speak to a licensure board investigator unless your attorney is present (Zur, 2011).
- Even if you are surprised and hurt that a client or colleague has filed a complaint against you, do not attempt to contact the complainant directly. Doing so could be interpreted as an attempt to coerce or unduly influence the client or colleague (Crawford, 1994).
- Seek emotional support from colleagues, friends, or family members, but focus your interactions on dealing with your emotions. Avoid discussing details of the case except with your attorney.
- Seek professional counseling if being accused results in distress that interferes with your personal or professional functioning.
- If you are guilty of having breached the code of ethics, seek assistance to help you avoid future breaches. This assistance could take the form of professional counseling, continuing education, supervision, or a combination of these resources.

**FIGURE 1** Steps to take if you are accused of unethical behavior or are sued

or incompetent practitioner, diminishes the profession. Counseling is a relatively young profession; this presents us with a unique opportunity to deal with unethical behaviors in a way that enhances the trust that our clients and society have invested in us. (p. 53)

The Introduction to Section H of the ACA *Code of Ethics* (2005) states, "Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary." This standard clearly communicates to counselors that they should consult when they are unsure whether another counselor is behaving in an unethical manner and should establish *direct and open communication* with the other counselor. When consultation and confrontation do not work, counselors are advised by the *Code of Ethics*, in serious cases, to take additional actions.

Standard H.2.a. of the ACA *Code of Ethics* (2005) states, "When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action." Two phrases in this standard require careful consideration. First, what is *knowledge*? And second, what constitutes *appropriate action*?

In determining whether you have knowledge that a colleague is acting unethically, we caution you against making a rush to judgment. You may hear rumors from colleagues that a fellow mental health professional engages in inappropriate behaviors such as sexually harassing clients or billing insurance companies for services that are not actually provided. Although you would be justified in feeling concerned, it would be unwise for you to take on the role of detective and investigate whether the rumors are true. Instead, urge the persons who are telling you the rumors to talk *to* the professional who is supposedly behaving inappropriately rather than talking *about* the individual.

At other times, a client might tell you directly about unethical behavior on the part of a former counselor. In these instances, your role can be one of assisting the client to decide whether to take action, if the client has been harmed by the former counselor's behavior. Only when you have direct knowledge of unethical behavior on the part of a fellow mental health professional should you feel obligated to take action.

With respect to what constitutes appropriate action, as we noted earlier, the code of ethics asks counselors to "attempt first to resolve the issue informally with the other counselor if feasible" (ACA *Code of Ethics*, 2005, Standard H.2.b.). It appears that some confusion may exist regarding this ethical obligation. Nearly 30% of the ACA members surveyed by Neukrug and Milliken (2011) believed it was ethical to report a colleague's unethical conduct without first consulting with the colleague. Of course, you will be uncomfortable and anxious if you must confront a counselor about your perception that he or she may have violated an ethical standard. Such feelings are understandable; however, accusing a counselor of wrongdoing is a very serious step, and your anxiety about accusing someone of possible wrongdoing is not a justifiable reason for not attempting to resolve the issue directly with a counselor. It is entirely possible that speaking informally with the other counselor will resolve the problem and thus avoid further discomfort for both parties.

Consider what you might do if you were the counselor in the following scenario.

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## 2 The Case of Ramona

Ramona is a counselor educator. At her university, the counseling program is housed within a larger department that includes counseling, educational administration, and school psychology. One day Ramona is visiting an intern at a United Way–funded agency. She notices a flyer on the bulletin board that announces, "John Smith, PhD, will be forming a counseling group for men who are divorced." John is a colleague in her department at the university. He has a master's degree in counseling, but his PhD is in educational administration. She realizes that his advertising himself on the flyer as holding a PhD may be a violation of the ACA *Code of Ethics* (2005, Standards C.4.a. and C.4.d.).

- Do you think that Ramona can ignore the situation? Or do you think she should do something about this possible ethics violation?
  - If Ramona should act, what actions should she take?
- 

**Discussion:** If Ramona were to decide to report John's behavior to their supervisor or to the ACA Ethics Committee, she would be creating problems—probably unnecessarily—for John and for their ongoing relationship as colleagues. Her first action should be to seek informal resolution by talking directly with John, pointing out that Standards C.4.a. and C.4.d. in the ACA *Code of Ethics* (2005) are of concern. John may reply that he was unaware of these standards and had no idea that his advertisement might be a breach of the code. Whether or not John's advertisement is an ethics violation is open to question, as a PhD in educational administration could possibly be interpreted as being in a field closely related to counseling. Ramona's goal should be to correct the problem, not to punish John. She can talk with him about what he can do to correct the situation. This might include taking down the flyers and printing new ones or being sure to clarify his credentials during the pregroup screening interview with potential group participants. If John were willing to take the steps agreed upon, Ramona probably would determine that the problem had been satisfactorily resolved.

What if the above scenario was different, and John had been romantically involved with a client rather than misrepresenting his PhD credential? We believe that the total situation would dictate Ramona's actions. If Ramona believed this was an isolated incident, and that the client had not been substantially harmed as a result of the relationship, then Ramona should confront John and hopefully obtain agreement that he had made a mistake and a promise not to engage in romantic relationships with clients again. On the other hand, if Ramona believed that John had a history of sexual or romantic relationships with clients, or that the client in this incident had been substantially harmed, then a confession and promise from John probably would not satisfy Ramona's obligation to the profession and to the public.

You will find that an informal resolution is always be possible when you have knowledge that another counselor may have engaged in unethical practices. The offending colleague may be unwilling to discuss your concern, circumstances may exist that preclude you from confronting your colleague, or you may not be able to raise your concern without violating the confidentiality of an involved party. If the privacy of an involved party is at risk, you should consult with colleagues who are uninvolved and who will not be able to ascertain the identity of the subject of the consultation.

If someone has been substantially harmed or is being substantially harmed by the unethical behavior, and if your consultants agree that you must take action, you must go forward and report the behavior (Smith, 2006). These circumstances will be rare. The 2005 ACA *Code of Ethics* states, "If an apparent violation has *substantially harmed*, or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or to the appropriate institutional authorities." We suggest that counselors report suspected ethics violations of other counselors to licensure and certification boards, and to association ethics committees, only when the conditions in Figure 2 have been met.

The last two items on the list may come as a surprise to many counselors, but they are understandable when the ACA Ethics Committee's policies and procedures for dealing with complaints and the procedures of licensure and certification boards are taken into consideration. For example, the ACA Ethics Committee accepts only written complaints that are signed by complainants. The committee does not accept anonymous complaints. If you believe you must file a complaint, you should write a letter to the Ethics Committee outlining the nature of the complaint, sign it, and send it in an envelope marked *Confidential*. If the person against whom you are making the complaint is an ACA member or was a member when the alleged violation took place, the committee will send you a formal complaint that identifies all the ACA ethical standards that might have been violated,

- It is impossible to resolve the issue directly with the counselor because of the nature of the circumstances, or because attempts at resolution have been unsuccessful. Being uncomfortable confronting the counselor or your anxiety about accusing someone of wrongdoing is not a justifiable reason for not attempting to resolve the issue directly with the counselor.
- You are certain and have direct knowledge that a serious ethics violation has occurred that is causing substantial harm, or has caused substantial harm.
- Colleagues with whom you have consulted agree that a report must be made.
- You are willing to participate in a hearing and testify against the counselor if a hearing is held.
- You are prepared to defend yourself if you have a counterclaim filed against you.

**FIGURE 2** Recommended necessary conditions for reporting a colleague for unethical behavior

if the accusations are true. You will be asked to sign the complaint (after suggesting modifications, if needed) and a release-of-information form. The accused member then will receive copies of the formal complaint and any evidence or documents you have submitted to support your complaint.

It is very distressing for counselors to have ethics charges filed against them by professional colleagues. Rarely does an accused counselor simply admit wrongdoing. Instead, the counselor may become defensive and sometimes may even make accusations of unprofessional behavior against the accuser. Usually, a long period of time passes while a complaint is being investigated and considered. The aftermath of the filing of an ethics complaint is stressful for both the accused and the accuser.

If you ever decide to file a complaint, you should request formal complaint forms from appropriate entities and follow precisely the instructions for filing the complaints. It is recommended that, before formally filing a complaint, you consult with an attorney and follow the attorney's advice (Austin, Moline, & Williams, 1990; Crawford, 1994). In many instances, depending on the circumstances and credentials of the counselor being accused, multiple complaints may be appropriate. Complaints may be filed at the same time with all of the following entities:

- All state licensure boards that have licensed the counselor
- All national certification boards that have certified the counselor
- Ethics committees that accept complaints of all professional counseling associations in which the counselor holds active membership
- The counselor's employer

Licensure boards, certification boards, and professional associations will inform individuals who inquire whether an individual comes under their jurisdiction and whether they accept ethics complaints against members. In the counseling profession, complaints are filed with and processed by ACA rather than with local or state chapters. When local chapters, state branches, regions, and divisions of ACA receive ethical complaints against members, they usually refer them to the national ACA Ethics Committee. On the other hand, the National Association of Social Workers and APA process ethics complaints against members on a local or state level. If an association processes complaints at the local level, information on the proper way to file complaints is available from the association's national office.

### **Unwarranted Complaints**

Standard H.2.f. of the 2005 ACA *Code of Ethics* states, "Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation." This standard provides a foundation for finding counselors in violation of the *Code of Ethics* if they purposefully file a formal ethics complaint against another counselor when they know the complaint is false or if they were not careful to gather and state facts accurately.

### **Inappropriate Discrimination Against Those Who Have Been Complained Against**

Standard H.2.g. of the ACA *Code of Ethics* (2005) attempts to guard against counselors being discriminated against when they have had ethical complaints filed against them, even though the complaints have not yet been resolved. Even the most ethical counselors could have complaints filed against them. All it takes to file a complaint is completing a form and sending it to the proper authorities. In addition, the standard makes an effort to guard against counselors being discriminated against



because they have filed complaints against other counselors. This standard states, “Counselors do not deny persons employment, advancement, admission to academic or other programs, tenure, or promotion based solely upon their having made or their being the subject of an ethics complaint.”

### **Illegal Behavior of Others**

Individuals in our society who know of illegal acts by others are not violating any laws if they choose not to report such activities. In the same manner, counselors who know of illegal acts of other counselors generally do not have to report those illegal acts. A citizen in our country cannot be charged with a crime for refusing or failing to report the criminal act of another person. However, some illegal acts by counselors would be unethical or might violate state licensure statutes or regulations as well. The previous section discusses how to proceed if you believe another counselor is acting unethically.

Counselors might become aware of the following illegal activities by other counselors:

- Lying to health care companies so that clients will get reimbursement for the counselors’ services
- Purposefully not reporting income to the Internal Revenue Service
- Engaging in a sexual relationship with a minor
- Smoking in a building in which smoking is prohibited
- Speeding while driving a car

Obviously, you might decide to report some of these illegal activities even though you are not legally obligated to do so. Some activities might fall into a *gray* area, and you would not even think of reporting others.

Counselors do not have an affirmative duty to report illegal activities of others. However, if they are questioned by police investigators or subpoenaed, they have to answer questions regarding the matter truthfully. Counselors cannot assist individuals who have broken the law if they are attempting to avoid being questioned, arrested, or convicted of a crime they have committed.

### **Cases Are Often Complex**

In this chapter, you have learned that you have an ethical duty to take appropriate action when you have good reason to believe that a fellow counselor is behaving unethically in a way that could cause substantial harm, and that sometimes you might choose to report an illegal activity. You should keep in mind that most real-world ethical and legal problems are very complex and do not lend themselves to easy solutions. A case example is presented in the following section that illustrates some of these complications.

---

## **3 The Case of Bill**

Assume that you are a Licensed Professional Counselor in private practice. In April of the past year you were contacted by Bill, a counselor in the local high school. Bill was calling because he wanted to refer Libby, an 18-year-old student. You made an appointment with Libby and met with her in late April. You counseled her for two more sessions. In mid-May, she called to cancel her next session. While on the phone, she told you that she wanted you to understand why she was canceling and terminating the counseling relationship. She also wanted the reassurance that you would not talk with her school counselor.

## Resolving Legal and Ethical Issues

In response, you reviewed with her the limits of confidentiality and assured her that you would not talk with him, but that if she told you of abuse or threatened harm to herself or others, you would have to report it to authorities. Libby then disclosed that she had been having romantic feelings for Bill for nearly a year and that she was upset and confused about the relationship. You stressed to Libby that this would not be a good time to discontinue counseling. Libby promised to think things over and call you back.

Libby returned for one more session in June, soon after she graduated from high school. She told you that she had decided that she and Bill should just be friends. She also disclosed that although she had not had sexual intimacies with Bill, he had talked of being attracted to her. Libby recalled that she had felt confused when Bill first flirted with her, and now felt that her trust had been betrayed. When you asked her for permission to talk with Bill, she adamantly refused. You encouraged her to talk to the school officials, but again she was adamant in refusing, stating that she didn't want to get him into trouble. She added that she had never told anyone, including her parents, about what had happened and that she didn't want anyone besides you to know about it.

You know Bill personally, although the two of you are not close friends. You see him at meetings of professional associations and local continuing education workshops. You believe that Libby is telling the truth. At the same time, Bill has always impressed you as a competent professional.

- What are your professional and ethical responsibilities to Libby?
  - What are your professional and ethical responsibilities to Bill?
- 

### **Discussion:**

#### **Regarding your responsibilities to Libby:**

- You should try to get more information from Libby regarding the exact behaviors of Bill in an effort to determine whether Bill had behaved inappropriately or whether Libby may have misinterpreted his attention.
- You have an obligation to respect Libby's privacy, unless you determine that she may have been subjected to inappropriate romantic overtures from Bill.
- If you have reason to believe that Bill acted inappropriately, you would have an obligation to take some type of action to ensure that he would be held accountable.

#### **Regarding your responsibilities to Bill:**

- You should assume that Bill has done nothing wrong until you determine in your mind that he may be guilty of inappropriate behavior with Libby.
- If you decide that Bill may have been inappropriate, you should talk to him directly about the situation and hear his side of the story.
- After talking to Bill, if you believe Libby had been substantially harmed, or that Bill may substantially harm other students, then you should take actions to ensure Bill is held accountable for his behavior.

There are a number of issues to consider in Libby's case. This situation lends itself well to consultation with others. If you are a student in a graduate course, try consulting with some of your classmates, supervisors, and professors. If you are a practitioner, you might share the case with a colleague. Try to apply the decision-making strategies you have learned.

### Guidelines for Avoiding Problems

No matter how carefully you practice or how conscientious you are as a professional, there is always a possibility that someone will accuse you of unethical or illegal behavior. Guidelines that have been suggested by Chauvin and Remley (1996) for avoiding problem situations follow:

- Restrict your practice of counseling to your areas of competence (Daniluk & Haverkamp, 1993; Gilbert, 1992).
- Do not sue clients for unpaid fees (Woody, 1988a). Those who are sued by you may, in turn, complain about your competency. If you avoid allowing clients to run up bills with you, collecting fees from them will never become an issue.
- Utilize a thorough and complete client disclosure statement in your practice (Beamish, Navin, & Davidson, 1994; Epperson & Lewis, 1987; Hendrick, 1988; Wheeler & Bertram, 2008).
- Never guarantee or imply a guarantee of outcomes (Woody, 1988a).
- Establish and maintain firm professional boundaries between you and your clients.
- Always use supervision for your practice, even if it is peer supervision (Remley, Benschhoff, & Mowbray, 1987).

We suggest and briefly discuss a few additional guidelines:

- Stay connected with your fellow mental health professionals. Attend meetings of professional organizations and continuing education workshops. Join a peer consultation group that meets regularly. Isolation can create blind spots (Mascari & Webber, 2006), and counselors who are isolated from their colleagues are more prone to burnout and to inappropriately trying to meet their own needs through their relationships with clients.
- Monitor your self-disclosures made in counseling relationships. Check to make sure that you are self-disclosing for the benefit of your clients rather than to have your own needs met. This is one important way to avoid a subtle slide into blurred boundaries and inappropriate dual relationships.
- Document carefully any circumstances and actions taken in difficult or dangerous client situations (such as abuse or threats to harm self or others) (Wheeler & Bertram, 2008).
- Keep current with developments in law and ethics. Ethical standards for the profession are not static, and in every state, laws and rules related to the practice of counseling are constantly changing (Hegarty, 2012). It is vital that you keep abreast of changes in requirements for practice and advances in knowledge in the field.
- It is commonly advised that, when in doubt, you should consult (Melonas, 2011). Decisions made in isolation are rarely as sound as those made in consultation with others. Choose your consultants wisely—fellow mental health professionals for ethical questions, and attorneys for legal questions—and follow their advice.
- Continually monitor your own effectiveness as a counselor. You have an ethical duty to do this (*ACA Code of Ethics*, 2005, Standard C.2.e.), as well as a moral responsibility. You may be familiar with virtue ethics. Virtuous counselors have such an abiding commitment to the ethical values of the profession that they hold themselves accountable even when others do not (Meara, Schmidt, & Day, 1996).

Taylor (1995) has suggested that the following are keys to professional behavior: (a) authentic caring; (b) willingness to examine our own motivations; (c) willingness to tell the truth to ourselves, our peers, and our clients; and (d) willingness to ask for help and to learn. These seem to us to be excellent touchstones for maintaining an ethically and legally sound counseling practice.

### Resolving Legal and Ethical Issues

A further suggestion is to take care of your own mental and emotional health. In our view, it is often the most conscientious counselors who fall prey to mental and emotional exhaustion. It may help to keep in mind that sound practice is not about achieving perfection; rather, it is about taking responsibility for one's actions and keeping client welfare foremost (Welfel, 2010). At the same time, we believe that there is an ethic of self-care. As Corey, Corey, and Callanan (2011) have stated, a key to retaining your vitality as a person and a professional is to realize that you do not have an unlimited capacity to give without replenishing yourself. Attending to your own wellness is fundamental to your ability to assist your clients in achieving emotional health and wellness.

Counselors must take care of themselves legally as well. Professionals who are sued or accused of wrongdoing are not able to function to their maximum potential. We owe it to our clients to protect ourselves legally as we practice, to seek legal advice when it is needed, and to maintain professional liability insurance. By protecting ourselves legally, we are able to help others as professional counselors.

# ACA Code of Ethics

## PREAMBLE

The American Counseling Association is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. ACA members are dedicated to the enhancement of human development throughout the life span. Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

Professional values are an important way of living out an ethical commitment. Values inform principles. Inherently held values that guide our behaviors or exceed prescribed behaviors are deeply ingrained in the counselor and developed out of personal dedication, rather than the mandatory requirement of an external organization.

## ACA CODE OF ETHICS PURPOSE

The *ACA Code of Ethics* serves five main purposes:

1. The *Code* enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members.
2. The *Code* helps support the mission of the association.
3. The *Code* establishes principles that define ethical behavior and best practices of association members.
4. The *Code* serves as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilizing counseling services and best promotes the values of the counseling profession.
5. The *Code* serves as the basis for processing of ethical complaints and inquiries initiated against members of the association.

The *ACA Code of Ethics* contains eight main sections that address the following areas:

Section A: The Counseling Relationship

Section B: Confidentiality, Privileged Communication, and Privacy

Section C: Professional Responsibility

Section D: Relationships with Other Professionals

Section E: Evaluation, Assessment, and Interpretation

Section F: Supervision, Training, and Teaching

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Section G: Research and Publication

Section H: Resolving Ethical Issues

Each section of the *ACA Code of Ethics* begins with an Introduction. The introductions to each section discuss what counselors should aspire to with regard to ethical behavior and responsibility. The Introduction helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the *ACA Code of Ethics*.

When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application.

Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

A brief glossary is given to provide readers with a concise description of some of the terms used in the *ACA Code of Ethics*.

## **SECTION A: THE COUNSELING RELATIONSHIP**

### **Introduction**

Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process.

Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (*pro bono publico*).

### **A.1 Welfare of Those Served by Counselors**

**A.1.a PRIMARY RESPONSIBILITY** The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

**A.1.b RECORDS** Counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures. Counselors include sufficient and timely documentation in their client records to facilitate the delivery and continuity of needed services. Counselors take reasonable steps to ensure that documentation in records accurately reflects client progress and services provided. If errors are made in client records, counselors take steps to properly note the correction of such errors according to agency or institutional policies. (*See A.12.g.7., B.6., B.6.g., G.2.j.*)

**A.1.c COUNSELING PLANS** Counselors and their clients work jointly in devising integrated counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review counseling plans to assess their continued viability and effectiveness, respecting the freedom of choice of clients. (*See A.2.a., A.2.d., A.12.g.*)



**A.1.d SUPPORT NETWORK INVOLVEMENT** Counselors recognize that support networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

**A.1.e EMPLOYMENT NEEDS** Counselors work with their clients considering employment in jobs that are consistent with the overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications, and other relevant characteristics and needs of clients. When appropriate, counselors appropriately trained in career development will assist in the placement of clients in positions that are consistent with the interest, culture, and the welfare of clients, employers, and/or the public.

## **A.2 Informed Consent in the Counseling Relationship**

*(See A.12.g., B.5., B.6.b., E.3., E.13.b., F.1.c., G.2.a.)*

**A.2.a INFORMED CONSENT** Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both the counselor and the client. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

**A.2.b TYPES OF INFORMATION NEEDED** Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be provided with an explanation of its limitations (including how supervisors and/or treatment team professionals are involved); to obtain clear information about their records; to participate in the ongoing counseling plans; and to refuse any services or modality change and to be advised of the consequences of such refusal.

**A.2.c DEVELOPMENTAL AND CULTURAL SENSITIVITY** Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

**A.2.d INABILITY TO GIVE CONSENT** When counseling minors or persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

### **A.3 Clients Served by Others**

When counselors learn that their clients are in a professional relationship with another mental health professional, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

### **A.4 Avoiding Harm and Imposing Values**

**A.4.a AVOIDING HARM** Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

**A.4.b PERSONAL VALUES** Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants.

### **A.5 Roles and Relationships with Clients**

*(See F.3., F.10., G.3.)*

**A.5.a CURRENT CLIENTS** Sexual or romantic counselor–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited.

**A.5.b FORMER CLIENTS** Sexual or romantic counselor–client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. Counselors, before engaging in sexual or romantic interactions or relationships with clients, their romantic partners, or client family members after 5 years following the last professional contact, demonstrate forethought and document (in written form) whether the interactions or relationship can be viewed as exploitive in some way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering such an interaction or relationship.

**A.5.c NONPROFESSIONAL INTERACTIONS OR RELATIONSHIPS (OTHER THAN SEXUAL OR ROMANTIC INTERACTIONS OR RELATIONSHIPS)** Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client. *(See A.5.d.)*

**A.5.d POTENTIALLY BENEFICIAL INTERACTIONS** When a counselor–client nonprofessional interaction with a client or former client may be potentially beneficial to the client or former client, the counselor must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. Such interactions should be initiated with appropriate client consent. Where unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, due to the nonprofessional interaction, the counselor must show evidence of an attempt to remedy such harm. Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community. *(See A.5.c.)*

**A.5.e ROLE CHANGES IN THE PROFESSIONAL RELATIONSHIP** When a counselor changes a role from the original or most recent contracted relationship, he or she obtains informed consent from the client and explains the right of the client to refuse services related to the change. Examples of role changes include

1. changing from individual to relationship or family counseling, or vice versa;
2. changing from a nonforensic evaluative role to a therapeutic role, or vice versa;
3. changing from a counselor to a researcher role (i.e., enlisting clients as research participants), or vice versa; and
4. changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, or therapeutic) of counselor role changes.

## **A.6 Roles and Relationships at Individual, Group, Institutional, and Societal Levels**

**A.6.a ADVOCACY** When appropriate, counselors advocate at individual, group, institutional, and societal levels to examine potential barriers and obstacles that inhibit access and/or the growth and development of clients.

**A.6.b CONFIDENTIALITY AND ADVOCACY** Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

## **A.7 Multiple Clients**

When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately. (*See A.8.a., B.4.*)

## **A.8 Group Work**

(*See B.4.a.*)

**A.8.a SCREENING** Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

**A.8.b PROTECTING CLIENTS** In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.

## **A.9 End-of-Life Care for Terminally Ill Clients**

**A.9.a QUALITY OF CARE** Counselors strive to take measures that enable clients

1. to obtain high quality end-of-life care for their physical, emotional, social, and spiritual needs;

2. to exercise the highest degree of self-determination possible;
3. to be given every opportunity possible to engage in informed decision making regarding their end-of-life care; and
4. to receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice.

**A.9.b COUNSELOR COMPETENCE, CHOICE, AND REFERRAL** Recognizing the personal, moral, and competence issues related to end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help.

**A.9.c CONFIDENTIALITY** Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties. (*See B.5.c., B.7.c.*)

## **A.10 Fees and Bartering**

**A.10.a ACCEPTING FEES FROM AGENCY CLIENTS** Counselors refuse a private fee or other remuneration for rendering services to persons who are entitled to such services through the counselor's employing agency or institution. The policies of a particular agency may make explicit provisions for agency clients to receive counseling services from members of its staff in private practice. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

**A.10.b ESTABLISHING FEES** In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. In the event that the established fee structure is inappropriate for a client, counselors assist clients in attempting to find comparable services of acceptable cost.

**A.10.c NONPAYMENT OF FEES** If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they first inform clients of intended actions and offer clients the opportunity to make payment.

**A.10.d BARTERING** Counselors may barter only if the relationship is not exploitive or harmful and does not place the counselor in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

**A.10.e RECEIVING GIFTS** Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and the counselor's motivation for wanting or declining the gift.

## **A.11 Termination and Referral**

**A.11.a ABANDONMENT PROHIBITED** Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination.

**A.11.b INABILITY TO ASSIST CLIENTS** If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors should discontinue the relationship.

**A.11.c APPROPRIATE TERMINATION** Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary.

**A.11.d APPROPRIATE TRANSFER OF SERVICES** When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

## **A.12 Technology Applications**

**A.12.a BENEFITS AND LIMITATIONS** Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments and other communication devices.

**A.12.b TECHNOLOGY-ASSISTED SERVICES** When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

**A.12.c INAPPROPRIATE SERVICES** When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

**A.12.d ACCESS** Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

**A.12.e LAWS AND STATUTES** Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity and observe all relevant statutes.

**A.12.f ASSISTANCE** Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

**A.12.g TECHNOLOGY AND INFORMED CONSENT** As part of the process of establishing informed consent, counselors do the following:

1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as Informational Technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users including family members and fellow employees who have access to any technology clients may use in the counseling process.
4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.
5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.
6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
7. Inform clients if and for how long archival storage of transaction records is maintained.
8. Discuss the possibility of technology failure and alternate methods of service delivery.
9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.
10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.
11. Inform clients when technology-assisted distance counseling services are not covered by insurance. (*See A.2.*)

**A.12.h SITES ON THE WORLD WIDE WEB** Counselors maintaining sites on the World Wide Web (the Internet) do the following:

1. Regularly check that electronic links are working and professionally appropriate.
2. Establish ways clients can contact the counselor in case of technology failure.
3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
4. Establish a method for verifying client identity.
5. Obtain the written consent of the legal guardian or other authorized legal representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.
6. Strive to provide a site that is accessible to persons with disabilities.
7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.
8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.



## **SECTION B: CONFIDENTIALITY, PRIVILEGED COMMUNICATION, AND PRIVACY**

### **Introduction**

Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

### **B.1 Respecting Client Rights**

**B.1.a MULTICULTURAL/DIVERSITY CONSIDERATIONS** Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

**B.1.b RESPECT FOR PRIVACY** Counselors respect client rights to privacy. Counselors solicit private information from clients only when it is beneficial to the counseling process.

**B.1.c RESPECT FOR CONFIDENTIALITY** Counselors do not share confidential information without client consent or without sound legal or ethical justification.

**B.1.d EXPLANATION OF LIMITATIONS** At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached. (*See A.2.b.*)

### **B.2 Exceptions**

**B.2.a DANGER AND LEGAL REQUIREMENTS** The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. (*See A.9.c.*)

**B.2.b CONTAGIOUS, LIFE-THREATENING DISEASES** When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party.

**B.2.c COURT-ORDERED DISCLOSURE** When subpoenaed to release confidential or privileged information without a client's permission, counselors obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to the client or counseling relationship.

**B.2.d MINIMAL DISCLOSURE** To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

### **B.3 Information Shared with Others**

**B.3.a SUBORDINATES** Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers. (*See F.1.c.*)

**B.3.b TREATMENT TEAMS** When client treatment involves a continued review or participation by a treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

**B.3.c CONFIDENTIAL SETTINGS** Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

**B.3.d THIRD-PARTY PAYERS** Counselors disclose information to third-party payers only when clients have authorized such disclosure.

**B.3.e TRANSMITTING CONFIDENTIAL INFORMATION** Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology. (*See A.12.g.*)

**B.3.f DECEASED CLIENTS** Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

### **B.4 Groups and Families**

**B.4.a GROUP WORK** In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.

**B.4.b COUPLES AND FAMILY COUNSELING** In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual's right to confidentiality and any obligation to preserve the confidentiality of information known.

### **B.5 Clients Lacking Capacity to Give Informed Consent**

**B.5.a RESPONSIBILITY TO CLIENTS** When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

**B.5.b RESPONSIBILITY TO PARENTS AND LEGAL GUARDIANS** Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling

relationship. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

**B.5.c RELEASE OF CONFIDENTIAL INFORMATION** When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard client confidentiality.

## **B.6 Records**

**B.6.a CONFIDENTIALITY OF RECORDS** Counselors ensure that records are kept in a secure location and that only authorized persons have access to records.

**B.6.b PERMISSION TO RECORD** Counselors obtain permission from clients prior to recording sessions through electronic or other means.

**B.6.c PERMISSION TO OBSERVE** Counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.

**B.6.d CLIENT ACCESS** Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the record in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that related directly to them and do not include confidential information related to any other client.

**B.6.e ASSISTANCE WITH RECORDS** When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

**B.6.f DISCLOSURE OR TRANSFER** Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature. (*See A.3., E.4.*)

**B.6.g STORAGE AND DISPOSAL AFTER TERMINATION** Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with state and federal statutes governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. When records are of an artistic nature, counselors obtain client (or guardian) consent with regards to handling of such records or documents. (*See A.1.b.*)

**B.6.h REASONABLE PRECAUTIONS** Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death. (*See C.2.h.*)

## **B.7 Research and Training**

**B.7.a INSTITUTIONAL APPROVAL** When institutional approval is required, counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

**B.7.b ADHERENCE TO GUIDELINES** Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

**B.7.c CONFIDENTIALITY OF INFORMATION OBTAINED IN RESEARCH** Violations of participant privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner. They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected. Regardless of the degree to which confidentiality will be maintained, investigators must disclose to participants any limits of confidentiality that reasonably can be expected. (*See G.2.e.*)

**B.7.d DISCLOSURE OF RESEARCH INFORMATION** Counselors do not disclose confidential information that reasonably could lead to the identification of a research participant unless they have obtained the prior consent of the person. Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved. (*See G.2.a., G.2.d.*)

**B.7.e AGREEMENT FOR IDENTIFICATION** Identification of clients, students, or supervisees in a presentation or publication is permissible only when they have reviewed the material and agreed to its presentation or publication. (*See G.4.d.*)

## **B.8 Consultation**

**B.8.a AGREEMENTS** When acting as consultants, counselors seek agreements among all parties involved concerning each individual's rights to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

**B.8.b RESPECT FOR PRIVACY** Information obtained in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

**B.8.c DISCLOSURE OF CONFIDENTIAL INFORMATION** When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation. (*See D.2.d.*)

## SECTION C: PROFESSIONAL RESPONSIBILITY

### Introduction

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the *ACA Code of Ethics*. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors advocate to promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

### C.1 Knowledge of Standards

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

### C.2 Professional Competence

**C.2.a BOUNDARIES OF COMPETENCE** Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. (*See A.9.b., C.4.e., E.2., F.2., F.11.b.*)

**C.2.b NEW SPECIALTY AREAS OF PRACTICE** Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm. (*See F.6.f.*)

**C.2.c QUALIFIED FOR EMPLOYMENT** Counselors accept employment only for positions for which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

**C.2.d MONITOR EFFECTIVENESS** Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors in private practice take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors.

**C.2.e CONSULTATION ON ETHICAL OBLIGATIONS** Counselors take reasonable steps to consult with other counselors or related professionals when they have questions regarding their ethical obligations or professional practice.

**C.2.f CONTINUING EDUCATION** Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. They take steps to maintain competence in the skills they use,

are open to new procedures, and keep current with the diverse populations and specific populations with whom they work.

**C.2.g IMPAIRMENT** Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. *(See A.11.b., F.8.b.)*

**C.2.h COUNSELOR INCAPACITATION OR TERMINATION OF PRACTICE** When counselors leave a practice, they follow a prepared plan for transfer of clients and files. Counselors prepare and disseminate to an identified colleague or “records custodian” a plan for the transfer of clients and files in the case of their incapacitation, death, or termination of practice.

### **C.3 Advertising and Soliciting Clients**

**C.3.a ACCURATE ADVERTISING** When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

**C.3.b TESTIMONIALS** Counselors who use testimonials do not solicit them from current clients nor former clients nor any other persons who may be vulnerable to undue influence.

**C.3.c STATEMENTS BY OTHERS** Counselors make reasonable efforts to ensure that statements made by others about them or the profession of counseling are accurate.

**C.3.d RECRUITING THROUGH EMPLOYMENT** Counselors do not use their places of employment or institutional affiliation to recruit or gain clients, supervisees, or consultees for their private practices.

**C.3.e PRODUCTS AND TRAINING ADVERTISEMENTS** Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices. *(See C.6.d.)*

**C.3.f PROMOTING TO THOSE SERVED** Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. However, counselor educators may adopt textbooks they have authored for instructional purposes.

### **C.4 Professional Qualifications**

**C.4.a ACCURATE REPRESENTATION** Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors



clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training. (*See C.2.a.*)

**C.4.b CREDENTIALS** Counselors claim only licenses or certifications that are current and in good standing.

**C.4.c EDUCATIONAL DEGREES** Counselors clearly differentiate between earned and honorary degrees.

**C.4.d IMPLYING DOCTORAL-LEVEL COMPETENCE** Counselors clearly state their highest earned degree in counseling or closely related field. Counselors do not imply doctoral-level competence when only possessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counseling or related field.

**C.4.e PROGRAM ACCREDITATION STATUS** Counselors clearly state the accreditation status of their degree programs at the time the degree was earned.

**C.4.f PROFESSIONAL MEMBERSHIP** Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of the American Counseling Association must clearly differentiate between professional membership, which implies the possession of at least a master's degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

## **C.5 Nondiscrimination**

Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law. Counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative impact on these persons.

## **C.6 Public Responsibility**

**C.6.a SEXUAL HARASSMENT** Counselors do not engage in or condone sexual harassment. Sexual harassment is defined as sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with professional activities or roles, and that either

1. is unwelcome, is offensive, or creates a hostile workplace or learning environment, and counselors know or are told this; or
2. is sufficiently severe or intense to be perceived as harassment to a reasonable person in the context in which the behavior occurred.

Sexual harassment can consist of a single intense or severe act or multiple persistent or pervasive acts.

**C.6.b REPORTS TO THIRD PARTIES** Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts,

health insurance companies, those who are the recipients of evaluation reports, and others. (See B.3., E.4.)

**C.6.c MEDIA PRESENTATIONS** When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, prerecorded tapes, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that

1. the statements are based on appropriate professional counseling literature and practice,
2. the statements are otherwise consistent with the *ACA Code of Ethics*, and
3. the recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

**C.6.d EXPLOITATION OF OTHERS** Counselors do not exploit others in their professional relationships. (See C.3.e.)

**C.6.e SCIENTIFIC BASES FOR TREATMENT MODALITIES** Counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. Counselors who do not must define the techniques/procedures as “unproven” or “developing” and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm. (See A.4.a., E.5.c., E.5.d.)

## **C.7 Responsibility to Other Professionals**

**C.7.a PERSONAL PUBLIC STATEMENTS** When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession.

## **SECTION D: RELATIONSHIPS WITH OTHER PROFESSIONALS**

### **Introduction**

Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

### **D.1 Relationships with Colleagues, Employers, and Employees**

**D.1.a DIFFERENT APPROACHES** Counselors are respectful of approaches to counseling services that differ from their own. Counselors are respectful of traditions and practices of other professional groups with which they work.

**D.1.b FORMING RELATIONSHIPS** Counselors work to develop and strengthen interdisciplinary relations with colleagues from other disciplines to best serve clients.

**D.1.c INTERDISCIPLINARY TEAMWORK** Counselors who are members of interdisciplinary teams delivering multifaceted services to clients, keep the focus on how to best serve the clients. They participate in and contribute to decisions that affect the well-being of clients by drawing

on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines. (*See A.1.a.*)

**D.1.d CONFIDENTIALITY** When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues. (*See B.1.c., B.1.d., B.2.c., B.2.d., B.3.b.*)

**D.1.e ESTABLISHING PROFESSIONAL AND ETHICAL OBLIGATIONS** Counselors who are members of interdisciplinary teams clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

**D.1.f PERSONNEL SELECTION AND ASSIGNMENT** Counselors select competent staff and assign responsibilities compatible with their skills and experiences.

**D.1.g EMPLOYER POLICIES** The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy conducive to the growth and development of clients.

**D.1.h NEGATIVE CONDITIONS** Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be effected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

**D.1.i PROTECTION FROM PUNITIVE ACTION** Counselors take care not to harass or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practices.

## **D.2 Consultation**

**D.2.a CONSULTANT COMPETENCY** Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed. (*See C.2.a.*)

**D.2.b UNDERSTANDING CONSULTEES** When providing consultation, counselors attempt to develop with their consultees a clear understanding of problem definition, goals for change, and predicted consequences of interventions selected.

**D.2.c CONSULTANT GOALS** The consulting relationship is one in which consultee adaptability and growth toward self-direction are consistently encouraged and cultivated.

**D.2.d INFORMED CONSENT IN CONSULTATION** When providing consultation, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved

about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality. Working in conjunction with the consultee, counselors attempt to develop a clear definition of the problem, goals for change, and predicted consequences of interventions that are culturally responsive and appropriate to the needs of consultees. (*See A.2.a., A.2.b.*)

## **SECTION E: EVALUATION, ASSESSMENT, AND INTERPRETATION**

### **Introduction**

Counselors use assessment instruments as one component of the counseling process, taking into account the client personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using appropriate educational, psychological, and career assessment instruments.

### **E.1 General**

**E.1.a ASSESSMENT** The primary purpose of educational, psychological, and career assessment is to provide measurements that are valid and reliable in either comparative or absolute terms. These include, but are not limited to, measurements of ability, personality, interest, intelligence, achievement, and performance. Counselors recognize the need to interpret the statements in this section as applying to both quantitative and qualitative assessments.

**E.1.b CLIENT WELFARE** Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information these techniques provide. They respect the client's right to know the results, the interpretations made, and the bases for counselors' conclusions and recommendations.

### **E.2 Competence to Use and Interpret Assessment Instruments**

**E.2.a LIMITS OF COMPETENCE** Counselors utilize only those testing and assessment services for which they have been trained and are competent. Counselors using technology assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology based application. Counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision. (*See A.12.*)

**E.2.b APPROPRIATE USE** Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

**E.2.c DECISIONS BASED ON RESULTS** Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of educational, psychological, and career measurement, including validation criteria, assessment research, and guidelines for assessment development and use.

### **E.3 Informed Consent in Assessment**

**E.3.a EXPLANATION TO CLIENTS** Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will

be given in the language of the client (or other legally authorized person on behalf of the client), unless an explicit exception has been agreed upon in advance. Counselors consider the client's personal or cultural context, the level of the client's understanding of the results, and the impact of the results on the client. (*See A.2., A.12.g., F.1.c.*)

**E.3.b RECIPIENTS OF RESULTS** Counselors consider the examinee's welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results. (*See B.2.c., B.5.*)

#### **E.4 Release of Data to Qualified Professionals**

Counselors release assessment data in which the client is identified only with the consent of the client or the client's legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data. (*See B.1., B.3., B.6.b.*)

#### **E.5 Diagnosis of Mental Disorders**

**E.5.a PROPER DIAGNOSIS** Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.

**E.5.b CULTURAL SENSITIVITY** Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders. (*See A.2.c.*)

**E.5.c HISTORICAL AND SOCIAL PREJUDICES IN THE DIAGNOSIS OF PATHOLOGY** Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.

**E.5.d REFRAINING FROM DIAGNOSIS** Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others.

#### **E.6 Instrument Selection**

**E.6.a APPROPRIATENESS OF INSTRUMENTS** Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments.

**E.6.b REFERRAL INFORMATION** If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized. (*See A.9.b., B.3.*)

**E.6.c CULTURALLY DIVERSE POPULATIONS** Counselors are cautious when selecting assessments for culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for the client population. (*See A.2.c., E.5.b.*)

#### **E.7 Conditions of Assessment Administration**

(*See A.12.b., A.12.d.*)

**E.7.a ADMINISTRATION CONDITIONS** Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

**E.7.b TECHNOLOGICAL ADMINISTRATION** Counselors ensure that administration programs function properly and provide clients with accurate results when technological or other electronic methods are used for assessment administration.

**E.7.c UNSUPERVISED ASSESSMENTS** Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring, counselors do not permit inadequately supervised use.

**E.7.d DISCLOSURE OF FAVORABLE CONDITIONS** Prior to administration of assessments, conditions that produce most favorable assessment results are made known to the examinee.

**E.8 MULTICULTURAL ISSUES/DIVERSITY IN ASSESSMENT** Counselors use with caution assessment techniques that were normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and place test results in proper perspective with other relevant factors. (*See A.2.c., E.5.b.*)

## **E.9 Scoring and Interpretation of Assessments**

**E.9.a REPORTING** In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or the inappropriateness of the norms for the person tested.

**E.9.b RESEARCH INSTRUMENTS** Counselors exercise caution when interpreting the results of research instruments not having sufficient technical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee.

**E.9.c ASSESSMENT SERVICES** Counselors who provide assessment scoring and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. The public offering of an automated test interpretations service is considered a professional-to-professional consultation. The formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to the client. (*See D.2.*)

## **E.10 Assessment Security**

Counselors maintain the integrity and security of tests and other assessment techniques consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.



### **E.11 Obsolete Assessments and Outdated Results**

Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose. Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

### **E.12 Assessment Construction**

Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of educational and psychological assessment techniques.

### **E.13 Forensic Evaluation: Evaluation for Legal Proceedings**

**E.13.a PRIMARY OBLIGATIONS** When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records. Counselors are entitled to form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors will define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

**E.13.b CONSENT FOR EVALUATION** Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not counseling in nature, and entities or individuals who will receive the evaluation report are identified. Written consent to be evaluated is obtained from those being evaluated unless a court orders evaluations to be conducted without the written consent of individuals being evaluated. When children or vulnerable adults are being evaluated, informed written consent is obtained from a parent or guardian.

**E.13.c CLIENT EVALUATION PROHIBITED** Counselors do not evaluate individuals for forensic purposes they currently counsel or individuals they have counseled in the past. Counselors do not accept as counseling clients individuals they are evaluating or individuals they have evaluated in the past for forensic purposes.

**E.13.d AVOID POTENTIALLY HARMFUL RELATIONSHIPS** Counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past.

## **SECTION F: SUPERVISION, TRAINING, AND TEACHING**

### **Introduction**

Counselors aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students. Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training.

## **F.1 Counselor Supervision and Client Welfare**

**F.1.a CLIENT WELFARE** A primary obligation of counseling supervisors is to monitor the services provided by other counselors or counselors-in-training. Counseling supervisors monitor client welfare and supervisee clinical performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review case notes, samples of clinical work, or live observations. Supervisees have a responsibility to understand and follow the *ACA Code of Ethics*.

**F.1.b COUNSELOR CREDENTIALS** Counseling supervisors work to ensure that clients are aware of the qualifications of the supervisees who render services to the clients. (*See A.2.b.*)

**F.1.c INFORMED CONSENT AND CLIENT RIGHTS** Supervisors make supervisees aware of client rights including the protection of client privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be used. (*See A.2.b., B.1.d.*)

## **F.2 Counselor Supervision Competence**

**F.2.a SUPERVISOR PREPARATION** Prior to offering clinical supervision services, counselors are trained in supervision methods and techniques. Counselors who offer clinical supervision services regularly pursue continuing education activities including both counseling and supervision topics and skills. (*See C.2.a., C.2.f.*)

**F.2.b MULTICULTURAL ISSUES/DIVERSITY IN SUPERVISION** Counseling supervisors are aware of and address the role of multiculturalism/diversity in the supervisory relationship.

## **F.3 Supervisory Relationships**

**F.3.a RELATIONSHIP BOUNDARIES WITH SUPERVISEES** Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Counseling supervisors avoid nonprofessional relationships with current supervisees. If supervisors must assume other professional roles (e.g., clinical and administrative supervisor, instructor) with supervisees, they work to minimize potential conflicts and explain to supervisees the expectations and responsibilities associated with each role. They do not engage in any form of nonprofessional interaction that may compromise the supervisory relationship.

**F.3.b SEXUAL RELATIONSHIPS** Sexual or romantic interactions or relationships with current supervisees are prohibited.

**F.3.c SEXUAL HARASSMENT** Counseling supervisors do not condone or subject supervisees to sexual harassment. (*See C.6.a.*)

**F.3.d CLOSE RELATIVES AND FRIENDS** Counseling supervisors avoid accepting close relatives, romantic partners, or friends as supervisees.

**F.3.e POTENTIALLY BENEFICIAL RELATIONSHIPS** Counseling supervisors are aware of the power differential in their relationships with supervisees. If they believe nonprofessional

relationships with a supervisee may be potentially beneficial to the supervisee, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counseling supervisors engage in open discussions with supervisees when they consider entering into relationships with them outside of their roles as clinical and/or administrative supervisors. Before engaging in nonprofessional relationships, supervisors discuss with supervisees and document the rationale for such interactions, potential benefits or drawbacks, and anticipated consequences for the supervisee. Supervisors clarify the specific nature and limitations of the additional role(s) they will have with the supervisee.

#### **F.4 Supervisor Responsibilities**

**F.4.a INFORMED CONSENT FOR SUPERVISION** Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which they are to adhere and the mechanisms for due process appeal of individual supervisory actions.

**F.4.b EMERGENCIES AND ABSENCES** Supervisors establish and communicate to supervisees procedures for contacting them or, in their absence, alternative on-call supervisors to assist in handling crises.

**F.4.c STANDARDS FOR SUPERVISEES** Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities. Supervisors of postdegree counselors encourage these counselors to adhere to professional standards of practice. (*See C.1.*)

**F.4.d TERMINATION OF THE SUPERVISORY RELATIONSHIP** Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Reasons for withdrawal are provided to the other party. When cultural, clinical, or professional issues are crucial to the viability of the supervisory relationship, both parties make efforts to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

#### **F.5 Counseling Supervision Evaluation, Remediation, and Endorsement**

**F.5.a EVALUATION** Supervisors document and provide supervisees with ongoing performance appraisal and evaluation feedback and schedule periodic formal evaluative sessions throughout the supervisory relationship.

**F.5.b LIMITATIONS** Through ongoing evaluation and appraisal, supervisors are aware of the limitations of supervisees that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, or state or voluntary professional credentialing processes when those supervisees are unable to provide competent professional services. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions. (*See C.2.g.*)

**F.5.c COUNSELING FOR SUPERVISEES** If supervisees request counseling, supervisors provide them with acceptable referrals. Counselors do not provide counseling services to supervisees.

Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning. (*See F.3.a.*)

**F.5.d ENDORSEMENT** Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

## **F.6 Responsibilities of Counselor Educators**

**F.6.a COUNSELOR EDUCATORS** Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession, are skilled in applying that knowledge, and make students and supervisees aware of their responsibilities. Counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior. (*See C.1., C.2.a., C.2.c.*)

**F.6.b INFUSING MULTICULTURAL ISSUES/DIVERSITY** Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

**F.6.c INTEGRATION OF STUDY AND PRACTICE** Counselor educators establish education and training programs that integrate academic study and supervised practice.

**F.6.d TEACHING ETHICS** Counselor educators make students and supervisees aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum. (*See C.1.*)

**F.6.e PEER RELATIONSHIPS** Counselor educators make every effort to ensure that the rights of peers are not compromised when students or supervisees lead counseling groups or provide clinical supervision. Counselor educators take steps to ensure that students and supervisees understand they have the same ethical obligations as counselor educators, trainers, and supervisors.

**F.6.f INNOVATIVE THEORIES AND TECHNIQUES** When counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as “unproven” or “developing” and explain to students the potential risks and ethical considerations of using such techniques/procedures.

**F.6.g FIELD PLACEMENTS** Counselor educators develop clear policies within their training programs regarding field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision and inform site supervisors of their professional and ethical responsibilities in this role.

**F.6.h PROFESSIONAL DISCLOSURE** Before initiating counseling services, counselors-in-training disclose their status as students and explain how this status affects the limits of confidentiality. Counselor educators ensure that the clients at field placements are aware of the services

rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process. (*See A.2.b.*)

## **F.7 Student Welfare**

**F.7.a ORIENTATION** Counselor educators recognize that orientation is a developmental process that continues throughout the educational and clinical training of students. Counseling faculty provide prospective students with information about the counselor education program's expectations:

1. the type and level of skill and knowledge acquisition required for successful completion of the training;
2. program training goals, objectives, and mission, and subject matter to be covered;
3. bases for evaluation;
4. training components that encourage self-growth or self-disclosure as part of the training process;
5. the type of supervision settings and requirements of the sites for required clinical field experiences;
6. student and supervisee evaluation and dismissal policies and procedures; and
7. up-to-date employment prospects for graduates.

**F.7.b SELF-GROWTH EXPERIENCES** Counselor education programs delineate requirements for self-disclosure or self-growth experiences in their admission and program materials. Counselor educators use professional judgment when designing training experiences they conduct that require student and supervisee self-growth or self-disclosure. Students and supervisees are made aware of the ramifications their self-disclosure may have when counselors whose primary role as teacher, trainer, or supervisor requires acting on ethical obligations to the profession. Evaluative components of experiential training experiences explicitly delineate predetermined academic standards that are separate and do not depend on the student's level of self-disclosure. Counselor educators may require trainees to seek professional help to address any personal concerns that may be affecting their competency.

## **F.8 Student Responsibilities**

**F.8.a STANDARDS FOR STUDENTS** Counselors-in-training have a responsibility to understand and follow the *ACA Code of Ethics* and adhere to applicable laws, regulatory policies, and rules and policies governing professional staff behavior at the agency or placement setting. Students have the same obligation to clients as those required of professional counselors. (*See C.1., H.1.*)

**F.8.b IMPAIRMENT** Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others. (*See A.1., C.2.d., C.2.g.*)

## **F.9 Evaluation and Remediation of Students**

**F.9.a EVALUATION** Counselors clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for

both didactic and clinical competencies. Counselor educators provide students with ongoing performance appraisal and evaluation feedback throughout the training program.

**F.9.b LIMITATIONS** Counselor educators, throughout ongoing evaluation and appraisal, are aware of and address the inability of some students to achieve counseling competencies that might impede performance. Counselor educators

1. assist students in securing remedial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions to require them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures. (*See C.2.g.*)

**F.9.c COUNSELING FOR STUDENTS** If students request counseling or if counseling services are required as part of a remediation process, counselor educators provide acceptable referrals.

## **F.10 Roles and Relationships Between Counselor Educators and Students**

**F.10.a SEXUAL OR ROMANTIC RELATIONSHIPS** Sexual or romantic interactions or relationships with current students are prohibited.

**F.10.b SEXUAL HARASSMENT** Counselor educators do not condone or subject students to sexual harassment. (*See C.6.a.*)

**F.10.c RELATIONSHIPS WITH FORMER STUDENTS** Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members foster open discussions with former students when considering engaging in a social, sexual, or other intimate relationship. Faculty members discuss with the former student how their former relationship may affect the change in relationship.

**F.10.d NONPROFESSIONAL RELATIONSHIPS** Counselor educators avoid nonprofessional or ongoing professional relationships with students in which there is a risk of potential harm to the student or that may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisee placement.

**F.10.e COUNSELING SERVICES** Counselor educators do not serve as counselors to current students unless this is a brief role associated with a training experience.

**F.10.f POTENTIALLY BENEFICIAL RELATIONSHIPS** Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; hospital visits; providing support during a stressful event; or mutual membership in a professional association, organization, or community. Counselor educators engage in open discussions with students when they consider entering into relationships with students outside of their roles as teachers and supervisors. They discuss with students the rationale for such interactions, the



potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time-limited and initiated with student consent.

### **F.11 Multicultural/Diversity Competence in Counselor Education and Training Programs**

**F.11.a FACULTY DIVERSITY** Counselor educators are committed to recruiting and retaining a diverse faculty.

**F.11.b STUDENT DIVERSITY** Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing diverse cultures and types of abilities students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

**F.11.c MULTICULTURAL/DIVERSITY COMPETENCE** Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice. Counselor educators include case examples, role-plays, discussion questions, and other classroom activities that promote and represent various cultural perspectives.

## **SECTION G: RESEARCH AND PUBLICATION**

### **Introduction**

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research programs.

### **G.1 Research Responsibilities**

**G.1.a USE OF HUMAN RESEARCH PARTICIPANTS** Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants.

**G.1.b DEVIATION FROM STANDARD PRACTICE** Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when a research problem suggests a deviation from standard or acceptable practices.

**G.1.c INDEPENDENT RESEARCHERS** When independent researchers do not have access to an Institutional Review Board (IRB), they should consult with researchers who are familiar with IRB procedures to provide appropriate safeguards.

**G.1.d PRECAUTIONS TO AVOID INJURY** Counselors who conduct research with human participants are responsible for the welfare of participants throughout the research process and should take reasonable precautions to avoid causing injurious psychological, emotional, physical, or social effects to participants.

**G.1.e PRINCIPAL RESEARCHER RESPONSIBILITY** The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

**G.1.f MINIMAL INTERFERENCE** Counselors take reasonable precautions to avoid causing disruptions in the lives of research participants that could be caused by their involvement in research.

**G.1.g MULTICULTURAL/DIVERSITY CONSIDERATIONS IN RESEARCH** When appropriate to research goals, counselors are sensitive to incorporating research procedures that take into account cultural considerations. They seek consultation when appropriate.

## **G.2 Rights of Research Participants**

*(See A.2, A.7.)*

**G.2.a INFORMED CONSENT IN RESEARCH** Individuals have the right to consent to become research participants. In seeking consent, counselors use language that

1. accurately explains the purpose and procedures to be followed,
2. identifies any procedures that are experimental or relatively untried,
3. describes any attendant discomforts and risks,
4. describes any benefits or changes in individuals or organizations that might be reasonably expected,
5. discloses appropriate alternative procedures that would be advantageous for participants,
6. offers to answer any inquiries concerning the procedures,
7. describes any limitations on confidentiality,
8. describes the format and potential target audiences for the dissemination of research findings, and
9. instructs participants that they are free to withdraw their consent and to discontinue participation in the project at any time without penalty.

**G.2.b DECEPTION** Counselors do not conduct research involving deception unless alternative procedures are not feasible and the prospective value of the research justifies the deception. If such deception has the potential to cause physical or emotional harm to research participants, the research is not conducted, regardless of prospective value. When the methodological requirements of a study necessitate concealment or deception, the investigator explains the reasons for this action as soon as possible during the debriefing.

**G.2.c STUDENT/SUPERVISEE PARTICIPATION** Researchers who involve students or supervisees in research make clear to them that the decision regarding whether or not to participate in research activities does not affect one's academic standing or supervisory relationship. Students or supervisees who choose not to participate in educational research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

**G.2.d CLIENT PARTICIPATION** Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether or not to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

**G.2.e CONFIDENTIALITY OF INFORMATION** Information obtained about research participants during the course of an investigation is confidential. When the possibility exists that others may obtain access to such information, ethical research practice requires that the possibility, together with the plans for protecting confidentiality, be explained to participants as a part of the procedure for obtaining informed consent.

**G.2.f PERSONS NOT CAPABLE OF GIVING INFORMED CONSENT** When a person is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

**G.2.g COMMITMENTS TO PARTICIPANTS** Counselors take reasonable measures to honor all commitments to research participants. (*See A.2.c.*)

**G.2.h EXPLANATIONS AFTER DATA COLLECTION** After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

**G.2.i INFORMING SPONSORS** Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

**G.2.j DISPOSAL OF RESEARCH DOCUMENTS AND RECORDS** Within a reasonable period of time following the completion of a research project or study, counselors take steps to destroy records or documents (audio, video, digital, and written) containing confidential data or information that identifies research participants. When records are of an artistic nature, researchers obtain participant consent with regard to handling of such records or documents. (*See B.4.a, B.4.g.*)

### **G.3 Relationships with Research Participants (When Research Involves Intensive or Extended Interactions)**

**G.3.a NONPROFESSIONAL RELATIONSHIPS** Nonprofessional relationships with research participants should be avoided.

**G.3.b RELATIONSHIPS WITH RESEARCH PARTICIPANTS** Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited.

**G.3.c SEXUAL HARASSMENT AND RESEARCH PARTICIPANTS** Researchers do not condone or subject research participants to sexual harassment.

**G.3.d POTENTIALLY BENEFICIAL INTERACTIONS** When a nonprofessional interaction between the researcher and the research participant may be potentially beneficial, the researcher must

document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant due to the nonprofessional interaction, the researcher must show evidence of an attempt to remedy such harm.

#### **G.4 Reporting Results**

**G.4.a ACCURATE RESULTS** Counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator that may have affected the outcome of a study or the interpretation of data. They describe the extent to which results are applicable for diverse populations.

**G.4.b OBLIGATION TO REPORT UNFAVORABLE RESULTS** Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

**G.4.c REPORTING ERRORS** If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum, or through other appropriate publication means.

**G.4.d IDENTITY OF PARTICIPANTS** Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data is adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

**G.4.e REPLICATION STUDIES** Counselors are obligated to make available sufficient original research data to qualified professionals who may wish to replicate the study.

#### **G.5 Publication**

**G.5.a RECOGNIZING CONTRIBUTIONS** When conducting and reporting research, counselors are familiar with and give recognition to previous work on the topic, observe copyright laws, and give full credit to those to whom credit is due.

**G.5.b PLAGIARISM** Counselors do not plagiarize, that is, they do not present another person's work as their own work.

**G.5.c REVIEW/REPUBLICATION OF DATA OR IDEAS** Counselors fully acknowledge and make editorial reviewers aware of prior publication of ideas or data where such ideas or data are submitted for review or publication.

**G.5.d CONTRIBUTORS** Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to

research or concept development in accordance with such contributions. The principal contributor is listed first and minor technical or professional contributions are acknowledged in notes or introductory statements.

**G.5.e AGREEMENT OF CONTRIBUTORS** Counselors who conduct joint research with colleagues or students/supervisees establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

**G.5.f STUDENT RESEARCH** For articles that are substantially based on students' course papers, projects, dissertations or theses, and on which students have been the primary contributors, they are listed as principal authors.

**G.5.g DUPLICATE SUBMISSION** Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in another journal or published work are not submitted for publication without acknowledgment and permission from the previous publication.

**G.5.h PROFESSIONAL REVIEW** Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors use care to make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and use care to avoid personal biases.

## SECTION H: RESOLVING ETHICAL ISSUES

### Introduction

Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that these standards are upheld.

Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work. They engage in ongoing professional development regarding current topics in ethical and legal issues in counseling.

### H.1 Standards and the Law

(See F.9.a.)

**H.1.a KNOWLEDGE** Counselors understand the *ACA Code of Ethics* and other applicable ethics codes from other professional organizations or from certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

**H.1.b CONFLICTS BETWEEN ETHICS AND LAWS** If ethical responsibilities conflict with law, regulations, or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations, or other governing legal authority.

## **H.2 Suspected Violations**

**H.2.a ETHICAL BEHAVIOR EXPECTED** Counselors expect colleagues to adhere to the *ACA Code of Ethics*. When counselors possess knowledge that raises doubts as to whether another counselor is acting in an ethical manner, they take appropriate action. (See *H.2.b.*, *H.2.c.*)

**H.2.b INFORMAL RESOLUTION** When counselors have reason to believe that another counselor is violating or has violated an ethical standard, they attempt first to resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

**H.2.c REPORTING ETHICAL VIOLATIONS** If an apparent violation has substantially harmed, or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when counselors have been retained to review the work of another counselor whose professional conduct is in question.

**H.2.d CONSULTATION** When uncertain as to whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities.

**H.2.e ORGANIZATIONAL CONFLICTS** If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics*. When possible, counselors work toward change within the organization to allow full adherence to the *ACA Code of Ethics*. In doing so, they address any confidentiality issues.

**H.2.f UNWARRANTED COMPLAINTS** Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

**H.2.g UNFAIR DISCRIMINATION AGAINST COMPLAINANTS AND RESPONDENTS** Counselors do not deny persons employment, advancement, admission to academic or other programs, tenure, or promotion based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.



### **H.3 Cooperation with Ethics Committees**

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation. Counselors are familiar with the *ACA Policy and Procedures for Processing Complaints of Ethical Violations* and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

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## Contact Information

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# Contact Information

## **Counseling Professional Associations**

### **American Counseling Association (ACA)**

5999 Stevenson Avenue  
Alexandria, VA 22304-3300  
800/442-2648

Fax 800/473-2329

membership@counseling.org (e-mail)

www.counseling.org (Web page)

All divisions of the American Counseling Association may be contacted at this address.

## **National Certifying Boards for Counselors**

### **National Board for Certified Counselors (NBCC)**

3 Terrace Way, Suite D  
Greensboro, NC 27403-3660  
336/547-0607

Fax 336/547-0017

nbcc@nbcc.org (e-mail)

www.nbcc.org (Web page)

NBCC offers the National Certified Counselor (NCC) credential.

Those who hold the NCC may also earn the following specialized credentials:

- Certified Clinical Mental Health Counselor (CCMHC)
- National Certified School Counselor (NCSC)
- Master Addictions Counselor (MAC)
- NBCC Approved Clinical Supervisor (ACS)

### **Commission on Rehabilitation Counselor Certification (CRCC)**

1835 Rohlwing Road, Suite E  
Rolling Meadows, IL 60008  
847/394-2104

Fax 847/394-2108

www.crc certification.com (Web page)

CRCC offers the Certified Rehabilitation Counselor (CRC) credential.

#### Contact Information

CRCC also offers the following specialized credentials:

- Master Addictions Counselor (MAC)
- Clinical Supervisor (CS)

#### **Agencies That Accredite Counseling Facilities**

##### **Commission on Accreditation of Rehabilitation Facilities (CARF)**

4891 E. Grant Road  
Tucson, AZ 85712  
520/325-1044  
Fax 520/318-1129

##### **International Association of Counseling Services (IACS)**

101 S. Whiting Street, Suite 211  
Alexandria, VA 22304  
703/823-9840  
Fax 703/823-9843

##### **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
630/792-5000

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## **Counseling Disclosure and Agreement Forms**

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# Counseling Disclosure and Agreement Forms

## CLIENT INFORMATION AND AGREEMENT FOR COUNSELORS IN PRIVATE PRACTICE

\_\_\_\_\_, M.Ed., NCC  
Licensed Professional Counselor (LPC)

I am pleased you have chosen me as your counselor. This document is designed to inform you about my background and to insure that you understand our professional relationship.

I am licensed as a Professional Counselor by the \_\_\_\_\_ Board of Examiners for Licensed Professional Counselors. Only licensed mental health professionals may provide counseling services in this state. In addition, I am certified by the National Board of Certified Counselors, a private certifying agency that recognizes counselors who have distinguished themselves through meeting the board's standards for education, knowledge, and experience.

I hold a Master's (M.Ed.) degree in counseling from the University of \_\_\_\_\_. The graduate program I completed is accredited by the Council on Accreditation of Counseling and Related Education Programs (CACREP).

I have been a counselor since \_\_\_\_\_. I provide services for clients in my private practice who I believe have the capacity to resolve their own problems with my assistance. A counseling relationship between a Professional Counselor and client is a professional relationship in which the Professional Counselor assists the client in exploring and resolving difficult life issues. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. Self-awareness and self-acceptance are goals that sometimes take a long time to achieve. While some clients may need only a few counseling sessions to feel complete, others may require months or even years of counseling. Clients are in complete control and may end our counseling relationship at any point and I will be supportive of that decision. If counseling is successful, clients should feel that they are able to face life's challenges in the future without my support or intervention.

My counseling services are limited to the scheduled sessions we have together. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of a local hospital and request mental health services.

Although our sessions will be very intimate, it is important for you to realize that we have a professional, rather than a personal, relationship. Our contact will be limited to the paid session you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way outside our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role.

My counseling practice is limited to adolescents and adults and includes career, personal, couples, marriage, and group counseling. I also am available for divorce mediation. I will keep confidential anything you say to me with the following general exceptions: you direct me to tell someone else, I determine you are a danger to yourself or others, or I am ordered by a court to disclose information.

In the event you are dissatisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, you may report your complaints to the State of \_\_\_\_\_ Licensed Professional Counselors Board of Examiners, (address, telephone number). I hold license # \_\_\_\_\_.

In return for a fee of \$ \_\_\_\_\_ per session, I agree to provide counseling services for you. Sessions are 50 minutes in duration. It is impossible to guarantee any specific results regarding your counseling goals.

## Counseling Disclosure and Agreement Forms

However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks are acceptable forms for payment. I will provide you with a monthly receipt for all fees paid.

In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session you missed.

If you are a member of an HMO, PPO, or some type of managed health care plan, I can tell you if I am an authorized provider of services under that plan. If I am an authorized provider, services will be provided to you under the terms of that plan's contract. Fees will be billed and collected according to the requirements of that plan. If I am not an authorized provider, you may still receive services from me for a fee, but your plan will not reimburse you for the cost of any of my services. Plans often will reimburse for only a limited number of visits per year. If you exceed that limit, you may still receive services from me, but your plan will not reimburse you for the cost of services that exceed its maximum number of visits.

If you wish to seek reimbursement for my services from your health insurance company, I will be happy to complete any necessary forms related to your reimbursement provided by you or the insurance company. Since you will be paying each session for my services, any later reimbursement from the insurance company should be sent directly to you. Please do not assign any payments to me.

Most health insurance companies will reimburse clients for my counseling services, but some will not. Those that do reimburse usually require that a standard amount be paid by you before reimbursement is allowed and usually only a percentage of my fee is reimbursable. You should contact a company representative to determine whether your insurance company will reimburse you and the schedule of reimbursement that is used.

Health insurance companies usually require that I diagnose your mental condition and indicate that you have an illness before they will agree to reimburse you. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I submit it to the health insurance company.

If you have any questions, feel free to ask. Please sign and date both copies of this form. You keep one and give the other copy to me.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Your Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Counseling Disclosure and Agreement Forms

**CLIENT INFORMATION AND AGREEMENT FOR COUNSELORS EMPLOYED IN AN AGENCY**

\_\_\_\_\_, Community Mental Health Center  
address  
city, state, zip  
telephone number  
\_\_\_\_\_, M.Ed., NCC  
Licensed Professional Counselor (LPC)

\_\_\_\_\_ Community Mental Health Center will be providing counseling services to you and I have been assigned as your counselor. This document is designed to inform you about the services provided by this agency and my background.

\_\_\_\_\_ Community Mental Health Center offers a variety of services, which include the following: \_\_\_\_\_. All residents of \_\_\_\_\_ County are eligible for services.

I am licensed as a Professional Counselor by the \_\_\_\_\_ Board of Examiners for Licensed Professional Counselors. In addition, I am certified by the National Board of Certified Counselors, a private certifying agency that recognizes counselors who have distinguished themselves through meeting the board's standards for education, knowledge, and experience.

I hold a Master's (M.Ed.) degree in counseling from the University of \_\_\_\_\_. The graduate program I completed is accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP).

I have been a counselor since \_\_\_\_\_. A counseling relationship between a Professional Counselor and client is a professional relationship in which the Professional Counselor assists the client in exploring and resolving difficult life issues. I believe that as people become more accepting of themselves, they are capable of finding happiness and contentment in their lives. Self-awareness and self-acceptance are goals that sometimes take a long time to achieve. While some clients may need only a few counseling sessions to feel complete, others may require months or even years of counseling. Clients are in complete control and may end our counseling relationship at any point and I will be supportive of that decision. If counseling is successful, clients should feel that they are able to face life's challenges in the future without my support or intervention. My counseling services are limited to the scheduled sessions we have together. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of a local hospital and request mental health services.

Although our sessions will be very intimate, it is important for you to realize that we have a professional, rather than a personal, relationship. Our contact will be limited to the paid session you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way outside our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role. My counseling practice is limited to adolescents and adults and includes career, personal, couples, marriage, and group counseling. I also am available for divorce mediation.

I will keep confidential anything you say to me with the following general exceptions: you direct me to tell someone else, I determine you are a danger to yourself or others, or I am ordered by a court to disclose information.

In the event you are dissatisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, you may report your complaints to \_\_\_\_\_, my supervisor here at the \_\_\_\_\_ Community Mental Health Center.

The general fee for services at \_\_\_\_\_ Community Mental Health Center is \$75 per session. However, if you apply for a reduction in fees for services based on your family's income, you may be eligible for a reduction in fees. If you are granted a reduction in fees, United Way, a local charitable organization pays the portion of the fees that you cannot afford. Based on your application for a reduction in fees for services, your fees have been established at \$ \_\_\_\_\_ per session.

Sessions are 50 minutes in duration. It is impossible to guarantee any specific results regarding your counseling goals. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

## Counseling Disclosure and Agreement Forms

The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks are acceptable forms for payment. I will provide you with a monthly receipt for all fees paid. In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session you missed. If you are a member of an HMO, PPO, or some type of managed health care plan, I can tell you if this agency is an authorized provider of services under that plan. If this agency is an authorized provider, services will be provided to you under the terms of that plan's contract. Fees will be billed and collected according to the requirements of that plan. If this agency is not an authorized provider, you may still receive services from me for a fee, but your plan will not reimburse you for the cost of any of my services. Plans often will reimburse for only a limited number of visits per year. If you exceed that limit, you may still receive services from me, but your plan will not reimburse you for the cost of services that exceed its maximum number of visits.

If you have any questions, feel free to ask. Please sign and date both copies of this form. You keep one and give the other copy to me.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Your Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**CLIENT INFORMATION AND AGREEMENT  
FOR COUNSELORS WHO EVALUATE INDIVIDUALS**

The purpose of our relationship is for me to gather information from you and to evaluate you so that I will be able to render an opinion regarding the best custody situation for your minor child. This process will work best if you are cooperative in providing me with the information I need and if we maintain a professional relationship throughout the evaluation.

Nothing that we discuss will be confidential. I will be required to give a written opinion to the judge who appointed me to your case. I may use any information in that report that you give to me during the duration of our relationship. In addition, I may be required to testify under oath at legal proceedings regarding interactions we have had and opinions I have rendered.

I guarantee you that I will be fair and unbiased in rendering my opinions in this case. The best interest of your child will guide my decisions.

In the event you feel I am acting in an unfair or biased manner, please have your attorney notify the judge who is presiding in this case and request that the judge determine whether my actions have been unprofessional.

Although I am a Licensed Professional Counselor in this state, I am not serving as your counselor. In the event you feel a need for counseling, I will be happy to refer you to agencies or individuals who might be able to assist you.

If you have any questions, feel free to ask. Please sign and date both copies of this form. You keep one and give the other copy to me.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Your Client's Signature  
Being Evaluated

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



**CLIENT INFORMATION AND AGREEMENT FOR COUNSELORS EMPLOYED  
IN AN AGENCY WHO ARE COUNSELING INVOLUNTARY CLIENTS**

\_\_\_\_\_ Community Mental Health Center  
address  
city, state, zip  
telephone number  
\_\_\_\_\_, M.Ed., NCC  
Licensed Professional Counselor (LPC)

\_\_\_\_\_ Community Mental Health Center will be providing counseling services to you and I have been assigned as your counselor. This document is designed to inform you about the services provided by this agency and my background.

\_\_\_\_\_ Community Mental Health Center offers a variety of services, which include the following: \_\_\_\_\_. All residents of \_\_\_\_\_ County are eligible for services.

You have been required to obtain counseling sessions from this agency by the judge who is handling your criminal case. As your counselor, I will be required to report to your probation officer whether you attended counseling sessions, whether you paid for services received, and whether I believe that you are benefiting from our counseling sessions. As a result, you must understand that anything you say to me in counseling may be transmitted to your probation officer and that I may be required to testify regarding the contents of our sessions at court proceedings regarding your case.

I am licensed as a Professional Counselor by the \_\_\_\_\_ Board of Examiners for Licensed Professional Counselors. In addition, I am certified by the National Board of Certified Counselors, a private certifying agency that recognizes counselors who have distinguished themselves through meeting the board's standards for education, knowledge, and experience.

I hold a Master's (M.Ed.) degree in counseling from the University of \_\_\_\_\_. The graduate program I completed is accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP).

I have been a counselor since \_\_\_\_\_. A counseling relationship between a Professional Counselor and client is a professional relationship in which the Professional Counselor assists the client in exploring and resolving difficult life issues. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. Self-awareness and self-acceptance are goals that sometimes take a long time to achieve. While some clients may need only a few counseling sessions to feel complete, others may require months or even years of counseling. If counseling is successful, clients should feel that they are able to face life's challenges in the future without my support or intervention.

My counseling services are limited to the scheduled sessions we have together. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of a local hospital and request mental health services.

Although our sessions will be very intimate, it is important for you to realize that we have a professional, rather than a personal, relationship. Our contact will be limited to the paid session you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way outside our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role.

My counseling practice is limited to adolescents and adults and includes career, personal, couples, marriage, and group counseling. I also am available for divorce mediation. In the event you are dissatisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, you may report your complaints to \_\_\_\_\_, my supervisor here at the \_\_\_\_\_ Community Mental Health Center.

The general fee for services at \_\_\_\_\_ Community Mental Health Center is \$75 per session. However, if you apply for a reduction in fees for services based on your family's income, you may be eligible for a reduction in fees. If you are granted a reduction in fees, United Way, a local charitable organization pays the portion of the fees that you cannot afford. Based on your application for a reduction of fees for services, your fees have been established at \$\_\_\_\_\_ per session.

## Counseling Disclosure and Agreement Forms

Sessions are 50 minutes in duration. It is impossible to guarantee any specific results regarding your counseling goals. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks are acceptable forms for payment. I will provide you with a monthly receipt for all fees paid.

In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session you missed.

If you are a member of an HMO, PPO, or some type of managed health care plan, I can tell you if this agency is an authorized provider of services under that plan. If this agency is an authorized provider, services will be provided to you under the terms of that plan's contract. Fees will be billed and collected according to the requirements of that plan. If this agency is not an authorized provider, you may still receive services from me for a fee, but your plan will not reimburse you for the cost of any of my services. Plans often will reimburse for only a limited number of visits per year. If you exceed that limit, you may still receive services from me, but your plan will not reimburse you for the cost of services that exceed its maximum number of visits.

Community Mental Health Agency does not participate in any type of health insurance reimbursement. If you have a health insurance policy that reimburses you for mental health services, it is suggested that you seek a provider who is qualified to render those services to you. If you receive services from me at this agency, you will be responsible for the fees for all services received.

If you have any questions, feel free to ask. Please sign and date both copies of this form. You keep one and give the other copy to me.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Your Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**CLIENT INFORMATION AND AGREEMENT FOR COUNSELORS  
EMPLOYED IN A SCHOOL**

Include a statement similar to the one below in a letter to parents at the beginning of the year, orientation materials, etc. The statement could be easily modified to be addressed to students themselves and included in a student handbook.

**"I'm Your Child's School Counselor"**

The counseling program at \_\_\_\_\_ school is designed to assist your child to make the most of his or her educational experiences. As your child's counselor, I am concerned about his or her emotional well-being, academic progress, and personal and social development.

I have a Master's (M.Ed.) degree in school counseling from the University of \_\_\_\_\_. My graduate program is accredited by the American Counseling Association's Council for the Accreditation of Counseling and Related Educational Program (CACREP), the nationally recognized accrediting agency for counseling graduate programs. I am a National Certified Counselor (NCC), National Certified School Counselor (NCSC), and a Licensed Professional Counselor (LPC) in \_\_\_\_\_. In addition, I am certified as a school counselor by the state of \_\_\_\_\_. Before beginning my duties as a counselor at \_\_\_\_\_ school, I held the following positions: \_\_\_\_\_. I currently serve as President of the \_\_\_\_\_ School Counselor Association.

The following specific activities are offered by the counseling program:

1. Periodic classroom lessons related to positive personal growth and development.
  - 2.
  - 3.
- etc.

Reasons that I might contact parents regarding their child include, but are not limited to, the following:

1. Assistance is needed from parents in specific areas to help their children achieve success in school.
  - 2.
- etc.

Unfortunately, I am not able to provide the following services to your child or to parents:

1. Testifying in court in child-custody matters.
  2. Providing intensive long-term counseling services when they are needed by a child.
  - 3.
- etc.

Your child will be participating in the school counseling program on a regular basis. In the event you have questions about the counseling program, please call me at \_\_\_\_\_. I sincerely look forward to working with you in the coming year to help your child have a successful experience in our school.

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## Client Request Form to Transfer Records

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## Client Request Form to Transfer Records

[This form was constructed to meet HIPAA requirements. In the event an agency or practice is not subject to HIPAA requirements, such a form could be simpler.]

I, \_\_\_\_\_ (fill in name of client), hereby request that copies of my counseling records as described below be transferred to the following individual or institution:

\_\_\_\_\_  
(name and address to where records should be transferred)

Only copies of records will be sent that are necessary to fulfill the purpose for which you are requesting this transfer. With that in mind, what is the purpose for requesting that copies of your records be sent? \_\_\_\_\_

Generally, notes made by your counselor after each session (known as *psychotherapy notes*) are not transferred. Would you like for copies of these psychotherapy notes to be sent also?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

Generally, copies of your records are sent one time only as soon as possible, and you would have to complete and sign a form again for additional requests. If you would like to alter this general procedure in any way, please indicate below your preferences:

To the best of your knowledge, when did you begin and end counseling services at this agency?

\_\_\_\_\_ Date Counseling Services Began  
\_\_\_\_\_ Date Counseling Services Ended

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date



## Client Permission Form to Record Counseling Session for Supervision Purposes

I, \_\_\_\_\_ [fill in name of client], hereby give my permission for my counselor, \_\_\_\_\_ [fill in your name], to audiotape/videotape our counseling session \_\_\_\_\_ [fill in date, or if over a period of time, fill in inclusive dates].

I understand that the purpose of this recording is for the clinical supervision of my counselor's work. I understand that only my client's clinical supervisor, \_\_\_\_\_ [fill in name of supervisor], will review the tape and that the tape will be erased after the supervisor has reviewed it.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

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## **Guidelines for Counseling Case Notes**

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## Guidelines for Counseling Case Notes\*

1. Write any case notes that assist you in being a more effective counseling practitioner. Do not hesitate to keep case notes if they help you in being a better counselor.
2. There is no general legal duty to keep case notes but, because maintaining case notes is a standard procedure in the counseling profession, it could be considered unusual if a counselor did not have case notes for a particular case.
3. Always assume any notes you write will someday be read in open court with you and your client present, along with newspaper, radio, and television reporters.
4. Separate your notes into at least two distinct sections: *objective* and *subjective*.
5. In the objective section, record precisely what the client said, what you said, and what you observed. Do not draw any conclusions or enter any speculations at this point. You might entitle this section "Observations."
6. In the subjective section, record any thoughts that you will need for the future: impressions of the client, speculations about the reasons for the client's problems, reminders to yourself of your present thoughts, or plans for the next session would all be acceptable. You might entitle this section "Impressions."
7. Keep case notes in locked file drawers and ensure that only clerical assistants and you have access to your notes. If notes are kept in a computer, be sure they are not accessible to others.
8. There is no general legal principle regarding the length of time you need to keep case notes once they are recorded. However, there are federal statutes that cover certain federally funded projects, hospital and counseling center accreditation standards, and particular agency procedures that require that case notes be kept for certain periods of time. Of course, such statutes, standards, and procedures should be followed if they apply to your case.
9. Regularly destroy your case notes. When you destroy them, be sure no identifying information remains. It is best to shred, burn, or in some other manner totally destroy the records.
10. Because there are no requirements in work settings regarding the length of time for retention, keep case notes as long as you think you might need them. However, you should destroy case notes on a systematic basis. For example, some counselors destroy case notes of terminated clients six months after termination, one year after termination, or three years after termination. It is a good idea to destroy notes only one or two days each year, for example, on every December 31st.
11. When destroying your case notes, do not include those notes in which you have documented steps you have taken to protect yourself in the event you are accused of wrongdoing. Keep these case notes for longer periods of time, perhaps indefinitely.
12. Never, under any circumstances, destroy case notes after you receive a subpoena or if you think you might be receiving a subpoena in the future. Such acts could be interpreted as obstruction of justice and you could be held in contempt of court.

\*Composed by T. Remley

## Clinical Supervision Model Agreement\*

I, Theodore P. Remley, Jr., agree to provide supervision for you for the purposes of becoming a Licensed Professional Counselor in the state of Louisiana.

I am licensed by the state of Louisiana as a Professional Counselor. I am also licensed as a Professional Counselor in Virginia and Mississippi. I hold M.Ed., Ed.S., and Ph.D. degrees in counseling from the University of Florida. I am a National Certified Counselor (NCC). In the past, I have served as a high school counselor, community college counselor, university career counselor, counselor educator, community mental health center counselor, and counselor in private practice. My areas of counseling expertise include personal and social adjustment, relationship issues, career decision making, work adjustment, divorce mediation, anger management, and serious mental illnesses.

It is your responsibility to obtain the degree necessary, meet the specific course content requirements, and complete the required practicum and internship necessary to register our supervision with the Louisiana Licensed Professional Counselors Board of Examiners (LPC Board) so that you may obtain the status of Intern. You must complete the LPC Board "Registration of Supervision" form and include all attachments. I will complete the section of the form for the supervisor, will provide you with a copy of my "Declaration of Practice and Procedures," and will sign where necessary. You must then submit the form to the LPC Board for approval.

The supervision I provide for you will be individual supervision. You will meet with me one hour each week during the time you are completing your required 3,000 hours of supervised experience as a counselor intern. The hourly fee for my services is \$\_\_\_\_\_, which has been set according to a fee schedule based on the income of you and your spouse or partner. This fee schedule will be reviewed annually and adjusted as appropriate. Fees are payable by check before each supervision session begins. In the event you must reschedule a session for some reason, you must notify me 24 hours in advance. If such notice is not received, you must pay the full fee for the missed session plus the fee for the current session prior to the next scheduled session. If you miss a session for circumstances beyond your control and were unable to contact me prior to missing the session, no fee will be charged.

Once our supervision relationship has been approved and you have been granted Intern status, our supervisory relationship will begin. Our professional relationship will be limited to the formal scheduled hours we have agreed to for your supervision. In the event situations occur in your role as counselor in which you need direction and advice, you should consult your immediate supervisor at the site where you are providing counseling services and follow his or her direction. My regular hourly fee for supervision must be paid by you for any telephone or face-to-face consultation requested by you outside our regularly scheduled supervision sessions.

My philosophy of supervision is that my role as your clinical supervisor is to assist you in practicing counseling in the most effective manner possible, given your choice of counseling

\*Note: This agreement was developed specifically to provide supervision to counselors preparing to be licensed as Professional Counselors in Louisiana. It should be modified to reflect the specific purpose and circumstances of a supervision relationship.

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### Clinical Supervision Model Agreement

theories, approaches, and interventions. I will review your work and give you my impressions of your strengths and weakness and will assist you in improving your skills as a counselor. In addition, I will evaluate your work on a continuing basis.

It is your responsibility to notify your administrative supervisor at the site or sites where you are collecting your hours of experience that you are receiving clinical supervision from me. You should explain the nature of our supervisory relationship. If your administrative supervisor wishes to consult with me regarding your work, ask him or her to contact me.

In order for me to supervise you, you must be able to audiotape or videotape one counseling session each week. You must follow any requirements your site or sites may impose regarding these tapes. At each meeting we have, you will provide me with a new tape. During the time the tape is in my possession, I shall ensure no one else has access to it. I will keep information revealed in the tape confidential. I will review the tape before our next meeting and will return the tape to you at that next meeting. It will then be your responsibility to erase or destroy the tape that has been reviewed.

During the time I am serving as your clinical supervisor, I will make every effort to review with you cases that you choose to bring to my attention for consultation. In addition, I will review the tapes you provide to me of counseling sessions. My duty to you is to provide you with professional clinical supervision. However, I will not be responsible for your day-to-day activities as a counseling intern. Your administrative supervisor or supervisors at your site or sites will be responsible for your ongoing counseling activities.

Because I must evaluate your professional performance as a counselor intern, we will not have a personal friendship during the time I am serving as your supervisor. While we may have a congenial and collegial professional relationship and may attend social functions together, we should not include each other in social interactions one of us has initiated. Please do not offer me gifts or invite me to your home or nonprofessional social events you are hosting during the time I am serving as your clinical supervisor.

You must complete a total of 3,000 hours of supervised experience. When you have completed the first 1,000 hours, I will provide you with a written evaluation of your progress and performance, including my determination of whether you are progressing satisfactorily toward your goal of becoming a Licensed Professional Counselor. I will provide you with another written evaluation at the end of the second 1,000 hours. At the end of your total 3,000 hours of supervised experience, I will verify the supervision I have provided to you to the LPC Board and will either recommend or not recommend you for licensure as a Professional Counselor.

I agree to provide clinical supervision to you of your counseling responsibilities in a professional manner to the extent described within this agreement. Our relationship is limited to the terms and conditions set forth herein. Either of us, with a two-week written notice to the other, may cancel this agreement for any reason. In the event the agreement is canceled by either of us, you agree to notify the LPC Board immediately.

By signing below, I am agreeing to provide you with clinical supervision according to the terms of this agreement, and you are agreeing to pay my fee and comply with the terms of this agreement as well.

\_\_\_\_\_  
Theodore P. Remley, Jr.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisee's Signature

\_\_\_\_\_  
Date



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