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Ethical Decision Making for Counselors

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This distance learning coursework was developed for CEUMatrix by Charlotte Chapman, M.S., MAC, CCS, LPC.

This course is reviewed and updated on an annual basis to ensure that the information is current, informative, and state-of-the-art. This package contains the complete set of course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'View Lesson Quitz'.

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About the Instructor:

Charlotte Chapman has been in the addictions field for thirty years. She has practiced as a counselor, supervisor and program director. Charlotte has been teaching ethics for the past twenty years. She has published articles and courses on ethics for addiction professionals and has served on state and national certification boards and ethics committees. Charlotte is a licensed professional counselor, a licensed substance abuse treatment provider, a certified Masters Addictions Counselor (MAC), and a certified clinical supervisor in Virginia. She is currently the director of counseling services at the University of Virginia's Women's Center, where she teaches and supervises graduate counseling students. More information is available at www.chapmantraining.com

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Introduction to the 2025 Edition

A few years ago, I took a course here on CEU Matrix titled *Ethical Decision Making for Counselors*. It went beyond the typical introduction to ethics that is common in most CEU courses. The author, Charlotte Chapman, wrote a course targeting primarily addiction counselors, but it is especially relevant for social workers, mental health counselors, marriage and family therapists, and other professionals in the behavioral health field. This course aims to teach a foundational skill: building a solid ethical framework that extends beyond simple adherence to a professional code (Welfel, 2022).

Ms. Chapman argues that ethical practice begins with self-reflection, moving past the idea of the ethical code as the sole answer to ethical dilemmas. Professionals must understand how their personal values regarding autonomy, justice, and privacy influence decision-making in order to avoid imposing beliefs on clients. Contemporary counseling ethics literature reinforces this position, emphasizing ethical decision making as an active, reflective, and values-informed process rather than a checklist of rules (American Counseling Association [ACA], 2023).

The course further stresses that ethical decisions are rarely made in isolation. Instead, they require collaboration through consultation and supervision, along with careful consideration of the client's cultural, social, and developmental context. This approach aligns with current professional guidance, which highlights the importance of shared responsibility, documentation, and cultural responsiveness in ethical practice (ACA, 2023; Welfel, 2022).

Key takeaways from the course content:

- Ethical practice demands more than compliance with a professional code; it requires reflection, judgment, and accountability (Welfel, 2022).
- The foundation of ethical practice is self-awareness and recognition of personal values and biases (Welfel, 2022).
- Ethical decisions must be informed by the client's cultural context and lived experience (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).
- Ethical challenges require consultation and supervision rather than isolated decision-making (ACA, 2023).
- Understanding core ethical theories strengthens decision-making beyond intuition alone (Welfel, 2022).

<u>The Belmont Report (National Commission, 1979): Relevance to Ethical Decision-Making for Counselors</u>

For Social Workers and Mental Health Professionals entering the substance abuse treatment field, the ethics of Addiction Counseling may be slightly confusing. Common ground for almost all of the behavioral health professions is the Belmont Report.

The Belmont Report (National Commission,1979) is one of the most influential ethics documents in the United States, establishing a clear structure for how professionals should understand and protect the rights and welfare of individuals. Although originally written to guide research with human participants, its core principles—Respect for Persons, Beneficence, and Justice (NASW, 2021)—extend far beyond research settings. For counselors, these principles align closely with the ethical foundations explored in this course and help deepen the counselor's understanding of professional responsibility, client rights, and equitable care.

Respect for Persons

Respect for Persons emphasizes two ideas: individuals must be treated as autonomous agents, and those with diminished autonomy (ACA, 2014) deserve additional protections. In counseling, this principle maps directly onto autonomy (2014), informed consent, and the ethical requirement to support client self-determination. While the Belmont Report (National Commission, 1979) addressed research subjects, the clinical parallel is clear: clients must be given accurate information, space to make informed choices, and opportunities to express preferences throughout treatment—not just during intake.

This principle also reminds counselors to evaluate the unique vulnerabilities of each client. Individuals coping with trauma, addiction, developmental limitations, or acute psychological distress may require additional safeguards and a more deliberate informed-consent process. By embedding this principle into counseling practice, clinicians maintain awareness of power differentials and avoid subtle forms of coercion, especially in mandated or institutional settings. Respect for Persons ultimately reinforces that autonomy is not a procedural task but a continuous ethical commitment that requires self-reflection and vigilance on the part of the counselor.

Beneficence

The Belmont Report frames beneficence as an obligation to maximize benefits and minimize harms. This aligns directly with the counseling principles of beneficence and nonmaleficence discussed earlier in the course. Counselors routinely make decisions that require weighing risks and benefits—determining when to break confidentiality, when to refer to a higher level of care, or how to proceed with vulnerable clients whose symptoms may intensify as therapy deepens.

By incorporating the Belmont lens, professionals are encouraged to approach these decisions systematically rather than relying on intuition. Beneficence prompts counselors to consider the client's welfare broadly—emotionally, culturally, and socially. It also emphasizes that harm is not limited to overt actions; it may stem from omissions, inadequate training, or providing treatment outside one's competence. In fields such as

addiction treatment, where clients often face heightened medical, psychological, and environmental risks, the Belmont perspective highlights the necessity of careful assessment, consultation, and ethical vigilance.

Justice

Justice (NASW, 2021), the third Belmont principle, focuses on fairness and equitable distribution of risks and benefits. In counseling, justice expands beyond basic nondiscrimination and speaks to the need for equitable access to services, culturally responsive care, and awareness of systemic barriers that shape client outcomes.

Counselors often serve populations affected by poverty, stigma, racial disparities, and limited mental health resources. Integrating Belmont's concept of Justice encourages counselors to reflect on institutional and societal inequities that influence treatment decisions. It supports ethical considerations around referral practices, waitlists, priorities for scarce resources, and the responsibility to advocate for underserved communities. Justice also underscores the importance of avoiding biases—conscious or unconscious—that may affect how counselors assess, diagnose, or engage with clients.

Alignment With the Course's Ethical Framework

The Belmont Report naturally aligns with the six ethical principles identified in this course. Respect for Persons corresponds with autonomy and discretion; Beneficence aligns with beneficence and nonmaleficence; and Justice parallels the ethical expectation of fairness. Together, these frameworks reinforce a consistent moral foundation that guides clinicians through complex dilemmas.

By integrating Belmont concepts, the course gains greater depth and historical grounding. Because the Report is widely referenced across healthcare disciplines, it also strengthens interdisciplinary collaboration—an essential component of modern counseling practice. Counselors frequently work alongside medical providers, social workers, researchers, and case managers, all of whom use Belmont-derived principles as part of their ethical reasoning.

In Sum

Although developed for research ethics, the Belmont Report offers enduring guidance for counseling professionals. Its principles support client autonomy, strengthen protections for vulnerable individuals, promote fairness in service delivery, and reinforce the counselor's responsibility to do good while avoiding harm.

Introduction

"What the code says is the beginning, not the end of ethical

consideration" (K.Pope)

Professionals who work in health care are often confronted with ethical dilemmas with little time to think about an ethical decision making process. The above- quote speaks to the issue of the need to do more in this process than just consult a code of ethics. Certainly codes are a vital part of ethical decision making, however, this course will examine many of the other elements that compose good ethical practice.

Several writers on this topic have suggested that an essential part of ethical decision-making involves self-reflection on the part of the therapist. To begin this process, please complete the following self-inventory. The purpose of this is to focus on some of the topics that will be discussed in this course and to provide an opportunity for reflection on personal values and beliefs regarding the helping relationship.

Self-Inventory

1. My primary professional identity is:
   a. psychologist
   b. counselor
   c. doctor/nurse
   d. social worker
   e. other

2. The ethical principle that is most emphasized in my professional training is:
   a. beneficence
   b. autonomy
   c. non-maleficence
   d. discretion

3. The most important part of the ethical decision making process is:
   a. following my code of ethics
   b. consulting with supervisor/colleagues
   c. following my own instincts
   d. prevention of harm to clients

4. The way I determine if client harm may occur is:
   a. based on my clinical training and experiences
   b. discuss the situation with the client
   c. consult with my supervisor/colleagues
   d. review my code of ethics

5. The most important quality for a helping professional to have is:

a. discretion
b. compassion
c. integrity
d. humility

6. Dual relationships are:
   a. always unethical
   b. can be therapeutic in some situations
   c. always illegal
   d. cause for consultation with a supervisor/colleague

7. Make a list of the reasons you entered the helping profession:

8. Now reflect on what personal values are evident in those reasons. How might those values impact your ethical decision-making?

Please discuss this self-inventory with a trusted colleague or the course instructor via email. Ethical decision-making is a process that should not occur in isolation. The answers to this survey will hopefully give you some insight and awareness about one of the key factors of this process: you, the helping professional.

Clarifying Terms

Since the audience for this course is helping professionals in general, the clarification of terminology might be helpful. The terms counselor, therapist, practitioner, and helping professional will be used interchangeably as will counseling, therapy, and helping relationship. Some professionals use patient or consumer to refer to clients; but for the purposes of this course, the term client will be used.

Morals will be used to refer to the right and proper conduct that occurs in the context of a culture or community. **Ethics** are principles adopted by an individual or group, such as, a profession or organization, to provide rules/guidelines for right conduct. Those rules are called codes of ethics. Whereas morals apply to any member of the culture or community, a code of ethics applies only to those members of the specific group. In some cultures, what is moral is determined by religious values. Ethics are based on a standard of behavior that is nonreligious. **Virtues** are desirable personal characteristics. They are not related to skill or behaviors so much as character, desire and motivation. Virtues are about who a person is rather than how that person may act. Virtues cannot be regulated. Some codes of ethics do include mention of virtues expected of members, such as personal self-awareness, but in general, codes refer to behaviors.

Values are entities or ideas that have worth and are seen as promoting the good life or the good society. Some philosophers use the term moral values to refer to humanly caused benefits that we provide to one another.

"Counselors and their clients center on issues of value and the meaning of life as they search out solutions for problems, goals and strategies related to this meaning. They use their own interpretation of what is good, bad, right, wrong and painful in their experiences and realities to guide them. These understandings are called values." (Cottone and Tarvydas, p. 121)

Laws are rules developed under the authority of a state, court or federal body. Statutes are the laws passed by a legislative body. An example of this is the law that requires the reporting of child abuse. Case law is laws that are prescribed by a court. An example of this is Tarasoff v. Regents of the University of California. Liability is a legal term and refers to a professional's responsibility to clients to perform competently. Four criteria must exist in order for the court to support the liability charge:

- The professional had a duty to the client
- The professional breached a duty to the client
- Evidence proves that the client was injured or damaged
- Proof that the injury was caused by the professional's breach of duty

Regulations are guidelines prescribed by a governing authority for a specific group. Regulations can be promulgated by private groups, like counselor certification boards or a professional association, and have no statutory authority. Regulations can also be promulgated by state and federal boards and agencies that do have statutory authority. The regulations only apply to the group for which they are promulgated. For example, the regulations for marriage and family counselors do not apply to someone who does not identify with this profession or hold this license. The most recent federal regulations that impact counseling are the Health Insurance Portability and Accountability Act (HIPPA).

Standards of practice are the minimal standard of behavior that is expected from a professional. In a liability suit, the standard of practice will be used to evaluate the counselor's professional judgment and conduct. The standards of practice are established through testimony of professionals who are considered experts in their field. Standards of practice are also influenced by ethical standards, state laws, cultural factors, and interpretations of case law.

Ethical Theories

Helping professionals would not attempt to practice their profession without a good grounding in psychological and/or counseling theories. However many professionals engage in ethical decision making without any knowledge of ethical theories. Theories give a foundation to why we may think or act in a particular way with clients. For example, if you believe the good of the many clients is more important than the good of one, that belief is based on a theory. How this theory

might look in practice is when a professional or agency sets limits on a set number of sessions for a client; resources are scarce and need to be distributed equally.

A brief discussion of ethical theories is covered in this section, with some questions for professionals to consider that will increase awareness of how these theories may impact practice.

Utilitarianism

Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873) are two of the authors associated with this theory. The main principle of utilitarianism is that humans should act in ways that will produce the most benefit to humanity; however, the greatest good was defined differently by each philosopher. Bentham thought the greatest good for humans is pleasure, defined as when a state of deprivation is replaced by fulfillment. Bentham proposed that we tally the consequences of each action we perform and thereby determine on a case by case basis whether an action is morally right or wrong. This aspect of Bentham's theory is known as *act-utilitarianism*. In addition, he proposed that we tally the pleasure and pain which results from our actions. For Bentham, pleasure and pain are the only consequences that matter in determining whether our conduct is moral. This aspect of Bentham's theory is known as *hedonistic utilitarianism*. Mill believed that happiness is the greatest good and defined this as the realization of goals. His form of utilitarianism is known as rule-oriented. This focuses on the consequences or outcomes of behavior to determine whether or not it is ethical. Even if someone's intention is ethical, if the outcome does not promote the greatest good that would be considered unethical within this theory. Further, utilitarianism proposes that humans are responsible for all of the consequences of their choices. Therefore, ethical decision-making would involve an examination of the good vs. bad outcomes.

A clinical example of the use of this theory would be that a counselor decides it is in the greatest good of society to respond to a subpoena to testify in court about a client's treatment, even though the client has not given the counselor permission to do so.

Questions to consider:

1. What are some examples in your practice where you have acted for the greater good of society in conflict with an individual client's good?
2. If you haven't, what are some situations where you think you might act this way?
3. Identify your own values in deciding which situations you would act this way or not.

Contract theory

Kant (1724-1804) is the philosopher most known for this theory. The main premise of contract theory is that moral life is about duty and that any moral

action is universal. Kant believed that there is a moral foundational principle of duty that encompasses our particular duties. It is a single, self-evident principle of reason that is called the "categorical imperative." A categorical imperative mandates an action; for example, “treat people as an end, and never as a means to an end.” Newton (1989) interpreted this theory to mean that the principles we use are the ones we would like applied to ourselves. To paraphrase, “do unto others as you would have them do unto you”.

A clinical example would be that a counselor who holds the value of justice would advocate for all clients for services regardless of the consequences.

Questions to consider:

1. What are some examples in your practice where contract theory has been applied?
2. If not, where would you like to see it applied? And how would you go about doing that?

Virtue Theory

Aristotle (384-322 B.C.) proposed that virtues are those strengths of character that promote human development. His definition of this has been interpreted by later writers to mean the results from actualizing human potential. This theory proposes that a virtuous person is not interested in outcomes but instead chooses actions because they have value. Plato described four virtues, which were later called *cardinal virtues*: wisdom, courage, temperance, and justice. In addition, these virtues are considered important in this theory: fortitude, generosity, self-respect, good temper, and sincerity. Virtue theory also includes the importance of moral education since it is believed that these traits are developed during childhood/adolescence. Adults are considered responsible for teaching and modeling these virtues for the young. After Aristotle, religious leaders developed a list of virtues which became part of Christianity; *theological virtues*: faith, hope, and charity.

A counselor practicing virtue theory would protect the privacy of a client because s/he believed in the intrinsic value of that privacy and would do so even if facing negative consequences, i.e. legal sanctions.

Question to consider:

1. What virtue ethics do you apply in your practice?

In reviewing these first three theories, the focus is on a relationship that is expert driven. In other words, one person or persons has the “right” answer. These theories have caused debate about certain issues: who defines the greatest good? who decides whether an action is moral?; who defines the virtues? However, these theories are often used as the basis for ethical codes and ethical decision-making models. Part of the debate is that these are seen as outdated and lacking contemporary relevance. Helping professionals today are dealing

with complex and diverse clients, fiscal accountability, legal mandates and shrinking resources. These theories were developed during a simpler time of healthcare services; however, it is clear to see that the values and belief systems from them still influence our ethical decision making. A few more theories will be briefly discussed which may be more helpful with current practice.

Care-based Ethics

In 1982, Carol Gilligan published a research project in which she had replicated Lawrence Kohlberg's research (1969) on moral development. Kohlberg had proposed a model of moral development based on his research that supported ethical decision-making based on general principles and "moral logic". However, this theory was based on a study of eighty-four boys. Gilligan used the same research design and focused on females instead. From her work, Gilligan concluded that females use a care-based ethic as opposed to a principle-based ethic.

Care-based ethics is based on connectedness in relationships. This theory proposes that ethical decision-making should be done within the context of the relationships central to the ethical dilemma. This theory moves away from the expert-based theory into a more collaborative model.

A counselor practicing care-based ethics might act in the following way. If served with a subpoena, the counselor would discuss the pros and cons of responding with the client. Even if the counselor and client disagreed, the client would understand the reasoning of the counselor's decision and efforts are made to preserve the helping relationship.

Question to consider:

1. Are there any ways in which you have practiced this ethical theory?

Ethical Relativism

Protagoras (480-411 BC) was a Greek philosopher who originated this theory based on the belief that moral standards originate from cultural norms.
This is in contrast to the theory that there are ideal moral standards and a "right" way to do things (ethical absolutism). Ethical relativism states that moral actions should be based on reality, i.e. how people/cultures really live as opposed to a philosophy or an abstract value. This theory states there is no "one truth" and that moral values differ from culture to culture.

Hinman (1997), a more current author on this theory, suggests that ethical relativism is based on:

- tolerance and understanding for each other
- recognition of moral diversity
- a non-judgmental approach to morality
- acceptance that reasonable people may differ on what is morally acceptable

However, an important concern with this approach is that it doesn't offer specific guidelines for decision-making when different cultures interact and are in conflict with their morals. Hinman states that ethical pluralism (see next paragraph) may be a more reasonable theoretical approach considering the recent increase in cross-cultural clinical experiences.

Ethical Pluralism

Somewhere between ethical absolutism and ethical relativism is ethical pluralism. It proposes that there are some universal values that cultures do agree on; for example, having respect and caring for elders. In this theory, cultures agree on those actions that are morally prohibitive; e.g., abuse of elderly. They then agree to tolerate values and actions that have legitimate differences, e.g., elders living in nursing homes rather than with their family. This theory views disagreements as strengths and supports the view that no one culture has all the "right" answers.

For further reading on these theories go to www.ethics.acusd.edu .

Stages of Moral Judgment

In addition to ethical theories, stages of moral development need to be considered as part of the ethical decision-making process. As previously mentioned, Kohlberg (1984) proposes stages of moral development based on his longitudinal research study of eighty-six boys. This work helps to understand how values interact with levels of moral judgment.

Level One: Pre-conventional - Obedience and punishment: fear-based decisions. The focus is on individual needs

Level Two: Conventional - External factors in society are basis of decisions. The conceptions of fairness are based on societal agreement

Level Three: Post-conventional - Belief in universal principles: able to use moral logic as basis of decisions

In Gilligan's work (1982) she noted that if Kohlberg's stages were applied to the responses of females, they (females) appeared to be less morally developed than the males. Therefore different contexts for moral reasoning other than logic and principles exist for females, such as, relationships.

Kohlberg's theory is valuable in that it is based on child development models and provides a framework to think about how people make ethical decisions. It can perhaps be applied to counselor development as well. Beginning counselors are often afraid to do the "wrong" thing and make decisions based on what their

supervisor has told them vs. their own reasoning. (Level one) Hopefully, they move from this stage through the others to where ethical and clinical practice is integrated and decisions are based on client welfare needs. (Level three)

Van Hoose and Paradise (1979) have adapted Kohlberg's stages to counselor development.
Stage 1: Punishment Orientation: focus on consequences of any decision
Stage 2: Institutional Orientation: focus on what higher authorities want
Stage 3: Societal Orientation: focus on duty and welfare of society
Stage 4: Individual Orientation: needs of the individual are weighed against society
Stage 5: Principle or Conscience Orientation: concern for individual welfare is the main focus

Gilligan's work is valuable in that it challenges some of the values inherent in Kohlberg's model and introduces collaboration in relationships as another value to consider in moral reasoning. This should be considered not only a gender issue but also a cultural one. Many cultures, such as American Indians, value preservation of community and relationships over individualistic values. For counselors working with clients in these types of communities, Gilligan's theory of moral reasoning may be more appropriate in addressing ethical dilemmas.
For more information on gender and ethical theories, go to the following website: www.ethics.acusd.edu.

Personal Values

"Values, assumptions, and practices are closely connected. The assumptions we make about people are influenced by our values. If we value self-determination very highly, we are likely to assume that in order to be psychologically healthy, most people should behave autonomously. These ideas, in turn, will influence practice." (Prilleltensky, 1997, p. 519)

There are many ways in which values influence ethical decision-making and clinical practice. Counseling approaches have inherent values. The counselor has personal values. Even a code of ethics is based on a value system. Add to all of this the values of a client, a community or a culture and it becomes clear why values clarification is such an important part of ethical practice.

There are training programs for counselors that caution against allowing personal values into the helping relationship. No matter how much experience or training a professional may have, personal values do exist and can influence practice, especially when addressing ethical concerns. However, a major focus in most training programs for helping professionals is to offer clients objectivity. This implies that the professional sets aside her/his own viewpoint and supports the client's autonomy and self-efficacy. The concern is that professionals will exert undue influence by imposing their own values and because of the imbalance in authority, this can cause harm to clients. However, some writers (Dougherty,

1995) believe that the lack of "moral courage" in therapists and the lack of discussion of moral issues with clients are some of the factors behind the current crisis in the counseling field. "I propose that therapists' failure to attend to the broader moral and community dimension has left psychotherapy vulnerable to being managed as just one more commodity in the healthcare market". (p. 8 To engage in a practice where moral and ethical discussions are the norm, the therapist would have to work hard on self-awareness of her own value system and moral reasoning process.

A suggested approach to discussing values in counseling that may be helpful is to view this issue on a continuum and discuss the pros and cons along this continuum. At one end is the professional who discloses his values to clients as a routine part of the counseling relationship and discusses values throughout the course of treatment. A positive of this approach is that it is good 'informed consent' because he is advising clients about the value system of the person who will be helping them, and then the clients can decide if this is compatible with their beliefs. Clients may even request this information, such as asking a counselor about their faith or religious beliefs. The negatives about this approach would be how to ensure client autonomy in a relationship with such an imbalance of power. Would a client who disagrees with this counselor's value system feel free to speak about that? And if so, how to work with clients who disagree with the professional's value system?

At the other end of the continuum is the professional who never discloses personal information to clients and practices in a neutral way regarding values. The positive of this is that the client is free to explore their own values without undue influence. The danger with this position is that, without adequate supervision, the counselor may lack awareness of personal values that do influence the counseling process. A counselor may believe she is practicing neutrality when stating to a client, "it is your choice to come here or not," but the value the counselor is promoting is autonomy/self-efficacy.

So the middle of this continuum would be the professional who assesses the needs of each client and the clinical situation and chooses to discuss values when it is clearly in the best interest of the client to do so. Examples are an informed consent situation, or when the values conflict renders the professional unable to provide good care. The ethical practice with regard to values is **not** that all counselors be neutral. Rather, the suggestion is that counselors clarify their own values through self-reflection, training and supervision in order to:

- increase awareness of their values and the impact of these values on their practice
- identify when it is clinically appropriate to address the issue of values with clients
- acknowledge values conflicts and determine the best way to address them

Questions to consider:

1. Review your informed consent form and decide whether you need to include any values that are missing.
2. If you were working with a client who held a value that was in conflict with your value system how would you handle it?

There are numerous values conflicts that can occur in the helping relationship. Perhaps the most obvious examples are those with clients whose culture, gender, faith and lifestyle differ from the therapist's. Ethical practice requires that counselors be aware of these differences and how they impact clients' communication patterns and other behaviors.

However, values conflicts arise just as easily with clients from the same culture and background. A client may not value honesty in an intimate relationship to the extent that the counselor does or may have a parenting style that the counselor feels is harmful. Values also impact the counseling relationship through counseling theory and program design. Counseling theories typically emphasize verbal interactions. In fact, non-verbal clients can be labeled as "resistant". Some experiential approaches allow for other forms of interaction but typically, treatment is seen as a verbal process. The belief system inherent in these theories is that it is helpful to talk to someone about personal problems. However, there are families/cultures that would disagree with this value. Instead, they value indigenous healing rituals such as a sweat lodge. This is an example of where clinical skills and cultural awareness are an integral part of an ethical decision-making process. If an ethical issue surfaces with a client from a different culture, the professional needs to be able to discern what the cultural issues are in order to correctly resolve the dilemma. In addition, treatment program design is based on value systems. If family members are required to attend, if group therapy is required, or consultation with a psychiatrist, all of these reflect the value of what professionals believe will be helpful. The ethical concern is when the treatment design does not meet client needs or is in conflict with a cultural norm of the client. Professionals should hold beliefs about a counseling approach and the values inherent in their counseling style. The ethical concern is to ensure that the approach does not compromise client welfare. A potentially unethical practice would be to blame the client because he/she did not fit the treatment approach. A more ethical process is to acknowledge the values and biases inherent in the treatment approach and assess fully the needs of the client.

Prilleltensky (1997) summarizes the values inherent in four approaches used in psychology and how these values influence ethical practice. They are as follows:

Traditional Approaches

(Examples: psychoanalytic; object-relations)
Values: Promote caring and self-determination of individuals. Major value emphasis is helping the individual, not communities or society. Good life and good society are based on value-free liberalism and individualism. Ethics are

defined as rules of conduct to be followed in delivering services. Autonomy is valued over other principles such as moral responsibility to others.
Potential benefits: Preserves values of individuality and freedom.
Potential risks: Victim-blaming (individual is responsible for problems) and no confrontation of unjust social practices and structures. Solutions are personal not societal. It is an expert driven model; the therapist has the answers.

Empowering Approaches

(Examples: feminist therapy; community psychology)
Values: Promote human diversity and self-determination of individuals and marginalized groups. Good life is based on ideas of personal control. Good society is based on rights and entitlements. Ethics are based on individual and societal principles, such as, distributive justice. Ethical concerns are for the well-being of people and extend beyond individual clients.
Potential benefits: Addresses sources of personal and collective injustices. “Assert your rights and fight this”.
Potential risks: Pursuit of own empowerment at expense of others. Can still be an expert driven model especially if the therapist is pushing this belief system. Client may not want to focus on injustice in society.

Postmodern Approaches

(Example: When a family-systems theory states that any family structure can be adaptive and therefore there is no “norm” for the definition of a family)
Values: Promotes human diversity and self-determination of individuals through collaboration and participation. Good life is associated with pursuit of identity. The legitimacy of professional ethics is questioned. Moral frameworks are subjective and constantly evolving.
Potential benefits: Values identity and the importance of context and diversity. “Others may see this as a problem but you should do whatever works well for you and your family”.
Potential risks: Skepticism and lack of a consistent moral vision regarding society.

Emancipatory Communitarian Approaches

(Example: Prilleltensky offers this definition for communitarian psychology: “Community members, clients and psychologists would collaborate in setting the agenda for personal or social change, and interventions would be primarily proactive and directed at social systems” (p. 529). This is a combination of communitarian and emancipation theories.)

Values: Promote balance between self-determination and distributive justice. Concern for both the well-being of individual and communities. Good life and good society are based on mutuality, social obligations, and removal of oppression. Ethics based on societal principles, such as, concern for the health needs of the entire community not just an individual client (distributive justice).
Potential benefits: Promote sense of community and addresses societal inequities. “Do what is best for this community”.

Potential risks: Sacrifice of personal uniqueness for good of the community.

Question to consider:
1. Based on these theories, which one do you identify as most prevalent in your approach or that of your treatment agency?

<u>Codes of Ethics</u>

The self-inventory asked which profession you identify with because values are also reflected in professional identity and in that professions' code of ethics. All helping professionals have a code of ethics: that is in fact one of the factors that defines a profession. These codes may look similar because they are all based on general ethical principles. These principles will be discussed fully in the next section. However, codes can differ in the professional values that are emphasized. Two codes, social work and the National Board for Certified Counselors, are discussed here as examples.

National Association of Social Workers

"The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living."

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

National Board of Certified Counselors

"The NBCC Ethical Code applies to all those certified by NBCC regardless of any other professional affiliation. Persons who receive professional services from certified counselors may elect to use other ethical codes which apply to their counselor. Although NBCC cooperates with professional associations and credentialing organizations, it can bring actions to discipline or sanction NBCC certificants only if the provisions of the NBCC Code are found to have been violated. NBCC promotes counseling through certification. In pursuit of this mission, the NBCC:

- Promotes quality assurance in counseling practice

- Promotes the value of counseling
- Promotes public awareness of quality counseling practice
- Promotes professionalism in counseling
- Promotes leadership in counseling

These are two very different codes. They both do a good job of explaining their mission and clarifying their values. This also illustrates the need for caution in judging another professional's behavior as "unethical" unless that professional's code has been reviewed. To summarize, differences in codes, theory of treatment, and value systems could make one professional's conduct appear unethical to another, but when examined within a context, the reverse may be true.

As stated in the opening quote for this course, codes of ethics are only one of the resources professionals have to assist in the ethical decision-making process. A professional could be in trouble if relying only a code to resolve problems because of several issues:

- Codes are written by members of a professional association. In looking at just two examples above, the value system of the professionals who wrote these codes is obvious.
- Codes are written as general guidelines. It would be impossible to include all of the information all professionals would need to meet the demands of a complex clinical situation.
- Codes can be in conflict with laws, community standards and cultural practices.
- Codes are minimal, mandatory standards. Hopefully, professionals aspire to practice above these levels.

For example, a counselor practicing mandatory ethics is someone who has a client under the age of 18 sign a written consent form for the counselor to consult with the client's parents. Although the law may allow for the counselor of a minor client to talk with parents at any time, a counselor practicing aspirational ethics respects the integrity of the counseling relationship and asks for the client's permission.

Codes are also problematic because they tend to be reactive rather than proactive. It takes a considerable amount of time for a group of professionals to write and come to a consensus about a code. Frequently, professionals are already working on solving problems that the code has yet to address. Because issues arise so rapidly, it is difficult for codes to always be current.

An additional concern with a code of ethics has to do with virtue ethics, discussed in the definition section of this course. As mentioned, virtue ethics cannot be regulated. These are personal attributes of a counselor, such as self-awareness, that are essential to an ethical decision-making process. All codes are based on the principle of non-maleficence, "do no harm". However, complaints are reported

to ethics committees and credentialing boards, indicating that there are professionals who act in ways that harm clients. This is an example of a professional lacking in virtue ethics.

In conclusion, professionals should always consult their code of ethics as it is a good resource in providing minimum guidelines for practice. Codes provide a sense of moral community in that all members are bound by these guidelines and have a responsibility to clients and each other to fulfill the expectations within the code. However, a code of ethics should not be the only resource used when trying to resolve an ethical dilemma for all of the reasons noted in this section.

Assignment:
Please go to www.nbcc.org and click on the link for ethics

Read the code and identify sections that illustrate the following:
1. Mandatory ethics
2. Aspirational ethics

Ethical Principles

The code that will be used for this course is the National Board for Certified Counselors located at www.nbcc.org.

Kitchener (1984) proposed that ethical decision making for psychologists should be based on ethical principles and not just personal value judgments. She identified the principles of autonomy, beneficence, non-maleficence, justice and fidelity. For the purpose of this course, six principles will be discussed: autonomy, beneficence, competence, discretion, justice and non-maleficence.

Autonomy

“”When counseling is initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and clearly indicate limitations that may affect the relationship as well as any other pertinent information. Counselors take reasonable steps to ensure that clients understand the implications of any diagnosis, the intended use of tests and reports, methods of treatment and safety precautions that must be taken in their use, fees, and billing arrangements.” (Section B: 8)

Autonomy is the principle that supports the self-efficacy of the client.

This means that the client has the choice to accept treatment or not and is given complete information to make a decision regarding treatment. When counselors provide informed consent to clients they are practicing this ethical principle. As is noted in the NBCC code, this process occurs throughout the counseling process,

not just in the first session. The following are some guidelines for good informed consent:

- Confidentiality of the relationship and records (these are two different legal entities)
- Situations which could lead to violation of client's confidentiality rights
- Qualifications of the helping professional, including code of ethics
- Benefits and possible harm of any treatment approach
- Expectations of client's behavior and if there are any conditions under which treatment will be refused
- Financial arrangements including how insurance/managed care is handled, cancellation guidelines, resolution of disputes
- What to do in an emergency: definition of an emergency can also be helpful
- Any other professional who may be involved in the treatment; for example, if you practice as a multi-disciplinary team

This is just a brief list of suggestions. In order to decide what else is needed in a particular setting, ask "What would I want and need to know if I were my client?"

<u>Ethical Dilemmas with Autonomy</u>

Professionals may find it challenging to practice this ethical principle with some client populations. It may seem dishonest to suggest to a client you are seeing in jail that he/she has freedom of choice. In fact, supporting some types of autonomy in some settings, such as criminal justice institutions or schools, could cause more problems for clients. This is where good ethical decision making is critical. Upholding the principle of autonomy within the counseling relationship is the ethical expectation with these clients with the additional responsibility of discussing with the client all of the possible consequences of making their own choices in this context. If a student has been sent to counseling by the principal but that student states they do not want counseling, the professional needs to respect this decision and at the same time discuss with the student the possible reactions of the principal to this decision.

In addition to the school setting or criminal justice setting, children and adolescents just by the nature of their developmental issues present ethical dilemmas with this principle. This is also where the helping professional's own value system and clinical approach could impact how he/she applies autonomy. A professional who believes in a family systems approach may resolve a dilemma differently than someone who treats adolescents as individual, independent clients. In addition, children and adolescents have different viewpoints and developmental issues than adults. Their decision-making skills can often put them at risk. Supporting the autonomy of a child or an adolescent could compromise other ethical principles such as client welfare.

There is also the issue of cultural values about autonomy. Self-efficacy and freedom of choice are ideals that are valued predominantly in Western European

cultures. A client from a culture that believes in the good of the community may not understand decisions made by a counselor who is supporting the client's autonomy. In addition, the clinical setting may be an influence in promoting autonomy.

The example of seeing a client in a jail setting has already been discussed. This is a very different setting from that of a private practice.

A counselor providing services in a private practice depends on clients to be functioning fairly autonomously as opposed to clients in correctional settings. And then, there is managed care. Typically these companies have a list of providers so the client is limited with regard to freedom to choose. The model most supported by managed care is that of brief therapy even if this approach does not meet the needs of the client. In addition, the case manager or reviewer for the managed care company has never met or talked with the client and offered the client any choices with regard to services. Licensed or certified counselors working in these positions need to carefully consider how they are upholding the principle of autonomy as do those professionals who contract with managed care and other third party providers. "When certified counselors are engaged in intensive, short-term counseling they must ensure that professional assistance is available at normal costs to clients during and following the short-term counseling" (Section B; 11)

The following case will provide an opportunity to practice ethical decision making with each of the following principles. We will start with autonomy.

<u>Case</u>:
You are a licensed counselor in a college counseling center. Donna, a sophomore, has been sent to you from the Dean's office for an evaluation regarding her mental health status and whether she can make it through the academic year. She is currently on academic probation. Your evaluation reveals that she has a diagnosis of major depression and post-traumatic stress because of a recent sexual assault and is in need of services. You recommend a psychiatric evaluation for medication in order for her to succeed with her classes. When you discuss the results of the evaluation with Donna, she becomes upset. She refuses to sign a release for you to give the Dean a copy of your evaluation because she says "the Dean will think I am crazy and call my parents. Then my parents will make me leave school". Donna says she will see you for counseling but refuses to see a psychiatrist.

1. What are your reactions to this client?
2. How would you respond to her?
3. Does your response support the principle of autonomy?

Beneficence

"The primary obligation of certified counselors is to respect the integrity and promote the welfare of the clients, whether they are assisted individually, in family units, or in group counseling…." (Section B: 1)

Beneficence is the principle of doing good. This is typically why most people enter the helping professions; they want to help others. Beneficence is also one of the principles cited when discussing client welfare issues. It may seem that this would be a simple principle to apply: doing good. It is complicated by two issues, the debate about what constitutes doing good as a therapist, and the definition of client.

<u>Ethical dilemmas with beneficence</u>

As discussed in the ethical theory section, "good" has been defined in different ways by philosophers. This is also true in the helping professions. Theories of counseling differ on what is helpful to clients vs. what is harmful. In the practice of an unethical practitioner, any theory or intervention can be harmful. Helping professionals hopefully are using a specific approach because they believe it will benefit the client. In our case example above, is doing "good" for Donna insisting that she seek the psychiatric evaluation? Or is it letting her schedule another appointment with you?

What are some questions to consider in deciding what is in the best welfare of a client? What is doing good?

1. Is doing good for the client defined by the decrease in symptoms? What about client populations whose symptoms may get worse as they begin counseling? For example, clients with trauma history or addictions.
2. Is doing good defined by the clients' feedback that they like the program or the counselor? What about the clients who report satisfaction but demonstrate no behavior changes?
3. Is doing good refusing to see clients who have relapsed a number of times? And how many times is the limit? Three, five, ten?

The second important issue in discussing beneficence is to clarify who is the client. Codes of ethics do not give guidance as to when a client becomes a client but this is an important guideline for practitioners to establish for themselves or their programs. This is important because once the person is identified as a client, all ethical, clinical and legal obligations begin. First of all, there may be funding guidelines that define the client population. Counselors working in public sector programs who serve everyone in a geographic area may consider all of the legal, tax-paying residents of that area as their clients. Another definition could be anyone who shows up at the clinic asking for services is the client. Some practitioners use the first phone contact as the guide for when someone becomes a client. Others use the point at which the client signs the informed

consent. Whichever guidelines are used, it is important that clients have this information, as well as, clarification by the provider of client loyalties.

If the family is considered the client, there needs to be discussion as to how ethical conflicts will be handled, especially confidentiality issues. One family member could disclose information about another that the counselor is ethically obligated to respond to in some manner. The same could happen in a school setting. Is the client the school? or individual students who meet with the counselor? In addition, it is important to define when a client is no longer considered a client because that is when ethical, clinical and legal obligations end. Some practitioners choose a length of time, such as two years after last contact. There are state legal guidelines regarding the statute of limitations in malpractice cases that some professionals use to determine how long client files are kept and professional obligations remain. If someone who was a client two years ago calls in a crisis, is there an ethical/clinical obligation to respond? This is where a good ethical decision making process would need to take place. Counselors should consult the regulations in their states as well as any state laws and know what the standard of practice is in their area. It is also recommended that practitioners include this information in their informed consent so that clients are aware of the limits of the professional relationship.

Some counseling theories hold that “once a client, always a client”. This is based on the theory of unconscious process. This theory proposes that there are unconscious dynamics, which occur in the therapeutic relationship that continue after the client has completed services. If a professional is practicing from this theory, the length of time is irrelevant. This would mean that the professional still has ethical and clinical obligations to the client. All legal confidentiality mandates support this theory in that there is no time at which a licensed or certified practitioner has permission to divulge information that someone was their client. The only exception to this is in a legal matter in order to prepare a self-defense or to respond to a court order.

There are many other concerns with regard to client welfare. The emergence of evidence-based practices is one area. Practitioners need to carefully review the research to determine if their client population is included in the clinical trials. Professionals must also be adequately trained in these models, most of which require more than just a one-day workshop to gain competence. Funding may be contingent on whether or not an agency is practicing this evidence-based practice so a dilemma could occur between continued funding for a program vs. whether this approach is beneficial to the clients. Another area of concern is the use of third party payment for mental health and substance abuse services. If a particular diagnosis is not covered by the funding source, does the professional change the diagnosis so that the client can have services paid for? Or tell the truth and risk the client not accessing services?

Question to consider:
What other areas of concern can you identify with regard to beneficence?

Returning to the scenario with Donna, review what you said you would do next.
Does this action support the principle of beneficence? If yes, how?
If not, what would you do to change your next step?

Competence

"Certified counselors offer only professional services for which they are trained or have supervised experience. No diagnosis, assessment, or treatment should be performed without prior training or supervision. Certified counselors are responsible for correction of any misrepresentations of their qualifications by others"(Section A: 6)

This is the principle that requires professionals to have the knowledge, skills, and abilities to be of help to clients. When professionals practice within the areas that they are trained and credentialed, they are practicing ethically. Some examples of unethical practice are:

- Accepting a client that you know you do not have the training or expertise to treat
- Advertising that you have a credential you do not have
- Lack of referral of a client who presents additional issues in treatment that are outside your area of expertise

Some states have definitions of scope of practice for the state issued credentials so this can be used as a guideline as well.

<u>Ethical Dilemmas with competence</u>
One of the concerns with this principle is how to develop guidelines to determine when someone meets the ethical standards of competence. The process of obtaining a graduate degree is used by some as a measure of competence. There are some standards set by academic credentialing bodies so that psychology programs or counseling programs have some similarities but there are also enough differences in these programs that this is not the only measure that should be used for competence. Others believe that credentials such as certification or license are a good measure of competence. In addition, clinical experience can be used as a measure of competence. However, a professional could hold appropriate credentials and have years of experience but still not be competent in providing services for a specific population, such as eating disorders. "What the states license is the absence of deficiencies, rather than the presence of competencies" (Procidano, Busch-Rossnagel, Reznikoff and Geisinger, 1995).

Question to consider:
What are the guidelines you use to determine if you are competent to treat a client?

Haas and Malouf (1995) recommend these two questions: (1) “Am I emotionally able to help the client?” (2) “Could I justify my decision to a group of my peers?”

Typically codes and credential regulations require ongoing education as part of the ethical practice of competence. However, it is usually left up to the individual as to what type of ongoing education he/she pursues. “Certified counselors recognize the need for and seek continuing education to assure competent services” (Section A: 7)

Mandatory ethics, aspirational ethics and virtue ethics were discussed in the first section of this course. Continuing education is a good example of these three theories to discuss. A professional may obtain the required number of hours of training for a credential, thus practicing mandatory ethics for the principle of competence. However, this same counselor realizes she needs additional training with regard to a special area of practice that was not covered in the requirements. Her value is to be proficient at what she does so she seeks the additional training. This is practicing virtue ethics and aspirational ethics.

Another dilemma with competence is that of impairment. “Certified counselors have an obligation to withdraw from the practice of counseling if they violate the Code of Ethics, or if the mental or physical condition of the certified counselor renders it unlikely that a professional relationship will be maintained” (Section A: 15). A professional could be very well trained, knowledgeable and have abilities but be unable to perform. It is hard to self-monitor this principle. That’s why having ongoing consultations or working within a team of professionals is critical. Employee assistance programs and professional peer assistance programs are also possible resources for help with impairment. An impairment can be temporary and, once medical attention is received, the professional can practice ethically. Other impairments may require the professional to stop practicing in order to be in compliance with this principle.

“NCCs who offer and/or provide supervision must: Ensure that they have the proper training and supervised experience through contemporary continuing education and/or graduate training.” (Section C: a)

For those professionals who also serve as administrators or supervisors, personnel guidelines should be developed for addressing impairment to ensure that all staff is treated the same. Being in a supervisory role can present many ethical dilemmas but definitely around the issue of competence. “Word of mouth” accusation from other counselors can influence how a supervisor treats someone but legal guidelines typically indicate that there has to be documentation to show impact on work performance. For example, a supervisor may know that a staff

has problems with depression and then hears from others that this staff member has stopped taking anti-depressant medication. The supervisor may not be able to take action on this information until there is a demonstration of a decline in work performance.

It is also an ethical dilemma for counselors who are promoted to a supervisory position and do not yet have the knowledge and skills to be a supervisor. These are different from the competency areas of a counselor. When accepting a new position for which a professional is not yet fully qualified, it is recommended that a learning plan needs to be in place with time lines for achieving areas of competence.

Questions to consider:

1. If a client or another professional asked you about your competency to do what you do, how would you respond?
2. Are there areas you have overlooked in your practice that you need to further your education in? what is your learning plan?

(For further information on supervisor competency guidelines, go to www.siv.edu/~epse1/aces .This is the site for the Association of Counseling Educators and Supervisors)

Case:
In the case scenario with Donna, some of the competency issues are:

- Have you been trained in treating trauma? depression?
- Do you have training in working with this age group?
- What other areas do you identify?

Discretion

"The counseling relationship and information resulting from it remains confidential, consistent with legal and ethical obligations of certified counselors…"(Section B: 16)

The obvious value system inherent in this ethical principle is that clients have the right to privacy. Counselors do not discuss with anyone that someone is a client nor do they discuss information that is revealed in therapy sessions without following specific legal and ethical guidelines. This is practicing the principle of discretion.

Ethical dilemmas with discretion

This is the principle that can cause numerous ethical dilemmas because of conflict with laws as well as clinical practice or the professional's own value system. Many codes have incorporated sections that state exceptions to the principle of discretion as well as advising that professionals should follow local, state, and federal laws. One of the most common dilemmas is based on the

value conflict of the good of society vs. the good of the individual. In other words, situations when this principle is in conflict with the principle of beneficence. Inherent in these situations is the value that human life must be preserved and that this value is more important than the value of client privacy. That may not be the value the counselor or client holds as most important but it is what this code of ethics uses as criteria for ethical conduct, and it is also what the legal system values as evidenced by duty to warn case law and statutes.

Because of the numerous dilemmas associated with the principle of discretion and legal mandates, it is helpful for counselors to have some knowledge of legal terms. This course cannot provide all of the information needed by professionals so it is recommended that students consult their state laws and receive additional training in HIPPA regulations.

- Privileged communication: The legal right of the client to have information that is given to a counselor protected from disclosure in a court of law without their permission. The degree to which it is protected and which information is protected will differ from state to state by statute. Privilege only applies in individual counseling. It is also questionable whether it will apply to a clinical supervisor. Glosoff, Herlihy and Spence (2000) conducted a search in the United States and published the status of privileged communication laws. (See reference section.)

  Privileged communication was upheld by the United States Supreme Court in Jaffe v. Redmond (1996). This is case law and the ruling would apply only in federal cases or could be cited by professionals in states where there is no privileged communication law.
  (Refer to definition of terms section regarding statutes and case law.)

- Duty to warn: The legal responsibility of the professional to advise a third party if there is imminent danger. The case law that established this concept was Tarasoff v. Regents of the University of California (1976). The court ruled that the professional should have reasonable belief that the client poses a serious danger and that there needs to be an identifiable third party. In this case, the court ruled that it was not enough that the psychologist involved contacted local law enforcement. He was held liable for not contacting the party who was threatened. This ruling began the debate regarding standards of practice for where client privilege ends and public welfare begins. Since this ruling, some states have enacted duty to warn statutes that will vary in terms of what is required of the practitioner. For states that do not have duty to warn laws, practitioners typically follow the guidelines established in the Tarasoff case. However, legal consultation is always advisable in situations where a client’s confidentiality will be violated without their permission.

- Duty to protect: Some state statutes may also include the duty to protect. This gives practitioners statutory authority to take action when a client is a danger to self. In other states, this duty may exist in regulations governing professional credentials and licensed programs.

- Duty to report: The legal responsibility of the professional to report mandated situations.

  The most familiar is the child abuse/neglect mandate. The law states that practitioners must report suspected situations. Again, states may vary on other mandated reporting, such as elder abuse, mentally impaired abuse, domestic violence, and impaired professionals.

In conclusion, some of the areas suggested for research in respective states/countries are: (enter key words on your state code website)

- Read the introduction to the legislation to determine if your profession or credential is covered by the law. Look for legislation on privileged communication.
- Look for a duty to warn statute and under what situations you have to report and what options you have
- If you receive federal funds for substance abuse treatment, you must follow federal regulations 42CFR (U.S. Department of Health and Human Services, 1987).
  www.gpo.gov/nara/cfr/indes.html
- If you work in a school setting you must follow the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) in addition to state statutes and school board policies.
  www.cpsr.org/cpsg/privacy/ssn/ferpa.buckley.html
- If you work with minors you need to know if they have the right to access treatment without parental consent. There may be two different statutes, one for mental health treatment and one for substance abuse.
- Some states are enacting statutes to require notification of parents if a child/college student threatens suicide/violence.
- Look for a scope of practice law that defines your area of practice and for the statute of limitations on malpractice suits.

These are some general areas of legal concern that can cause ethical dilemmas. As will be discussed in the ethical decision-making process section, whenever there is an ethical/legal conflict, practitioners are encouraged to seek legal advice.

Thompson (1990) discusses six different interactions between ethics and the law.

- Ethical and legal. This is following a just law that promotes ethical practice.
  Example: Providing access for services for all clients who are eligible. Responding to a subpoena to testify in court when your testimony benefits the client.

- Ethical and illegal. This is breaking a law but acting ethically.
  Example: Refusing to respond to a subpoena because you believe it will harm your client for you to testify in court.

- Ethical and alegal. This is practicing ethically where no law applies.
  Examples: Testifying at your state legislature to increase funding for under-served clients. No law requires that you do this but it is considered good ethical practice to advocate for services.

- Unethical and legal. This is practicing unethically but following a law.
  Example: Responding to a subpoena to testify and when on the stand, revealing more information than is necessary to complete the testimony.

- Unethical and illegal. This is disobeying the law and practicing unethically.
  Example: Failure to report child abuse.

- Unethical and alegal. This is practicing unethically and no law applies.
  Examples: Requiring clients to testify on behalf of a program's funding needs. There is no law that forbids this, but it is exploitation of clients. They have the right to violate their own privacy by admitting to being a client, but the program's request forces this issue.

In addition to legal issues, there are other ethical dilemmas regarding the principle of discretion. Even when legally authorized to release confidential information, helping professionals are expected to have discretion with regards to the content of the information. "Need to know" guidelines are expected, which means, only information is revealed that is relevant to the situation. For example, a client signs a release of information for her parents and one for her psychiatrist. What the professional discusses with the psychiatrist is different than what will be discussed with the parents. These same "need to know" guidelines apply to staff communications and interagency communications. Even when mandated to report, such as child abuse, the professional only discloses the information necessary to make the report. If additional clinical information is sought by the social services agency, the client would need to sign a release or the social services agency would need to obtain a court order. These guidelines are also important when sending information to third-party payers, such as Medicaid or disability reports. Clinicians should only send the minimum amount of information needed to assist the client in receiving reimbursement.

For practitioners working within the legal system or with a caseload of legally mandated clients, it is important to clarify these guidelines with all professionals involved. Employees of the court, regardless of their professional credential, may have different exceptions under a privileged communication statute.

Discretion concerns also arise with regard to confidentiality of records. All codes place the responsibility on the counselor to ensure the protection of client records.

"Records of the counseling relationship….and other documents are to be considered professional information for use in counseling. Records should contain accurate factual data. The physical records are property of the certified counselors or their employers. The information contained in the records belongs to the client and therefore may not be released to others without the consent of the client…." (Section B: 5) In addition here are some recommended guidelines for record keeping. Again, students should have HIPPA training for the most current record keeping guidelines if you are under HIPPA regulations.

- Accurate, written records should be maintained on all clients because it is the documentation of what has occurred in the helping relationship; in a court of law, written records take precedent over verbal reports.
- Records should provide documentation of the counselor's professional judgment , not personal reactions, as well as treatment recommendations and the client's response to treatment.
- There should be no demeaning comments about clients or their family members; any record could one day be read in a public court or be reviewed by a third party payer or professional ethics committee.
- Avoid statements that cannot be proven. For example, "client reports she has been abused" vs. "client has an abusive husband". Unless the practitioner has made a clinical assessment or has other documentation, there is no verification for this statement about the husband.
- As stated in the NBCC Code above, the physical record belongs to the healthcare provider, but the information inside the record can be requested by the client. Some states and agencies limit access to records if it might endanger the client's mental status. Carefully read any contracts with hospitals and third-party payers regarding their rights to access your records.

Technology offers some unique challenges to record-keeping responsibilities. Computerized records must be secure. Fax machines, answering machines, cell phones, laptop computers are all devices that professionals use to benefit clients. However, they must be sure these are secure enough to protect the client's privacy. Here are some suggested guidelines that might be helpful with regard to technology issues and discretion:

- Treat computer files with client information, progress notes and evaluations the same way you would hard copy files.

- Use the informed consent process to discuss with clients any ways in which confidential information could be compromised via technology. For example, if you communicate with clients via email you need to be sure they understand the limits of privacy.
- Document the client's response. If they indicated concern, document what you did to respond to this concern; e.g., agree to communicate by phone only.
- Get client's permission regarding leaving messages on answering machines/voice mail systems at home and work, and discuss the best ways for these messages to be worded. Make a note so you don't forget.
- If you use a cell phone, advise clients of this and what procedure you have for safeguarding their privacy. For example, if you are called while in a public place, what do you do?
- Use caution if using computers in a public place where anyone could see client information.
- If you provide counseling via the internet, please see guidelines established by the American Counseling Association at www.counseling.org .

For further information about HIPPA, go to www.hhs.gov/ocr/privacy/index.html .

Case:
In continuing with the scenario with Donna what are the need to know guidelines for communicating with the Dean? Would you contact the Dean even without Donna's permission? If yes, why; if no, why not. Under what circumstances, if any, would you contact her parents without her permission?

Justice

The ethical principle of justice is about a commitment to fairness in all professional relationships. Equal treatment of clients and equal access to treatment are part of this principle. Non-discrimination is part of all codes of ethics.
"Through an awareness of the impact of stereotyping and unwarranted discrimination, certified counselors guard the individual rights and personal dignity of the client in the counseling relationship" (Section A; 12)
The principle of justice requires that professionals practice non-discrimination. Part of the ethical practice involved with this would be for counselors to increase their own self-awareness and obtain training regarding multi-cultural issues, gender issues, age and lifestyle issues. Lack of knowledge in these areas could lead to a counselor practicing discrimination, overtly or covertly.

Ethical Dilemmas with Justice

As discussed in the section of this course on values, there are traditional mental health approaches that may or may not be helpful for clients with different cultural worldviews. In addition, clients can also be victims of discrimination with regard

to referral source or diagnosis. Clients who are court-ordered are often treated in a different way than a client who self-refers as this client appears more "motivated". Clients who have a co-occurring illness may be seen as more "hopeless" than other clients. This is understandable due to the complicated problems a client with a co-occurring diagnosis often presents. However, therapists are obligated to provide the same standard of care for any client regardless of their diagnosis or referral source. The ethical practice of justice is not that counselors have no bias; that would be inhuman. Rather it requires that counselors be aware of their biases and take steps to address them so that clients are able to access services equally. If professionals are aware of discriminatory practices regarding clients within agencies or by other practitioners, it is their ethical obligation to address this also.

Another one of the ethical dilemmas with this principle is equal access to treatment. Client waiting lists may exist due to lack of staff and adequate funding. This is a reality that conflicts with this principle. Some programs are funded to provide services to a specific population, for example, co-occurring illness, or adolescent clients. These programs are created to address an underserved population and professionals must abide by the funding regulations. Ethical practice does not require every agency to treat every client; however it is important to have a good referral network so that if clients present who do not meet admission criteria, they can still access services elsewhere.

Another dilemma with justice could present when a counselor is following the principle of competency and believes he is not qualified to work with this client's diagnosis, culture or age. This could lead to denying service to some clients. The ethical response, again, is to maintain a good referral network to be able to help clients gain access to qualified providers. This referral network is also the key to ethical practice when trying to follow the Americans with Disability Act. This Act requires that anyone with a disability who is trying to access services must be accommodated.

For more information on the ADA go to
http://www.usdoj.gov/crt/ada/adahom1.htm

Case:
In the case of Donna, would you deny her services? And if so why? What are the other possible ethical concerns regarding justice?

Nonmaleficence

Non-maleficence is the principle of do no harm. The question then is what do we consider harm to a client?

Many professionals, including regulatory bodies and ethics committees, judge harm based on client self-report. If a client believes that she was harmed by the

professional’s behavior, this is considered strong evidence to charge the practitioner with unethical behavior. The NBCC Code of Ethics gives some guidelines for what is considered harmful practice. These will be used as examples in this section.

“Certified counselors know and take into account the traditions and practices of other professional disciplines with whom they work and cooperate fully with such. If a person is receiving similar services from another professional, certified counselors do not offer their own services directly to such a person…” (Section B; 2) This is indicative of a belief that multiple counselors could be harmful to a client’s treatment, especially if the counselors are not communicating about the client’s care or have different approaches. Sometimes clients do not disclose the information that they are receiving services elsewhere. This presents a dilemma when a counselor discovers this information after already initiating treatment. This is another example of a dilemma that would best be resolved by using an ethical decision-making process.

“When certified counselors are engaged in intensive, short-term counseling, they must ensure that professional assistance is available at normal costs to clients during and following the short-term counseling” (Section B; 11) This is referring to harm as abandonment of clients due to your role or your treatment model when the client needs more services.

Ethical dilemmas with nonmaleficence: Dual Relationships

All professional codes of ethics have guidelines regarding dual relationships. A dual relationship is when a client and counselor engage in a second relationship either while the client is in treatment or after the client has ended treatment. This could be a friendship, a romantic relationship, a business relationship or a professional relationship. If a counselor provides treatment to someone they already have a relationship with, like a relative, friend or colleague, this is also considered a dual relationship.

“Certified counselors who have an administrative, supervisory and/or evaluation relationship with individuals seeking counseling services must not serve as the counselor and should refer the individuals to other professionals…Dual relationships that might impair the certified counselor’s objectivity and professional judgment must be avoided and/or the counseling relationship terminated through referral to a competent professional.” (Section B: 9)

Relationships are fluid and rigid boundaries are unrealistic as well as hard to maintain. The main issue with a dual relationship is for the counselor to avoid exploiting the client because of the fact that the person is a client.

Client/counselor relationships exist in many different forms. The nature of this relationship depends on who the client is, how the relationship starts and in what setting, and the ethical and legal responsibilities of the counselor. A licensed

professional counselor who provides in-home services has a different relationship with his clients than a licensed professional counselor in a private practice. However, the same standard of care should exist regarding the principle of do no harm.

Even in a private practice setting where a therapist can clearly define the parameters for the relationship, what was appropriate behavior with a client in the beginning phase of treatment may not be appropriate as the client progresses and ends therapy. For example, when a client is in a crisis state, just entering treatment, a counselor may extend herself by offering additional sessions or spending extra time on the phone to help stabilize the client. This behavior would not be in the best interest of the client when trying to terminate and could be interpreted as boundary violations of the client.

In clarifying ethical behavior within the client/counselor relationship, it is helpful to discuss several issues:

- the contrast of relationship vs. social contact
- the contrast between professional and personal relationships
- boundaries
- objectivity
- clients' needs
- exploitation
- confidentiality

A relationship is not the same as social contact. Social contact is something that happens accidentally; for example, going to a PTA conference and seeing the parent of a client or a client. Unethical behavior can still occur within this type of contact, such as the counselor saying something inappropriate, but it does not constitute a dual relationship. Relationships are typically defined as ongoing, planned and mutual. A counseling relationship may have some of the same characteristics as other relationships; planned meetings which occur frequently; personal information discussed; emotional attachments. This is one of the reasons that entering into a dual relationship can be harmful because of the confusion it causes for both client and helping professional. So in dealing with the ethical dilemmas of dual relationships it is helpful to clarify some things:
Why do clients seek out professional help rather than seeking help from a friend or family member? What are the differences between a client/counselor relationship and a personal relationship?

Here are some guidelines that might help:

Personal Relationships	**Therapeutic Relationships**
Mutual needs met, mutual sharing of personal information	Clients' needs are primary
Access to each other anytime	Access within prescribed limits (Office hours, appointments)
Visit in each others' homes	Visits occur in a prescribed place: professional visits at client's home only to provide services
No payment for listening to problems	Payment involved
No assessment process, treatment plan	Professional obligation to assess, diagnose, write goals, keep written records
No confidentiality obligations	Ethical and legal obligations for confidentiality
No obligation to report information disclosed	Ethical and legal obligations to report certain information
No competency expected in helping with problems	Expectation of knowledge and skills to assist with problems
Limited objectivity	Objectivity expected
Physical touching; sexual needs met	Touching for therapeutic reasons only; no sexual contact

Question to consider:
1. Are there other items you would add to this list?

Since the therapeutic relationship can become confusing, one of the ways to reduce confusion for clients and professionals is to maintain clear and consistent boundaries in the professional relationship. So what are boundaries? Everyone has a comfort level with physical space in terms of how close someone stands to another person, how often someone uses touch, etc. These are physical boundaries. There are also verbal boundaries, like saying the wrong thing at the wrong time. Boundaries in any relationship can be seen on a continuum. There are boundary crossings that occur which may or may not be harmful. A friend can cross a boundary by giving you feedback you did not ask for. The feedback may be helpful, but if said in a hurtful manner, that could be a verbal boundary crossing. If the friend is asked to stop, but continues this behavior, a boundary violation has occurred. These crossings and violations also occur in professional relationships.

For example, seeing a client in another setting like the PTA meeting mentioned previously. Within the professional relationship, the counselor and client may not eat together. But the PTA meeting is having a spaghetti dinner so eating together is expected. This is a boundary crossing that probably does not exploit the client or harm the integrity of the therapeutic relationship. Inviting the client to dinner on a regular basis would be seen as a boundary violation. This is not part of the normal treatment process and instead causes confusion by moving into a more social relationship.

Other areas of boundary crossings that can occur are touching, self-disclosure, giving and receiving gifts, amount of time spent together and special treatment of the client. Within each of these areas, there may be appropriate, therapeutic behaviors. Careful consideration must be given to these boundary crossings as the counselor could move down the continuum and become involved in a boundary violation. The following examples illustrate each of these areas.

- There are clinical assessments that involve asking clients a lot of personal information. This is a boundary crossing that is hopefully not harmful to the client when done with good informed consent and by a competent professional. However, asking clients for more details about something that is not relevant to the clinical assessment, like a sexual encounter, would be a boundary violation.

- Another counseling technique that needs to be monitored for boundary concern is the use of self-disclosure. Again, when used by a competent counselor this can be an effective counseling tool. However, the use of self-disclosure should meet the therapeutic goals of the client and not the personal needs of the professional. Excessive use of self-disclosure by the therapist changes the focus of the professional relationship moving it into a more social, mutual relationship. It can change the nature of the counseling relationship to the point that the client experiences it as a friendship, again, causing confusion.

- The same confusion can occur with gifts. In some cultures, accepting a gift from a client is the respectful, appropriate response and to refuse it could harm the therapeutic relationship. This would be a boundary crossing that is not harmful. Exchanging personal gift items on a regular basis with clients again invites a social aspect into the counseling relationship that can be harmful.

  As with many boundary concerns, professionals need to assess the age, culture, and clinical profile of the client in helping decide the most ethical response. Some counselors include information in their informed consent about their gift policy and request that clients make donations to a worthy cause instead. Some agencies have policies that state their employees may not receive gifts. The problem is that clients do not always follow our policies

and instead, follow cultural norms, such as bringing a gift when the counselor has a baby. Some counselors may be comfortable accepting gifts such as food or homemade items but not items that have a high monetary value.

What is important in managing this boundary issue is to have established guidelines that have been reviewed for ethical and clinical appropriateness and take into account the profile of the clients being served. An example of a client profile that might preclude accepting gifts is court-ordered clients. The gift could be seen as a bribe for a good report to the judge. Any counselors who feel this way should refrain from accepting all gifts from this client population.

- Clients can cross boundaries in the helping relationship. Some clients have histories of being violated or were raised in families where personal boundaries were not valued. They may act out some of this in the treatment process. Codes of ethics and the courts have clarified that even if a client initiates a dual relationship, it is the responsibility of the professional to assess the possible harm of this and to maintain the integrity of the counseling relationship. In other words, professionals cannot defend their actions of engaging in a dual relationship by stating that the client was the one who started the social relationship.

- One of the characteristics listed in the table that differentiates friendships from therapeutic relationships is that the counselor offers objectivity. If the helping professional becomes involved in another relationship with the client, her objectivity as a treatment provider can become compromised. For example, if a client becomes an employee, the counselor has a different kind of emotional investment now because the client is doing something for the counselor. It could be in the client's best interest to accept a job offer and re-locate; but the counselor, as employer, may have difficulty remaining objective or supporting the client's autonomy

- This leads to another important characteristic of a helping relationship; focus on the client's needs. "Certified counselors are aware of the intimacy in the counseling relationship and maintain respect for the client. Counselors must not engage in activities that seek to meet their personal or professional needs at the expense of the client." (Section A; 8)

  Once a professional enters into another type of relationship, as in the previous example of an employee, she is at risk of placing personal needs ahead of client's needs. The nature of a personal relationship is mutuality, so a shift would occur from focusing on the client to mutual needs. For example, the client has been hired to renovate the counselor's office but in counseling sessions it becomes clear that the client's depression is increasing and there is a need for inpatient services. The counselor's need to have the renovation project continue vs. the client's need for services would be in conflict.

- Conflict of needs can lead to exploitation of the client. As previously mentioned, this is the main concern with dual relationships. The client/counselor relationship is seen as a hierarchical relationship where there is an imbalance of power. Anytime there is this type of imbalance in a relationship, there is the potential for abuse and exploitation. In one of the previous examples, the counselor who has hired the client may delay sending this client for needed treatment in order to get the office renovation completed. This is exploitation. Other examples are counselors using client information for self-promotion and/or to increase income such as writing a book with a client; getting free legal advice from a client who is an attorney; asking a client to provide special favors, such as a client who works in a bakery bringing free baked goods.

- One of the other abuses that can occur is the violation of confidentiality. Privacy is another essential aspect of the helping relationship that contributes to treatment effectiveness. If a counselor enters into a social relationship with a client, it may be difficult to monitor which personal information was disclosed within the professional relationship and which was disclosed in the other relationship. As shown in the table comparing the two types of relationships, there are no ethical or legal obligations to keep information confidential that is discussed in social relationships. This would also be a concern in relationships with former clients as there is no time limit on how long a professional must maintain the principle of discretion.

Writers in the field of professional ethics disagree regarding guidelines for dual relationships. Kitchener (1988) believes that therapists cannot accurately predict or monitor all the factors inherent in a dual relationship and therefore should avoid them completely as a client welfare concern. Herlihy and Corey (1992) believe that dual relationships should be reviewed on a case- by- case basis and that to take a rigid position about these relationships is not realistic, especially when considering cultural issues such as those encountered when practicing in rural areas or small communities like a military base.

Questions to consider:

1. Have you engaged in a dual relationship? What were the reasons? What was the outcome?
2. If you have not engaged in a dual relationship do you see any positive reasons that you might do so with your current client population?

In conclusion, obviously practitioners need to monitor this area of ethical practice. If a pattern develops where a counselor is frequently involved in dual relationships, this would be of concern. A standard of practice should exist in the community and agency regarding guidelines for any type of dual relationship.

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Ethical dilemmas with nonmaleficence: Sexual Relationships

To continue with the discussion of boundary violations, one of the most harmful is sexual conduct between a helping professional and a client.

“Sexual exploitation exists on a continuum that begins with poor judgment, proceeds to covert exploitation, and ends with overt sexual exploitation.” (Benowitz, p. 73)

”Sexual intimacy with clients is unethical. Certified counselors will not be sexually, physically, or romantically intimate with clients; and they will not engage in sexual, physical, or romantic intimacy with clients within a minimum of two years after terminating the counseling relationship.” (Section A; 10)

Pope (1990) did a review of the research regarding therapist/client sexual conduct and discovered the following issues that clients have difficulty with after the sexual contact:

(1) ambivalence
(2) guilt
(3) emptiness and isolation
(4) sexual confusion
(5) impaired ability to trust
(6) boundary disturbance and diffusion of identity
(7) emotional lability
(8) suppressed rage
(9) increased suicidal risk
(10) cognitive dysfunction in the areas of intrusive thoughts, flashbacks and nightmares

This list clearly indicates that sexual conduct with a client is in violation of the principle of non-maleficence. Some of the symptoms are those associated with a diagnosis of post-traumatic stress syndrome which would indicate that this sexual contact with a professional is experienced as trauma by some clients. So what type of professional would engage in what is clearly harmful behavior with a client?

Bates and Brodsky (1989) state: “The best single predictor of exploitation in therapy is a therapist who has exploited another patient in the past” (p. 141).

Schoener and Gonsiorek (1989) interviewed counselors who had admitted to being involved sexually with clients. They analyzed their responses and developed profiles which explain the counselors’ actions:

- Uninformed/naïve. Someone who has not been trained.
- Healthy/situation breakdown. Someone who is reacting to a stressful situation and acts out one time.

- Neurotic/socially isolated. Someone with chronic problems and who is over-invested in role as counselor. Sexual behaviors become a part of the intense emotional involvement in the therapy.
- Impulsive/compulsive character disorder. Someone who is careless and has poor judgment. Could also sexually harass staff members as well as clients.
- Sociopathic/narcissistic. Someone who is self-centered and exploitive. Typically a repeat offender who avoids accountability and blames the client for what occurs.
- Psychotic/borderline. Someone whose orientation to reality is questionable. They may accumulate power and develop “therapy cults” before detected, or they may be easily detected because of bizarre thinking and behaviors

Pogrebin, Poole and Martinez (1992) reviewed cases adjudicated by the Colorado State Grievance Board involving psychotherapists who had sexual misconduct charges. In their article they quote responses of these psychotherapists. Some of these quotes are offered here to illustrate the profiles identified by Schoener and Gonsiorek.

- “I did not know that seeing clients socially outside of therapy violated hospital policy.” p. 237. (Uninformed/naïve)
- “I was in the worst depression I had ever experienced in my entire life when we began our sexual involvement.” p. 241 (Situation breakdown)
- “The following situations are not represented as an excuse for my actions…They are simply some of what I feel are circumstances that formed the context for what I believe is an incident that will never be repeated: 1. My mother-in-law who lived with us died. My oldest son and, the next fall, my daughter had left home for college. 2. I dealt with these losses and other concerns in my life by massive over-scheduling.” P. 242 (Socially isolated)
- “I am firmly aware that my judgment at the time was both poor and impaired. I am also aware that my thinking was grandiose and immature…” p. 247 (Impulsive/poor judgment)
- “While my actions were reprehensible, both morally and professionally, I did not mislead or seduce her or intend to take advantage of her. My fault, instead, was failing to adequately safeguard myself from her seductiveness, covert and overt.” P. 241 (Sociopathic or narcissistic)

This information is helpful in identifying some of the reasons sexual violations occur so that prevention strategies can be developed. Also for clinicians and supervisors who may be treating or supervising a counselor who participated in sexual misconduct, this can help with rehabilitation efforts. In conclusion, it is helpful to remember that every offender is not the same.

In addition to the information from Schoener and Gonsiorek another factor that should be considered in all dual relationship and boundary issues is transference and counter-transference.

Transference

Transference is the process in which clients project onto the therapeutic relationship feelings and attitudes that relate to other significant people in their lives, typically authority or intimacy/attachment figures. It can represent a repetition of past conflicts, or it could be a current pattern. One example of a current issue is a client whose father abandoned her family. Every time the counselor is late for an appointment, the client is in crisis, believing the counselor has abandoned her. Clients may experience many reactions to their counselors, such as, love, anger, fear, dependency, shame, hurt. Transference reactions are typically a projected image or experience and not something that has really occurred.

One possibility of what may occur in boundary violations in the client/counselor relationship is that professionals fail to treat these transference reactions as projections from the client's life experiences, and instead, take them personally, thereby acting on them. (Edelwich and Brodsky, 1991).

It should be noted that clients' reactions are not always based on transference. They may be responding to a professional's behavior. For example, a therapist who is always late for appointments may get anger reactions from a client. It would be important to distinguish this reaction from the transference pattern previously mentioned.

Watkins (1983) identified patterns of transference in counseling. The following is a discussion of these patterns and their ethical implications.

1. Counselor as ideal. The counselor is perfect and can do no wrong. The counselor is placed on a "pedestal" by the client.

   Ethical issues. The counselor accepts this idealized image and believes he can make no mistakes. This could prevent him from seeking consultation when needed. This could also lead to a cold distancing in the therapeutic relationship and escalate a client's shame issues. When the counselor does make a mistake or act human, the client could then have an extreme reaction, such as leaving treatment prematurely or rage.

2. Counselor as all-knowing. The counselor is the expert and has more knowledge than the client or any significant person in the client's life.

   Ethical issues. If the counselor accepts this role of "all-knowing", it undermines the client's self-efficacy and violates the ethical principle of autonomy. It also undermines the client's support system and could create a dependency on the therapist that could be harmful. As in the above example, when the therapist acts human; e.g., doesn't have the right answer; the client can have an extreme reaction.

3. Counselor as nurturer. The counselor is seen as the nurturing parent and the client acts as helpless/dependent child.

   Ethical issues. Counselors can offer nurturing to clients without doing anything unethical. The concern would be if nurturing is all that is offered and the counselor gets stuck in this transference pattern. Clients often need other types of interventions that may not feel so nurturing such as directive approaches. A counselor caught in this transference pattern would not be able to provide the full range of clinical interventions to meet the client's treatment needs. Again, if the counselor does try another approach, the client could have extreme reactions.

   The counselor is also in danger of creating dependency by being the sole source of nurturing for the client. Principles of autonomy and beneficence could be compromised.

4. Counselor as frustrator. The counselor does not respond in ways that the client demands, either covertly or overtly. The client becomes frustrated and tests the counselor's limits with behaviors such as defensiveness, confrontation, and/or complaints.

   Ethical issues. The counselor who has a need for approval may have a difficult time with this pattern and attempt to meet the client's demands, even if ill-advised. At the other extreme, the counselor may react to the client's defensive and become defensive as well, possibly escalating the problem. In either response, the client's treatment needs will not be adequately addressed. These responses could also compromise the counselor's competency.

5. Counselor as non-person. The counselor is perceived as non-human, without needs or problems.

   Ethical issues. The counselor who needs feedback and emotional connection with clients may have difficulty with this pattern. Reactions may be to move too close to the client in order to get more of an emotional reaction thus crossing a boundary. The other response might be to distance further from the client. Either of these reactions can damage the therapeutic relationship. Clients may act abusively towards the counselor, perceiving him as an object. A counselor could react in unethical ways to this abuse. Again, when the client does realize the counselor is human, an extreme reaction can occur which could disrupt treatment.

Case:
Please review this case scenario again.

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You are a licensed counselor in a college counseling center. Donna, a sophomore, has been sent to you from the Dean's office for an evaluation regarding her mental health status and whether she can make it through the academic year. She is currently on academic probation. Your evaluation reveals that she has a diagnosis of major depression and post-traumatic stress because of a recent sexual assault and is in need of services. You recommend a psychiatric evaluation for medication in order for her to succeed with her classes. When you discuss the results of the evaluation with Donna, she becomes upset. She refuses to sign a release for you to give the Dean a copy of your evaluation because she says "the Dean will think I am crazy and call my parents. Then my parents will make me leave school". Donna says she will see you for counseling but refuses to see a psychiatrist.

Questions to consider:

1. Identify the possible transference patterns
2. The first time you read the case you were asked to list your personal reactions to this client. Please review those as an introduction to the concept of counter-transference.

Counter-transference

Since this is a relationship, clients are not the only ones with reactions. Counselors' reactions could range from just having a bad day to personal issues or to responding to a client's transference. Counter-transference is a process where the therapist projects onto the client emotional reactions either from the therapist's own issues or in reaction to a client's projection. Counter-transference is not necessarily unethical. Counselors will have many reactions to clients and many of these reactions are normal and appropriate. Counselors who are not aware of their counter-transference can engage in ethical misconduct.

Pope and Tabachnick (1993) surveyed three hundred females and three hundred males who were members of the American Psychological Association. The survey asked about emotional reactions to clients. Two hundred and eighty-five responses were received.

Some of the findings were:

- 97.2% reported feeling fear about clients
- 46% reported feeling so angry with a client that they had done something they regretted
- 87.5% reported feeling sexual attraction to a client
- 57.9% reported experiencing sexual arousal while with a client

The authors state: "In summary, the findings are a reminder of the intense, exciting, complex, stressful, and sometimes dangerous work that psychologists do and that the responsibilities of that work are not the sort that can be carried out in an unfeeling manner." (p. 151)

These findings suggest that professionals do have counter-transference reactions and these reactions raise ethical concerns. If counselors are feeling fear about a client, how effective would they be in their treatment approach?

Sexual attraction to a client is not unethical but the manner in which it is addressed can be. 65% of the psychologists in the study reported that their training did not prepare them for handling sexual attraction issues. This lack of training raises ethical concerns.

Reactions to clients can be a positive or a negative element of the therapeutic relationship. A counselor who is aware of counter-transference and uses supervision/consultation to assist with this process, may learn valuable information that improves their effectiveness with a client. For example, a client who provokes certain negative responses from a therapist may also be doing this in his other important relationships. Utilizing this counter-transference information could assist the client in making changes so that these other relationships become more positive.

Negative counter-transference can be seen as when a therapist's own needs or reactions interfere with the therapeutic process. This can cause loss of objectivity, compromise competence and weaken professional boundaries, all of which are ethical concerns previously discussed and relate to the issues regarding dual relationships. Therefore it is of clinical and ethical importance for helping professionals to be knowledgeable about and aware of possible counter-transference patterns.

- Overprotective with clients: Referring back to the survey, this pattern can develop in counselors who have fears regarding clients' abilities to make good decisions. It is sometimes appropriate to have fears about clients who are engaging in risky behaviors. The distinction here is that this would be a pattern in the counselor's relationships vs. an appropriate clinical response to a specific behavior.

  In this pattern, clients are treated as fragile, helpless, and unable to function.

- "Nice guy": These are counselors who need to be seen as a good person. In this pattern, difficult issues in therapy are avoided as the counselor does not want to upset the client. Therapeutic objectivity and professional boundaries eventually disappear and the sessions become friendly conversations.

- Over-identification: This pattern can develop in professionals who work with a client population that have many of the same characteristics or life issues as the counselor. For example, a social worker in recovery from addiction who specializes in working with clients who have been diagnosed with addiction. Some identification with clients is necessary for development of a positive therapeutic relationship in that it promotes empathy and positive regard. This

pattern is when a professional over-identifies to the point that objectivity is lost, such as, a client is told how to do something based on how the counselor did it without considering if this course of action meets the client's needs. Over-identification can also manifest when professionals see traits in clients that they dislike in themselves. This pattern could lead to distancing from clients or other acting-out such as being so angry the professional does "something regrettable. "(quote from the Pope survey)

- "True love": This is the pattern of believing that the feelings between the client and the helping professional are romantic feelings. This pattern can lead to sexual misconduct on the part of the professional. All codes of ethics forbid sexual relationships with current clients and vary regarding length of time post-treatment when it can occur with past clients. Even then, the research indicates that a percentage of helping professionals still engage in sexual relationships with clients suggesting that this pattern of counter-transference does occur. (Pope, 1990)

  Information has already been covered regarding possible profiles of counselors who engage in sexual misconduct with clients. In addition, this pattern of counter-transference along with some of the others discussed may help explain why this boundary violation occurs.

Questions to consider:

1. Do you identify any of these counter-transference patterns in your own work? If so which ones? Please discuss with a trusted colleague or supervisor

Simon (1995) reviewed cases of therapists who had been charged with sexual misconduct by clients and identified specific behaviors and a pattern that occurred in these cases:

- Counselor's neutrality gradually decreases
- Sessions become less clinical/more social
- Client is "special"
- Counselor touches client, leading to embraces
- Extra sessions occur
- Counselor manipulates transference
- Sessions are scheduled for the end of the day/sessions become longer
- Counselor stops billing client
- Counselor and client have dinner after sessions/dating begins

Again, the concern here is that this becomes a pattern. There may be times when extra sessions are needed for a client who is in crisis, etc.

One of the ethical dilemmas professionals can encounter is the situation where a current client accuses a former treatment provider of sexual misconduct. Part of the dilemma is whether or not to believe the client. It may be difficult to believe that colleagues would harm clients or engage in unethical behaviors. Some of the information in this course may be helpful in assessing the situation; for example, if the client describes some of the behaviors listed in the pattern identified by Simon. It is also important that clients' experiences not be discounted and under-reported.

As discussed in Schoener's (1989) research, there are offenders who will re-offend if not sanctioned. Another part of the dilemma is the implications for the current therapeutic relationship regarding boundary and transference concerns. Adding to this dilemma, professionals are ethically, and in some states may be legally, obligated to report this type of accusation. Often clients in these situations refuse to sign written consent forms to speak with the former therapist or to speak with the appropriate authorities. This is another example of where professionals will need to utilize an ethical decision making process because of all of the clinical and ethical issues involved.

As mentioned previously, clients can violate the boundaries of the professional relationship. Edelwich and Brodsky (1991) suggest that professionals should have guidelines for how to respond to clients who make sexual suggestions or advances. They caution against ignoring this behavior in the therapeutic relationship. Their suggestions are:

- Don't be rejecting of the client: express non-sexual caring
- This is an opportunity to re-set clear limits about the nature of the professional relationship and stick to them

- Don't be drawn into personal discussions that could lead to mixed messages. For example, " If you were not my client I would go on a date with you". This is confusing to the client and implies a future romantic involvement.
- Do confront the issue in a straight forward manner
- Do seek consultation/supervision and acknowledge your own feelings there: not with the client
- Do not refer out unless advised to do so by supervisor

Sexual Relationship with Former Clients

As seen previously in the NBCC code, there is permission for a sexual relationship after a two year period. However, the responsibility still rests with the helping professional to examine specific factors with regard to non-maleficence. It is considered unethical to terminate a counseling relationship for the purposes of beginning a sexual relationship even if the counselor waits for the two years. All ethical and legal obligations still exist even after a two year period.

The following guidelines were adapted from the work of Gonsiorek and Brown (1989). They stated that sexual contact with former clients should **never** be considered under the following conditions:

- After long-term therapy where there was a clear imbalance of power
- With severely disturbed clients
- With clients with a history of childhood abuse
- When post-termination contact is initiated by the therapist
- When the therapist has not obtained an independent consultation
- When there is any risk of harm to the client

The American Psychologist Association states: "Because sexual intimacies with a former therapy patient or client are so frequently harmful to the patient or client, and because such intimacies undermine public confidence in the psychology profession and thereby deter the public's use of needed services, psychologists do not engage in sexual intimacies with former therapy patients and clients even after a two-year interval except in the most unusual circumstances. The psychologist who engages in such activity after the two years following cessation or termination of treatment bears the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated, (2) the nature and duration of the therapy, (3) the circumstances of termination, (4) the patient's or client's personal history, (5) the patient's or client's current mental status, (6) the likelihood of adverse impact on the patient or client and others, and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the patient or client. (4.07)"

This section although applicable only to psychologists is a good guideline for all counselors in considering the many factors that should be considered with regard to sexual relationships with former clients. The psychologist's code refers to how this behavior not only has potential to harm an individual client, but how it can also undermine society's opinion of psychologists and thus impact access to services for future clients. This relates back to the concept that helping professionals are members of a moral community and one person's behavior can impact many people. One psychologist or counselor who engages in a harmful relationship with a client, potentially harms other professionals and clients.

In addition, these codes state that professionals cannot offer services to someone with whom they have had a sexual relationship in the past. Therefore, if a counselor engages in a sexual relationship after a two-year period with a client, that person will not be able to access treatment with their former counselor. The client- counselor relationship transforms into a personal, mutually beneficial relationship. This is an informed consent issue that would need to be discussed with the former client as it is denying access to future services. Again it is the professional's ethical obligation to ensure that the client understands the impact this new relationship will have on their former professional relationship.

In concluding this section on ethical principles, all of the issues that have been discussed apply to ethical conduct with a former client . Some professionals believe that there is no end to the counselor/client relationship "Neither transference nor the real inequality in the power relationship ends with the termination of therapy…Similarly, pragmatic efforts to define a post-termination waiting period, after which sexual relations might be permissible, disregard both the continued inequality of the roles of the therapist and former patient and the timelessness of unconscious process… (Herman, Gartrel, et al. 1987, p. 168)

Case Analysis

Throughout this section on ethical principles, a case scenario was offered for consideration in applying some of the concepts. Here is a brief overview of some of the issues to consider.

The principle of autonomy could be upheld by discussing with the client her options and the pros and cons of communication with the Dean. It could be that Donna is needing more informed consent with regard to what the Dean will or will not do with your evaluation. The counselor cannot release the information without the written consent; so if Donna continues to refuse, the counselor will need to decide whether to provide services or not. Denying access to services because of refusal to follow the evaluation or sign a release could be seen as denying access to services. It would need to be clearly stated as a policy of the counseling agency that staff reserve the right to refuse services in these situations. Clarification in the informed consent about client loyalties is also important. Is Donna the client ?

In the area of competency, it is possible that the counselor is not trained to assess or work with clients who have had a traumatic experience. A license does not guarantee competency in all areas. Donna has agreed to continue to see the counselor but not the psychiatrist, which adds more dilemmas regarding client welfare and whether the counselor is offering the best treatment. A counselor is not competent to provide a psychiatric evaluation and again that would need to be discussed with the client as part of the decision-making. Whether the counselor is receiving supervision in these issues would also be a competency concern.

Possible transference patterns are that Donna sees the counselor as “frustrator” and not meeting her needs/expectations. Possible harm could occur if the counselor reacts defensively or argumentatively and asserts his/her therapeutic power in an abusive manner or acts in a parental, authoritarian manner. The counselor could let this reaction influence decision making and decide it is in “Donna’s best interest” to get a report to the Dean in spite of no written consent.

Ethical Decision-Making

All of the sections of this course are components that comprise an ethical decision making process for helping professionals. Although this is a concept discussed throughout the literature on professional ethics, there has not been enough research on any one model to validate efficacy. Cottone and Claus (2000) offer a review of various models. Some of those will be discussed in this section.

The American Counseling Association offers a model developed by their ethics committee (Forester-Miller and Davis, 1996). This model is based on Kitchener's (1984) principle ethics discussed in the previous section. She named this the critical-evaluative process for justifying an ethical decision. Forester-Miller and Davis provide seven steps as guides in the process.

1. Identify the problem
2. Apply the ACA Code of Ethics
3. Determine the nature of dilemma
4. Generate potential courses of action
5. Consider potential consequences, determine course of action
6. Evaluate selected course of action
7. Implement

Other than Kitchener, no theory or research is available regarding the effectiveness of this model. Forester-Miller and Davis also cite Van Hoose and Paradise (1979) who offered these guidelines for ethical practice:

- Maintain personal and professional honesty
- Coupled with the best interests of clients
- Without malice or personal gain
- With justification that these actions are his/her best judgment.

In reviewing the section on ethical theory, Kitchener's model is principle based and adheres most closely to utilitarianism (consequences). Van Hoose and Paradise's model is based on virtue ethics. The ACA model is a combination of the two and is perhaps best interpreted as a standard of practice to utilize if a professional is a member of this association. (ACA)

Another model in the American Counseling Association literature has been developed by Herlihy and Corey (1992) specifically for the issue of dual relationships. They suggest that when a professional encounters a dual relationship, the following model could be helpful in responding:

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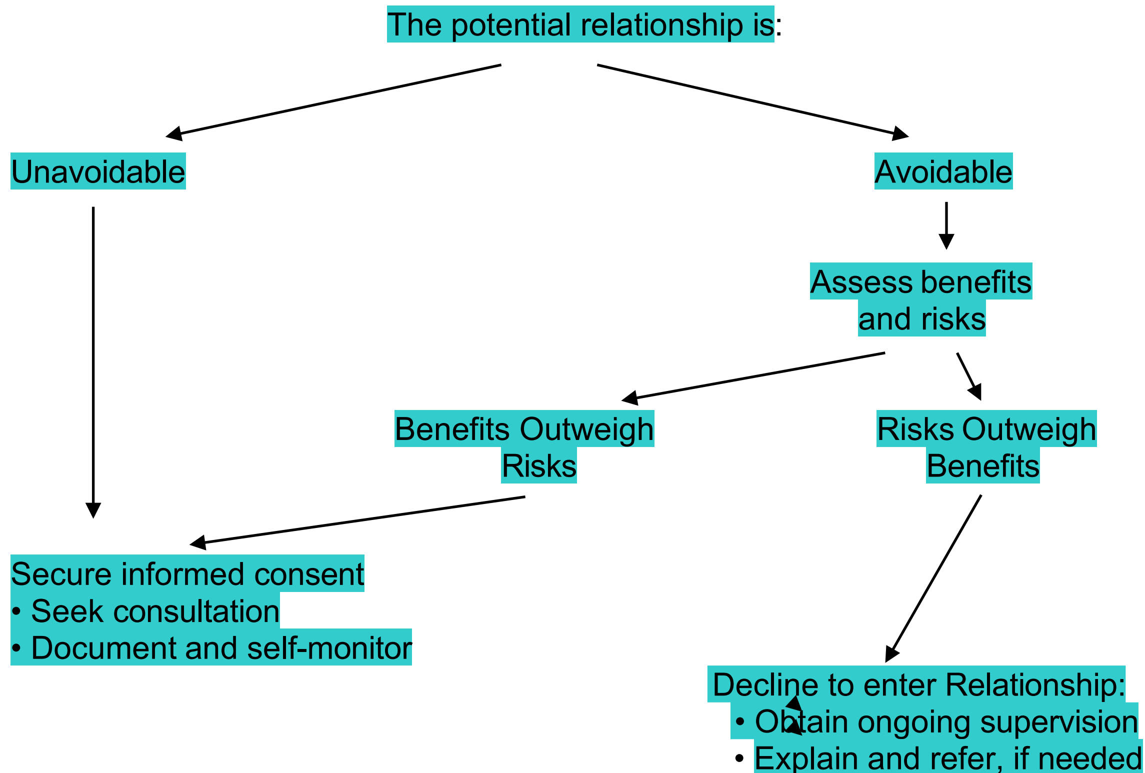

(p. 231) This is another model that is based on utilitarianism theory.

Rest (1984) introduced a model based on the research of Kohlberg (1969, 1980), previously discussed in the section on moral judgment. This is a process for deciding on a moral course of action. This is not based on virtue ethics or principle ethics; rather a moral reasoning process.

1. Interpret the situation in terms of how one's actions affect the welfare of others
2. Formulate what a moral course of action would be and identify the moral ideal in the situation
3. Select among competing outcomes, the one to act on
4. Execute and implement

Rest summarized this model as: Moral Sensitivity, Moral Reasoning; Moral Motivation; Moral Character.

Moral sensitivity is the process of recognizing that a situation involves the welfare of others. For example, a helping professional discussing a client's case with another professional at a dinner party is someone lacking in moral sensitivity.

Moral reasoning is the process of deliberating the alternatives in the moral situation and making a decision about the best course of action. This part of

Rest's model relates to Kohlberg's and Gilligan's research discussed earlier on realizing that people have different developmental stages of moral reasoning. This would impact this part of Rest's theory. Following the example of the professional at the party, one therapist in this situation may reason that no harm was done since the client won't know it happened. Another therapist in the same situation may be upset about her behavior and seek advice from a supervisor.

Moral motivation is the process of deciding whether to carry out the moral alternative selected. This is where the values and reactions of the professional can impact Rest's theory. Continuing with the professional who has discussed a client at a party, this person has decided the best moral action is to advise her supervisor. However, she is afraid of the supervisor's response because it could lead to sanctions or loss of job. This could prevent the therapist from acting in the moral motivation stage of this theory.

Moral character is the process of implementing the moral action. This is where Rest's theory coincides with virtue ethics theory. He suggests that professionals need character to be able to follow through with the identified moral action. In the example discussed, this professional would need the virtue of courage to proceed. This model is described here because it is frequently cited in the ethical decision-making literature for psychologists.

Another model, which has been adopted by the Canadian Psychological Association, is offered by Tymchuk (1986). His process is based on utilitarianism and involves the following steps:

1. Determine stakeholders
2. Consider all possible alternatives
3. Consider consequences for each alternative
4. Balance risks and benefits to make the decision
5. Decide on level of review
6. Monitor the action and outcome

Challenging models based on principles or moral reasoning, Betan (1997) offers a hermeneutic perspective to ethical decision making. In this approach, the professional takes steps to gain awareness of ethical dilemmas within a personal and cultural context.

He emphasizes the need to take into account the subjective, shared experiences of the counselor, client and society. His model fits with the theories of ethical relativism and ethical pluralism.

Tarvydas (1998) integrated the work of Rest and Kitchener. Her recommended steps are:

1. Interpret situation
2. Review problem or dilemma

3. Determine standards that apply to dilemma
4. Generate courses of action
5. Consider consequences for each course of action
6. Consult with supervisors or peers
7. Select an action by weighing competing values within a context
8. Plan and execute the selected action
9. Evaluate course of action

Practitioners may have an ethical decision-making model recommended by their professional association or by an ethics committee in their work environment. This section is offered to help evaluate current models and understand the theories and values inherent in these models. For those helping professionals who don't have a model, it is suggested that this information be used to develop one that is appropriate for current practice.

Pulling it all together: Case Practice

Three scenarios are offered to practice applying an ethical decision-making model along with all of the information discussed in this course.

First identify the model and code of ethics that fits with your professional identity.

<u>Case One: Ann</u>

Ann is a licensed social worker working in a public mental health agency. She runs a group for women recovering from addiction who have histories of abuse, and the group has been going for three years with clients coming in and out. Ann has recently become pregnant and although she rarely self-discloses, she told the clients in the group so they could start preparing emotionally for her pregnancy leave. When Ann comes to the next group meeting, one of the women has brought her a knitted blanket for the baby. Another woman offers her a wrapped gift for the baby. The three women who did not bring gifts ask Ann what else she needs to get ready.

1. Consider your ethical decision making process.
2. If you were Ann, what would you do and why?
3. What is the primary ethical principle in your decision? Primary value?

<u>Case Two: Sonya and John</u>

Sonya is a counselor in a private agency who provides intake assessments on anyone trying to access treatment. She is a trainee under supervision for her license as a professional counselor. She is the only intake counselor at the agency today when John comes in asking for services. Sonya realizes John is a boyfriend from college three years ago. They dated off and on and were physically intimate a few times.

John recognizes her and says he is really desperate for services as he has been depressed for the past year, having trouble sleeping and not able to hold a job. He comments that he is relieved to see “a familiar face” so that he doesn’t feel so bad talking about all of this. Sonya tries to contact her supervisor for advice but he does not respond to the cell phone call.

1. Consider your ethical decision making process.
2. What would you do if you were Sonya?
3. What is the primary ethical principle in your decision? Primary value?

Case Three: George

George is a licensed psychologist who provides family therapy in his private practice. His son, a freshman in college, wants to go with his girlfriend’s family to the beach for spring break. George says he would like to meet the girlfriend and her parents first before making a decision. They arrange a dinner meeting in a restaurant. When George arrives, he recognizes the family as former clients. He remembers that Leah had been in trouble with the courts for smoking pot and that he had been concerned about possible violence in the home. The family does not acknowledge that they know George. Afterwards, George’s son asks if he can go with the family for spring break.

1. Consider your ethical decision making process.
2. What would you do if you were George?
3. What is the primary ethical principle in your decision? Primary value?

Conclusion

This course has offered an overview of ethical theories, principles and decision-making models that will hopefully provide helping professionals with resources to address many of the ethical concerns that occur in their practice. The goal is for practitioners to be able to integrate ethical and clinical practice in a way that fits with their treatment environment and client population. When ethical dilemmas occur, a model can be utilized to assist professionals in sorting through these more complex concerns. The final section of the course offers references and resources for those who want more detailed information in specific areas.

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Appendix A: Post Test and Evaluation for
<u>Ethical Decision Making for Counselors</u>

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

> *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:
>
> http://www.ceumatrix.com/studentcenter
>
> Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.
>
> To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.
>
> NOTE: THE QUESTIONS AND/OR ANSWERS MAY BE IN A DIFFERENT ORDER ON THE ONLINE EXAM.
>
> If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. All of these are ethical theories except:
   a. Contract theory
   b. Ethical relativism
   c. Principle or conscience orientation
   d. Virtue ethics

2. One of the values that is part of the postmodern therapeutic approaches is:
   a. Supports human diversity.
   b. moral vision
   c. self-determination of individuals.
   d. Both a and c

3. The difference between mandatory ethics and aspirational ethics is:
   a. all practitioners follow mandatory ethics.
   b. mandatory ethics are reactive; aspirational ethics are proactive.
   c. mandatory ethics are minimal standards; aspirational ethics are ideal.
   d. All of the above.

4. A professional practicing the ethical principle of autonomy would:
a. discuss informed consent
b. refuse to treat a client if there was a values' conflict
c. provide only individual counseling.
d. practice a cognitive behavioral approach

5. Beneficence is the ethical principle:
a. that supports client welfare
b. that supports distributive justice.
c. that supports self-efficacy of the client.
d. do no harm

6. Duty to warn is:
a. the ethical principle of do no harm.
b. the legal responsibility of the professional to prevent a client from harming himself/herself.
c. the ethical principle of discretion.
d. the legal responsibility of the professional to contact a third party who has been threatened by a client.

7. An ethical dilemma with competence would be:
a. treating a client without doing informed consent
b. refusing to testify in court
c. treating a client you have not been trained to treat
d. All of the above.

8. The ethical principle of justice requires that:
    a. professionals do no harm.
    b. professionals practice non-discrimination.
    c. professionals maintain competence.
    d. professionals practice discretion.

9. The primary ethical concern with regard to dual relationships is:
    a. being charged with fraud by third party payer
    b. discrimination.
    c. exploitation of the client.
    d. loss of credentials

10. According to Bates and Brodsky's research, the best single predictor of exploitation in therapy is:
    a. a beginning, untrained therapist.
    b. a therapist who has exploited another patient in the past.
    c. a therapist without adequate supervision.
    d. a therapist who lacks self-awareness; needs own therapy.

11. Need to know guidelines are part of the principle of:
    a. discretion
    b. beneficence
    c. justice
    d. competence

12. Ethical guidelines for counselors in using technology include:
    a. do not use email to communicate with clients
    b. include information in the informed consent about how you communicate with clients
    c. fax only non-clinical information
    d. do not use provide counseling via the internet

13. Codes of ethics are based on principles.
    a. True.
    b. False.

14. Whereas morals apply to any member of the culture, a code of ethics applies only to those members of the specific group.
    a. True.
    b. False.

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15. One of the differences between a counseling relationship and a personal relationship is:
    a. personal relationship is mutual
    b. counseling relationship has ethical guidelines
    c. objectivity is expected in a counseling relationship
    d. All of the above

16. An example of a boundary crossing is:
    a. an accidental meeting with a client in the community
    b. sexual contact with a client
    c. touching a client without permission
    d. All of the above.

17. Boundary crossings are always unethical:
    a. True.
    b. False.

18. A counselor ‘s primary obligation is to respect the integrity of the client is an example of which principle:
    a. autonomy.
    b. beneficence.
    c. competence.
    d. discretion.

19. Autonomy is something that is valued by all clients, regardless of the culture in which they were raised.
    a. True.
    b. False.

20. It is important to clarify when someone becomes a client and when someone is no longer your client in order to follow which principle:
    a. competence.
    b. autonomy.
    c. professionalism.
    d. beneficence.

21. Which of the following would be an example of an unethical practice?
    a. Refusing to accept a client that you are not qualified to treat.
    b. Referring a client who presents additional issues in treatment that are outside your area of expertise.
    c. Failing to seek ongoing training and supervision.
    d. Advertising services that you are trained or qualified to provide.

22. Which of the following would be an example of "duty to report?"
    a. Reporting a client's threats against you
    b. Reporting a client's HIV status to a state health authority.
    c. Reporting a client's child abuse or neglect.
    d. Reporting a client's illegal drug dealing activity

23. Equal treatment of clients and equal access to treatment are part of which ethical principle:
    a. justice
    b. non-discrimination
    c. competence
    d. beneficence.

24. If a counselor provides treatment to someone they already have a relationship with, like a relative, friend or colleague, this is considered a dual relationship.
    a. True.
    b. False.

25. Sexual activity with a client would be a boundary violation.
    a. True.
    b. False.

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The final step in the process is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. **If you submit your evaluation online, you do not need to return this form.**

NAME:____

COURSE TITLE: **Ethical Decision Making for Counselors**

DATE:___________________________

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

COURSE MECHANICS	
Course materials were well organized	☐ Start Over ☐ Needs work ☐ Good ☐ Very Good ☐ Excellent
Materials were received in a timely manner	☐ Start Over ☐ Needs work ☐ Good ☐ Very Good ☐ Excellent
Cost of course was reasonable	☐ Start Over ☐ Needs work ☐ Good ☐ Very Good ☐ Excellent
OVERALL RATING	
I give this distance learning course an overall rating of:	☐ Start Over ☐ Needs work ☐ Good ☐ Very Good ☐ Excellent
FEEDBACK	
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: ____________________________
What I liked BEST about this course:	
I would suggest the following IMPROVEMENTS:	
Please tell us how long it took you to complete the course, post-test and evaluation:	_________ minutes were spent on this course.
Other COMMENTS:	