Chapter 8

Counseling

Client Empowerment and Counselor Integrity

Confidentiality, Counseling, and Clients Who Have AIDS: Ethical Foundations of a Model Rule

Nonsexual Multiple Relationships

Lying and Deception in Counseling

In the last chapter, we considered many ethical issues that can arise in the context of the medical profession. These topics appear primarily because of the kinds of relationships that are created whenever one person has to trust another for her physical well-being. This is no less true for the present chapter. A counseling situation creates a fiduciary relationship between (at least) two people. The counselor, like the medical professional, is concerned for the well-being of her client; however, the goal in counseling focuses on the mental health of the client. In order to attain this goal the counselor and client must spend time together talking. During a session the client is encouraged to reveal many personal facts about herself (and maybe others). Sometimes this includes exposing one's private feelings, illicit desires, dreams, and unspoken goals. The process can be frightening, as it makes one feel vulnerable. Like the medical professional, the counselor should maintain her client's discussion in trust; nobody should be privy to the topics or content. Neither is the counselor allowed to cash in on her client's disclosures. And yet, conflicts arise. Sometimes the counselor creates the conflict by betraying her clients' confidences; other times the clients create the conflict by the things they reveal; and other times tension arises because the counselor and clients do not share the same values or beliefs.

Joseph Kupfer and LuAnn Klatt begin our discussion of counseling ethics. An overriding goal of counselors is to empower their clients, which entails helping them to develop the tools (emotional and otherwise) needed to formulate and carry out their own decisions with confidence. Using terminology familiar in other contexts of professional ethics, the goal is to enhance client autonomy. An interesting ethical question arises, however, when empowering a client violates the counselor's own values. Kupfer and Klatt illustrate that such a conflict can arise over the particular choices the client wants to make, over the kinds of outlook or attitude the client maintains, and over the basic values the client embraces. The authors examine each problem and offer suggestions for dealing with such conflicts, including a suggestion that involves analyzing the concept of autonomy in yet further detail and distinguishing between "first-order" and "second-order" autonomy.

Elliot Cohen's article focuses on the topic of counseling clients who have AIDS and who are reluctant to disclose this to innocent third parties. Though the specific example is of clients with AIDS, the general ethical issue concerns the extent to which counselors are ethically obligated to protect the confidential information given them by clients. Recall from Mary Beth Armstrong's article (in Chapter 4) that the professional duty to maintain confidentiality is a prima facie duty, and may justifiably be overridden when there is a conflicting prima facie duty that is more pressing. The question is whether possible harm to others—and a duty to protect innocent third parties against such harm—is an overriding circumstance. Cohen argues that an answer can be discovered in the traditional moral theories, especially in Kantian deontology and in utilitarianism. Cohen's view is that the counselor is indeed morally obligated to disclose the confidential information provided by her client if doing so is necessary in order to warn innocent third parties. He adds, however, that there are important rules to follow when considering such a move. For example, Cohen advocates a rule method (consistent with both Kant's views and with utilitarianism) according to which the counselor should first attempt to convince the client to disclose the information himself. Only after the counselor has failed to convince her client, and only after she makes clear her intentions to her client, may she proceed with the disclosure.

Kenneth S. Pope and Melba J. T. Vasquez bring to our attention the problems that can be caused by "dual relationships," in which counselor and client develop or maintain a different kind of relationship, such as simple friendships and business relationships. Despite these problems, there have been different ways in which counselors have rationalized, tolerated, or overlooked the existence of dual relationships. The authors

review some of these "strategies" and explain how each is lacking. Their conclusion is that any type of dual relationship undermines the goal of counseling.

The final article, by Ronald H. Stein, takes up the issues of lying and deceiving. According to Stein, a person lies not only when he intentionally states a false or deceiving message but also when he refrains from correcting an erroneous belief; allowing a client to go on believing something that is false is, morally, no better than lying. Stein rehearses various reasons that a counseling professional might use to try to justify lying to or deceiving a client, and then proceeds to explain the various harmful effects that can result from such actions. He does, however, allow for lying and deceiving as a last resort, but only when certain conditions are met.

Client Empowerment and Counselor Integrity

JOSEPH KUPFER AND LUANN KLATT

THE INTEGRITY OF PROFESSIONALS may be challenged whenever clients ask for or demand behavior that conflicts with the professionals' convictions or values. Integrity requires acting consistently with our commitments, yet clients may have legitimate competing claims on us. This tension can encompass a wide range of professions, from journalism and advertising to engineering and insurance. Indeed, it is difficult to imagine a profession in which compromising or jeopardizing integrity could never in principle be an issue. Behind the many obvious cases, such as physicians being asked to euthanize, are such subtle conflicts as those faced by political strategists who oppose negative campaigning, or publishers who object to material they are pressured to print. Some of our discussion may speak broadly to the professions, but our focus is on professionals, counselors in particular, who see their responsibility as empowering clients.

Working to empower clients is a dominant strategy among counselors. It is advocated in texts used in counseling programs, professional seminars, and in discussions among practitioners. Client empowerment is embraced by counselors as diverse in training as psychiatrists, psychologists, social workers, human resource managers, health care professionals, teachers, substance abuse therapists, lawyers, financial advisers, and the clergy.

But what happens when empowering the client seems to violate the counselor's own values or principles? Mightn't empowering a client to do something which the counselor believes is immoral compromise the counselor's integrity? Professions which involve counseling attract people who care about others and strive to serve them. But this shouldn't mean totally subordinating one's own moral convictions or assuming the client's value structure.

This paper begins by examining empowerment itself and the client strengths in which it is supposed to result. We then discuss three ways in which empowering clients can generate ethical conflicts for counselors: in particular choices, outlook or attitude, and basic values. We also offer a positive suggestion for dealing with such conflicts. The objective of empowerment itself can sometimes, but not always, provide the counselor with

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a method for coping with her ethical differences with clients. By reflecting on the meaning and means of empowering clients, the counselor may be able to work for the client's independence without jeopardizing her own integrity.

I. Empowerment and Autonomy

The empowerment strategy directs the counselor to help her client develop the ability to make his own discoveries and decisions. These decisions can then be carried out with minimal further guidance. This is in contrast to a variety of other possible objectives, such as modifying behavior, developing self-analysis, dispensing advice, or concentrating on having clients arrive at specific answers to presenting problems. Of course, counselors want clients who are presenting problems to receive attention and some form of resolution. But if the client "solves" a problem without developing the more encompassing ability to deal effectively with similar future difficulties, then the counselor can't feel truly successful. Thus we find in a leading textbook an opening chapter on the "Nature of Social Work" which emphasizes "increasing client self-determination" and helping people "resolve their own problems."[1]

Texts on ethics and values in counseling see empowerment as central. This pervasive view is well-represented by Van Hoose and Kottler who urge that empowering is a moral obligation of counselors. The obligation "is to keep the responsibility on the client to change. . . . [This] preserves individual independence and the power to make one's own decisions."[2] For the counselor to impose her values on the client is wrong because it deprives the client of his right to choose for himself.[3] The NASW Code for social workers also lists working for the client's "self-determination" as a counseling duty. On this view, for social workers to try to solve clients' problems for them, or otherwise fail to promote client independence, would not just be ineffective, it would be a dereliction of duty. Discussing the ethics of alcoholism counseling, Stephen Valle argues that counselors have the obligation to "help clients clarify their own values, determine how their values affect their behavior, . . . to accomplish the goal of fostering individual responsibility for behavior."[4]

It might be helpful here to gather together the various strands within the objective of empowerment—what the empowered client is supposed to be and be able to do. Most discussions of empowerment talk of the client as being able to solve problems. But notice that this is a complex ability, or a complex of abilities. It requires being able to engage in a realistic assessment of situations and fashion an array of options. Moreover, in order to solve problems, people must have the initiative to decide and act on their choices. The concept of empowerment is therefore necessarily connected to a normative notion of human being, one which centers on autonomy. When a counselor helps empower clients, she assists them in functioning more autonomously.

Helping people function more autonomously is helping them think, choose, and act for themselves. This involves a cognitive component: identifying what they really want or value and understanding their difficulties in achieving it. A realistic assessment of their situation can include their relationships with others, what they want from others, and whether relationships are going well or poorly. This involves being able to reason out various courses of action and evaluate their consequences. But this is not enough without the ability to reach decisions and act on them. The active component of autonomy requires choosing among competing alternatives and then acting upon them. Empowering a client might mean helping her stand up to an overbearing spouse, discipline a child, or simply say "no" when she feels like it. Even when people know what to do, they don't always do it.

Among the conditions that can inhibit autonomous functioning, some come from without and some from within. Parental pressure, work demands, and lack of money are common external constraints on our autonomy. On the other hand, fear of rejection, uncontrollable anger, avoidance

[1] B. Compton and R. Galaway, *Social Work Processes* (Belmont, CA: Wadsworth, 1989), p. 11.

[2] W. Van Hoose and J. Kottler, *Ethical and Legal Issues in Counseling and Psychotherapy* (San Francisco: Jossey-Bass, 1977), p. 60.

[3] R. Ajzen, "Human Values and Counseling." *Personnel and Guidance Journal*, 1973, 52 (2), pp. 77–81.

[4] S. Valle, *Alcoholism Counseling: Issues for an Emerging Profession* (Springfield, IL: Charles C. Thomas, 1979), p. 89.

behavior and similar traits limit autonomy from within. Of course, past external constraints can result in present internal restrictions on autonomy. So, although a client may currently be in an environment which actually promotes autonomy, old negative messages and habits, such as learned helplessness or lack of self-esteem, may prevent him from acting autonomously.

In order to function autonomously, we must either be relatively free from such constraints, or develop ways to minimize their impact on us. No one is absolutely autonomous, but the counselor's task is to help clients develop the capacities for functioning as autonomously as possible given the limits and opportunities of their circumstances and personalities.

The empowerment strategy can be challenged at its very heart: what's so valuable about autonomy? The importance of autonomy is clarified by contrasting it to debilitating alternatives, such as dependence. With dependence, the individual follows the decisions made for her by others or has her needs directly met by others. Either way, she is at the mercy of their desires, tastes and whims. Other failures to function autonomously encompass two extremes: impulsive behavior and indecisiveness. Impulsive behavior isn't autonomous action because the behavior doesn't result from deliberate choice; instead, strong desires or emotions compel the client to act on the spur of the moment. Indecisiveness falls short of autonomous functioning because the individual is immobilized by the inability to choose among competing courses of action.

But perhaps the value of autonomy is best noted by the counselor when clients suffer from its lack. They don't get critical needs met. Nurturing the capacities that comprise autonomy-empowerment is the way to help clients meet their needs. Additionally, what is so significant about autonomy is that for most of us functioning autonomously is itself valuable and enjoyable. We thrive on being able to figure things out for ourselves, make our own decisions, and then bring them to fruition by taking appropriate action.

II. Conflicts

So far, there is nothing especially problematic about the objective of increasing the client's autonomy or the counselor's role in empowerment. But consider the likelihood that in the course of a career a counselor will be called upon to help empower someone to realize decisions or goals that she, the counselor, either doesn't endorse or actually opposes. "So what," you may say, "that's not relevant to the counselor's work or worry." But here we need to see that another crucial value is at stake—the counselor's integrity.

This is critical in the counseling professions which are value-saturated. People usually are drawn to the counseling professions out of concern for others, as with most helping professions. In addition, to engage in counseling, specific value-laden approaches and objectives must be embraced over others.

Thus, besides autonomy, most counselors value individuality and equality. As a result of such emphasis in family counseling, for example, each member's welfare is given equal weight. This contrasts with approaches which value the family constellation over the welfare or autonomy of its members. Counseling, then, is value-oriented on at least these two counts: overall motivation for choosing the career and explicit evaluative objectives of the profession. Because counseling is especially value-laden for these reasons, it would be ironic indeed if the integrity of the counselor herself were of no importance.

The value conflict between counselor and client which precipitates this tension between client empowerment (autonomy) and counselor integrity can exist on various levels: (A) particular choices; (B) outlook/attitude; or (C) basic values. Regardless of the level, the objective of empowerment means that the counselor seems called upon to help the client realize goals and values with which she herself may disagree. Empowerment doesn't occur in a vacuum. People need to be capable of choosing and acting for themselves so as to bring about this rather than that set of outcomes. And outcomes embody goals and values.

In assessing conflict between the counselor's integrity and the client's empowerment, we will suggest how the goal of autonomous functioning itself can often provide the counselor with a principle for ethical deliberation. When faced with such conflicts, we need the resource of a touchstone or base from which to reflect. Finding such a starting point inherent in the dilemma itself—in

the form of considerations of autonomy—is reassuring. Not only are we already familiar with it, but we know that taking autonomy into account is ethically relevant.

PARTICULAR CHOICES

Let's look first at value-conflict on the level of choosing particular actions. Suppose a client comes to his minister intent on divorce. The counseling minister is committed to the value of family, as well as family values. She sees her parishioner's divorce as premature and perhaps immoral. At the time the client voices the desire to divorce, therefore, disagreement over what should be done exists. Is it the counselor's function to help the client work effectively toward divorce? If so, wouldn't this compromise her integrity?

One avenue for resolving this sort of problem is for the counselor to explore the ways in which empowering the client to make this decision autonomously also further the counselor's goal of having the client proceed deliberately rather than precipitously. In other words, the counselor can act with integrity if, in furthering the client's ability to get a divorce, she is also empowering him to make this decision *autonomously.* For our hypothetical minister, this would no doubt involve bringing the spouse in for joint counseling. The counselor may disagree with her client's final decision, but she will do justice to her own values by ensuring that the *process* by which the client arrives at his decision meets the demands of autonomy.

In this situation, there are cognitive and action dimensions of autonomy that work as intermediate goals for counselor and client. The notion of intermediate goals can be useful in bridging the gap between the client's interest and what the counselor sees as moral or good. The intermediate goal can be compared to a crossroads which must be navigated regardless of whether the client stays on his announced path (of divorce) or takes the direction preferred by the counselor. In this way the counselor is acting with integrity. Such an intermediate goal can be as simple as seeing what the consequences of a particular action are likely to be or what further options the client will have in the face of different consequences. This requires that the counselor reflect on her *own* responses—why she objects to the proposed choice in the first place.

Imagine a client who plans on giving her child up for adoption and that the counselor is opposed to this. Why is she opposed? If the counselor challenges herself to answer for herself, she might say that she sees this woman's proposed behavior as irresponsible. Rather than examine other ways of coping with her problems, the mother is washing her hands of them and running away. But this is precisely the type of behavior which is neither autonomous nor empowered. Autonomy implies taking responsibility for one's actions if only so that in the future the behavior that generates the difficulties might be avoided. This includes considering the impact of our behavior on others—in this case, the child.

By looking at why she objects to the planned action, the counselor is able to unearth an intermediate goal, one that is consistent with empowering the client and her own integrity. For the mother wishing to have her child adopted, an intermediate goal is getting her to face the seriousness of her intended choice. This includes looking at how she arrived at the decision, its impact on her child, what the alternatives are, and finally taking responsibility for it. In this case, but perhaps not in all others, the solution lies within the conception of empowerment itself. Because empowering the client involves getting her to take responsibility for her action, the counselor is able to maintain her own integrity.

Consider a financial adviser whose client proposes filing for bankruptcy as a way out of serious debt. The adviser is averse to such drastic measures in general. With this client in particular, she sees the perpetuation of a pattern of short-sighted and impulsive behavior. She encourages the client to look backward at the rash behavior that led to the heavy debt. She asks what future relations with creditors and potential creditors are likely to be. Is taking shelter under bankruptcy law dealing with creditors in a far-sighted way? Is having a bad credit-rating something the client can live with? By urging the client to take a long-term perspective, both on his past and future, the financial counselor promotes autonomy by challenging the pattern of impulsive behavior.

Congruence of counselor integrity and client autonomy probably cannot always be achieved. In some situations, the counselor may have to terminate working with a client because of conflict

between helping the client act autonomously and being true to herself. Nor does acting autonomously guarantee acting morally. It is possible for people to do wrong in an autonomous fashion. When this seems to the counselor to be occurring, we think that the counselor is permitted to discontinue working with the client. She might even have a duty to herself to do so, since to empower the client is likely to mean facilitating behavior the counselor considers immoral (and not merely wrong-headed).

OUTLOOK/ATTITUDE

Sometimes in counseling there will be conflict with the client's outlook or perspective. The counselor may feel that the client's outlook is immoral. A male client, for example, comes for counseling in order to regain control of his life. This client feels that he has been unjustly treated by the legal system in his bitter divorce proceedings just because he is a man. He sees the law as part of a general social conspiracy to favor women at men's expense. The counselor finds this client's sexist attitude repugnant, although he seems to have received an unfair divorce settlement. Should she attempt to disabuse him of his male bias? Should she argue with his unfounded claim that convicted rapists, such as Mike Tyson, are the scapegoats of an unjust legal system?

How can the goal of empowerment itself suggest a way of resolving this conflict? In the example just described, the client's sexism obstructed his perception of the problem, making him incapable of functioning autonomously. Instead of focusing on his own situation, he spent his time and energy bemoaning the fate of men in American society, even writing letters to newspapers. This diverted his attention and energy away from options which he could exercise. The sexist outlook was unrealistic, resulting in unproductive thought and action. As a result, the counselor could implicitly subvert the client's sexism by recalling him to the task of taking control of his own life. Because the client's point of view, judged by the counselor to be immoral, restricted his autonomy, the counselor did not have to dispute it overtly; she only had to challenge its specific manifestations.

Imagine a lawyer whose potential client wishes to sue her previous employer. She claims discrimination and cites instances of what she considers demeaning language. She points out that she received neither promotions nor raises while employed. The attorney soon learns that the would-be litigant missed work frequently for no good reason, received low performance ratings, and has been unemployed for six months—making no effort to find work. She readily blames others for her misfortune, including female as well as male co-workers.

The lawyer begins to form an impression of this potential client as someone who denies her role in the unemployment, who sees herself as helpless. Regardless of how strong a legal case he thinks he can construct, the lawyer can try to help the potential client see how her self-concept as victim prevents her from functioning autonomously. From her behavior on the job to her rationalization for being fired and continued unemployment, she refuses to see herself as having any power. The lawyer theorizes that the lawsuit itself is an attempt at retaliation to force someone else to take care of her.

Counseling the client against the lawsuit harmonizes with the lawyer's belief that to pursue the case would curtail the woman's autonomy. He can point out how her behavior at work and delay in filing a suit not only weakens her case, but stems from her perceived helplessness. Only when she confronts her basic attitude toward herself and relation to the world as victim can she begin taking care of herself.

Are all points of view judged by counselors to be immoral incompatible with functioning autonomously? It would strengthen our position if this were true, but proving that it is true is beyond our present undertaking. It is interesting, however, how many immoral attitudes (including such opposites as racism and self-denigration) keep individuals from facing reality and real options.

BASIC VALUES/FIRST- AND SECOND-ORDER AUTONOMY

Lastly, we should examine conflict in basic values. This discloses something new and significant about both autonomy and the counselor's objective of empowerment. Imagine a client with a religious background whose values are at odds with the counselor's. Also imagine that the client has not autonomously arrived at these values or even

the choice of religion. Both were acquired in an uncritical way. They have been "accepted" rather than autonomously chosen after rigorous deliberation. Is it the counselor's job to call into question the client's religion and the values it espouses?

We believe that generally it is not—though we will discuss exceptions. Notice that if the client's values were in accord with the counselor's, the counselor probably wouldn't be tempted to challenge the religion or its values. This certainly seems like bias. What does this indicate about empowerment? It indicates that autonomy operates on at least two levels. One is the everyday level of particular choice and action. Autonomous people are able to identify their options, weigh the consequences, and act in accord with their values and commitments. They are not unduly hemmed in by the ideas, behavior, or wills of others. Nor are they cripplingly dependent on the ideas, behavior, or wills of others. Let's consider this realm of concrete choice and action "first-order" autonomy. It is a focus of empowerment.

There is also "second-order" autonomy. This is the ability to reflect critically on the values and commitments which underlie our first-order decisions. The first-order decision to vote against a policy of censorship or gun control could, for example, rest upon the value of freedom. Second-order autonomy includes actually choosing these values for oneself rather than accepting them unreflectively or simply imitating the valuing of others. A person exercising second-order autonomy scrutinizes his values, notes conflicts and confluences among them, and modifies them in light of such scrutiny. Such a person typically also self-consciously decides what sort of person he wishes to become; he fashions his own ideal or at least autonomously chooses among ideals he encounters. For such a person, the values and commitments are fundamentally his own.

Obviously, it is possible to exercise first-order autonomy without exercising second-order autonomy. We can make our own decisions relatively free of constraint or dependence—without examining the values or commitments on which these decisions rest. This is true of our hypothetical religious client. He simply accepts his religion as right, and its values become his own. He has not autonomously arrived at his religious convictions or the values that go with them. Nevertheless, it makes sense to speak of empowering him by developing his ability to make everyday, first-order decisions and to act on the basis of his values—regardless of how they were acquired.

The counselor's task will typically be to help clients develop and exercise first-order autonomy. Although this may involve getting clients to reflect on their values, this value-clarification is a far cry from value-justification. The objective of empowerment usually stops short of empowering the client to do the second-order scrutiny and decision-making which he may never have done before.

This limit is helpful in addressing the issue of client empowerment when the client's values conflict with the counselor's. It establishes the counselor's domain as restricted. How and why clients come to hold deep-seated values are beyond the counselor's professional scope. We are speaking of non-pastoral counseling, where the counselor is not trained in theology or philosophy. Obviously, clergy may need to discuss how client-parishioners have acquired their religious convictions. For the lay counselor, questioning the justification of clients' basic values would be like a philosophy instructor presuming to psychoanalyze students in the middle of a theoretical discussion. In addition, clients do not come for this sort of help—with an exception to be noted. Clients' legitimate expectations would be violated were the counselor to confront them over their values.

Narrowly construing the counselor's role in empowerment leaves room to respect the clients' right to choose according to their own values. Forcing clients to defend their values or how they were acquired would be a violation of that respect. The counselor's task is to help empower clients to make decisions within the framework of the clients' values. But couldn't this ultimately threaten the counselor's integrity? Should she be asked to help people realize values which she herself finds objectionable?

There are several situations in which direct discussion of the client's values, even confrontation over them, may be called for. We believe that in all of them, the client's own empowerment is at stake. Client values are a legitimate topic of counseling when these values or the counselor's opposition to them are relevant to the client's autonomous functioning. The most obvious situation in which discussion of client values would be appropriate is

one in which a client presents his values as problematic or troubling. When the client comes to the counselor agonizing or philosophizing about his long-cherished values, the counselor is right to question and scrutinize them with the client. But the *reason* is not conflict with the counselor's own values since she would assist the client with this second-order autonomy even if the client's values accorded with hers. The reason the client's values are at issue is that they trouble him and the counselor can help him achieve the second-order autonomy he seeks.

A second situation in which the counselor's values may come directly into play would be one in which the client's behavior indicates values which are antagonistic to empowerment itself. We have in mind "authoritarian" values—power, command, obedience, and conformity—rather than independence and egalitarian collaboration. Those who hold authoritarian values tend to accept what they are told because of its source rather than its content. Authoritarian institutions, such as the military and some religions, require that these values guide subordinates as well as those in power. Schools, athletic teams, and businesses may also be run along authoritarian lines. . . .

. . . Value conflicts usually should be explicitly addressed in therapy when they are directly relevant to the particular matter at hand because it is over particular affairs that clients exercise first-order autonomy. The main consideration is client empowerment. Perhaps a lawyer has a different conception of justice from the client's. Or, a physician's commitment to the sacredness of life conflicts with a patient's request for abortion. Bringing the opposition in values into counseling is relevant when it is in the interest of empowering the client. Challenging the client's values could shift her viewpoint so as to further her autonomy.

But this is too restrictive. It gives the counselor's values entrance to the therapeutic situation because they might help empower the client. If they weren't likely to, the counselor wouldn't be permitted to air their differences. However, the divergence between the counselor's and the client's values can also hinder the counselor's empowering efforts. After all, the counselor might feel so alienated from or disgusted with the client that she is incapable of helping the client achieve greater autonomy. Indeed, she might find herself repelled at the thought of helping empower someone with such a warped sense of justice or indifference to human life.

The criterion of client empowerment is pivotal in the decision to bring the value-conflict to the client's attention. When the counselor is reasonably sure that this conflict is keeping her from being effective, she clearly has a duty to acknowledge it. The therapeutic ramifications of counselors not dealing with their moral disapproval of clients' choices, outlooks, or values can be considerable. Where the conflict is powerful and the counselor feels that it is threatening what she stands for as a person or professional, she runs the risk of rejecting the client by withdrawing from him emotionally.

In order to make the client aware of this situation or risk, the counselor has to be aware of how she is reacting and be open to self-criticism. This requires that she know herself, including her basic values and commitments. When a counselor reflects on her values and how they may impede her effectiveness with a client, she engages in self-empower on the level of second-order autonomy. Without this, she cannot do what she wants—help the client. And this is a feature of first-order autonomy. Thus, in some situations, for a *counselor* to exercise first-order autonomy, she must also have second-order autonomy. It continues the self-scrutiny most counselors go through when deciding on entering the counseling profession. Perhaps more than most other professions, counseling demands ongoing autonomous functioning on this deeper level of self-reflection.

We suspect, however, that all professionals whose integrity is challenged by their clients' interests will have to examine their own values. Remaining true to convictions requires staying in touch with them. For professions committed to client empowerment, such as counseling, examination of values is even more critical. It is needed to evaluate whether opposition to clients' values can foster or hinder the development of autonomy. We have argued that the goal of promoting client autonomy provides a touchstone for resolving value conflicts with them. The professionals' own empowerment through value scrutiny enables them to know themselves well enough to maintain their integrity by dealing therapeutically with client conflict.

Discussion Questions

1. According to Kupfer and Klatt, what is the goal of therapeutic counseling? Do you agree with their assessment of the goal?
2. How do the authors characterize autonomy and why do they claim it is important in a counseling situation?
3. Describe the sorts of conflicts with which Kupfer and Klatt are concerned and some of the methods they advocate using to minimize the conflict.
4. Are there any moral theories that a counselor might enlist in order to help minimize the conflicts described in this article?
5. In Chapter 4, Taylor described the role of autonomy in professional ethics and noted that the autonomy of both the client and the professional warrant recognition. To what extent do the ideas of Kupfer and Klatt seem reasonable in light of Taylor's comments? To what extent is the distinction between "first-order" and "second-order" autonomy appropriate in light of Taylor's comments?

Confidentiality, Counseling, and Clients Who Have AIDS: Ethical Foundations of a Model Rule

ELLIOT D. COHEN

THE PURPOSE OF THIS ARTICLE is to provide input into a specific question of professional ethics concerning acquired immune deficiency syndrome (AIDS) within the context of counseling. This question pertains to the ethical obligations of counselors to their clients and to third parties in cases where counselors "find out" that their sexually active clients carry the human immunodeficiency virus (HIV).

The question is complicated by the fact that the counselor's belief—that the client has AIDS and is risking giving the fatal disease to the sexual partner—may be due to information obtained *in confidence* from the client in the course of counseling. For instance, according to the *Ethical Standards* of the American Association for Counseling and Development (AACD), "the counseling relationship and information resulting therefrom must be kept confidential, consistent with the obligations of the member as a professional person" (AACD, 1988, Section B.2).

On the other hand, the AACD *Ethical Standards* also state that "when the client's condition indicates that there is a clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities" (AACD, 1988, Section BA). From this general standard it might be inferred that when a "clear and imminent danger" exists to the sexual partner of a client who has AIDS, it is the counselor's professional responsibility to inform the sexual partner.

The latter inference from the AACD *Ethical Standards,* per se, would obscure and oversimplify the basic ethical principles underlying an ethically feasible attempt at resolving the problem at hand.

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Rather, what is requisite in order to appreciate the urgency of specific measures concerning the rights of clients who have AIDS and those affected third parties is a deeper comprehension of the ethical foundations on which the AACD *Ethical Standards* themselves rest. In this article these ethical foundations are elicited and, in light of the emerging analysis, a *model rule* is advanced concerning the limits of confidentiality in cases where clients have a fatal and contagious disease such as AIDS.

Confidentiality and Ethical Theory

Why, in the first place, should the AACD recognize confidentiality as a significant ethical standard?

The recognition of a bond of confidentiality between client and counselor can be ethically justified by appealing to classical ethical theories, that is, to basic principles of morality that have held an important status in the history of Western thinking on ethics. In general, there are two traditions that provide important justifications for recognizing a bond of confidentiality; they are (1) *utilitarianism* and (2) *Kantian ethics.*

According to one formulation of utilitarianism, an act (or type of act) is obligatory for a person if, and only if, the person's performing it has a "maximal net expectable utility," that is, it can, "on the available evidence," be expected to maximize net utility (Brandt, 1959, pp. 380–405). By "utility" in this context classical utilitarians have intended "pleasure" and "the absence of pain"; but however these terms are construed, the intent of the principle is to determine the obligatory character of actions (or types of actions) on the basis of the *amount* of net utility accruing from the performance, multiplied by the *probability*—based on available evidence—of realizing that quantity. Thus two main questions of utilitarianism are "How much (net) good will the performance do?" and "How *likely* is it to produce this value?"

Utilitarianism provides a warrant for recognizing a professional rule under which counselors are obligated, *other things being equal,* to respect client confidentiality. First, it is evident that without reasonable assurance of confidentiality "those requiring treatment [many of whom may be "potentially violent yet susceptible to treatment"] will be deterred from seeking assistance." Second, it is evident that without such a general rule clients will not speak openly with their counselors thereby thwarting effective treatment (*Tarasoff v. the Regents of the University of California,* 1976, Dissenting Opinion). In short, "maximal net expectable utility" is realized in a therapeutic context in which confidentiality is generally respected.

The second ethical tradition that supports confidentiality is Kantian ethics (i.e., the ethical theory advanced by the eighteenth century German philosopher Immanuel Kant). The latter ethics can, for present purposes, be set forth in two formulations of what Kant termed *The Categorical Imperative.* According to one formulation: "Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end" (Kant, 1964, p. 96). What Kant means is that persons must never be treated as objects to be manipulated or used by others. Rather, they should always be treated as "ends in themselves," that is, as rational, autonomous (self-determining) agents. Persons must never be confused with objects. Unlike the latter, the former possess inherent dignity and a right of self-determination.

Treating clients in counseling as ends in themselves requires that confidentiality be respected. If the client willfully *consents* to the counselor's disclosure to a third party of information obtained in the course of counseling, then, other things being equal, the client's right of self-determination is preserved. The disclosure of such information without first obtaining the client's consent, however, may be to treat the client as a mere means—say to advance third party interests.

Furthermore, treating clients as ends in themselves requires that clients' consents be given only after they are *reasonably informed* (by counselors) of the nature of such disclosure and *without force or coercion.* As Kant held, it is the rational agency of persons that "marks them out as ends in themselves" (Kant, 1964, p. 96). A client acts autonomously only if she or he acts rationally—and rational action presupposes knowledge and understanding. To exact consent from clients by withholding relevant information from them is again to treat them with the indignity of mere objects; to employ force or coercion, say in the form of a threat, is at most to pay lip service to the Kantian standard of respect for persons.

According to the second formulation of Kant's Categorical Imperative: "Act only on that maxim through which you can at the same time will that it should become a universal law" (Kant, 1964, p. 88). Part of what Kant means is that persons as rational agents must be willing to accept the logical implications of the reasons for their actions when these reasons are applied to all relevantly similar cases. For instance, a counselor who is considering breaching a client's confidence, say in order to help a third party, must be willing to make a universal law out of the reason for his or her action. This, in turn, requires that the counselor as rational agent be willing to see such a breach occur even if, other things being equal, he or she were in the client's position. Since a counselor as rational agent would not be willing to have his or her trusts disclosed, without his or her informed and freely given consent, it would be wrong, or *prima facie* wrong, for a counselor to place a non-consenting client in such circumstances. Thus, consistent application of respect for persons as autonomous agents demands that confidentiality be respected.

Both utilitarian and Kantian ethics therefore support a general rule of confidentiality in counseling. These standards, however, have sometimes been viewed as being *in conflict* with each other, at least in some contexts. Consider, for example, the circumstances of the well-known *Tarasoff* case, in which a therapist is told by a client, in the course of treatment, of his intention to kill a third party (*Tarasoff v. the Regents of the University of California,* 1976). Assuming for the moment (what cannot easily be assumed) that the therapist had strong evidence to believe that his client would actually carry out his intention as announced, a case for the therapist's breaching confidentiality and informing the relevant third party (in this case, the victim's parents) could be made out on utilitarian grounds. But would Kantian ethics conflict with the decision to breach confidentiality in such a case?

Of course, it could be argued that the client would then be treated as a mere means so long as his informed and freely given consent was not secured. Moreover, it could be argued that such a failure to treat the client as a self-determining agent could not be rationally and consistently turned into a "universal law." Nevertheless, the client does intend to do something that Kantian ethics would itself condemn, namely, kill an innocent third party. A paradox arises (but not an outright contradiction): The therapist who preserves confidentiality on Kantian principles would do so when it is evident to him or her that doing so would only permit the client's grotesque violation of those very same principles—since preserving confidentiality would permit this client to kill an innocent third party.

If the Kantian standard upholds confidentiality in such a case, it is at least a somewhat diminished or weakened Kantian justification. In this regard a distinction can be drawn between *strong* and *weak* Kantian (ethical) justifications for keeping client confidences. A *strong* Kantian justification exists when (i) keeping the confidence respects the inherent dignity and/or right of self-determination of the client and (ii) it does *not,* thereby, at the same time, enable the client to substantially violate the inherent dignity and/or right of self-determination of another person(s) (or, as in the case of suicide, the client himself or herself). A *weak* Kantian justification exists when (i) is true but (ii) is false.

In the case of the client who is taken to have AIDS and to be sexually active with a third party, there can be only a weak Kantian justification for upholding confidentiality. The client in question is treating his respective sexual partner as a mere means by not informing him of his fatal and contagious condition. Moreover, the manipulative character of such action is not the sort that can be turned into a universal law. Therefore, respect for the client's secret in such a case can at most be accorded a weak Kantian justification in the sense explained above.

It may be said by some that there can be *no Kantian justification whatsoever* (weak or strong) for maintaining clients' confidences in the type of case in question. According to this line, since clients with AIDS who willfully subject their sexual partners to this deadly disease treat them as mere means, counselors' failure to inform the affected third parties could never, rationally, be made into a "universal law."

As persuasive as the preceding position might sound, it fails to do justice to the perspective of the counselor who perceives the disclosure of the confidential information as a betrayal of the trust

generated by the intimacy of the counselor-client relationship. Insofar as such disclosure is viewed as manipulative—treating the client as a mere means or as an object—the recognition of a weak Kantian justification for nondisclosure is defensible.

The position taken here is that a rule of conduct concerning the limits of confidentiality with clients having a contagious and fatal disease such as AIDS is justified to the extent that *both* Kantian and utilitarian considerations are satisfied. In the text that follows an attempt is made to construct a rule of disclosure that is defended along the following general ethical lines. First, there can be only a weak Kantian justification for maintaining client confidentiality in cases where clients who have AIDS place their unaware sexual partners at significant risk for contracting AIDS. Second, in such cases there is also a compelling utilitarian justification for *breaching* client confidentiality. Third, the latter utilitarian justification *overrides* the (weak) Kantian one for maintaining confidentiality. Fourth, the latter overriding utilitarian justification supports a *general obligation* of disclosure. Finally, the latter obligation of disclosure is itself defined by *more specific* counselor obligations, for which there is also utilitarian and/or Kantian warrant.

Limits of Confidentiality: Constructing a Model Rule

As noted, an important variable in the application of the utilitarian standard is the *probability,* based on available evidence, of obtaining a determinate quantity of utility. Employing this standard, an adequate rule limiting confidentiality in the cases under discussion would require relevant *medical evidence* supporting a strong probability claim that the client presents a danger to some third party (Kain, 1988). For example, that the client is gay would not constitute such evidence; that the client has tested positive for HIV and that he or she is actively engaged in (unprotected) genital or anal sex with a third party would appear to satisfy this requirement.

As also noted, a further major consideration in applying the utilitarian standard is that concerning the *quantity* of net utility that can be expected to result from an action. It is beyond the scope of this article to defend any particular theory of utility. It appears, however, that in most reasonable theories (for instance, ones recognizing health and freedom from pain as positive values and disease and its attendant suffering as negative values) there is substantial net expectable utility in informing third parties that they are sexually active with HIV-positive individuals (assuming that the evidence on which this fact-claim is based satisfies the evidential requirement mentioned earlier).

Under such conditions the third party either will have already contracted the disease (from the client or from some other source) or he or she will be at serious risk for contracting the disease in the future. In the former case the third party may, if informed, have the option of early detection, monitoring of the disease through periodic medical examinations, medication to prevent AIDS-related complications, increased longevity, and generally greater control over his or her life. Such utility must be weighed against the disutility of trauma associated with finding out that one has AIDS, but this finding out is inevitable in any case. Moreover, there is evidence to support the position that the net positive utility would be substantial (Bok, 1986, p. 75).

If the third party has not yet contracted the disease, alerting him or her about the potential danger allows him or her to take adequate precautions against contracting it in the future (e.g., if the sexual relationship continues, the use of condoms). Again, in such a case, any disutility arising out of informing the third party appears, other things being equal, to be outweighed by the positive utility of a life spared from the suffering associated with AIDS. Therefore, a utilitarian warrant exists for third party disclosure when the evidential requirements stated earlier are satisfied.

Given the compelling character of the utilitarian warrant for disclosure and the weak status of any Kantian warrant for nondisclosure (nondisclosure permits clients to treat third parties as mere means, thereby violating their right of self-determination), a general obligation of disclosure is ethically justified. Nevertheless, such disclosure of confidential information raises further Kantian objections.

From a Kantian perspective, a utilitarian warrant for disclosing confidential information, based on third party well-being, is not sufficient. The client must also be treated as a rational, autonomous agent. What the latter requires is that he or she be adequately informed about his or her

situation. Otherwise, the client cannot be presumed to act rationally. Respect for the rational autonomy of the client would therefore demand that, prior to disclosure, the counselor make a reasonable effort to inform or educate him or her about the disease of AIDS and its implications for third parties (Gray & Harding, 1988). Moreover, part of treating the client as a rational, autonomous agent would be to provide him or her with the support, understanding, encouragement, and opportunity conducive to the client disclosing the information to the affected party *on his or her own*. This is also the treatment that a rational being could will to be a universal law: The rational counselor would want to be treated in the same manner were he or she in the client's circumstances, and therefore the counselor could not will that the client be treated otherwise without contradicting his or her own will. Similarly, the counselor should not threaten or attempt to coerce the client into disclosing the information, for that would not be to obtain the freely given kind of consent entailed by rational autonomy or universalizability.

While a counselor must promote the client's self-disclosure, it should be borne in mind that, from a utilitarian perspective, it can be counterproductive for a counselor to permit "too long" of a duration before disclosure is made to the third party. The longer the third party remains uninformed, the greater becomes his or her chances of contracting the disease. While it is not feasible to set inflexible temporal limits within which disclosure must be made, a counselor should recognize an obligation to make disclosure, where indicated, in a timely fashion.

If after a reasonable amount of time the client has not informed the third party, the counselor should inform the client of his or her intention to do so. That the counselor should speak candidly with the client rather than "going behind the client's back" follows from the Kantian requirement not to treat clients as mere means. Moreover, informing the third party without first informing the client could hardly be universalized because a rational being would, presumably, want to be informed.

A counselor must be selective about *who* receives the confidential information and must take due care to see that the information is disclosed only to the party at risk or to the legal guardian (in the case of minors). This proviso can be justified on both utilitarian and Kantian grounds. First, on Kantian grounds, it has been argued that the Kantian warrant for keeping the information in question confidential is weak in those cases where disclosing the confidential information prevents the client's treatment of a third party as a mere means. But a disclosure to a third party that does not (efficiently) serve this purpose cannot have any value from a Kantian perspective, and, for practical purposes, it is thus a disclosure that violates a strong Kantian warrant.

Second, on Kantian grounds, it is arguable that for each additional party to whom the confidential information is disclosed, there corresponds an additional violation of the Kantian trust, thereby multiplying Kantian wrongs. For example, a person who discloses confidential information about another to just one person who might have some interest in the information might still be condemned on Kantian grounds; but the gossiper who tells almost everybody he or she knows might be thought so much the worse from a Kantian perspective.

Third, on utilitarian grounds, the quantity of net expectable utility can be substantially diminished by disclosures, especially indiscriminate ones. In the case of AIDS, the potential for prejudice is great (Kain, 1988). For example, a client could thereby suffer the loss of a job, housing discrimination, or the alienation of coworkers, friends, family, and other persons.

Moreover, the obligation to disclose confidential information to third parties when they are at serious risk for contracting AIDS must be limited to *specific* information and should not be construed as giving the counselor *carte blanche* to disclose just *any* confidential information that might be even remotely related. Treating a third party as an autonomous, rational agent, however, would appear to require that the counselor inform the third party *not merely* that the client (probably) has AIDS but *also* of the grounds on which this judgment rests. That is, the information conveyed should include some general statement respecting the medical evidence that exists (or which the counselor has good reason to think exists). It does not seem feasible that such information include details such as physicians' names and addresses, due to the confidential nature of medical records. Such medical information (e.g., test results) thus could only be imparted in a very general form.

From a utilitarian perspective, this should suffice: The third party has been alerted. From a Kantian perspective, the third party has reason on which to exercise rational autonomy. The disclosure of any further information would be unnecessary, if not objectionable, from both utilitarian and Kantian perspectives. (Of course, this general disclosure assumes the disclosure of certain background information, specifically, that the client has been in counseling with the counselor making the disclosure.)

Finally, a counselor has an obligation to make his or her professional services available to third parties at risk upon their being informed of the HIV-positive status of their sexual partners, or, if for some (plausible) reason this is not possible, to provide an appropriate referral. This obligation is also founded on both utilitarian and Kantian principles.

First, net expectable utility can be increased by minimizing the quantity of expectable *dis*utility produced by the disclosure. By making counseling services as accessible as possible to affected third parties, counselors can increase the chances that these individuals will successfully "work through" their problems.

Second, a rational counselor could not accept a universal law in which counseling services are *not* made as accessible as possible to affected third parties, since the counselor himself or herself would not wish to be abandoned to such a precarious situation. There is, therefore, both substantial Kantian and utilitarian warrants for counselors offering their counseling services to affected third parties after disclosure.

The foregoing ethical analysis is intended to provide the ethical foundations of a model rule concerning the professional limits of confidentiality in cases where clients have a contagious and fatal disease such as AIDS. In light of this analysis, the following rule is suggested:

A Model Rule Concerning the Limits of Confidentiality in Cases Where Clients Have a Contagious and Fatal Disease

(A) A counselor who receives confidential information from a client suggesting that the client may have a disease commonly known to be both communicable and fatal must disclose (pertinent) information to a (relevant) third party(ies) if, and only if, the counselor has a reasonable belief, or should have a reasonable relief, that

1. there is medical evidence (e.g., a lab report) establishing with a high probability that the client does, in fact, have the disease
2. the client bears a specific relation (e.g., a sexual relation) to a third party(ies) that, on the basis of current medical authority, places the third party(ies) at high risk of contracting the disease from the client
3. the client has not already informed the third party(ies) about his or her disease nor is the client likely to make such disclosure, in any timely fashion, in the future

(B) In cases in which the above-mentioned conditions, (A) 1–3 are satisfied, the counselor's general obligation to make disclosure to a third party is defined by the following more specific obligations:

1. within the counseling context, prior to disclosing the confidential communication, the counselor must make all reasonable efforts to educate the client about the disease and to provide the client with the support, understanding, encouragement, and opportunity (consistent with professional standards) conducive to the client's making the disclosure of the information to the affected party on his or her own
2. the counselor must make third party disclosure in a timely fashion so as not to defeat the very purposes for which disclosure is made
3. prior to disclosing the information, the counselor must inform the client of his or her intention to do so
4. the counselor must disclose the information only to the party(ies) at risk or to the legal guardian(s) (in the case of minors)
5. the counselor must limit third party disclosure to general medical information regarding the client's disease
6. the counselor must, in earnest, communicate to the party(ies) at risk a willingness to provide support in the form of counseling or to provide an appropriate referral

One utilitarian objection likely to be raised against the preceding rule is as follows: Although disclosure in *some* cases might arguably produce

maximal net utility, it is unlikely that a *rule* requiring disclosure to third parties in the class of cases in question will produce maximal net expectable utility. The reason for this is that if such a rule were recognized and generally upheld, many prospective clients who had AIDS would either not enter counseling at all or else would withhold the relevant information from their counselors. Consequently, there would be substantial reduction in net expectable utility due to those who might otherwise have benefited, or benefited more, from counseling. Moreover, counselors would then have lost the opportunity to facilitate the client's *own* disclosure to third parties, the latter itself affecting a significant reduction in net expectable utility.

The above objection has merit as a utilitarian argument, but it does not appear to be overriding from a broader ethical perspective. First, it is incumbent on those who argue this way to produce *empirical evidence* that the proposed exception to confidentiality is likely to deter clients who have AIDS from seeking counseling. After all, clients who have AIDS may not respond precisely in the same manner as those who are not afflicted with such a fatal illness. But, more importantly, even if a confidentiality rule that does *not* permit disclosure could in fact be expected to produce greater net utility, it would do so at the expense of those who unwittingly continue their sexual involvement with clients who have AIDS while both client and counselor (wittingly) say nothing. In Kantian terms the gain in net expectable utility from such a rule of nondisclosure would only be purchased at the expense of treating the latter third parties as mere means to the production of utility rather than as ends in themselves.

It might be reiterated, of course, that counselors' disclosures of confidential information to third parties also treat the clients as means to advancing utilitarian interests. However, the clients who are said to be treated as means are themselves violating Kantian principles by virtue of treating third parties as means. On the other hand, the third parties cannot be presumed to be guilty of any analogous Kantian transgression.

Conclusion and Summary

In this article a model rule has been proposed for limiting confidentiality in cases where clients have a contagious and fatal disease such as AIDS and where serious risk to third parties is involved. It has been argued that where the terms of this rule are satisfied, the counselor incurs a moral obligation to disclose the confidential information to the relevant third party. This obligation is founded on the following considerations. First, in the class of cases in question, there can exist only a weak Kantian justification for keeping the information confidential. Second, the net expectable utility arising from disclosing the information in accordance with the terms of the rule is substantial and overriding. Finally, the counselor who complies with the rule otherwise acts with utmost regard for the rational autonomy of the client.

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Discussion Questions

1. According to Cohen, what is the moral justification for the counselor's general obligation to maintain confidentiality?

2. Why does Cohen argue that there can exist only a weak Kantian justification for keeping information confidential?
3. How, exactly, does Cohen apply utilitarianism to this issue? Do you agree with his analysis?
4. Can a legitimate comparison be made between the ethical issue of whistleblowing (see Mike Martin's article in Chapter 6) and the ethical issue of client counseling? (Is the issue in counseling whether to "blow the whistle" on one's patient in order to serve the "public interest"?)
5. An analysis using virtue ethics would take into account the virtue of loyalty, and one might suggest that practicing the virtue of loyalty means always protecting the client's confidential information. How might one use a virtue ethics approach to respond to this line of reasoning?

Nonsexual Multiple Relationships

KENNETH S. POPE AND MELBA J.T. VASQUEZ

DUAL RELATIONSHIPS are relatively easy to define; they are much more difficult for many of us to recognize in our practice. A dual relationship in psychotherapy occurs when the therapist is in another, significantly different relationship with one of his or her patients. Most commonly, the second role is social, financial, or professional.

In some cases, one relationship follows the other. The mere fact that the two roles are apparently sequential rather than clearly concurrent does not, in and of itself, mean that the two relationships do not constitute a dual relationship. Most of the important relationships in our lives have at least some sort of carry-over. Thus a therapist would avoid treating her ex-husband even though they were divorced and the marriage was clearly over.

In part it may be the relative simplicity and abstraction of the definition that lulls many of us into ignoring the diverse ways, many of them exceptionally subtle, that dual relationships occur in psychotherapy, sometimes with potentially devastating results. Specific examples, more than abstract definitions, may provide us with a useful awareness of how these entanglements occur. The following three fictional scenarios, dismayingly typical of actual practice, illustrate nonsexual dual relationships. . . .

Helping as a Friend Rosa, an attorney, is going through one of the worst times in her life. For several weeks, she had been experiencing mild abdominal discomfort and had dismissed it as a muscle strained while jogging or nervousness about the case she was preparing to argue in her first appearance before the state supreme court. The pains become worse and she manages to drive herself to the emergency room. A rather brusque medical resident informs her that he has located a large lump on her ovary. He advises her to make an appointment to undergo extensive tests to determine the nature of the lump, which may be cancerous. Rosa is terrified. The tests are scheduled for two days from now. She has to cope not

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only with the pain but also with the uncertainty of what the physicians will discover. She goes immediately to the house of her best friend, June, a psychotherapist. June suggests showing Rosa some self-hypnotic and imagery techniques that might help her cope with her pain and anxiety. As June leads her through the exercises, Rosa begins to feel relieved and comforted. However, when she tries to use the techniques by herself, she experiences no effects at all. June agrees to lead her through the hypnotic and imagery exercises two or three times a day until the medical crisis is resolved. During the fourth meeting, spontaneous images that are quite troubling begin occurring. Rosa starts talking about them and feels they are related to things that happened to her as a little child. She discusses them in detail with June, and by the end of the sixth session, June recognizes that an intense transference has developed. She encourages Rosa to consult another therapist but Rosa refuses, saying that there is no one else she could trust with these matters and that terminating the sessions would make her feel so betrayed and abandoned that she fears she would take her own life.

The Opportunity Bill has just opened a private practice office and has exactly two patients. One of them, Mr. Lightfoot, is an extremely successful investment analyst who is grateful to Bill for all the benefits he is getting from psychotherapy. The worst of Mr. Lightfoot's depression seems to be in remission, and he is now focusing on his relationships to those whose financial matters he handles. Bill, who genuinely likes Mr. Lightfoot, finds himself especially attentive when his patient talks about new investment opportunities. Unexpectedly, Mr. Lightfoot says that Bill might make a great deal of money if he invests in a certain project that is now being planned. The more Bill thinks about it, the more this seems like a terrific opportunity. It will help Mr. Lightfoot's sense of self-esteem because he will be in the position of helping Bill rather than always receiving help from him. It will not cost Mr. Lightfoot anything. Finally, it may allow Bill to survive in private practice and thus enable him to continue to help others. (Bill's overhead was greater than expected, the anticipated referrals were just not materializing, and he was down to his last $10,000 in savings, which would not last long given his office rent and other expenses.) He decides to give his savings to Mr. Lightfoot to invest for him.

Employee Benefits Dr. Ali is a successful psychotherapist who now owns and manages his own mental health clinic. Lately, he has noticed that his normally outstanding secretary, Mr. Miller, has been making numerous mistakes, some of them resulting in considerable financial losses for the clinic. Dr. Ali's customary toleration, encouragement, and nonjudgmental pointing out of the errors have not improved his secretary's performance. He decides that a serious and frank discussion of the situation is necessary. When he begins talking with his secretary about the deteriorating performance, Mr. Miller begins telling him about some personal and financial stresses that he has been encountering that make it difficult for him to attend to his work. Dr. Ali is aware that his secretary cannot afford therapy and that the chances of hiring a new secretary with anywhere near Mr. Miller's previous level of skills is at best a long shot. Even if a good secretary could be found in what is a cutthroat job market, there would be a long period of orientation and training during which Dr. Ali anticipates he would continue to lose revenue. He decides that the only course of action that makes sense, and that creatively solves all problems, is for Dr. Ali to take on Mr. Miller as a patient for two or three hours each week until Mr. Miller has a chance to work through his problems. Mr. Miller could continue to work as secretary and would not be charged for the therapy sessions. Dr. Ali would provide them without charge as part of a creative and generous "employee benefit."

Problems with Dual Relationships

As these fictional scenarios illustrate and as the clinical and research literature have discussed, dual relationships can jeopardize professional judgment, clients' welfare, and the process of therapy itself. Some of the major difficulties with dual relationships follow.

First, the dual relationship can erode and distort the professional nature of the therapeutic relationship, which is secured within a reliable set of boundaries upon which both therapist and patient can depend. When the therapist is also the patient's lover, landlord, best friend, or employer,

the crucial professional nature of the therapeutic relationship is compromised. Note that terming the therapeutic relationship "professional" in no way implies that it is or needs to be cold, distant, unfeeling, uncaring, or otherwise stereotypical of the worst professionals.

Second, dual relationships can create conflicts of interest and thus compromise the disinterest (*not* lack of interest) necessary for sound professional judgment. The therapist as professional professes to place the interests of the patient foremost (except in those rare instances in which to do so would place third parties at unacceptable risk for harm). But if the therapist allows another relationship to occur, the therapist creates a second set of interests to which he or she will be subject. Thus the therapist who is treating a friend may be reluctant to allow the patient to explore options that may upset the therapist's social network; additionally, the patient may be afraid to explore such options. The therapist who is treating a patient in exchange for some services may find himself or herself manipulating or otherwise influencing the patient to provide better services or might become so critical of the patient's seemingly poor services that the therapeutic process becomes destructive for the patient. In dual relationships, the therapist is engaged in meeting his or her own needs (for example, sexual or social).

Third, dual relationships can affect the cognitive processes that research has shown to play a role in the beneficial effects of therapy and that help the patient to maintain the benefits of therapy after termination.

Fourth, because of the therapist-patient relationship, the patient cannot enter into a business or other secondary relationship with the therapist on equal footing. One aspect of the power differential is as follows. When we believe we have been wronged by, say, our plumber or next-door neighbor, we can attempt various methods to resolve the difficulty and, if those methods are unsuccessful, we can take the matter to court. But the patient who feels seriously wronged in a business, financial, or social transaction with his or her therapist faces troubling obstacles in seeking legal redress. The therapist can use the secrets and intensely private material about the patient that the therapist became aware of during the psychotherapy in planning the most effective defense. Further, therapists may use a variety of false diagnostic labels by which to discredit the patient, a practice that is unfortunately common.

Fifth, if it became acceptable practice for therapists to engage in dual financial, social, and professional relationships with their patients, whether prior or subsequent to termination, the nature of psychotherapy would be drastically changed. Psychotherapists could begin using their practices to screen their patients for each patient's likelihood of meeting—either during therapy or some time after termination—the therapists' social, sexual, financial, or professional needs or desires. The lonely therapist could look for patients with whom he or she might like to socialize after termination. The therapist who wanted a second (or subsequent) career in the film industry could keep an eye out for a famous but troubled screenwriter with whom the therapist could collaborate on scripts, either as part of the process of therapy or after waiting a suitable time after termination of therapy. Therapists could use their practices as a dating service, looking for prospective dates or mates (the therapist being in an exceptionally good position to learn about the prospect before actually asking them out after termination). If dual relationships were acceptable, patients also would learn that therapists were available for extratherapeutic possibilities (perhaps after termination) and could alter their behavior accordingly.

Sixth, both during the course of therapy and at any time after, the therapist may be invited or compelled (through subpoena or court order) to offer testimony regarding the patient's diagnosis, treatment, or prognosis. Such testimony may be crucial to the patient in personal injury suits, custody hearings, criminal trials, and other judicial proceedings. If the therapist was also the business partner, live-in lover, or "we frequently share vacations together" type of friend, the objectivity, reliability, and integrity of the testimony as well as the information and documents reflecting the therapy (such as chart notes and insurance form diagnoses) become suspect.

Seventh, Pipes (1997), in discussing post-termination nonsexual dual relationships, notes the formal complaints that may arise.

> Finally, from a more pragmatic perspective, there are often legal reasons for avoiding post-therapy nonsexual relationships. Because state

boards vary in their interpretation of ethical standards, and because legal statutes vary from state to state, it is clear that the safest approach to post-therapy relationships is to use caution and discretion when contemplating entering one. Following a survey of state association ethics committees and state licensing boards, Gottlieb et al. (1988) noted: "One psychologist was considered in violation for an affair that began 4 years after termination. It is now quite clear that SBs [state boards] are deciding that a psychologist may be held liable for his or her actions long after terminating a therapeutic relationship and that in such matters the therapeutic relationship may be assumed to never end" (p. 461). Despite the external constraints imposed on the behavior of psychologists by legal and regulatory bodies such as state boards, and whatever the view of the APA Ethics Committee, it is the responsibility of each psychologist to consider carefully what duty is owed former clients and what behaviors on the part of the psychologist adequately (and preferably, best) represent ethical obligations to former clients [p. 35].

Explicit Standards and Mechanisms of Accountability

Dual relationships form the major basis of licensing disciplinary actions, financial losses in malpractice suits involving psychologists, and ethics complaints against psychologists. Vested with statutory authority to protect consumers from harm or abuse by therapists, licensing boards originally addressed dual relationships by focusing mainly on allegations of sexual dual relationships. In the past two decades, however, state licensing boards have addressed more vigorously—in words and actions—the issue of nonsexual dual relationships, particularly bartering of professional services. For example, the California licensing boards distributed to all licensed therapists in the state a pamphlet emphasizing that "hiring a client to do work for the therapist, or bartering goods or services to pay for therapy" constituted "inappropriate behavior and misuse of power" (California Department of Consumer Affairs, 1990, p. 3). The APA ethics code states that "psychologists ordinarily refrain from accepting goods, services, or other nonmonetary remuneration from patients or clients in return for psychological services because such arrangements create inherent potential for conflicts, exploitation, and distortion of the professional relationship. A psychologist may participate in bartering *only* [only is underlined in original] if (1) it is not clinically contraindicated, *and* [and is underlined in the original] (2) the relationship is not exploitative." Similarly, some licensing boards have imposed periods of suspension and additional terms following investigations of allegations concerning nonsexual dual relationships. Licensing boards' attention to such cases may parallel the APA's highlighting of nonsexual dual relationship ethics cases (1987a, pp. 79–85), the formal resolutions of which were intended by the association (p. vii) to serve as precedents for national, state, and local ethics committees of psychologists (see also Ethics Committee of the APA, 1988b).

Strategies of Toleration and Justification

If both sexual and nonsexual dual relationships have historically been viewed by the mental health professions as harmful, what strategies enable us to tolerate or justify them? Any answer, at least at this stage, can only be speculative, but such speculation may help generate research hypotheses and prompt more thoughtful consideration of any temptations we may feel to engage in harmful dual relationships with our patients. Perhaps part of the answer lies in the consistent research finding that for not only sexual but also nonsexual dual relationships in therapy (as well as for dual relationships in teaching, supervision, and administration), the perpetrators are overwhelmingly (but not exclusively) male and the victims are overwhelmingly (but not exclusively) female. Reflecting the larger society, the mental health professions unfortunately seem exceptionally resourceful in finding ways to deny, justify, trivialize, and discount forms of serious harm for which the perpetrators are mostly men and the victims are mostly women. Perhaps another part of the answer lies in some of the strategies outlined below.

SELECTIVE INATTENTION

One of the most prevalent ways in which dual relationships—and many other forms of unethical behavior—are made tolerable is through selective

inattention. The therapist blocks out sustained, useful awareness of the duality of relationships by splitting the two relationships and refusing to acknowledge that both relationships involve the same patient and have implications for the patient and the patient's treatment.

Selective inattention is a more advanced version of carelessness or negligence, and all of us who have maintained a clinical practice have probably engaged in it in one form or another. For example, we may have been treating a patient and have found ourselves becoming terribly drowsy or bored during a session. Such feelings may have important implications for the treatment of that patient and may represent an evolving countertransference reaction. However, attending to such feelings may make us uncomfortable and we may choose to treat them carelessly, trying to ease or shove them out of our awareness and to split off any remaining awareness we have of those feelings from our considerations about this particular patient and the treatment. As another example, we may work in a hospital and find ourselves talking with other treatment and clerical staff about patients over lunch in the hospital cafeteria. At the end of the day, were anyone to ask us, we would deny having breached any patient's confidentiality, having blocked off awareness that chatting about patients in an informal public setting, such as a hospital cafeteria, violates our responsibilities to safeguard the privacy of our patients and their treatment.

One indication that selective inattention may have played a role in the development of a dual relationship is the lack of any mention of a second relationship in the treatment notes. Thus anyone reviewing the patient's chart would be completely unaware that the therapist has formed a business partnership with the patient, has borrowed next month's rent from the patient, or has moved into the same house with the patient. The chart contains no mention of the duality of the relationship, no consideration of how the two relationships may be interacting, and no discussion of how the dual relationship may affect the patient's clinical status, prognosis, treatment plan, or response to the treatment plan. The form for informed consent to treatment will also lack any information regarding how the dual relationship may affect the treatment.

Selective inattention may foster dual relationships in another manner. Often the colleagues of a therapist who is entering a dual relationship may choose to screen out and remain selectively inattentive to evidence that the therapist is engaging in activities that put the patient at risk for harm. Again, such selective inattention regarding some of our closest colleagues is common to virtually all of us who practice as clinicians. At times, we may not want to risk losing a friendship; we fear that the warmth of our relationship with a colleague who is engaging in a harmful dual relationship with a patient might disappear, perhaps permanently. At times, we may fear the anger or the power of our colleague. Perhaps she is our employer or supervisor; perhaps he is a valuable source of referrals. At times, we may not want to rock the boat and upset the tranquility of a formal organization, such as a clinic, or an informal network of colleagues. And at times, we may experience the "glass house" phenomenon: We may avoid raising ethical issues with others because we are afraid that they will begin raising them with us. Thus we may enter into a tacit pact with our colleagues: Everyone will ignore everyone else's ethical violations. In such situations, selective inattention becomes an important aspect of the interpersonal or social ecology. When selective inattention becomes the norm, any attempt to overcome the splitting off of awareness must overcome the tendency of the interpersonal or social system to maintain homeostasis. The accumulated resistance to acknowledging the duality of the treatment relationship becomes quite powerful.

BENEFITS

A second way in which dual relationships are sometimes justified is that they are beneficial for the patient. When the initial malpractice suits alleging sexual dual relationships were tried, defendants frequently stressed that the sexual relationship was an important component of the treatment plan. The addition of the sexual relationship was said to provide the patient with a more nurturing, less coldly professional relationship; a more complete sense of acceptance; a way for the patient to experience and work through "overt transference"; and a safe "bridge" between the therapeutic and nontherapeutic environment (that is, the patient could "try out" on the therapist what the patient had discovered about sex and intimacy during the early stages of therapy so that the

patient could be sure of making it work "in real life"). The sexual relationship was also claimed to help the patient develop—under the watchful eye of the therapist—a healthier view of his or her own sexuality and a more varied and complete array of sexual responses; to provide sexually corrective experiences that would help the patient recover from dysfunction caused by prior sexual trauma; and to give the opportunity to overcome a disabling "mind-body" split in which the patient's reactions were overly intellectualized.

One difficulty the proponents of this view experienced was that mention of the dual relationship—supposedly a key component of the treatment plan—was often absent from any part of the chart notes or informed consent procedures. Therapists had difficulty explaining why, if they had carefully considered how a dual relationship was the treatment of choice and had implemented it carefully, they had neglected to obtain the patient's informed consent for the procedure and why they failed to note the consideration or use of the treatment strategy in the chart notes.

A second problem faced by those who sought to justify their behavior to the civil courts, licensing boards, and ethics committees was their difficulty finding substantial research evidence that implementing dual-relationship treatment was a safe and effective way to produce positive therapeutic change. Such research was exceedingly rare. Perhaps the most frequently cited exception was the study of 1,500 cases of therapist-patient sexual intimacy, each supposedly benefiting the patient, reported by McCartney (1966). McCartney maintained that engaging in sexual dual relationships must be done in an exceptionally careful manner with scrupulous attention to all ethical aspects, an approach that is still frequently echoed today by those who would defend sexual or nonsexual dual relationships. The therapist, for example, must be certain that he or she is free from any self-serving or self-interested motives. In all cases the patient's welfare must be protected. McCartney's approach and the conclusions he drew from the 1,500 patients, however, were not persuasive to most therapists, or to most courts, licensing boards, or ethics committees.

Some therapists acknowledged that there was virtually no research evidence or other systematic data supporting the hypothesis that dual relationships are a safe and effective method to produce therapeutic change. They maintained that their implementation of the dual relationship was on a trial basis, as part of a research or quasi-research effort to obtain just such evidence. However, it was often difficult for these therapists to establish that they had provided adequate procedural safeguards (such as informed consent) to the patients on whom this experimental method was being tested.

PREVALENCE

Therapists may attempt to justify engaging in dual relationships with their patients by asserting that many other therapists engage in the practice. In some instances, this assertion is carelessly made and seems little more than the frequent claim of those in the public eye who cannot find other means to justify less-than-savory behavior: "Everybody does it!" But in other cases, it is a carefully crafted and articulated attempt to establish the legitimacy and acceptability of a behavior because at least a "sizable minority" of the professional community engage in it. Such a defense is often effective in malpractice trials. The professional does not need to establish that the method he or she used is generally accepted by peers but only to show that a sizable or "respectable" minority endorse the procedure. This approach was used in some of the early malpractice trials in which therapists who acknowledged engaging in sexual dual relationships with their patients emphasized that the early surveys of therapist-patient sexual involvement indicated that around 10 percent of male therapists reported engaging in sexual relationships with their patients. This 10 percent figure, according to the defense, represented a sizable minority of the professional community who accepted and endorsed, via their own behavior with patients, the legitimacy of therapist-patient sexual relations.

The reflexive acceptance of the "prevalence" argument may have encouraged or facilitated both sexual and nonsexual dual relationships. But the argument itself does not seem to address the issue of whether dual relationships are indeed a safe and effective way to produce beneficial change in the patient. Various behaviors that may be unethical, illegal, or clinically contraindicated may unfortunately be practiced, from time to time, by a sizable

minority and sometimes even a majority of the professional community. National surveys of therapists have indicated, for example, that over 20 percent of the participants have rendered clinical services for which they (by their own judgment) were clearly incompetent, over 20 percent intentionally breached their patient's legal right to confidentiality, a majority performed clinical work when they were so distressed that they were unable to function effectively, and a majority breached their patient's legal right to confidentiality through negligence. The fact that a substantial number of professionals engage in a practice does not, in and of itself, indicate whether the practice is ethical, legal, safe, or effective.

TRADITION

Some dual relationships are created through an exchange of services. For example, the therapist provides psychotherapy to the patient; in exchange, the patient does typing and filing for the therapist, creates a painting to decorate the therapist's waiting room, or provides child care for the therapist's sons and daughters. Therapists who develop this kind of dual relationship with their patients often assume that the practice is ethical and not harmful because bartering has a rich historical tradition.

The problem for this justification is that the tradition of service bartering in early American life and culture did not include psychotherapy. Attempts to assert that psychotherapy is functionally equivalent to those services that have traditionally been the subject of bartering ignore the context. Nearly any practice such as bartering may be not only sensible and safe but also socially beneficial in certain forms of exchange and may indicate no harm or risks in the abstract. In virtually all cases, however, the context is crucial. Thus the tradition of giving gifts may be a wonderful one; giving an expensive gift to a judge who is trying a case in which one is a principal participant is frowned upon. The tradition of passionate sexual relationships may be treasured by many; such relationships, when they involve therapist and patient, can be disastrous. The professional or psychotherapeutic context cannot be ignored.

CLIENT AUTONOMY

Sexual and nonsexual dual relationships are often rationalized by reflexively asserting the concept of "client autonomy." This concept becomes a cloak for unethical behavior; it appears to refer to a client's right that is so fundamental, absolute, and unquestionable that no other consideration could possibly intervene.

The basic premise is that if the client desires a sexual or nonsexual dual relationship with a therapist, whether before or after termination, the therapist has no right—let alone responsibility—to refuse because to do so would interfere with the client's autonomy. Thus ethical, professional, and similar prohibitions against harmful behaviors must be set aside, according to this argument, if they threaten the fundamental value of client autonomy.

Such arguments tend to appear merely as assertions, rather than in the context of coherent ethical and clinical theory. But perhaps most striking is their proponents' failure to apply the concept to other areas of practice. For example, for a nonmedical therapist (one neither trained nor licensed to prescribe medication) to provide drugs to a client would put that client at risk. Yet what if a client begged his or her nonmedical therapist to personally provide drugs? An ethical therapist would respectfully but firmly decline, explaining the reasons for declining and exploring options such as referral to a physician. An ethical nonmedical therapist would not invoke the concept of the client's inviolable autonomy as a rationalization to provide the client with drugs. As another example, if a client or former client wanted to take up residence in the therapist's waiting room, the therapist would not agree to such an arrangement to avoid interfering with the client's autonomy.

Proponents' inconsistent use of the concept of client autonomy (or other superficial rationalizations such as "right to assemble") reveals the degree to which the actual meaning of this concept has been taken out of context and misused in service of the therapist's desire to engage in sex (or in some other dual relationship) with someone to whom he or she has agreed to provide professional services.

NECESSITY

Dual relationships may be accepted with virtually no ethical or clinical scrutiny when they are asserted to be "necessary." The therapist claims that there was no alternative but to engage in a

dual relationship. The therapist using this justification refuses to accept any responsibility for entering a dual relationship; the therapist must simply accept what is determined by forces beyond his or her control. Thus dual relationships may be termed "inevitable" or "unavoidable."

Yet the "my hands were tied" approach may represent a combination of a failure to explore and create alternative approaches that meet the highest clinical, legal, and ethical standards and an unsubtle attempt to evade responsibility. Careful, determined, imaginative attempts to meet the needs of patients without resorting to sexual or nonsexual dual relationships can overcome the rationalization of necessity. Michael Enright, for example, discussed the dilemma of therapists in a very small town in which the hospital administration called for a periodic review of all current patients (personal communication, May 13, 1989). The therapists at the hospital were to conduct this review. The problem it presented is obvious: Although they had scrupulously avoided treating patients with whom they had other ongoing (social or business) relationships, the therapists would, by conducting this periodic review of all cases, become aware of diagnostic and treatment issues as well as other "private" information about their friends and business associates. Enright pointed out that among a whole tangle of ethical and clinical issues is that of informed consent: The patients did not understand that their social and business associates would be reviewing their course of treatment, nor had they consented to such a review. Examination of these issues led to the idea that a clinician from a different community could be brought in on a regular basis both to review current cases and to ensure that all patients adequately understood and consented to the review process.

Conclusion

The harm and exploitation that can result from both sexual and nonsexual dual relationships is perpetrated overwhelmingly by male professionals on an overwhelmingly female patient population, a pattern that may have played a role in our difficulty addressing this issue vigorously and effectively. The initial research has led to specific recommendations for education and training (Borys & Pope, 1989), but much remains to be done. The vulnerability of individuals who are seeking help from a therapist and the harm that is done both to the welfare of the patient and to the integrity of the profession when the role of therapist is abused makes it extremely hard to justify further neglect of the issue in our research, writings, and professional efforts to ensure the highest level of ethical and clinical practice.

It is crucial to clarify our relationship to each patient and to avoid sexual and nonsexual dual relationships which prevent that clarity and place the patient at great risk for harm. Achieving that clarity is impossible without adequate awareness and appreciation of cultural, contextual, and individual differences.

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Discussion Questions

1. What, exactly, are nonsexual multiple relationships?
2. Of the seven different problems with dual relationships described by Pope and Vasquez, which ones do you think are most serious?
3. Of the various strategies that counselors use to tolerate or justify dual relationships, which one is most promising? Is it sufficient to allow dual relationships to be permissible, at least in some contexts? Or do you agree with Pope and Vasquez that even the most promising strategy is inadequate?
4. Develop an example of a dual relationship in counseling that one might argue is ethically permissible. Use a moral theory (or moral theories) for justification. How would Pope and Vasquez criticize the relationship in your example? Would you agree with that criticism?

Lying and Deception in Counseling

RONALD H. STEIN

Definitions

One of the most fundamental ethical principles of an effective counselor-client relationship is veracity; the relationship builds upon an ethical bond of honesty, integrity, candor, and truthfulness. As a general rule, the relationship is seriously undermined when either of the parties engages in deception or lying.

Bok (1978) defines a lie as "any intentionally deceptive message which is stated" (p. 13). A lie may be either spoken or written. Regardless of the form it takes, there must be a clear intent by the author to deceive the person receiving the information. This form of lying is termed a "lie of commission" because an affirmative act has been committed. I will argue that there is another form of lying called the "lie of omission." This lie occurs when the counselor deliberately allows another person to believe that information is true when in fact the counselor knows it to be false. Intentionally allowing a client to believe something that the counselor knows to be false, and not bringing this fact to the client's attention, is as much a deliberate act of deception as a lie of commission.

Deception is a much broader category because it involves both intentionally deceptive statements and deceptive acts. Synonyms for deception include double-dealing, trickery, subterfuge, and fraud.

Reasons for Lying and Deception

Why do people lie and practice deception? The most common reason given is that those who lie are really performing an act of kindness. Consider the following case: You are a seventeen-year veteran counselor in an agency that serves infants and children who suffer from severe multiple physical handicaps. Two months ago the Smedleys registered their nine-month-old son, Bobby, on the advice and recommendation of a pediatrician. Bobby is the Smedleys' only child. You have had numerous occasions during the past two months to observe Bobby as well as discuss his case on a regular basis with his physical therapist and the agency's consulting pediatrician. All who have

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observed Bobby conclude that not only is he severely physically handicapped but severely mentally retarded as well.

One day the Smedleys come to you and, during casual conversation, they remark that "it is tough to have a handicapped child." They have struggled at great length with the problem, not only between themselves but also with members of their family. The Smedleys have finally come to accept the fact that Bobby is severely physically handicapped. But the one thing they know they could never accept, and "thank God, will never have to accept," is the fact that he would be mentally retarded. They then turn to you in a questioning fashion and say, "Thank God, isn't it wonderful that he is not also mentally retarded."

How do you respond? You appear to have two options. First, confirm the parents' statement that, "yes, it is wonderful that he is not mentally retarded," or second, you could, with great skill, say to them that "we need to talk about this because, based upon our observations and our experience, your son appears to be mentally retarded, though it is too early to tell the extent of it."

You decide to lie to the Smedleys because you think it would be an act of kindness and, in your opinion, in the best interests of your clients. You reached this conclusion for the following reasons: There is probably very little that the Smedleys can do to change the reality that their son is mentally retarded; therefore, living a little longer with this myth would not do any harm and certainly would not affect the development of the child. In fact, it may be good for the Smedleys to have a little longer to adjust to the situation that their baby is not normal and to have an opportunity to develop additional support systems to deal with this fact as well as to address the grief of the family members, which many times develops in situations such as this.

Also, perhaps it is not your job to tell them. Certainly, as the child gets older, it should become more obvious to the parents that their child is mentally retarded and, therefore, the best approach is for them to discover this for themselves. So, with a little luck, you should probably be able to dodge the problem altogether.

It might be argued that this case is similar to the act of kindness that causes one not to tell a dying patient that she is dying. Using similar reasoning, a counselor might decide not to tell a patient she is dying because it would not change the circumstances of her death. Also, it might be in the patient's best interest to let her enjoy her remaining time without being needlessly confused or caused unnecessary pain and suffering (Bok, 1978).

Letters of recommendation written on behalf of students and employees by counselors are often cited as another act of lying out of kindness (Bok, 1978). The reasoning runs something like the following: In this day and age there are only two types of recommendations—good recommendations and great recommendations. Since the system has become so inflated, the counselor feels obligated to compensate by supplying the client with an exaggerated recommendation. The counselor reasons that the lie is justified because he is only acting on the best interests of the student by "leveling the playing field."

Another explanation offered for why people lie is that it prevents harm. The best example of this is lying to an enemy in war. In this instance, the lie is justified because it saves lives and saves the country from some evil, in this case the enemy. For the counselor, there may be an occasion to lie to save a life. For example, a crisis intervention counselor or hotline operator may stretch the bounds of truth when a person calls and threatens suicide. The caller says he will carry out the act unless the counselor gets hold of the individual's parent. The counselor may deceive the caller into believing that the parent is being summoned while stealing precious moments necessary for the police to respond.

Another, less magnanimous reason for lying is to achieve personal gain. The counselor may exaggerate his credentials in a brochure soliciting clients for his consulting business. It is important to note that many times what is represented as a lie for the public good is, in reality, a lie for private gain. In the words of Bok (1978), "We cannot take for granted either the altruism or the good judgment of those who lie to us, no matter how much they intend to benefit us. We have learned that much deceit for private gain masquerades as being in the public interest" (p. 169).

Finally, fear is often given as a justification for lying. For example, a person may lie because he is afraid of what other people may think of him if he told the truth. This explanation is often used to justify exaggerations. Lies are often perpetrated out of fear; the consequences of telling the truth

may be too great. We may lie to escape punishment for doing something wrong, or we may lie to escape involvement in an awkward or unpleasant situation.

Some counselors claim that it is not wrong to lie because they possess a certain professional license that frees them from ordinary moral constraints when they are in the service of clients. In essence, it is all right to lie if it improves the counseling relationship. In the words of a colleague who wished to remain anonymous, "Other professionals regard fabricated disclosures as merely a synthesis of life experiences tailored to a particular situation and, therefore, not deception but a method of enhancing communication in the counseling relationship."

One interesting point about lying and deception is that when the counselor chooses to lie rather than tell the truth, he feels morally obligated to defend his action to himself and/or to others. While the truth needs no defense (Bok, 1978), a lie always needs to be defended as just, right, or proper by providing adequate reasons. The reasons counselors offer for choosing to lie or use deception rather than telling the truth are many and varied. First, since it is the job of the counselor to help the client, the counselor may decide to lie because the falsehood is in the best interest of the client. This is a "means/ends" argument, where the lie (the means) becomes justified by the result (the end) it creates. For example, a counselor might argue that he was justified in lying to a client if to do so helped the client deal with a problem or was in keeping with the counselor's higher obligation to protect the client's rights; for example, in protecting the client's right to confidentiality. Certainly we can think of cases where such justification is valid, such as in instances where a lie saves a life.

However, all too often this justification is used in cases where it is not clear that the end would not have resulted without the lie, or where the lie actually created more harm than good. Nonetheless, this justification is the most common rationale offered by counselors when confronted with having lied.

Other justifications offered in defense of lying include the argument that the agency or individual would not understand the information or would misuse it if provided; therefore, the counselor is justified in lying or withholding information. A parallel argument offered by counselors is that clients or parents really cannot handle the truth; therefore, the counselor is acting in their best interest (albeit paternalistically) by feeding them information that the counselor believes they can handle, i.e., a lie. Sometimes telling the truth is dismissed by the counselor on the grounds that it really will not do any good; therefore, it does not really matter. Conversely, counselors may justify lying because it does not cause harm. As Bok (1978) points out, it is naive and foolish to believe that lying does not cause harm.

Sometimes a justification for lying is offered on the grounds that the counselor has been forced into the situation. In this instance, we might hear such statements as, "Sure, I lied. What do you expect from me? I didn't want to get involved in the first place." Or, "Sure, I lied, but only because you made me do something that wasn't in my job description." In this justification, the counselor shifts the blame or guilt to the supervisor or colleague since, the counselor argues, it is permissible to lie when one has been mistreated or has had one's rights violated—i.e., as a result of coercion.

Finally, a justification may be offered in the form of using a lie to educate the victim or to get revenge: "It's all right to lie to a liar because he's only getting what he deserves."

The counselor may in fact lie or deceive on behalf of the client. These acts of deception usually take the form of letters of recommendation, reports to other agencies, parents, or reports to students. A counselor may also lie to or deceive his supervisor or employer regarding absenteeism, lack of productivity, or personal problems that affect job performance. Supervisors may lie to or deceive counselors when doing evaluations and in telling the counselor why the supervisor is upset.

The Harm in Lying and Deception

As we have seen, one of the justifications given by a person who lies or deceives is that the lie or deception has not caused any harm. Bok (1978) has identified a number of harms that result from lies and deceit. A lie hurts the liar by reducing the confidence of clients and peers. The counselor who lies fears getting caught. This fear produces vulnerability and could even lead to treachery or

blackmail. Lies hurt, then, because they isolate the liar. A lie biases the counselor's judgment by making it appear as though lying is a viable option for extricating oneself from a tight spot. Eventually, greater risks are taken on the naive assumption that one more lie will remove the danger.

Perhaps the most insidious effect of lying is the freedom it robs from the person on whom the lie is perpetrated. The liar's victims are unable to make choices for themselves according to the most accurate information available. They are unable to act as they would have wanted to act had they known the truth (Bok, 1978). In fact, the lie may cause a client to choose some detrimental course of action, which most probably would not have been chosen had the truth been known (Steininger et al., 1984).

Besides reducing one's range of choices, lying is coercive. It takes power away from the victim and gives it to the liar. Lying enables the perpetrator to manipulate the behavior of his victim. This is an excellent example of the old adage "Knowledge is power."

Finally, lying can undermine and destroy the counseling relationship and ultimately undermine the credibility of the profession of counseling in the public's eye.

It is not my intention to suggest that there are no circumstances in which it would be appropriate for the counselor to lie. Such a statement would be naive and foolish. In fact, Bok (1978) offers a test to determine the circumstances in which it would be appropriate to lie rather than tell the truth.

When considering deception, counselors should ask themselves two questions: (1) Could a truthful alternative to lying be chosen? If so, then counselors should choose to tell the truth rather than lie. Engaging in a lie should be done only as a last resort (Bok, 1978). (2) What moral arguments can be made for and against the choice to lie in the specific situation? Counselors need to consider carefully the justifications put forth in defense of lying. They should ask themselves several important questions: Are these justifications adequate? Are they defensible? Do the arguments in favor of the lie clearly and convincingly outweigh those against the lie?

Finally, the decision to lie should only be made after applying Bok's "Test of Publicity," which requires that counselors ask what the public's reaction would be if society knew that counselors had chosen to lie over telling the truth, given the specific circumstances of some case. In a sense, Bok has suggested a reasonable-man standard to guide counselors in assessing the appropriateness of choosing to lie over telling the truth. If the public would accept and understand the choice to lie rather than tell the truth, then the counselor's decision to lie would be justified. "We must share the perspective of those affected by our choices, and ask how we would react if the lies we are contemplating were told to us. We must, then, adopt the perspective not only of liars but of those lied to; and not only of particular persons but of all those affected by lies—the collective perspective of reasonable persons seen as potentially deceived. We must formulate the excuses and the moral arguments used to defend the lies and ask how they would stand up under the public scrutiny of these reasonable persons" (Bok, 1978, p. 93).

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Discussion Questions

1. Stein identifies two ways of lying. What are they and what is the basic difference?
2. According to Stein, what types of harm is lying to clients likely to cause? Are there any therapeutic reasons for lying?
3. Most moral theories emphasize the importance of honesty. In light of this, how could dishonesty in the counseling profession be justified by, say, virtue ethics, which specifically cites honesty as a virtue? How could dishonesty be justified by Ross's version of deontology, or by Kant's version? (Isn't lying to clients treating them as means and not as ends?)

Cases

Case 8-1

Dr. Lisa Granfield practices counseling with an emphasis on suicide intervention and recovery. While she is sympathetic with the deep sadness her clients feel, Dr. Granfield thinks that there is never a good reason to commit suicide. This commitment even extends to individuals who are terminally ill and suffering nontemporary, intolerable pain. Dr. Granfield believes that any individual who contemplates suicide and takes serious steps toward that goal is incompetent to make his own choices and should be institutionalized.

1. Dr. Granfield's aversion to suicide might put her at odds with her clients who are contemplating it. According to Kupfer and Klatt, what sort of disagreement is this?
2. Can you think of ways that Dr. Granfield can soften her strong aversion to suicide, at least to the point where those contemplating suicide need not be institutionalized? In light of the article by Kupfer and Klatt, does she have an ethical obligation to soften this aversion?
3. In what ways could Dr. Granfield's personal feelings have an effect on the autonomy of her clients? Recalling the article by Salem (in Chapter 7), do you think it is possible for a terminally ill individual to think autonomously about suicide? If so, does Dr. Granfield have an obligation to keep her personal feelings out of counseling sessions with such clients? What would Kupfer and Klatt say?

Case 8-2

Debbie and Jim have celebrated their seventh wedding anniversary. Unfortunately, the last two years have been a bit rocky for their marriage. Jim has been distant, argumentative, and even depressed. Their sex life has also suffered. Debbie feels that Jim, for some reason, has lost interest in her. She sincerely loves Jim and has pleaded with him on numerous occasions to go to counseling. He has been resistant to the idea, but in order to quiet Debbie's complaints, Jim agrees to talk with someone. Like most individuals who go to counseling for the first time, Jim is suspicious and uncooperative during the first few sessions. After a while he begins to open up. The counselor makes it a bit easier for him by assuring him of the strict confidentiality of their conversations. Shortly afterward, however, Jim reveals that he has been involved in an extramarital affair and has contracted a sexually transmitted disease. Additionally, he has not been successfully treated by a health clinic, but he has limited his sexual contact with his wife. The counselor presses Jim about revealing this to his wife, but Jim refuses, claiming it is none of her business what sort of disease he has.

1. Does the counselor have any good moral reasons for holding to the principle of strict confidentiality? Should the counselor inform Jim's wife? What moral theory (or theories) could support your answer?
2. In the light of Cohen's article, what principle of confidentiality should the counselor hold? What moral reasons could support this?
3. Suppose Jim refuses to tell Debbie. On one hand, the values of autonomy and privacy seem to support maintaining confidentiality, while on the other hand the value of health seems to support breaching that confidentiality and informing Debbie. Given this conflict of values, do you think breaching confidentiality is permissible or even required? How might one "weigh" the values against each other?

Case 8-3

Dr. Charles D. Singer has seen this kind of behavior before. Timothy, one of his students, exhibits the classic symptoms of manic depression. Dr. Singer's familiarity comes from his psychiatry practice where he has successfully treated many patients with the same problem. One day, Timothy makes an appointment with Dr. Singer. In their discussion, Timothy reveals his desire for help and pleads with Dr. Singer to take him on as a patient. Timothy makes it clear that he only trusts Dr. Singer and that he will not go to any other doctor that Dr. Singer recommends. Nevertheless, Dr. Singer refuses to help because of the problems with dual relationships.

1. What are the potential problems with Dr. Singer agreeing to accept Timothy as a client? In these circumstances, do the problems justify Dr. Singer's refusal to help? What moral theory (or theories) might support your answer? What would Pope and Vasquez say?
2. The issue of client empowerment could be relevant to the issue of dual relationships. What are some possible connections between the two issues? Are there any relevant connections for this case?
3. What kinds of exceptions to the prohibition of dual relationships can you think of? Do the facts of this case meet the conditions of any of those exceptions? What would Pope and Vasquez say about this?

Case 8-4

When Sara Wilson, a psychologist and hospital social worker, answers her phone, she knows immediately who it is and what she wants. It is her colleague, Dr. Tania Chelsea. Tania is a pediatrician who handles critical care children. One of her patients is dying and she needs Sara's counseling expertise for the parents. Sara has been through this kind of situation before. It is not easy because parents of very sick children often blame themselves for the illness. In her experience, revealing to the parents that their child is dying only makes matters worse. Instead (with Tania's cooperation) Sara sidesteps such questions and focuses instead on the (albeit unlikely) possibility of the discovery of new drugs and the possibility of spontaneous recoveries.

1. In light of your understanding of Stein's article, do the doctors have ethically sound reasons for misleading the parents about their child's condition? What about flat-out lying to them?
2. Do you see lying to parents as a form of empowerment or as a way of diminishing their autonomy? Explain.
3. Does the behavior of Sara and Tania fit one of the models of the physician-patient relationship discussed by the Emanuels in Chapter 7? If so, is it the appropriate model?